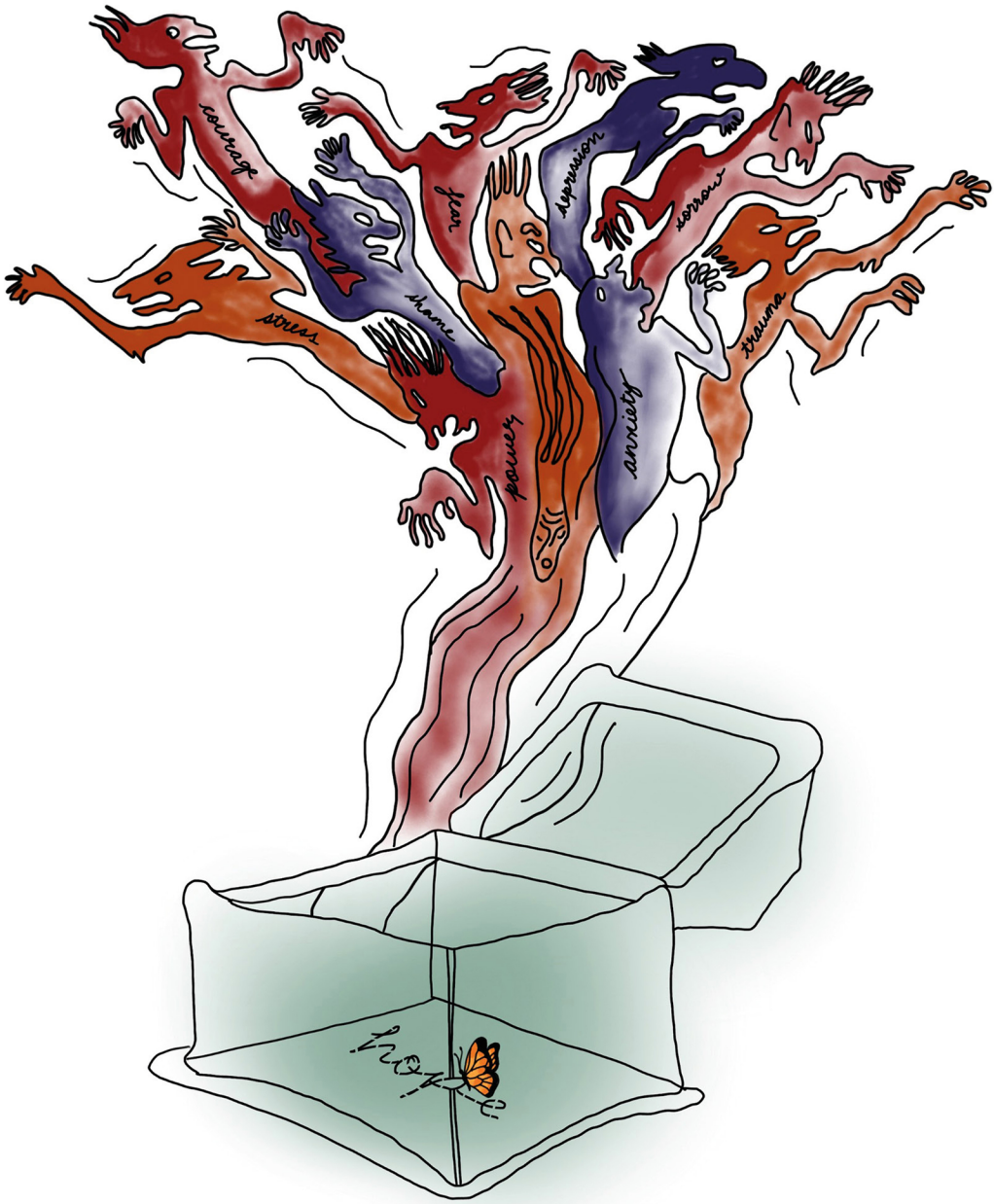


# TALKING ABOUT NON-RECENT CHILD SEXUAL ABUSE

## Survivor, Clinician and Researcher Perspectives

Edited by Daniel Taggart and Joanne Stubley

ROUTLEDGE

# Talking about Non-Recent Child Sexual Abuse

This book addresses the issue of non-recent child sex abuse and its long-term impact on adult survivors from a broadly psychodynamic perspective.

Non-recent CSA is not a subject that can or should be confined to the clinical arena. It has legal, welfare and profound social implications, with its impact broadening out from the survivor to the family to the community and into wider society. The politics of power and oppression are intertwined with the experience and may be unconsciously repeated into adult experiences, often worsened by the interplay of intersectionality and the withdrawal of public services and support for people with complex mental health problems. This book has been developed to support survivors, families, practitioners and the wider public break the social taboo around the topic of child sexual abuse. It unites a broad range of voices to encourage better community support and improve social services to support those impacted.

With an ethical commitment to the field, this book will appeal to clinicians working in mental health but will also hold interest to those in other fields such as the social sciences, as well as the interested public, and CSA survivors in particular.

**Dr Daniel Taggart** is a reader in clinical psychology at the University of Essex. He previously worked as the clinical lead for the Truth Project and principal psychologist at the Independent Inquiry into Child Sexual Abuse.

**Dr Joanne Stubley** is a medical psychotherapist and psychoanalyst. She is the lead clinician of the Tavistock Trauma Service and has co-chaired the Royal College of Psychiatrists expert reference group on NRCSA. She is co-author with Linda Young of Complex Trauma: the Tavistock Model which was nominated for a Gravida Award in 2022.

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# Talking about Non-Recent Child Sexual Abuse

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**Edited by Daniel Taggart and Joanne Stubley**

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# Contents

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**Kiki Hassen** is a recently qualified Clinical Psychologist who completed her doctoral thesis on the lived experience of dissociative identity disorder. She has extensive experience working with complex trauma survivors in a variety of settings including forensic, complex needs and health services, many of whom are survivors of Child Sexual Abuse. As a Sri Lankan born migrant to the UK, she is passionate about advocating and increasing awareness of culturally sensitive trauma-informed approaches to meet the needs of survivors from marginalised communities.

**Michael May** works through consultancy, strategic planning and training to equip organisations with skills and insight into better understand experiences of minoritised stakeholders. A former leader in the voluntary and public sectors, he brings a history of management, leadership, psychological training and lived experience to help others better understand and solve issues of Inclusion.

**Maria Podlejska-Eyres** is a consultant psychiatrist in medical psychotherapy and a psychoanalytic psychotherapist. She is a co-chair of the Royal College of Psychiatrists Expert Reference group on non-recent child sexual abuse. She graduated from medical school in Poland in 1991 and has been practicing psychiatry and psychotherapy in the UK since 1997. It is in this work where she met many adult survivors of child sexual abuse and her interest and understanding of their experiences grew. Her passion for language and literature is longstanding and fuelled further by her migration, working in multilingual London and by her experience of being a mother.

**Khadija Rouf** is a consultant clinical psychologist, working with adult survivors of trauma in an NHS service. She has worked in a range of settings across her career, including in primary care, inpatient settings and in community mental health teams. She is an active member of the British Psychological Society (BPS), has previously served as Chair of the Safeguarding Advisory Committee and is one of the authors of the BPS guidelines on Responding to Disclosures of Non Recent Abuse (2023). She is committed to writing, communicating and raising the profile of applied psychology. She has collaborated with many colleagues and has authored a number of chapters, articles and self-help materials. She brings expertise to her work which is informed by both professional training and lived experience. She is committed to working with victims and survivors to highlight areas of unmapped experience, aiming to prevent abuse and to working collaboratively to improve the rights of victims and survivors to access help to heal.

**Laura Salter** is a social worker and psychoanalytic psychotherapist with over thirty years' experience of working in mental health services in the NHS

with both children and adults. More recently, she worked as a psychotherapist in the non-recent child sexual abuse service within the Tavistock Trauma Unit, providing individual and group psychotherapy. She is now a senior lecturer within the Tavistock, and the course lead for the online training "Disclosure: Supporting the Adult Survivor of Child sexual abuse", as well as working in private practice.

**Maggie Schaedel** has worked for many years in joint NHS and university settings. As Lead Consultant Psychoanalytic Psychotherapist in a NHS Trust in South London, she founded and developed *The Woman's Service*, a unique, award-winning NHS specialist psychotherapy service for adult survivors of child sexual abuse.

Alongside this role and as lecturer in psychoanalytic psychotherapy at the University of Kent she developed and taught on clinical training programmes in psychoanalytic psychotherapy with a special interest in the clinical applications of the work of D.W. Winnicott.

Maggie has taught and made keynote presentations in a range of settings, including The Squiggle Foundation, Arbours Association, The Tavistock and various NHS Trusts. In 2019, she received an award for innovative excellence by The British Psychoanalytic Council.

**Sara Scott** is a BCP registered psychotherapist at the Fitzrovia Group Analytic Practice working with individuals, couples and groups. She manages the Non-Recent Child Sexual Abuse Team as part of the Trauma Service at the Tavistock Clinic.

Sara's first training was at Goldsmiths College where she trained as an Art Therapist. She trained at the Institute of Group Analysis and is a Training Group Analyst. She trained as an Individual Psychoanalytic Psychotherapist at the Tavistock Clinic as well as taking courses in organisational consultancy there. She supervises both groups and individual work.

**Valerie Sinason** PhD is a poet, novelist, lecturer, prolific writer and a child psychotherapist (rtd) and adult psychoanalyst who has now retired from ongoing clinical work. She has specialised in trauma and disability for half a century at The Tavistock Clinic, St Georges Hospital Medical School. She has written, edited and co-edited 25 books and several hundred papers and chapters. Founder and now Patron of the Clinic for Dissociative Studies, she is President of the Institute for Psychotherapy and Disability and received the ISSTD Lifetime Achievement Award 2017 and the British Psychoanalytic Council's innovative excellence award.

**Joanne Stubley** is a consultant psychiatrist and psychotherapist at the Tavistock and Portman NHS Trust. She is the lead clinician of the Tavistock Trauma Service, a Fellow of the Royal College of Psychiatrists and a psychoanalyst who has also been trained in trauma-specific modalities of care. She is a co-chair of the Royal College of Psychiatrists Expert Reference Group on non-recent child sexual abuse. She is an honorary lecturer at University

College London and has written widely on trauma, teaching nationally and internationally. She is co-editor of "Complex Trauma: the Tavistock Model" with Linda Young, published in 2022, which was nominated for a Gravida Award.

**Daniel Taggart** is a reader in clinical psychology at the University of Essex, and a chartered psychologist. He worked at the Independent Inquiry into Child Sexual Abuse from 2019–2022 where he was the principal psychologist and clinical lead for the Truth Project. He has worked as an advisor to the Northern Irish Historical Institutional Abuse Redress Scheme, the Scottish Child Abuse Inquiry and Redress Scheme, the Jersey Care Inquiry Citizens Panel and the Mother and Baby, Magdalene Laundry and Workhouse Truth Recovery process in Northern Ireland. His current research is focused on survivor participation in non-recent institutional abuse inquiries, the ways that childhood trauma impacts engagement with public services, and what value survivor testimony has in both facilitating recovery from trauma and creating change in institutional practices.

**William Tantam** is senior lecturer in anthropology at the University of Bristol. He worked as part of the Research team at the Independent Inquiry into Child Sexual Abuse in England and Wales from 2020 to 2021.

**Katie Wright** is an professor of sociology at La Trobe University. Her research focuses on social change, social justice, and the cultural impact of psychological knowledge. She is committed to interdisciplinary research that addresses complex social issues, and is currently leading three research projects related to institutional child abuse: "Reclaiming child rights", an Australian Research Council funded study investigating the history of child rights, advocacy and activism in the domain of institutional child abuse; "Creating Safer Futures", funded by the National Centre for Action on Child Sexual Abuse, focused on raising awareness of child sexual abuse among young adults; and "The Age of Inquiry", a project mapping the rise of institutional child abuse inquiries globally. Recent publications include *Childhood, Youth and Activism* (2024), *Lived Experience Panels Consulting to Inquiries* (2023) and *Examining the Past and Shaping the Future: The Australian Royal Commission into Institutional Responses to Child Sexual Abuse* (2022).

**“This book is dedicated to Michael L and all the survivors who have not had their stories heard”**

# Introduction

*Daniel Taggart and Joanne Stubley*

When Sigmund Freud was working through his relinquishment of the so-called seduction theory which linked presentations of "hysteria" in adults with experiences of childhood sexual abuse, he wrote to his colleague and friend Wilhelm Fleiss in unpublished letters,

> Surely such widespread perversions against children are not very probable.

This letter was then found and quoted by Jeffrey Masson in his 1984 book "The Assault on Truth" in which Masson essentially accuses Freud of cowardice, turning away from the reality of the ubiquity of sexual abuse of children. Whilst the nuance of this question of what emphasis Freud gave to external reality may continue to occupy many psychoanalysts and therapists today, the quotation highlights the powerful wish to turn away from trauma, and particularly from child sexual abuse. Indeed Judith Herman (1992) suggests:

> The ordinary response to atrocities is to banish them from consciousness. (p. 1)

This book joins other voices, urging us not to turn away. It was conceived to give voice to survivors who have experienced silencing, shame and stigma and to acknowledge the urgency and necessity for societal recognition of this form of atrocity. This is inevitably political, in the sense that it concerns matters of import at a societal as well as an individual level.

At the time of the book's conception, two once in a lifetime events were taking place in the United Kingdom – the COVID-19 pandemic and the Independent Inquiry into Child Sexual Abuse. For the two of us, these events were instrumental in a decision to create a small group, subsequently named as "Non-recent child sexual abuse (NRCSA): the network for the promotion of change". The Network brought together survivors, clinicians, academics and researchers (many of whom may hold more than one of these identities) to consider together how to bring the reality of child sexual abuse and its impact

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into the light, to strengthen conversations that would lead to improved recognition, validation, treatment and support for survivors.

And at the heart of our endeavour is a wish to prevent sexual abuse. Two intertwined themes, support for survivors and safeguarding children are often treated as separate. For us, these domains are deeply interconnected with much to learn from one another (Jess chapter).

Many of the chapters in this book have been written by members of this network. The rest have been written by colleagues working in related but distinct areas who we invited to contribute their perspectives and experiences to offer a set of conversations about this most vexing of topics.

NRCSA stands for non-recent child sexual abuse, and this brings the question of the use of language in this area to the fore. In the past when describing adult survivors, the term 'historical' abuse has been used, but this has been challenged in recent years as it fails to capture the reality that for adults who have had this experience, it rarely feels as though it is 'historical', placed in the past, but rather continues to be experienced as though present – in flashbacks, nightmares and intrusive images or bodily sensations – or through its potential ongoing impact on relationships, academic achievements, physical health, occupational security, and so on.

We are highlighting the change in language used in this area as it is an almost inevitable aspect of trauma that symbolic capacities collapse, that the words and language used can be experienced as a concrete repetition of trauma, denial and betrayal (Maria's chapter). There is no one universal survivor experience and whatever words are used may not feel right to some. We have attempted to shift, for example, between survivor, patient and client at different times in the book, steering away from victim which can so easily reinforce the disempowerment at the heart of trauma experience, while also recognising victimhood as a legitimate and necessary framing of these injuries at certain points for many.

We are also aware that trauma as a word has become so overused and ubiquitous that it may serve to diminish the reality of the unbearable attack on personhood which is child sexual abuse. We recognise that many childhood traumas are also unbearable, and indeed may often co-exist, with child sexual abuse. However, we believe there is a necessity in highlighting this particular trauma so that it does not somehow become forgotten, so strong as the pressures to bury these the existence of these experiences. From our perspective, this risk becoming another means whereby we as a society erase it from our consciousness. In our view, this links to the way in which the trauma-informed care movement, despite holding important and helpful ideas, has, through its widespread adoption, become depoliticised and tamed, turning for some into a tick box exercise that allows the denial and distancing from the horror of survivors' experiences to deepen. The current lexicon is inadequate in conveying the texture needed to communicate with each other. Child sexual abuse may, in this context, be hidden within the notion of complex trauma, buried under this less confrontational language and

potentially medicalised through the link with complex post-traumatic disorder (Khadj's and Jo's chapters).

The conception of the Network, and subsequently, this book occurred during the COVID pandemic, a time when our connections with each other and our communities were often sorely tested. It was also a time in which annihilatory anxieties were reactivated in many – we were frightened and alone with an inherent and necessary suspicion about potential contamination from others. The neoliberal economic and political context, the climate crisis and ongoing wars and genocides attest to a world which continues to confront us with the reality of existential threat, a growing epidemic of loneliness and amplified feelings of rage directed towards perceived threats from 'othereds'. We have seen that child sexual abuse can be used in bad faith to stoke division in our communities by weaponising crimes to make false claims about the risks from certain groups.

What we hope to make clear through the book is that this subject matter has for too long provoked strong reactions and condemnation from our society as an avoidance of collective moral culpability. What instead is needed is careful and painstaking work to slow down and understand rather than pass speedy judgement and evade.

In this book, we decided to extend this balance to include the voices of those working with perpetrators, a step too far for many in the field who understandably need to keep victims and abusers separate in all spaces, including those held within a book (Nicola chapter). We did this to try to draw together these two polarised positions, not to grant abuser the same ethical status as survivor, but instead to argue a serious attempt to address the social problem of child sexual abuse necessitates linking and synthesising as opposed to polarising and splitting.

Making new connections and hearing multiple voices created a collective in which the primary political intent was to contribute to conditions for change. We are aware that as a group we are not alone in this wish – survivor activists, clinicians working in this field, researchers and academics and indeed politicians – are also part of this movement. We see connecting as a powerful antidote to the isolation that sexual abuse perpetrates. We see the work that has gone into this book as an offering to others working to bring about change in the field, as a guide on some different perspectives and as message of solidarity to keep going together.

We have attempted to create a balance of survivor voices alongside those of clinicians and researchers, with some chapters combining multiple voices in a single author (Susanna's chapter). While there are many books that draw on survivor experiences in groundbreaking ways (Carolyn Spring and Sophie Olson's work among others are cited here), we are not aware of other examples where they are located side by side with professional perspectives. This feels like a distinct contribution in some ways, but it also may overlay complexity because in our experience the journey of survivors using their voices publicly is rarely simply empowering and straightforward. As a group who are

committed to co-production in this field – in this book and in other spaces – we are wary about idealisation of this approach, especially when it is poorly defined and we are still trying to work out together what this means and how it is managed in the context of power imbalances, when lived experience is central for some of us and less so for others. There is also a significant emotional cost to activism and using voice, despite the seismic contributions this type of knowledge and labour has brought to the field. Participation may offer reparation and epistemic validation to some, but it can concretise the survivor identity, creating an identity trap while also holding creative potential.

It is beholden on us all to consider what drives us to do this work and to speak about it publicly, with greater nuance as to our own personal and familial stakes. To be in this field is to expose ourselves, to run the risk of exclusion and shame from colleagues and the wider public (Katie and Danny's chapter). To ironically reverse the Groucho Marx maxim, we are members of a club that other people, and at times ourselves, do not want to join. We can say wholeheartedly that the connections we have forged to the other authors in the development of this book have offered succour and compassionate containment for those moments when we wonder, what are putting our names to?

The Independent Inquiry into Child Sexual Abuse in the United Kingdom began in 2015, with its final report issued in October 2022. Its focus was on institutional abuse, highlighting the multiple failures of statutory and non-statutory organisations to protect children and the complicity, denial and disavowal this required at an institutional level. As part of IICSA, the Truth Project heard testimony from over 6,000 survivors, some of whom were speaking for the first time decades after their abuse. This unprecedented listening exercise, the largest of its kind linked to a UK public inquiry at the time, demonstrated beyond doubt that the harms of child sexual abuse carry on into our adult lives and can push survivors to the margins of our society. IICSA brought aspects of intersectionality in relation to sexual abuse to light in new and distinct ways (Kiki's and Michael's chapters) although we recognise that pioneers such as Valerie Sinason in her work with disability and child sexual abuse, have carried this issue for decades already (Valerie's chapter). It has also been possible to draw on IICSA's approach to investigating institutional practices to glean insights into how clinical practice and theory has compounded survivor's experiences of alienation and invalidation (Danny's chapter). While we believe that therapeutic practices can offer balm and social connection to survivors of child sexual abuse, we need to first examine the ways in which we have failed to do so to chart a different path for the future.

One of IICSA's key recommendations was to call for mandatory reporting of allegations of child sexual abuse for certain key professionals working with children and adults. This has created a lot of anxiety in the field, with practitioners fearing a directive to report could jeopardise the delicate work of dialogue, that requires uncertainty, ambiguity and, more than anything, time and control for survivors to come to terms with and find words for what has happened to them. While we have not written this book to offer technical

guidance on how to manage these preliminary, faltering and impartial, verbal and non-verbal, symbolic and concrete conversations we simplistically name 'disclosure', we have included an empirical overview of the area (Emma's chapter) and some therapeutic perspectives on what might work (Laura's chapter). While we understand the impetus for practitioners to leaf through a book such as this desperately looking for guidance on how to engage in and respond to this particular type of talk about child sexual abuse, we hope that engagement with less immediate recommendations contained across the chapters can socialise the reader to the range of dialogue that is possible, making the immediate service needs more manageable.

Perhaps the most important change to come out of IICSA is not at a policy level but as a diffuse cultural sea change. To quote Ann Scott, it has made speech about child sexual abuse "more stable and indeed culturally validated." This book, borne from a professional collaboration that began through IICSA, aims to offer a continuation of that stabilisation and validation, to continue the work of 'unforgetting'. The book also draws attention to other examples of an increased space for narrative in this area, including the proliferation of memoirs from survivors, many of them well known for other areas of their lives (William's chapter). Often preoccupied with silence, these types of narratives demonstrate a strange paradox, speaking out about the silencing of child sexual abuse in a way that disrupts the silence without eradicating it. While writing a memoir of this type takes courage, we are struck by the many unpublished and unwritten memoirs of abuse that do not get read. In preparing this manuscript part of our motivation, referred to in one opening acknowledgement, is to, in absentia, honour the stories of survivors who have not been heard despite their best efforts to make themselves understood. Often it is a failing to properly listen, rather than some lack of comprehensibility on behalf of the speaker where silence encloses once again.

Whilst these kinds of inquiries and royal commissions bring the issue of child sexual abuse into the public eye, the reality that most sexual abuse occurs within the family system remains shielded. As is its gendered nature in a wider context of violence against women and girls. And while the societal level justice processes that inquiries and increased public awareness offers are important, most of the conversations about child sexual abuse happen in closed, private spaces, such as consulting rooms. For all the pluralism on evidence in this book, it is the therapeutic encounter between practitioners and adult survivors that receives the most space. Rather than offering a clinical overview or 'how to work with' approach, the clinical perspectives home in on certain aspects of therapeutic practice, such as the affective consequences of abuse (Sara), the need for reflective spaces for practitioners (Louise), and practitioner needs in enabling this work to happen (Maggie).

While psychological therapies are increasingly accessible to many in short form treatment, offering it as a democratic right rather than esoteric privilege, this has led to manualised approaches to practitioner training and interventions. Many of us are working at the fringes of an evidence base, trying to offer

bespoke and tailored therapeutic interventions. Short term interventions may be inadequate for spiritual and relational injuries.

For this reason, in this book, we have instead cultivated an ethos, sensibility and approach to working with survivors that privileges ethics over technique, disposition over knowledge, intention over skills. This is in not to endorse a common misconception that only 'specialist' services can work safely and effectively with adult survivors of child sexual abuse. On the contrary, it is our wish to encourage practitioners and clients alike to recognise the common threads that link different treatment typologies and the shared humanity, interpersonal and moral ingredients required for survivors to experience professional help as supportive and contributing towards healing.

One of the main barriers to change in this area of social life is the overwhelming psychological nature of the crime itself, the impacts on the victims, but also the lack of resources to adequately support survivors. A familiar conversation among those of working in this area follows a descent from clear ideas about what survivors need and deserve, often articulated most clearly and reasonably by survivors themselves. The next stage of the dialogue addresses the gaps between the therapeutic needs and moral imperatives, and the resource depleted realities of public service provision in the early decades of the 21st century. The enormity of the chasm leaves us all feeling a mixture of anger and despair at the injustice of such a societal failing, possibly accompanied by some guilt at being a part of the systems that are failing people. We want this book to speak to that type of conversation too and not to shy away from talking into those realities, depressing though they are. They are a matter of health inequalities, and must be addressed as part of our social contract in civil society. They are a matter of human rights.

We also want this book to offer some realistic hope, in the recognition that hope can often be one of the most painful feelings as it is infused with a vulnerability to being dashed. The hope we wish to offer is one encased in the offer of a collective series of voices, which this book might be modestly added to. The other way this hope is offered is by inviting the reader to engage in acts of imagination that can enable us to imagine more and better for survivors of child sexual abuse. Remember how impossible it was 20 years ago to imagine over 6,000 adults in England and Wales travelling by train, car, bus and bike to locations where they met with kind strangers in rooms, where they shared the details of the worst things that had happened to them. Thousands of people came forward, in a huge act of emotional generosity, in order to make a civic contribution to prevent the sexual abuse of future generations of children. They did it in the Truth Project and proved once and for all that these crimes can be spoken about and good can come from the dialogues that follow.

Imagine what the next step might look like in building on their contributions.

Imagine what each of us can do, in our own ways, to move the conversation on.

Imagine…

## Section I

# Scene setting

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# 1 Survivors speak about trust and the (un)trustworthiness of service providers

*Susanna Alyce*

## Trust is important

Survivors of child sexual abuse (CSA) know that trust is important; as Anna said: *"everything on my records is really outdated and it's sort of written by people I've never actually opened up to because I haven't trusted them enough".* Without trust, relationships tend to remain guarded against revealing vulnerabilities (Hardin, 2002; Simpson, 2007). Trust is recognised as important, maybe even essential, in many spheres of life; I invite you to try a thought experiment. Take a moment to imagine, or recall, what it would be or is like to not be able to trust your boss, partner, friends, doctor, dentist, in basic ways. How would that change how you live your life? Establishing trust within the therapeutic relationship is recognised as of paramount importance for successful outcomes (Dalenberg, 2004). Yet, little research has ever been conducted into how to build trust with survivors of CSA. And none drawing directly on the perspective of those who know best: CSA survivors themselves. The story of trust in therapeutic relationships is one whereby trust is necessary, but beyond that maxim, little is written about how that trust is fostered, especially when the person coming for help is doing so because of broken trust.

Survivors of CSA may find trust to be a particularly sensitive area (Finkelhor, 1984; Freyd, 1996; Herman, 1992; van der Kolk, 2014). This statement has arisen, predominantly, out of research and clinical work by 'experts', and their scholarship speaks *about* survivors. In doing a literature search of previously published peer-reviewed papers which mention trust, only one study had involved survivors in the design and execution of that study (Matheson & Weightman, 2020). When survivors are included in study design and/or execution, or when the researcher herself shares defining characteristics with the people she is researching, her own lived experience can inform the deductions and meanings she sees in her participants' words (Beresford & Russo, 2022). This is the Mad Studies paradigm.

This chapter adopts this Mad Studies approach and shares the voices of survivors speaking about their experiences of trust, researched by a survivor of CSA, and the chapter reveals how the trustworthiness of the service provider is as, if not more, important in facilitating recovery than previously (mis)

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understood abilities or 'propensities' CSA survivors may have to be able to trust. The chapter shares how the process of 'entrusting' unfolds for survivors, what can make the process easier, and what prohibits their trust.

## Participants

Anna, whose words you read above, is one of the 17 participants who generously shared their experience of trust and trustworthiness in this qualitative study. Anna was not her real name, and all of the testimonies have been anonymised. I, the author of this chapter and the researcher, have not anonymised myself; I identify as a survivor because I no longer feel the shame I once did; I no longer want to hide my past away. I want to use my lived experience in the hope that it might help other survivors in their recovery.

## Why Mad Studies?

Before answering this question, maybe there is a more fundamental one: what is Mad Studies? Mad Studies is a kindred spirit to the civil rights movements in the USA, and the struggle for the liberation of all indigenous peoples against colonisation and domination. Mad Studies advances the benefits of the scholarship and activism of such oppressed groups (LeFrançois et al., 2013), and others such as feminists, LGBT+ communities, and the disabled. By championing the use of knowledge and wisdom from marginalised and disenfranchised peoples, these groups seek to change society for the good of all. The knowledge of people seen, and labelled, as 'mad', however, has been troubled in this quest by an added dimension of injustice: those labelled as suffering from mental ill-health have been seen as without 'reason'; incapacitated of the mental faculty to contribute to the discourse, and their powers of rational thought and engagement impaired by their distress.

Madness as a 'construct' has a long history and is beyond the scope of this chapter, but in brief, the way in which society has sought to draw a line between what is accepted as 'sane' and 'insane' has caused untold suffering to those people whose inner world has not conformed to the norms and stereotypes of the majority, and undermines the very real embodied illness people feel when they are mentally ill. In more recent times, the obfuscation of mental and emotional worlds into 'mental ill-health' sanitised by the label 'mental health', has led to a plethora of diagnoses and treatments which try to correct the thinking and feeling of those in distress. While the motivation for this may have been arising from a place of care, the actual damage it can and has caused is spoken about by survivors (Alyce, 2022; Lomani, 2022; Watson, 2019). It has also created an intersecting series of 'psy' disciplines which have drawn their theories and approaches from the knowledge of the clinician and academic. Their research has used 'expert' (sometimes claimed to be 'objective' or 'non-biased') meaning-making and interpretation to deliver data *about* distress and its causes, which oftentimes is then taken to be factual

and treatments are developed which, sadly, can be misunderstood to be cures or solutions. Mad Studies pushes back by offering insight and information from those who live with or are closely associated with distress and the further distress caused by systems which cause damage in their attempts to help.

Are survivors of CSA 'mad'? Some of us may identify with this descriptor, and some may not; not all survivors live with the effects of trauma, but many of us do. Those survivors who turn to mental health services and social care for support will have discovered that it is a series of diagnostic categories which open the door to support and treatment. Certainly, studies show CSA links to a wide range of mental, psychosocial, and physical health issues (Hailes et al., 2019; Maniglio, 2009), and participants in the Truth Project underpin this (IICSA Truth Project, 2022). In our system of health care, survivors are treated according to their symptoms rather than the understandable, rational, and predictable effects of abuse (Sweeney & Taggart, 2018). While trauma-informed care is trying to turn the tide on this, there is some way to go (Sweeney & Taggart, 2018). Therefore, while not necessarily 'mad', the use of 'Mad Studies' is advanced in this chapter as a helpful methodological approach to adopt.

When distress is arising from a view of the world at odds with the expert opinion, Mad Studies recognises that the 'expert' may be failing to comprehend, or accurately interpret, the inner world of the person they seek to help. By giving voice to the person themselves, by way of making them the researcher, academic, and expert from their Lived Experience, then power is returned to the so-called 'mad' or 'mentally ill' person. Whose view of the world is right? When a clinician says a person is seeing the world incorrectly, why is their view taken to be right? The Mad Studies view draws on the philosophy of Hermeneutics (that is, the study of meaning and meaning-making) (Caputo, 2018), and Phenomenology (Smith et al., 2009; Zahavi, 2018). Phenomenology as philosophy offered a new approach to science and was advanced initially in the 1960s by Edmund Husserl (1859–1938); the alliance between hermeneutics and phenomenology was developed by Martin Heidegger (1889–1976), in many ways Husserl's heir. Further scholarship issued from other thinkers such as Sartre, Gadamer, Merleau-Ponty, Levinas, and Arendt, to name but a few.

Yet, meanwhile, the ongoing development of the 'scientific' approach of the medical model to mental illness and health took over and shaped our systems of care. This chapter argues the benefit of pausing to listen to the phenomenological and hermeneutic experiences of the subjects themselves, because survivors of CSA have a lot to tell us about how they experience trust.

In short then, Mad Studies values and prioritises the views and knowledge of the CSA survivors who participated in this study, as well as the author herself, and seeks to gain the benefit of their insights arising from their lived experience of CSA. This is to inform, and possibly correct, the current discourse regarding survivors' trust, which may have been misunderstood by those who have not had first-hand experience of such things.

## Us and them

I share this chapter not just as a CSA survivor whose research centres on my lived experience, but also as a teacher and therapist. I started teaching yoga in 2000, and Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT) in 2009. I completed my Masters in Mindfulness Based Approaches in 2009 and a Person-Centred Counselling Diploma in 2024. I say this because I am both an 'us' and a 'them' and, as such, I empathise with the struggles of others as both survivor and service provider, each in relation to the other.

I share the results of this study not to chastise or berate anyone working in services supporting survivors – it is possible you may find some of the quotes in this chapter challenging. You may find yourself wanting to push back against the claims being made, or defend your (or your service's) choices, policies, and actions. CSA seems to do this: it has a heritage of separating, isolating, and silencing the parties involved and leaving them (us) with a legacy of blame and guilt.

I share my day-job persona, and my survivor identity, in an attempt at solidarity with you, no matter who you are. And I also do this because I know how many people working to support CSA survivors are survivors of abuse and sexual violence themselves and so share the dual identity of an 'us' and a 'them'.

## This study

How can we be sure that research accurately reflects the experiences of the population under consideration? Research Methodology's main task is to address this central and guiding question. But when the population is characterised by silence and isolation, how can a study be designed in a way that will glean the truth about material that may feel shameful, deeply hidden, or fraught with emotional turbulence? The double bind of this study was that in researching how survivors experience trust, they needed to trust the researcher. The study was constructed to place front and centre the identity of the researcher as a survivor, and to offer support at all stages of the research process to both the participants and the researcher. The Ethics Committee at the University of Essex approved the study when it was satisfied that the design made the process safe for all. Safety reduced the chances of the natural retreat or withdrawal and subsequent distress because the risk of threat was lessened. In safe environments, the participants felt able to openly speak about their experiences of trust and the vulnerability that trust necessitates. The researcher explicitly speaking about her identity was a major part of creating this safety. As Tessa said:

> I feel safe, I feel safe, I know you do this stuff and I know it's happened to you, and you've just got a nice vibe to me so, you know, so it's fine,

> I don't expect you to do anything terrible, (laughter), I don't think you've got a hidden agenda […] I don't need a house from you, I don't need anything from you.

There was something about shared histories that meant we could meet on common ground, or a *"level playing field"*, as Ruby called it. Jasmin said:

> I'm grateful for being asked to participate in this so thank you for listening and thank you for sharing also your personal stuff and also for meeting me exactly where I am, and not, that's also very big, to just being able to jump around things and being distant or this or that, just to blaaaaaah and babble on about it, so thank you.

**Can survivors trust?**

Most of the survivors in the study expressed what, in trust literature, is known as a 'generalised distrust' (Mayer et al., 1995). Generalised distrust in any person recognises a tendency towards certain types of people, for example specific genders, races, professionals or all people, and even society as a whole. Tessa said: *"if you want to ask me about trust and the world, I am the least, I don't trust anything, society, […] society is my biggest thing […] society doesn't give a toss".*

As stated above, because survivors of CSA may seek help from services, many will have had to receive a diagnosis, which makes claims about their propensity to trust. The DSMV (American Psychiatric Association, 2013) has diagnostic criteria for post-traumatic stress disorder (PTSD), stating that survivors may have "persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., 'I am bad', 'No one can be trusted', 'The world is completely dangerous')" (National Library of Medicine, 2013). The World Health Organisation diagnostic criteria state that the presenting issues for a person with Complex PTSD include: "Persistent difficulties in sustaining relationships and in feeling close to others. The person may consistently avoid, deride or have little interest in relationships and social engagement more generally" (WHO, 2019), which alludes to trust. Freyd writes: "A child sexually abused by an adult who has power and authority over that child is in a bind. The child needs to trust his or her parents and caregivers" (Freyd, 1996, p. 164).

Other survivors receive a diagnosis of Borderline Personality Disorder (Hailes et al., 2019). Peter Fonagy said, "In a state of epistemic mistrust, the recipient of social communication may well understand what is being expressed to him/her, but he/she cannot encode it as relevant, internalize it, and appropriately reapply it" and "The persistent distress and social dysfunction associated with Personality Disorders is the result of the destruction of epistemic trust in social knowledge of most kinds" (Fonagy et al., 2017, p. 3).

These quotations are speaking of generalised distrust, and an inability to internalise knowledge which is said to be true, because of damaged trusting capacities. So, we can see that there is a general discourse of survivors being deficient in the ability to trust.

In this study, when asked why they felt a generalised distrust, some participants' responses included speaking about how the abuse had shaped them. Jo said: *"for me the damage of the abuse is that I'm not always good at managing trust".* Others named that it was the grooming the abuser used to maintain silence that left them mistrusting. Jake said: *"the person who abused me kept telling me people won't believe you"*; Jake could not trust people to listen or believe him. Other survivors said it was a groomed belief of the *danger* of breaking the silence, of the sense that to do so would cause harm to the ones they loved. Stella said: *"there was a long period of time when I didn't share any information [concerning CSA] with anyone and I was 37 before I ever shared anything with anyone".*

Clearly, the social and cultural landscape of the abuse experiences (not just the actual abuse) played a part in these participants being cautious when trusting again; however, by far the most commonly cited reason for caution was not due to the abuse, but due to experiences around initial attempts at seeking help. Many times survivors had tried to tell others at the time of the abuse: sometimes, people who might have stopped the abuse, or friends in an attempt to seek advice. When these first tentative disclosures had been shut down, this reinforced a caution in later life.

Whether disclosing to professionals, family or friends, survivors had often felt rejected, ignored, disbelieved, challenged, vilified, accused of lying or of making up false memories. Quotations of all these incidents are too numerous to share here, and so I select these three testimonies about moments in relationship with professionals whose job it was to help. There is a fuller documentation in my final thesis (Alyce, 2023). Chloe was a teenager when she went to her family doctor for help – this GP had attended her birth, and was GP to her abuser, her father:

> I don't think he believed me which set me back, which then closed me up for quite a few more years before I reopened it again, so yeah, […] yeah, he sort of "are you sure" was the vocal words, have you misstrued [sic] this, misread it, and he just didn't seem, I didn't feel like the trust was there so I just closed down and left and walked out.

Chloe next sought help when she was in her 30s. Helen spoke about her experience of disclosing to a psychiatrist:

> a psychiatrist […] said to me last year when I was having whatever they were, body memories, flashbacks whatever they were, she said I am creating them […] so I was pretty angry […] and I felt quite stamped on really […], I was just gobsmacked I think, and I just wanted to get out of there.

Helen did not seek help again for several years, and only did so when her self-harm reached a point where her need for support overruled her fear of such a rejection happening again. Jake tried to seek help over and over again:

> I tell you I tried to disclose to teachers, um, it was brushed under the carpet. I was told I was making too much of it and I was referred to an educational psychologist who again didn't want to hear what I had to say and then when I was 16 I sort of disclosed officially to um a doctor whose reaction was that it happened in my childhood um and that I needed to pull my socks up. […] When I was 18 because of the depression and anxiety and my OCD I was referred to a psychiatrist who after I had been seeing her for a few months I then disclosed again to her and her reaction was just to forget about it and move on and then I tried to kill myself.

Let's pause the results to take stock. I invite you to notice if you need to take a moment to ground yourself and find some steadiness with which to consider what these survivors are saying. To consider how their experiences have landed with you. Do you believe them?

It may be easier to believe that these incidences happened a long time ago, and things have changed now, or that the professionals have been misunderstood or misrepresented, or that as a professional yourself you would never do such a thing. Tessa implores you to listen and try to comprehend: *"I wish people could be in my skin for a day and just understand"*. When CSA, and trauma, is outside the personal experience of the listener, there may be a natural tendency to close off. Perhaps part of the difficulty is that 'we' do not want to be in the skin of a CSA survivor because it is such a painful and abhorrent thought. It is aversive and so we try not to think about it, which can lead to betrayal, withdrawal, and self-protection. All these responses can unwittingly arise; vicarious trauma is powerful (Alyce, 2022; Chouliara et al., 2009; Ratcliffe, 2012). Understanding can be difficult because it may be beyond a non-traumatised person's terms of reference. Disbelief can arise because to believe is to accept something of what humans (we) are capable of and this may threaten our basic safety (Herman, 1992).

In this study, these survivors are asking the people they turn to for help (in 'trust jargon' these people are called 'potential trustees'), to stay open and engaged and not repeat the long-held status quo of those receiving disclosure, that being to shut them down, and to shut down themselves. These stories *are* painful, just as the details of CSA are painful; they have a very real power to cause the listener to recoil and defend against vicarious trauma (Chouliara et al., 2009), but if we as listeners do that, we may be replicating the frameworks that made abuse possible, and caused (re)traumatisation for survivors as they grew into adults seeking help.

**Does generalised distrust prohibit trusting?**

If survivors make statements of generalised distrust, does that mean they cannot trust? The suggestion of a trust deficiency implies this. My research suggests that this is not so. Every participant bar one shared examples of trusting people when they were children and gave other examples of trusting as adults; this suggests that these survivors' ability to trust had not been destroyed, neither as children nor as adults.

Trustees in childhood included family members, such as non-abusive parents and grandparents, teachers, and friends. As adults, many had long-term significant-other partnerships, or had parents they trusted, and many spoke of relationships with trusted professionals. Rachel spoke of trusting water:

> I have a real affinity with water, I have all my thoughts, my dreams, not premonitions, what's the word […] because it's about that thing about trust isn't it, um if (pause) I damaged my knee so I couldn't go swimming for a while and life didn't feel right, I went back to the pool last week for the first time and it's like, yeah it was a calling, I had to be there […] I didn't want to get out, […] maybe the fact that it supports you, it holds you, maybe it's the fact that it's just you in the water or there's something around you.

They could describe trust and trusting. They knew what trust was like as a 'felt-sense' (Gendlin, 1991). Betty said:

> um it's definitely it's a sense I can let my guard down […] it's a definite feeling like somebody's got my back, I don't have to um be on that constant alert, I probably still am on some level but it's a noticeable shift, I can just really feel like I can really be myself, I can be authentic.

Frank felt his ability to read people, and his ability to gauge trustworthiness came from the abuse experiences:

> I must say I'm pretty good to get a feeling of what people I can talk to and people that I cannot talk to, I think it has to do with the ability that I developed when I was a kid, to see, to start with I was able to sense, will it happen tonight, the abuses so I, I read the, I mean, the how should I put it, I was like a radar system.

In this way, the abuse had equipped him to stay safe now as an adult.

These survivors felt they knew how to evaluate and judge trustworthiness. For this sample, trusting was not just possible but happened regularly when conditions were favourable. When a trustee could demonstrate their trustworthiness, then trust in the survivor flowed. This speaks against a belief in the

*Table 1.1* Trusted and Untrusted Qualities and Attributes in the Service Provider

| | *Trusted attributes* | *Untrusted attributes* |
|---|---|---|
| Personal qualities | Authenticity, friendliness, soft, gentle, true, kind, open body language, gesture, voice, and appearance | Unfriendly, hurried, closed body language, failure to use or maintain eye contact, features similar to the abuser |
| Skills and abilities | | |
| Paying attention | Active engagement, presence, listening | Ignoring, rejecting, dismissing, overriding |
| Attitude | Non-judging, valuing, patience, acceptance, empathetic, believing | Lack of respect, demeaning, devaluing, controlling, pathologising |
| Resilience | Demonstrating ability not to be harmed by survivor narrative | Appearing to fear harm to self, displaying 'fight flight freeze' reaction |
| Insight | Perception, seeking to understand the meanings being made by survivor | Demonstrative failure to understand, not recognising the depth behind initial disclosure, or nuance of effects of abuse |
| Transparency | Open, honest, revealing | Withholding information, breaking promises, accidentally revealing previously concealed facts, unwillingness to share information or include survivor in decision making, secrecy, duplicity |
| Approach | Availability, offering choice, trauma-informed training and deployment, flexibility, boundaried in collaboration with the survivor | Control and the use of professional power over survivor's wishes, removal of choice, failure to protect or honour boundaries or adhere to a duty of care, repeatedly referring on to other services |

survivor's broken ability to trust and calls for service providers to learn how to become trustworthy. Table 1.1 captures the qualities and attributes they experienced as trustworthy and untrustworthy.

### Accidentally misunderstanding trust

When we believe that survivors cannot trust, have we accidentally created an identity as a person deficient, or lacking, in some way? Some literature suggests survivors have trouble trusting (Finkelhor, 1984; Freyd, 1996; Herman, 1992) and this is sometimes termed a low "propensity to trust" (Mayer et al., 1995). With these views, has a shift been made from something a survivor

does (as in 'generally' does not trust) to something he/she *is*? A person with a defunct ability to trust? These survivors challenge that view. They knew what trust felt like and this suggests that the abuse had not destroyed the capacity to trust, just that it made them cautious when trusting. This is a crucial point: when we think of trust as a binary 'do trust/don't trust', we are misunderstanding how trust operates. This may stem from the obfuscation caused by the use of the word 'trust' in the English language. The word trust is both a noun and a verb. When seeking help from a service provider, trust is better thought of as 'entrusting'… it is a verb; it is a process of discovering and enacting the placing of vulnerability in the hands of someone survivors turn to for help. This definition of entrusting holds across all domains and disciplines. When we are entrusting, we have a need, or an 'orienting task', that draws us towards someone who can help us attain or achieve this task. That is true of all 'trustors', not just survivors. Yet no one can ever know for certain that trustees will do as they say, as much as we all hope they will … if there was certainty we would not need trust. Trust is always relational. Always. And trust always includes an element of risk.

## Seeking safety

The question for a survivor or indeed any human is, how much of a risk to take when relying on another person, and what is the downside if a trustee does not deliver? To what extent will we be hurt or disappointed if the person we needed help from does not fulfil the promise made when entering the trust contract? For survivors, the risk can be huge. Firstly, for many, if the survivor is questioned or challenged, this fulfils the groomed beliefs introjected by the abuser that "nobody will believe you". As Jake said above, it is safer to stay silent. Staying silent keeps the survivor trapped in trauma distress with all its flashbacks, fears, and isolation.

The second risk is that such a rejection may cause the survivor to question themselves, their memory, and their sense of reality. Trauma memories are often fragmented, out of sequence and appear as flashbacks or sudden feelings of fear without connection (Sinason & Conway, 2021; van der Kolk, 1994). When these memories are questioned, this can cause the survivor to double-down with doubt. Chloe said:

> I am quite out there but I think my self-esteem will always be the little back burner […] yeah, I will always have that thing, I just self-doubt myself and I think I always will.

And lastly, the risk is that the survivor will be left with their original need for help now allied with this new (re)traumatisation. Isolation is, in itself, often retriggering because the abuse will have happened when the child was isolated, away from protection. Isolation is a trigger of fear and trauma distress, as well as a place to avoid retriggering. This paradox, of seeking help with a

past isolating experience only for it to be repeated in the act of help-seeking, is one of the most painful for survivors.

The main point is the enormity of the pain and vulnerability CSA leaves with the child, which continues into adulthood, as Jake explained:

> I think there is a massive lack of awareness of the enormity of what child abuse does to you subtly as well as overtly with the depression or with the chronic long term mental health problems, the subtle things it does to you about your self-esteem and confidence, how you appraise the world.

Survivors spoke of the harm they had experienced when misunderstood or rejected, and the fear of speaking out: Tessa said: *"you're not always safe to talk because they don't, you can feel they don't want to know"*.

Caroline had her children removed because of a BPD diagnosis; when the court returned them, apologised, and absolved her of any wrongdoing, she was left devastated by this trauma in addition to her CSA trauma. In the initial court action no claim against her abilities as a mother was cited, it was purely the BPD diagnosis and the generic shadow it cast over her ability to parent. Caroline said of the period after the return of her four children: *"I've been left to pick up the pieces myself because nobody will help"*. Seeking help from her GP, mental health services, and social services was a risk that resulted in more, not less, difficulty.

Will was abused by a Catholic priest, and he said:

> the church oh god, because the lawyer we wanted on my side, the church nabbed him from the top […] and you think, you fuckers, and this is before they had any, they would not acknowledge anything at all, I tell you what it makes you feel like, one that you's making it all up, and two well no, that's it, yeah, you've fabricated everything, you're doing this for some other incentive, […] and what they threw back at you, this is supposed to be a caring church and that's the thing that fucked my mind up, this is the church.

These examples illustrate that for these survivors, trusting service providers with their CSA history was dangerous, and this danger made them cautious when seeking future services. Julie said:

> I think structurally there's a major issue in the police in the sense […] so even when I did have a really good policeman I still distrust the actual Police force if you see what I mean.

Surely being cautious when trusting again after such experiences is a sane response to potential danger? How is it a pathology not to trust a psychiatrist, doctor, social worker, the Police, or the Criminal Justice System (CJS), when they have been the cause of so much distress?

### The need for help

Whatever the reason for not reaching out, trauma distress and/or other needs eventually brought many of the participants to a tipping point where the need for support or care outweighed the fear and danger. The need became worth the risk. Jo said:

> when I first started kind of accepting and facing that I had had quite a lot of experience of abuse that I needed to do something about, […] where previously I had suppressed it all and um but it got to the point where it was intruding into my daily life and my mental health such that I knew I needed to do something um I was quite depressed, I had suicidal ideation.

For others, it might be the need to see the dentist, get help with social housing or seek justice through the CJS. These needs drove the participants to seek someone to trust.

### Testing the water

When first encountering a potential trustee, Milla used an image of 'testing the water': *"it's like a process, it's like you give things in dribs and drabs you give them something, test the water, see how they react"*. Until enough proof of trustworthiness was garnered many spoke of remaining guarded, or behind a front or façade. Rachel said: *"nobody sees the child inside fighting away"*.

In these early stages of trust-building, each moment of a trustee's behaviour, demeanour or action could cause a retreat or an advance towards further vulnerable sharing of details and emotions. Even if the service needed was not addressing the abuse (for example, a dentist), getting help still necessitated disclosure in order to ensure safety.

Disclosure is often written about as a one-off incident (Alaggia et al., 2019), but the participants in this study spoke of small steps towards a fuller trust and only when such a fuller trust was established would all the details emerge. Chloe said:

> there was something about him I knew I could trust, […] we started talking and I opened up, I didn't tell him everything that day, it took me a little bit of time but he knows absolutely everything now, but then we started from there and there was a process.

I have written above about participants' caution because of fears for themselves, but this was not the only reason for caution and a slow pace, as Patrick said: *"at first you're very cautious because first what you're going to tell this woman is going to blow her mind"*. Many of the participants were

acutely aware of how their story might cause vicarious trauma to a listener who was not resilient, resourced or well supported enough to hear the horrors of their childhoods. Vicarious trauma is a very real issue for the NHS (Chouliara et al., 2009; McNeillie & Rose, 2021); perhaps survivor knowledge might be used to shape and inform approaches to its mitigation (Alyce et al., 2023).

Jo captures the process of building trust:

> it's a gradual process of being vulnerable with each other to a point where you feel there's safety and a checking out of that goes along so it's almost like we're all like the onion thing, we're all onions and we're peeling off layers and layers to the point where we're not hiding behind any more layers, we're being really real with each other.

This process is portrayed in Figure 1.1: The Trust Enactment Model

The trust enactment model shows the steps to building trust: the back and forth, the exits and new beginnings, and the brilliance of the 'full trust' relationship where healing from trauma distress is facilitated.

During the process towards establishing a 'full trust', that is, a relationship where a fuller vulnerability can be risked or full disclosure made, survivors described an ability to 'trust enough'. In trust studies conducted in the discipline of business management, this is called 'transactional trust' (Reina & Reina, 2009) and this concept may be useful in mental health service provision.

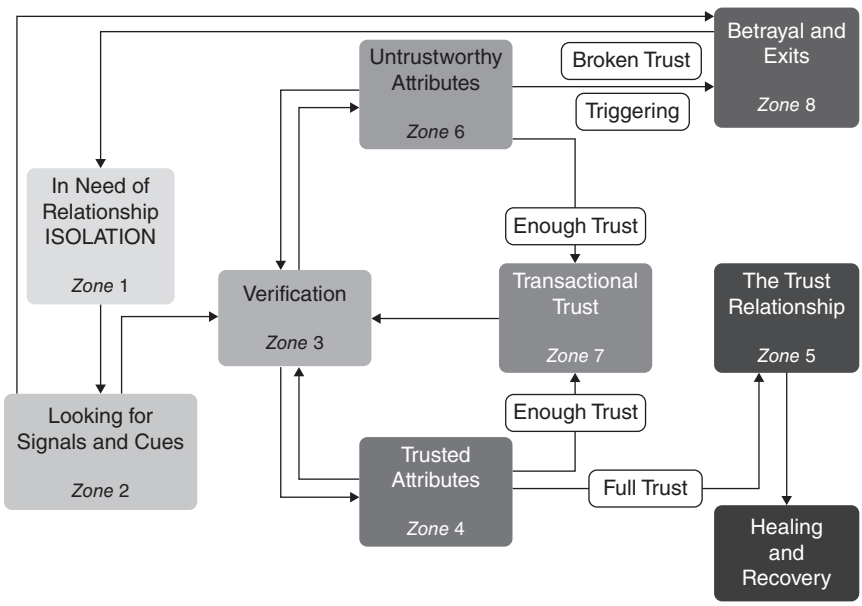


*Figure 1.1* The Trust Enactment Model

Frank gives an example of his ability to engage in transactional trust when undergoing a colonoscopy:

> then I told the doctor that would be performing that investigation that I had been subject to sexual abuse "so it's a little bit sensitive to me how you make it when you start with the instrument" and she said "ok", and then she started […], I mean she was very good at it but um I didn't feel that, I mean, nothing like trust because I didn't get any response really.

This consultant, while proficient at the task, was trusted *enough* by Frank to continue with the procedure. This was not a full trust and consequently did not help him resolve his trauma distress. This may seem reasonable to the reader: why should we expect a colonoscopy doctor to help Frank recover from trauma? But surely we would expect such a professional not to contribute further to a survivor's trauma distress? Anna needed surgery on her abdomen, but exposing her skin had been a lifelong trigger caused directly by the abuser's actions. Anna had communicated her CSA history, and her triggers, in writing to the hospital team, and yet:

> suddenly, despite my earlier second mouse-like plea to the charge nurse about needing a female doctor… the curtains flew open and in came the male specialist with his male junior doctor, a couple of female ward nurses and another female specialist nurse all suddenly surrounded my bedside.

Anna was triggered into a severe dissociation where she could no longer speak, and her surgery had to be postponed.

When we compare this to Helen's story about the trust she established with her dentist, we start to see how any person who is experienced as trustworthy and trusted beyond transactional trust can impact the survivor in a positive way:

> I've had a massive fear of dentists for so long and fear of everything in my mouth um, […], and the first thing was just sitting in the chair, no, sitting talking and basically she built the rapport up and within the third session I was actually starting to have fillings […] and she said "shall we do this, all of this or shall we do one at a time", and I thought just do it because it was a such a relief of um this whole trauma of my mouth which still goes on psychologically but it was like I was nurturing the part that was (abused).

For some of the participants, the healing took place in trust relationships in psychological-clinical settings, for others in romantic relationships. For Will, it was in his role in the Fire Service. The official role of the trustee may be less important than how they behave towards the survivor. The main point I am making is that trauma can be healed by any form of trustee if there is sufficient trust.

Trust, then, would appear to be a significant factor facilitating healing. Frank again:

> I was dissociated, so, I mean, she started talking to 'us' rather than talking to me, she said 'I understand that there are many of you here today and and and I'm talking to all of you' and then she started to build the trust with all these small persons within me.

When trust is established, the survivor changes how they feel about themselves. Anna trusted her psychiatrist and said of their relationship: *"I feel less like I'm a just nothing, I don't know, been a bit more valued or something"*. Healing the relationship survivors had with themselves was central to these participants.

This process of establishing trustworthiness paints an interesting picture when one considers how, so often, service providers are assessing and judging aspects of a service-user's behaviour and personality. To know that this is a two-way street may, perhaps, change the way service providers present themselves. This study suggests that they will only glean the necessary information for an accurate assessment if they meet the criteria survivors have before sharing their stories. It also needs to be highlighted that it is the survivor's parameters of what they, personally, identify as trustworthiness that are important, more than the service provider's understanding of what denotes trustworthy – their title or training, for example, may not be relevant to the survivor as much as their kindness, attentiveness or compassion. Trust is relational and thus trustworthiness is something forged within the relationship.

When evaluating trustworthiness of a potential trustee, survivors spoke of particular personal attributes or character traits, which engendered a sense of safety; these are given in Table 1.1. Stella said that her trusted supervisor *"imbued trust"*. Maybe it seems obvious that a person who is open, kind, friendly, and warm will be trusted; who wouldn't want these qualities in someone they were going to share extreme vulnerability with? But such a person had been hard to find for many of the participants: *"you may never find that right person, you can probably go for years and years and years, go to different counsellors, different people and never find that right connection,"* Chloe noted.

Maybe it is surprising that this study shared experiences with so many trustees who did not bring kindness and warmth to the consulting room or therapy space. Anna had a psychiatrist who on first meeting caused her to withdraw from the possibility of trust:

> I was already sort of apprehensive kind of walking in and it was just his whole body language as well, he just had that pose about him that it was just, "I am the doctor", and […] it was like a full-on flashy suit, and the whole thing um, […] he just had this arrogance about him, it was instant, it hit me instantly.

Anna's experience speaks to the power imbalance between a person seeking help and a person offering help; this imbalance is very much part of every relationship which necessitates trust, and so a hypervigilance and 'testing the water' seems a reasonable course of action, especially when bearing in mind the magnitude of vulnerability a survivor is bringing and the sensitivity of the material. Given all this, survivors knew that extra care was needed. This required time both for meetings or sessions and the number of appointments; flexibility to offer time may be something that many service providers find is constrained by the service they work within, yet survivors needed time to build trust because of the process of testing and verifying their trustee. If services are to deliver targeted outcomes of recovery, then this is an important point for consideration by those who do have the power to shape services for CSA survivors.

Understanding the ramifications of CSA and meeting these is, undoubtedly, challenging and the participants appreciated this. They also knew that as an individual they had their own specific needs. Survivors' trust grew more strongly and deeply with service providers who both knew the broad-brush effects of CSA and yet still made space to listen to *and* seek to hear with empathy and kindness: *"hearing with their heart"*, as Helen said. The quality of the listening was essential, and the willingness to hear the specificity of difficulty without making assumptions or judgements. Jake said:

> they don't understand, it's sometimes it's the tiniest, littlest sort of subtle things that are the most painful, I was sexually abused for 6 years but it was that moment when my dad didn't trust me that was hardest, again, but if you're a clinician you'd go but yeah, surely it's the six years of trauma, not necessarily.

When a trustee's willingness to try to understand went hand in hand with respect, trust flowed more easily. When there was a lack of respect, survivors spoke of closing down or shutting off, particularly when they were obliged to continue in the relationship. When a survivor had a choice to exit a relationship, that choice had frequently been enacted. Anna's testimony above shows how if physical exit is not possible, the psychological exit of dissociation can be triggered.

Anna's example was one of many where the participants felt dehumanised; being robbed of our humanity is recognised as untenable in documents such as the Declaration for Human Rights. For survivors, the issue is exacerbated because the sense of not being respected, or of being demeaned, had for many been a very visceral reminder of the abuse, and in so doing brought untenable feelings such as guilt, shame, and self-hatred. It had, of course, also caused a triggering to the reactions of fight, fight, freeze, flop (that is, dissociation) of the autonomic nervous system. In addition, there is the tendency to 'tend and befriend' the aggressor in an initial attempt to placate and thus stay safe (van der Kolk, 2014). When survivors had felt

under threat, they talked about times when they had utilised the overly 'nice', acquiescent, 'people-pleasing' aspect of themselves, or *"fawning"* as Tessa said. Just because a survivor was acting deferentially or complying with the trustee's requests or orders, this did not necessarily signify that trust was being built.

It was stated earlier that entrusting is always relational and depends as much on what the trustee is bringing to the relationship as the survivor. Survivors who had formed deeply trusting relationships, in which significant healing and recovery had taken place, repeatedly named one significant quality in their trustee: the willingness to engage as a human. By this, I mean a willingness to reveal something of themselves, of their own human heart, of their own vulnerability, and sensitivity. Some trustees shared something of their personal life. Trustee vulnerability and openness had to be allied with a resilience, a psychological strength and the ability to hear the worst memories, to see the rawest of emotions and still be steady for the survivor. The trusted ally did not need the survivor to rescue them, but was nonetheless human. This was a meeting with some sort of equality; not in terms of skills or qualifications, survivors knew they needed expertise from their trustees, but the trustee left the survivor feeling like a valued, worthwhile, useful and respected person. When survivors had experienced this from their trustee, they started to experience this of themselves; the experience of being trusted *by* the trustee fostered trust in themselves. Chloe remarked:

> I think, when I finally [became] who I am, it's like, ooo I am a person. I am me. I am, and it's a bit like that Pinocchio story, isn't it, I am real, I am a real person, and I think for years you don't believe you're a real person you're just this little, quiet shallow thing.

There is so much more to share of these results, and many more words from the survivors which illustrate the many points made in this chapter. The study is available online to read (Alyce, 2023).

**Where next?**

- The 17 survivors in this study made clear their wish to be respected, listened to and valued as equals with the people they trusted to help them.
- They wanted people to be trustworthy by not adding to their distress, by not believing them, ignoring or rejecting them.
- They wanted to be able to speak openly about their experiences of child abuse without that being used to label them with mental health diagnoses which further added to their distress or be sent down pathways of mental health care which did not include their histories as part of their mental and physical health picture. To only address symptoms without the context of what caused those symptoms was a form of ignoring and devaluing.

## Conclusion

To conclude, the survivors in this study would dispute that they cannot trust when in relationship with a trustworthy service provider, partner, friend, or employer. They have shown in this chapter how they can trust when the conditions for entrusting are favourable.

This throws the ball back to those service providers who want to help survivors recover from the injustices of a childhood wrecked by abusers and an adult life tormented by trauma. Society let CSA happen and has done little to atone for this (IICSA, 2022), yet there are many in society now working to change this, and to help those for whom CSA has left a legacy of fear and shame. If things are to change, I believe strongly that forming a community would be a beneficial step for us to take together. In so doing, we would be disavowing the isolation of CSA. A community of survivors and service providers working together would be a counterweight against CSA's heritage of silenced isolation.

You are reading this chapter. You are one of these people. And on behalf of all of the survivors in this study, I thank you.

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# 2 What is meant by disclosure

*Emma Facer-Irwin*

The term disclosure is broadly defined as the telling of abuse to another person; this can be done formally or informally, voluntarily or in response to another's invitation to tell (Ullman 2002). Disclosure is often conceptualised differently across professional contexts and abuse experiences can be conveyed in many different ways (Alaggia 2004).

There is comparatively less research on the process of telling, or the sequence of disclosure (Tener and Murphy 2015). While disclosures made during childhood are often spontaneous or even unintentional (McElvaney et al. 2012), adults' decisions to disclose are more commonly conceptualised as more thoughtful or purposeful, often made with the intention to seek support or prevent abuse from happening to others (Alaggia 2004, Del Castillo and O'Dougherty Wright 2009). Whether prompted by others (such as professionals or family members), or self-motivated, adult survivors describe a deliberate consideration and self-dialogue about whether or not to reveal information about the abuse to another person, or when the right time for disclosure may be (Del Castillo and O'Dougherty Wright 2009). Adult survivors often describe processes of assessing potential disclosure recipients, spending time searching for someone they can trust, and continuously monitoring the responses of those with whom they have chosen to share their story (Stige et al. 2022). Each time an adult survivor must enter a new situation, relationship, or social system (formal and informal), they may be faced with the decision of whether or not to disclose (Tener and Murphy 2015).

Yet, disclosures of CSA in adulthood can also occur unintentionally (e.g. when triggered or overwhelmed) (Tener and Murphy 2015), spontaneously following recognition or new insights about the abuse that occurred. They can build gradually over time, until, like a 'pressure cooker effect' (McElvaney et al. 2012), the survivor feels unable to contain their secret any longer. Survivors may feel also coerced or pressured into disclosing their abuse experiences, for example by being confronted by the discovery of evidence or being prompted by others attempting to understand what might have occurred. One paper by Del Castillo and O'Dougherty Wright (2009) characterised two distinctly common ways of disclosing amongst survivors: (1) telling the story in a detached way with little apparent affect, as though they were reporting

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the news; or (2) revealing the whole story at once with little control over its components, as though the survivor were 'vomiting' the story. In the wake of the Me Too movement, disclosure experiences may increasingly be digital and largely impersonal, consisting of disclosures made on social media and to far-reaching, unknown audiences (Scoglio et al. 2022). There is comparatively very little research into the impact of these forms of disclosure experiences on survivors.

Understanding around disclosure of CSA has evolved from a singular or one-time event to a dialogical process that occurs over time through reciprocated interactions with family members, spouses, other CSA survivors, and healthcare professionals (Alaggia 2004, Easton and Parchment 2021). The very nature of disclosure as a dynamic process means that often disclosures are partial, with vague or even absent detail which may or may not emerge over time (Allnock et al. 2019, McElvaney 2015). Disclosure is thus best understood as an iterative, relational, and dynamic process, one that is 'complex, progressive, and multifaceted', akin to the metaphor of 'storying' (Draucker and Martsolf 2008). Each telling can enable a survivor to incorporate more insights into his or her story, which may eventually support them to change their narratives (Draucker and Martsolf 2008). Particularly when considered within healthcare or professional contexts, disclosure is relationally dependent and emerges through open dialogue (Brattfjell and Flåm 2019) (survivors may require significant periods of time to build the trusted relationship that supports disclosure, particularly if they have had previous negative experiences of interacting with authority figures (Brattfjell and Flåm 2019, Örmon et al. 2014).

### What do we know about adult disclosures of CSA?

While research has often centred on disclosures made during childhood, a substantial body of evidence suggests that many survivors do not verbally disclose CSA until well into adulthood (London et al. 2008, McElvaney 2015, Lemaigre et al. 2017). One review of 13 international studies found that between 31% and 45% of adults with histories of CSA had talked about their abuse to an adult soon afterwards or during their childhood (London et al. 2008). Research into latency periods to disclosure report a mean delay of anywhere between three and 18 years (Hébert et al. 2009). One study of a large representative Canadian sample highlighted that almost 60% of adult survivors delayed disclosing for five years or more, with one in five reporting never having disclosed to anyone (Hébert et al. 2009). This is concerning, as the longer disclosures are delayed, the longer individuals potentially live with the serious negative effects of abuse (Ullman 2007).

Yet, healthcare professionals are rarely the first person an adult survivor will disclose to. Survivors of CSA most often disclose to a peer, friend, or family member in the first instance (Brattfjell and Flåm 2019, Stige et al. 2022), and teachers are the professionals to whom children most commonly make

initial disclosures (Allnock et al. 2019). Level of parental support and quality of response to early disclosure are both factors which are considered as having a significant impact on later disclosures to professionals.

Disclosure is often understood as a turning point, which can be negative or positive (Schoon and Briken 2021). Reactions to a survivor's initial disclosure can often have a significant impact on their later decisions to disclose to others, with negative or inadequate responses to early disclosures often impeding further disclosure attempts. Research has suggested that while positive, supportive responses to disclosure are associated with better long-term mental health outcomes for survivors (Easton 2019), negative responses are more detrimental to survivors' health than positive responses are beneficial (Dworkin et al. 2019).

Disclosure can be traumatic and have short- and long-term effects on survivors' wellbeing. Some survivors report feeling 'relief' and 'pride' following disclosure; however reports of heightened feelings embarrassment, anger, sadness, shame, and guilt are also common (Berliner and Conte 1995, Foster and Hagedorn 2014).

### What prevents survivors from disclosing abuse to healthcare professionals?

There are many other factors which can influence decisions to disclose among adult survivors of CSA. Non-disclosure and delayed disclosure of CSA must be understood in the context of the significant challenges that survivors face in seeking help following sexual abuse. Across the lifespan, survivors' decisions to disclose to others are likely to be influenced by developmental and emotional challenges, by relationships and by wider community and social norms and practices (Alaggia et al. 2019, Collin-Vézina et al. 2015).

Despite the widely acknowledged trend across the literature that disclosures tend to increase as survivors get older, prior research has highlighted a general lack of understanding on how CSA disclosure processes and pathways may shift or change over the life course (Alaggia et al. 2019). Given that CSA was considered a relatively taboo subject, with limited visibility or availability of resources until more recent decades, a survivor's current age may influence their likelihood of disclosing to professionals. However, relatively few studies to date have included samples of survivors over the age of 50, and our understanding of disclosures made during older adulthood are limited (Alaggia et al. 2019).

Significant gender differences have been found regarding rates of disclosure in both childhood and adulthood. Early disclosure rates by boys typically range between 10% and 33% (Holmes et al. 1997). In one study of disclosure patterns in adult CSA survivors, 26% of male respondents reported telling someone at or around the time of the abuse, compared to 63.6% of female respondents (O'Leary and Barber 2008). Such low rates may continue into adulthood as males continue to delay disclosure or do not disclose at all – in

one national survey, the proportion of male survivors who reported never telling anyone about the sexual abuse was higher than in female survivors (Finkelhor et al. 1990). Men have been found to take longer to discuss CSA in adulthood than women, with one study reporting that approximately 45% of adult male survivors waited more than 20 years to discuss the sexual abuse (O'Leary and Barber 2008). Male CSA survivors face disclosure barriers including stigma, fear of not being believed, or fear of being labelled a homosexual (Easton et al. 2013). However, our understanding of disclosure patterns for male CSA survivors is comparatively limited.

Unique barriers to CSA disclosure exist for those from black and minority ethnic backgrounds, such as stigma or the influence of culturally informed perceptions or beliefs about abuse experiences (Allnock et al. 2019). However, it is not clear whether such barriers translate into lower disclosure rates for adult CSA survivors, and current research in the area of CSA disclosure continues to vastly overrepresent the voices of white women, both as survivors and recipients of disclosure (Dworkin et al. 2019). Further research examining the specific barriers survivors from marginalised or racialised communities may experience is desperately needed. Experiences of racism, particularly institutionalised racism and betrayal by systems and organisations, are also important factors when considering disclosure to professionals.

Characteristics of the abuse experiences of survivors have also been found to influence disclosure amongst survivors, with those who experience incest or sexual abuse perpetrated by a family member typically found to be less likely to disclose to professionals due to the impact of issues such as power, shame, stigma, and fears of negative repercussions (Hershkowitz et al. 2005, Paine and Hansen 2002). Delayed disclosure has also been found to be particularly common among clergy abuse survivors; however, little is known about specific disclosure patterns of this subgroup of CSA survivors (Smith and Freyd 2014).

Experiences of fear, embarrassment, guilt, and shame have been frequently cited as emotional obstacles which prevent survivors' from disclosing their abuse (Alaggia et al. 2019, Scoglio et al. 2022, Tener and Murphy 2015). Across the literature, survivors cite multiple and varying fears which act as powerful barriers to disclosure. Many relate to the internalised stigma and shame associated with CSA, such as fears of being perceived by others as permanently damaged, broken, or different (Scoglio et al. 2022). Survivors also report feeling ashamed or guilty for not having been able to prevent or stop the abuse, which in many cases may result in beliefs that they are somehow culpable or to blame (Tener and Murphy 2015). These feelings of complicity may be particularly pertinent to why male survivors disclose less; because of the way the male body responds to sexual stimulation, they may feel additional guilt if the abuse 'felt good' at the time (Sivagurunathan et al. 2019).

Other commonly identified fears centre more around the impact of disclosure itself, or how the other person might react in hearing it. Fears of not being believed by others, or being blamed for their abuse, are commonly cited

across the survivor research. Understandably, these fears may have a particularly silencing effect on survivors if they have experienced previous negative and/or blaming reactions from people in the past, thereby preventing further disclosure (Ahrens et al. 2007, Schoon and Briken 2021). How a person's family responded to earlier disclosures can prevent survivors from choosing to disclose to professionals (Schoon and Briken 2021). Similarly, survivors are less likely to disclose to professionals if their previous encounters of healthcare professionals or people in authority positions involved disclosure responses that were ill-informed, inadequate, or even harmful (Alaggia et al. 2019).

Survivors also report fearing the process of disclosure itself. Survivors frequently cite concerns that they might become retraumatised or unable to cope by speaking the words out loud or describing the details of what happened (Ullman 2002). Similarly, survivors may be afraid of the potential impact of disclosure on the other, and fear that professional will not be able to handle or tolerate the information and become emotionally overwhelmed themselves (Alaggia 2004). Many survivors report worrying that by disclosing they may trigger formal procedural processes which would be distressing or uncomfortable, such as having to make a formal report, having to make repeated disclosures to multiple professionals, or even having to face the perpetrator again if the case was taken to court (Tener and Murphy 2015).

### What stops us from asking?

Perhaps one of the most striking findings across the disclosure literature is that, despite a growing recognition of the prevalence and impact of CSA in healthcare settings, routine enquiry by professionals in healthcare settings remains low (Hepworth and Mcgowan 2013, Read et al. 2018a). Therapists or other healthcare professionals not openly speaking or enquiring about abuse experiences is considered one of the most powerful (and frequently cited) barriers to CSA disclosure amongst adults.

Evidence suggests that certain client characteristics may play a role in whether therapists decide to ask about abuse experiences. Professionals are considerably less likely to enquire about CSA if the client is a male, suggesting that they are not immune from the powerful gender norms and societal belief systems which can similarly prevent male survivors from coming forward (Read et al. 2018a, Ross 2010). In one study, a third of professionals reported that they never asked men directly about sexual abuse (Lab et al. 2000). While certain diagnoses (such as depression or PTSD) may prompt professionals to ask about abuse experiences, others (such as psychotic disorders) have consistently been found to be associated with poorer professional responses to disclosure (Read et al. 2018a). Despite strong associations between CSA and psychotic experiences, professionals are less likely to enquire or respond to disclosures of CSA made by individuals with psychosis (Cavanagh et al. 2004, Read et al. 2018a, Ross 2010). Similarly, therapists report

being less likely to ask about abuse experiences if the person is presenting as generally unstable or with other, more immediate, primary treatment concerns. It has been suggested that this reluctance to ask may be due to fears amongst professionals of upsetting or destabilising already unwell individuals or increasing the risk of inducing delusions or 'false' memories (Read et al. 2018a, Ross 2010). Professionals also often neglect to ask about CSA if it is not considered relevant to the presentation requiring treatment, or if there are multiple competing clinical priorities (McLindon and Harms 2011).

Another central theme across research examining the perspectives of healthcare providers is that directly asking about CSA can often feel too risky or invasive. Like survivors, therapists seem to recognise that sharing stories of abuse can have both healing and harmful potential, and thus a driving concern across professional groups is how they can access survivors' stories without causing further harm (Stige et al. 2022). Often, a reluctance or hesitation to ask about abuse experiences may be well-intentioned, stemming from professional desires to respect their clients' privacy, or protect their clients. Therapists report feeling worried that by asking their clients directly about abuse they may inadvertently destabilise them, evoke angry or distressed reactions, cause a decline in functioning, or cause offence (Lab et al. 2000, Stige et al. 2022). Fears of the potential damage this might have on the therapeutic relationship or a client's engagement in treatment have further been identified as concerns which impede direct enquiry by professionals (Stige et al. 2022). Some therapists may also perceive direct enquiry of abuse as too intrusive, coercive, or controlling (Lab et al. 2000), and avoid doing so in an effort not to re-enact trauma or abuser dynamics. In response, many therapists and healthcare professionals describe a process of waiting for their patients to take the lead in bringing it up (Kennedy et al. 2021, Walsh et al. 2022). Professionals often report believing that CSA should not be raised explicitly unless the client chooses to do so (McLindon and Harms 2011) or that they should work in ways which support spontaneous disclosure rather than taken an active role in unearthing these experiences (Dusoulier 2023).

Professionals, too, may often hold beliefs about the unpredictable, uncomfortable, and even harmful consequences disclosure can have. In many cases, this can underpin inadvertent avoidance of asking about CSA histories. A commonly cited fear amongst healthcare providers is that asking clients about CSA may retraumatise, destabilise, or worsen a patient's condition (Kennedy et al. 2021, Lab et al. 2000, Young et al. 2001). Particularly, if therapists have had previous experiences with survivors where disclosure has not gone well or resulted in unwanted consequences, they may be less likely to bring it up with future clients (Stige et al. 2022). Staff cited fears of 'opening Pandora's box' may be further compounded by the contexts within which disclosures take place. Service restrictions around number of sessions, limited specialist treatment provision, or lack of available follow-up services are all factors which may impede professionals in healthcare settings from initiating conversations around CSA.

Supporting and responding to disclosure are readily perceived by practitioners as requiring sufficient skill and expertise, which many professionals may believe they lack. Therapists frequently report feeling underqualified to enquire about CSA and fearful of saying the 'wrong' thing (Walsh et al. 2022). Across a range of settings, and disciplines, health care professionals report that they lack training in enquiring about and responding to disclosures of CSA (Kennedy et al. 2021, Walsh et al. 2022, Young et al. 2001). This perceived lack of knowledge and skill thus further delays or prevents professionals from uncovering abuse histories (Mansfield et al. 2017). In many cases, professional beliefs of being ill-equipped to respond may be unfounded or underpinned by anxiety or fear of making mistakes. Yet, research also indicates that too often medical and healthcare providers are not trained to recognise the signs and symptoms of CSA (Sampson and Read 2017, Sweeney et al. 2018). Survivors frequently report that when they have disclosed to professionals working in mental health and legal systems, practitioners have often lacked the necessary expertise or sensitivity to support them effectively (Schoon and Briken 2021). In another parallel with research on survivors' experiences, healthcare professionals have similarly identified ways in which anxiety around legal processes and service-specific protocols (e.g. mandatory reporting) might get in the way of their ability to comfortably sit with and respond to disclosures in more helpful ways (Stige et al. 2022). Ensuring workforces are adequately trained to support survivors is therefore essential both in building staff confidence and reducing the potential for unhelpful or harmful professional responses to disclosure.

Vicarious trauma, and the emotional impact of exposure to CSA disclosure on professionals, is also likely to contribute to avoidance by healthcare providers. Therapists' feelings of discomfort when talking about CSA have been identified as a barrier to asking about abuse histories (Day et al. 2003, Kennedy et al. 2021, Lab et al. 2000, McLindon and Harms 2011). Uncomfortable or disturbing emotions cited by professionals as arising through clients' disclosure might include hopelessness, powerlessness, isolation and loneliness, disgust, embarrassment, over identification with the survivor's experiences or anger towards the perpetrator (Frenken and Van Stolk 1990, Stige et al. 2022). Healthcare professionals have described the process of hearing and responding to clients' disclosure of CSA as dirtying, unsafe, or getting stuck in their heads and impacting their wellbeing for days afterwards (Kennedy et al. 2021, Stige et al. 2022). Avoidance of direct enquiry may thus be conceptualised as a protective countermeasure taken by professionals to limit the amount of information that might be shared. Service-wide challenges relating to limited accessibility or availability of clinical supervision for professional staff may further increase the burden of disclosure on staff members (Kennedy et al. 2021, Walsh et al. 2022).

### What helps survivors to disclose?

Compared to research on what gets in the way of disclosure, considerably less research has examined what factors may encourage CSA survivors to

disclose to professionals (Alaggia et al. 2019). Many adult survivors describe the occurrence of 'turning points' in their lives which prompt them to re-evaluate their appraisals of CSA experiences or the impact it has had on their lives. Commonly identified milestones include the entry into adulthood, the establishment or continuation of a secure committed relationship, or the birth of children (Alaggia 2004, Alaggia et al. 2019). More generally, experiences of personal empowerment or achievement have been found to facilitate disclosure, perhaps through their capacity to challenge early deeply held beliefs (e.g. of failure, of powerlessness) which so often prevent survivors from feeling able to come forward (Somer and Szwarcberg 2001). Crises, or other more negative critical life events, can also serve as powerful catalysts of disclosure, as survivors may be confronted with the extent to which they have been impacted their CSA experiences and decide to seek help (Sivagurunathan et al. 2019). Examples of such experiences cited across the literature include: getting fired from a job, losing their home, relationship conflict or dissolution, parenting difficulties or stressors, or the onset or worsening of disruptive coping mechanisms (e.g. alcohol/substance misuse) (Alaggia et al. 2019). Survivors may also only become aware of abuse or able to describe experiences as abuse later into adulthood (Tener and Murphy 2015). For example, adult survivors may access therapy or support which assists in the retrieval of memories or acknowledgement that abuse occurred.

CSA disclosures may also be facilitated by factors relating to changes in survivors' relationships with or proximity to perpetrators. Moving away from home or the location where the perpetrator lives has been identified as a common catalyst for disclosure amongst survivors (Alaggia 2004). As seen in recent high-profile cases (e.g. Jimmy Saville), perpetrators dying can also often enable survivors to feel able to disclose to professionals. Media attention to similar cases, or other survivors publicly disclosing their experiences of the CSA, can also prompt disclosures (Sivagurunathan et al. 2019, Somer and Szwarcberg 2001, Tener and Murphy 2015). Survivors also report deciding to disclose to professionals after learning that others may have been abused or be at risk of being abused by their abuser (Tener and Murphy 2015).

### How can professionals facilitate and improve responses to disclosures?

There is relatively little research on what responses by healthcare professionals are perceived by survivors as most helpful or positive. Both professionals and children highlight the importance of trusting relationships in facilitating helpful disclosure experiences. At its core, CSA disclosures to healthcare professionals typically must involve a degree of intimacy or trust for survivors to feel comfortable (Deering and Mellor 2011). The emotional bond with a therapist or professional has been identified by survivors as a crucial facilitator of disclosure, through the provision of a safe therapeutic context within which sexual abuse can be explored (Solberg et al. 2021). This generally means that

the best time for professionals to ask about abuse is when rapport between clinician and client has already been firmly established (Kennedy et al. 2021, Young et al. 2001). Psychological therapists report relying on the therapeutic relationship and their own intuition to bring questions about historical abuse into assessment and/or treatment (Toner et al. 2013). Such professional intuition might be based on non-verbal signals (such as body language, facial expressions, and tone of voice), as well as other clinical indicators that the person may have experienced CSA. While this intuitive approach by therapists may promote sensitivity, it does also raise the question of how more routine or systematic enquiries by professionals can be implemented.

Despite evidence of professional anxiety and reluctance to do so, therapists asking directly about abuse have been consistently identified as a potential facilitator of disclosure (Solberg et al. 2021). Research into survivor perspectives has highlighted the importance of the burden and responsibility for disclosure not always falling to the survivor. Professionals asking survivors direct questions about their abuse histories can thus be experienced by survivors as a helpful way of reducing the reliance on survivors to offer this information in the first instance, helping to put words to experience that they might find too difficult or painful to verbalise. Across several studies of survivor perspectives, professional enquiry and prompts to tell are frequently viewed as necessary and/or worthwhile (Fontes and Plummer 2010, McElvaney 2015). Significant discomfort or distress arising from being asked about abuse histories is generally considered uncommon, with some suggestions that a lack of enquiry by therapists into whether they have historical experiences of CSA can leave survivors feeling disappointed or unsure about accessing treatment (Lothian and Read 2002).

Several studies have emphasised the importance of professionals conveying knowledge and information about CSA and its impact. Survivors have identified this as a central tool which can facilitate and encourage disclosure through helping them to recognise the effects of CSA on their life, validating and normalising responses following sexual abuse, and shattering unhelpful societal myths or beliefs around abuse which may prevent them from coming forward (Solberg et al. 2021). Normalisation of CSA experiences and/or impact through sharing information can also help to reduce feelings of isolation amongst survivors. In some cases, survivors may find it hard to accept that sexual violence has occurred. In this way, having a professional name the experience accurately as violence, placing accountability onto the perpetrator, and emphasising who the victim was can all help to validate survivors' feelings about abuse and support integration of this into their own worldviews (Scoglio et al. 2022).

There are several characteristics of therapists and healthcare professionals which CSA survivors report finding helpful or supportive consistent with broader literature on therapeutic processes, survivors report being more likely to disclose to professionals who possess personal qualities such as being: supportive, understanding, caring, thoughtful, empathetic, emotionally open,

compassionate, and patient (Easton and Parchment 2021). Survivors emphasise the importance of therapists' nonverbal communication, such as active listening and positive body language, in creating a supportive environment where disclosures can occur. Survivors also value those who respond with genuine warmth and empathy, but who also possess a sense of calm, and who do not react with surprise or shock (Allnock et al. 2019). There is some evidence to suggest that the professional background or gender of staff may play a role in level of responsiveness to disclosures; however, research examining this is fairly minimal. In one systematic review, female staff were found to provide higher levels of responses to abuse disclosures than their male counterparts and were also more likely to refer survivors for abuse-related therapy (Read et al. 2018b). The gender of professional staff has also been cited by survivors as a factor which plays a role in decisions of whether (or not) to disclose, for both male and female survivors (Easton and Parchment 2021, Easton et al. 2014, Scoglio et al. 2022).

Qualitative research into survivor experiences has highlighted several professional responses to CSA disclosure which are considered helpful or unhelpful. Crucially, and perhaps unsurprisingly, survivors describe a need to be believed by those they choose to disclose to. While much of the literature examining the emotional impact of not being believed has focused on family or peer support systems, professionals can of course also (consciously or unconsciously) deny or misbelieve survivors' disclosure of abuse experiences (Örmon 2014). Related to this, survivors have described ways in which healthcare professionals minimise or dismiss abuse experiences as not 'relevant' to their mental health or set disclosures aside as less important than the treatment of immediate presenting difficulties. Professionals who change the subject too quickly or decline to explore these disclosures further may be perceived by survivors as disinterested or dismissive (Read et al. 2018b, Tener and Murphy 2015). Blaming responses have also been repeatedly identified by survivors as painfully negative and silencing reactions, which can inevitably prevent them from continuing to disclose or disclosing to others (Scoglio et al. 2022, Ullman 2002). Within healthcare settings, blaming responses by professionals may take the form of asking detailed questions about how or why the abuse occurred, querying choices or responses taken by survivors, or identifying ways in which the abuse could have possibly been prevented. Survivors also describe professional inaction or 'unsupportive acknowledgement' as an unhelpful and often harmful response, whereby survivors' experiences and subsequent needs are acknowledged, but inevitably lead to no further responses or support being offered (Read et al. 2018b, Relyea and Ullman 2015, Stige et al. 2022).

It is not only professional underreactions which are experienced by survivors as unhelpful. Anxious and uncontained reactions by professionals have similarly been cited in research as negative responses which can prevent survivors from feeling safe enough to open up further (Tener and Murphy 2015). These can include signs that the listener is uncomfortable or panicked, which

can often trigger worry in survivors that the person they are disclosing to cannot handle or tolerate the burden of being told, or may act unpredictably. Asking too many questions, particularly about sexual details, may frequently be experienced by survivors as intrusive, unnecessary, or voyeuristic (Tener and Murphy 2015). Professionals expressing anger towards perpetrators has also been described by survivors as frequently unhelpful or overwhelming, perhaps due similarly to the risk that these feelings may dominate and thus leave less space for survivors' own emotional reactions (Tener and Murphy 2015). Survivors also cite ways in which professionals may bulldoze or take control of the situation following disclosure, thus communicating an insensitivity to survivors' needs.

One of the most helpful responses cited across the literature is for professionals to listen actively to disclosures, without judgement or immediate attempts to fix, repair, or heal (Easton and Parchment 2021, Scoglio et al. 2022). Survivors report particularly valuing therapists who can demonstrate a capacity to sit with and bear the discomfort and pain of sexual violence (Scoglio et al. 2022). Validation of survivors' experiences can occur through acknowledgement of the pain of what has occurred, while simultaneously highlighting ways in which this disclosure does not define the survivor or alter the way they are perceived by the professional (Scoglio et al. 2022). Provision of agency, choice, and empowerment is generally considered as pillars of trauma-informed healthcare systems. In response to disclosures, survivors have emphasised the importance of being offered choices and being given the power to decide next steps. Professional responses which acknowledge and support survivors to choose what further action or support they may want to take (or not) are largely considered the most helpful, whereby help is offered but not enforced (Easton and Parchment 2021). Following disclosure, it is generally considered important to ask survivors whether they have told anyone before, and if so, how helpful this response (Read et al. 2018b). Confidentiality is understandably important to survivors; while this can often be a complicated balance for healthcare professionals, the importance of professionals being open, honest, and transparent if maintaining confidentiality may not be possible following a disclosure, and keeping survivors informed about what actions they might need to take, has been repeatedly emphasised by both professionals and survivors (Allnock et al. 2019).

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# 3 "To think about what we are doing"

## Childhood sexual abuse and disciplinary trustworthiness

*Daniel Taggart**

### Introduction

What does it mean to act politically in the context of child sexual abuse? This need to think politically about what in some senses might be considered a matter primarily for criminal justice and clinical treatment emerged in part from a conversation I had where a colleague said to me that the longer she works in this field of child abuse and trauma, the more she sees the need for a political dimension to our action and thinking. My response was to think immediately 'yes absolutely' but then afterwards I wondered why is that so important and what do I mean when I think about acting politically? This chapter is my attempt to begin an answer to that question. I have included this preface because I want to emphasise the importance of it having emerged from a dialogue. The act of people thinking and speaking together seems central to me in the realm of political thought and action. Later I will draw on the work of the philosopher Hannah Arendt who was acutely aware of the dangers of not thinking and storytelling, but instead reducing knowledge formation to a solitary and statistical process devoid of human connectedness.

The chapter is divided into three parts. To look at the importance of trust and trustworthiness in trauma treatment, to examine examples of untrustworthiness in psy disciplines and how these have developed, to look at how the field of philosophy, in particular the work of the late Hannah Arendt, can help us address these.

### Trust and trustworthiness

Trust is suggested to be a central and underpinning construct in the development of collaborative therapeutic relationships and seen as necessary but not sufficient in achieving therapeutic change in psychological therapies with

* This chapter is based on a talk that was delivered as part of the Tavistock Trauma lecture series in May 2021. At the time, I was working as a clinical psychologist at the Independent Inquiry into Child Sexual Abuse (IICSA), specifically the Truth Project. IICSA ran from 2015 to 2022, the Truth Project from 2017 to 2021. More information about IIICSA and the Truth Project can be found in this volume.

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people with mental health problems. We can see this in relation to people with interpersonal trauma in the literature relating to Trauma-Informed Approaches (TIA), treatment for Complex Trauma and Epistemic Trust as an important construct in the aetiology and treatment of mental health problems.

TIA – Sweeney and colleagues in their seminal 2016 paper on the application of TIA in UK healthcare contexts cite nine core principles of a TIA and the building of trust through organisational trustworthiness and transparency is one of those.

Complex Trauma – In the treatment of complex trauma, trust is positioned as simultaneously a barrier to treatment, an interpersonal mechanism through which therapeutic work can happen, and lastly a marker of treatment success. In their book on treating complex trauma, Christine Courtois and Julian Ford (2016) note that, "Developing a sense of trust in the therapist … is both expected and fraught with inherent difficulties that are amplified by each client's unique history of betrayal trauma, loss and relational distress". Furthermore, the development of a therapeutic relationship is curative in itself as it "provides a crucial opportunity for clients to have a different relational experience involving trust and security from which to decrease their isolation and improve their relationship skills and expectations" (p. 135).

Epistemic Trust – I want to touch on two aspects of Epistemic Trust. The first is that Epistemic Trust is presented as developing in key early attachment relationships and that it is a developmentally and an evolutionary driven form of learning that takes place in the context of social communication. It is proposed that significant disruption to the development of epistemic trust as a result of a lack of sufficiently trustworthy information being imparted in key relationships can be seen to underpin problems in mentalising and attachment formation leading to psychopathology later in life. This lack of epistemic trust, or epistemic hypervigilance or epistemic petrification, continues to impair social learning, increases interpersonal suspicion, impedes resilience based on new learning and impairs the development of trusting therapeutic relationships.

The second point is the way that the problem is described in the literature. The patient's difficulty with Epistemic Trust is seen as a deficit arising from their developmental history and therefore something that needs to be repaired or replaced in 'them'.

> The consequence is that the regular process of modifying one's stable beliefs about the world in response to social communication is closed down or disrupted. This generates the quality of rigidity and being 'hard to reach' that therapists have often described in their work in the field of so-called Personality Disorder. Change cannot happen in the therapeutic setting because, although the patient can hear and understand the communications transmitted to them by the therapist, the information cannot be accepted as relevant to them and generalizable to other

> social contexts. The persistent distress and social dysfunction associated with PDs is the result of the destruction of epistemic trust in social knowledge of most kinds.
>
> (Fonagy and Campbell., 2017)

Therefore, the impetus for change is on behalf of the patient and a failure in social learning is due to previous relational problems during early development. While the treating clinician needs to address this deficit of trust in the patient, it is expected that this can be done through normal therapeutic practice such as mentalisation-based treatment and the more general need for 'mentalising therapists'. Its particular focus on patients with personality disorder diagnoses is significant when thinking about sexual abuse because of the extraordinarily high rates of abuse in the histories of people diagnosed with these problems, making childhood trauma a significant aetiological factor in the development of these problems.

So, the evidence presented here is that ongoing epistemic vigilance is a deficit that can lead to psychopathology and inhibits relational learning. In an ironic, cruel twist is also a quality that makes it more challenging for the traumatised person to be able to engage in an interpersonal process of therapeutic work that help them with their relational difficulties and their traumatic symptoms. In some therapeutic modalities, this struggle with trust and subsequential difficulties in 'engagement' in therapy might be described as a 'therapy interfering behaviour'. In other treatment forms, it is the essence of the therapeutic task itself, but the emphasis is still on the patient to address their trust deficit through engagement with a benign therapist.

Across two of the three areas of treatment for trauma described above, the emphasis is on the deficit of trust being grounded in the patient and the use of clinical expertise to mitigate these deficits, a bit like the metaphors that we use a lot in the psychological therapies – containment, scaffolding, lending the patient the therapist's 'thinking brain', guided discovery, Socratic questioning, etc. In Sweeney and colleagues' case of TIAs, this was the only paper I cited that talks about the development of 'trustworthiness' and is also the only one written from an explicitly survivor perspective, which I find significant. Trustworthiness is the corollary to trust, for a person to trust there needs to be some trustworthiness in return. As Susanna Alyce outlines in Chapter … trust is a relational process and one in which, in contrast to how it is presented in traditional trauma literature, two people are implicated. A lack of trust might be evidence of a deficit in the traumatised person, but it is equally plausible and it is because of a lack of trustworthiness in the practitioner or service system, or perhaps some messy combination all three, one compounding the other and creating a distancing that can be hard to articulate. I think this is where we often see blame and counter blame developing in the breakdown in therapeutic relationships. It is a particular issue for people in the helping professions. So much of what brings us into this line of work is a desire to help others, when confronted with a

lack of trust in someone we are trying to help it is understandable we react with disbelief and see the fault in the other. Psychoanalysis calls this projection, but we can think of it also as a form of moral protection of our identity as a helper. While this type of insecurity is normal and understandable, when it gets into the systems we work in, it can become toxic and dangerous. I attended one of IICSA's public hearings where a large Children's 3rd sector organisation was being challenged on its record of child sexual abuse of British nationals taken overseas. Their response was one of disbelief born of a sense of moral superiority, "but how could we do this, we are the ones who protect children" (Lynch, 2022).

So if this moral defence against our identity as helpers, or even more perniciously 'healers', gets carried unawares by us into our organisational systems we can see how that might play out for a person coming for help but having a slightly complicated relationship to authority and trust. What I want to look at now though is, what happens if it also gets into our disciplinary guilds, our training institutions and subsequently into the discourses we have available to talk about trauma, trust, and belief?

## Truthworthiness in the psy disciplines

If trust is a key ingredient in forming therapeutic relationships, is seen as being deficient in traumatised people and requires a relational approach with survivors of CSA, how do we assess the trustworthiness of the disciplines and institutions set up to serve this population? We can ask our clients, that is certainly a central way. But we can also take an historical analysis which assesses institutional practices towards survivors across time. The primary form that these historical analyses of Institutional practices in relation to child abuse in higher income countries over the past several decades have been in the form of public inquiries of various types. In the last decade, we have seen high profile Historical Institutional Abuse Inquiries in Germany, England, Wales, Scotland, Australia, Northern Ireland, the Republic of Ireland, and Norway. As part of all of these Inquiries consideration has also been given to the impacts that CSA has across the lifespan including ongoing state failures to protect and support survivors. This has included failures of the criminal justice system to adequately support CSA survivors' justice claims but also for survivors to be believed and taken seriously. In the Truth Project as part of IICSA, the most common feedback from survivors is the fear that they will not be believed as this has happened for them so many times in the past. The name of the project is itself a testament to this legacy of disbelief, denial, and silencing and an attempt to offer CSA survivors a different experience and a form of testimonial justice that makes some amends for past harms (Barker et al., 2023).

There are a number of documented Institutional defences that can be seen to have made it hard for Institutions to respond to allegations of CSA to begin with and then to listen effectively to survivors. The ones I want to focus on in order to draw parallels to the psy disciplines are Clericalism and Historicism.

Clericalism refers to a division between clerics in Catholic orders and the laity, that has been long regarded as divine in origin and a theologically based belief that dates back to St Paul. It is built into the Catholic Church's hierarchy and sees laity as inferior in status to members of the clerical state; priests, deacons and bishops. This can create problems when the rule of law of the secular state is in opposition to the prevailing Church law, which is also seen as divine law. Clericalism is what can happen when that gap creates a sense of superiority in the Church, we are ruled by divine law, not human law. One example of how this creates problems around the sexual abuse of children is in relation to Church law regarding the vow of celibacy required for ordination into the priesthood. This vow prohibits any form of sexual contact, both between consensual adults, adult sexual assault, and the sexual abuse of children. So, the risk is there is an inbuilt struggle to relatively rate the seriousness of CSA compared to other, consensual forms of sexual contact as they are all prohibited. Furthermore, as this infraction refers to Church law, it is also something that may be seen as an internal matter, relating to a clerical problem and not a legal one (Benkert & Doyle, 2009).

Historicism is an institutional defence that was on display a lot at IICSA and in other child abuse inquiries. It is the belief that while there may have been problems in the past, this is something that has been resolved now and there is no longer any institutional failures to watch out for. It could be seen in Lambeth's council's response to IICSA's finding that it had failed children under its care, and that children from ethnic minority groups had suffered disproportionately. Alongside what appeared to be genuine contrition was a desire to draw a line between the past and the present, as its CEO said in a statement; "While accepting the clear and inexcusable failings of the council over decades, I want to make clear that there is a big difference between the council of the past with the Lambeth of today" (Lambeth Council, 2021). This sort of corporate distancing is needed and makes some sense in terms of continuing to function as an institution that has been found to fail so badly as Lambeth was, however, it risks defending against similar risks being present now.

The final organisational defence on display at Historical Child Abuse Inquiries I wanted to draw attention to is exceptionalism, referred to above in the belief that certain institutions are incapable of failures in child protection as they are of fundamentally higher calibre. In addition to organisations that are founded to look after children, we can also see exceptionalism in religious orders, we are doing 'God's work' and as such are above reproach. We can think of these defences as fault lines that run through institutions in how they relate to failures internally, while they may be addressed by remedial action to fix previous problems, there may be remaining sedimentary weaknesses in the system leaving it vulnerable to further failures.

One thing that must be noted is that the philosophy of science has changed since the modernist era when Freud was writing. Freud's image of himself as an archaeologist of the mind is a compelling one but his belief that he was

discovering pre-existing, immutable and universal truths about the psyche feels like it belongs to a different time. The emergence of the postmodern turn in the psy sciences, the softening of positivism from a realist ontology towards a more critical realist perspective that recognises the socially and historically situated nature of empirical evidence. Now, there is a broader acceptance that the psy disciplines as well as describing the human mind, are also to some extent constructing the image of the mind that we have available to us and setting the parameters of what the mind can or cannot be. To use the philosopher Ian Hacking's title of a seminal essay in the area, when developing systems of classification for psychological types or problems we are in some senses 'Making up People'.

> We think of many kinds of people as objects of scientific inquiry …. We think of these kinds as definite classes defined by definite properties. As we get to know more about these properties, we will be able to control, help, change, or emulate them better. But it's not quite like that. They are moving targets because our investigations interact with them, and change them. And since they are changed, they are not the same kind of people as before. The target has moved. I call this the 'looping effect'. Sometimes, our sciences create kinds of people that in a certain sense did not exist before. I call this 'making up people'.
>
> (Hacking, 2006, p. 1)

If we take a moment to look at the type of mind the psy disciplines describe for survivors of child sexual abuse, a mixed picture emerges. On the one hand, we have gathered a vast amount of empirical evidence that the sexual abuse of one person by another has a profound impact on the health and social wellbeing, this has legitimised sexual abuse as a traumatic event requiring treatment and access to justice. It has given CSA a status of victimhood that it did not always have. The psy disciplines have also, to a certain extent, developed evidence-based treatments that can help alleviate the suffering of survivors and offers them important psychosocial rehabilitation that can assist them in reconnecting with their social worlds. On the other hand, there is a less benign story and one that we need to examine if we are considering the trustworthiness of the psy disciplines from the perspective of survivors of CSA. Let's take three examples, one each from each of the main psy disciplines – psychiatry, psychology, and psychoanalysis in order to test the trustworthiness of our disciplines in responding to child sexual abuse survivors and test to what extent there may be disciplinary failures that mirror institutional failures investigated by HIA Inquiries.

Firstly, in my own discipline of psychology, survivors of CSA have been subject to questioning of the veracity of their testimony of abuse, based on appeals to scientific credibility in the form of memory research. The famous memory wars of the 1990s pitched survivors and clinicians against a coalition of parents who had been accused of CSA by their children and psychological

researchers who had conducted experimental studies into the unreliability of childhood memory, people's susceptibility to developing false memories through suggestibility, and the risk that certain forms of psychotherapy can inadvertently induce false memories of abuse. The case for the unreliability of memory is eloquently summarised in a book by the writer Karl Sabbagh, where he interviews leading memory researchers including Elizabeth Loftus, entitled "Remembering our childhood: how memory betrays us" (2011). The book summarises some of the research in the area and concludes that many people are subject to false beliefs of CSA, that these are brought about by ethically questionable therapeutic practices, and that the criminal justice system needs to attend more to scientific evidence from experimental psychology over the dubious accounts of 'alleged' memories of victims. Sabbagh was a member of the British False Memory Society's scientific committee alongside a number of researcher psychologists and his writing was described by Loftus as having a "keen insight" into how memory works and what it means. Sabbagh's credibility as an objective observer of scientific research and a rationalistic sceptic questioning if CSA was an explanatory framework for damaged people looking for the source of their unhappiness, was undermined in 2019 when he was convicted for grooming a 13-year-old girl. He was convicted for 45 months not based on the victim's testimony, but on the retrieval of data from his phone, presumably not subject to the same lack of reliability that our memories have (Delahunty, 2021). What this shows is that while scientific evidence from experimental psychology studies purports to be objective and neutral in contrast to the emotional and irrational accounts of experience, it is subject to misuse and as such cannot be independent of the field of CSA it purports to study.

The appeal to science inherent in false memory debates is reminiscent of the clericalism used as a defence by the Catholic Church in managing attacks on its credibility. Science, not God this time, becomes the higher authority and anything that does not operate according to its internal logic and hierarchy of evidence is treated with suspicion. However, as we have seen, science does not exist outside the social frame it studies, and when we turn to the work of Hannah Arendt, we will explore how dangerous it is to look to science to tell us what we *should do*, particularly when that happens at the expense of denigrating people's testimony of their own lives (Arendt, 1958). As one activist put it, "Women cannot be experts in their own lives. We have to defer to the people who have the appropriate degrees, went to appropriate schools, and know our psychology better than we do" (Whittier, 2009, p. 159).

The theory that false memory science blamed for therapeutic practices which implanted false memories of abuse, was Sigmund Freud's theory of 'repression'. At the heart of the psychoanalytic idea of repression is an assertion that "there are psychic processes capable of excluding other psychic processes from consciousness" (Freud, 1991, p. 519). Furthermore, this exclusion is purposeful, it isolates instinctual impulses that conflict with another

party of the mind, but in repressing them outside awareness they return to consciousness in the form of, "an unrecognizably distorted substitute, and creates what we call a symptom" (Freud, 1991, p. 24). The theory of false memory relies on the notion that Freud's description of psychic conflict and repression is also represented in how memories of external events are processed and stored. It is fair to say that Freud had a somewhat more complicated view on the relationship between internal phantasy and external reality. This nuanced understanding of the interplay between the way we make sense of the world around us and what happens in our environment is still a hallmark of psychoanalysis' distinctive contribution today. Assertions from false memory researchers that Freud's unscientific theory of repression led the way to 'recovered memory' therapy might suggest that psychoanalysis aligned itself with traumagenic explanations of psychological disturbances. However, the story is less straightforward and is an example of another psy discipline operating to undermine the testimony of survivors of abuse, in ways that parallel experimental psychology and can be understood as similar mechanisms of defence to those employed by other institutions in relation to allegations of CSA.

Freud's relationship to accounts of sexual abuse in his patients is one of the great talking points of the history of psychoanalysis. One of the most accessible, entertaining, and illuminating of books on the subject is Janet Malcolm's "In the Freud Archives". The book documents Jeffery Masson's discovery and revealing of letters from Freud to his colleague Wilhelm Fleiss, that demonstrated his move away from seeing truth in his female patients' accounts of incestuous sexual relationships with their fathers and other male relatives, to reconstructing it as evidence of phantasy. One key excerpt Masson published was from Letter 69 to Fleiss in 1897:

> I will confide in you at once a great secret that has been slowly dawning on me in the last few months. I no longer believe in my neurotica …. Then came the surprise at the fact that in every case the father, not excluding my own, had to be blamed as a pervert – the realization of the unexpected frequency of hysteria, in which the same determinant is invariably established, *though such a widespread extent of perversity towards children is, after all, not very probable*.
>
> (Freud, 1897, italics added)

In Malcom's book, there is another incident that convinced Masson that Freud was reneging on his seduction theory to protect institutional authority, in this case, Fleiss himself who had mistakenly left a gauze in a patient's nose, leading to a possible infection and serious blood loss. Over time in Freud's mind, the incident becomes more about the patient's hysterical longing than Fleiss' mistake. The clericalism inherent in Freud only being able to see in his patient's distress through a psychoanalytic frame, and the exceptionalism in not being able to countenance his friend's mistake was unforgiveable for

Masson, who said, "ever since then analysts have been denying the realities of their patients' lives" (Malcolm, 2018, p. 50).

Judith Herman's analysis is that this was, in part, a political, strategic move on Freud's part, it was simply too controversial to take seriously the notion that large numbers of girls and women were being sexually exploited in their middle-class homes. Instead, he concluded that, "these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up" (Freud, 1925, cited in Herman, 2022, p. 20). Easier to develop a psychological theory that was, "founded in the denial of women's reality" (p. 20), than to challenge patriarchal systems. In this sense, Freud was no more than a man of his time, albeit one who also took an unusual amount of interest in women's internal worlds, even if he struggled to fully link it to their external realities.

One can link this debate on the veracity of survivors of sexual abuse accounts of their experiences encapsulated from these two examples in psychology and psychoanalysis to the ways that subjective accounts of pain radically differ depending on who is giving the account. Elaine Scarry in her book, 'The Body in Pain' points out that, "the recognition of the way pain enters into our midst as at once something that cannot be denied and something that cannot be confirmed … To have pain is to have certainty; to hear about pain is to have doubt" (Scarry, 1985, p. 13). It is not possible for psychology or psychoanalysis to reach into our minds and find whether our experience is phantasy, an accurate description of our experience, or some mixture of the two. It is unclear why the psy disciplines think that their account should be more credible than a person's own recollections, but it is instructive that they do. The erosion of the value of subjective experience by scientific data and theoretical modelling is not limited to the field of child sexual abuse, but it has particularly pernicious effects there as it coalesces with other forms of denial in public bodies, as we have seen in the case of IICSA. The final example we turn to demonstrate the lack of trustworthiness of in the psy disciplines from the vantage point of CSA survivors is psychiatry.

The primary institutional defence I want to highlight in relation to psychiatry is historicism, but firstly we need to examine some ways in which the discipline has caused iatrogenic harm for survivors of child sexual abuse. Most psychiatric diagnoses, with PTSD and C-PTSD being notable exceptions, do not engage in aetiological analyses of the roots of psychiatric disorders. This places people impacted by trauma in a potentially disadvantageous position if the constellation of their psychological difficulties maps on to anxiety, psychosis or obsessive–compulsive disorder for example, as it means the underlying interpersonal injury gets lost. Given how important it can be for survivors of child sexual abuse to have their experiences listened to, believed, and treated with dignity, it is understandable that a failure to recognise the centrality of abuse in the cause of distress may cause harm. However, the difficulties with psychiatric diagnoses go further than a failure to recognise and esteem victimhood.

One diagnosis that has caused harm to women who are survivors of sexual violence is that of borderline personality disorder, also known as emotionally unstable personality disorder. Somewhere between half and two-thirds of adult women diagnosed with borderline personality disorder report sexual abuse in childhood (Temes, Magni, Aguirre, Goodman, Ridolfi & Zanarini, 2020), making it more prevalent in people with this diagnosis than most other psychiatric patients. Despite this, survivors labelled in this way report having limited access to trauma-specific treatment and describe serious iatrogenic harm in their contact with mental health services (Lomani et al., 2022). This harm comes in the form of being told their personality is disordered and as such that the distress they are experiencing is their problem, rather than a consequence of serious violent crimes. Survivors describe being offered behavioural interventions that do not take account of the underlying trauma, often being told they are not allowed to talk about their abuse as part of treatment. Such is the stigma around this condition that when presented with two different vignettes describing the same clinical presentation, with one having the diagnosis of borderline personality disorder included, clinicians will rate prognosis more pessimistically for the borderline vignette (Lam et al., 2016). The core features of the disorder map on to trauma responses, such as emotional lability, interpersonal insecurity, and negative self-concept, and make sense as adaptive responses to threat, albeit ones that can cause distress and impact quality of life. However, in packaging these behaviours and experiences in a psychiatric diagnosis, the underlying abuse narrative gets lost and leaves survivors wearing the psychological scars of sexual violence but lacking an explanatory framework and leading survivors to often feel blamed for their current difficulties. When psychiatric services recreate core features of abusive relationships, by either coercing survivors into invasive treatment, or abandoning them in their distress, there is a mirroring of the original abuse that we sometimes describe as retraumatisation.

At heart here, there is also, like in the examples of psychology and psychoanalysis, an attempt to undermine the testimony of the survivors by placing a technical, clinical term in place of one that recognises the underlying injury. As such, enforced psychiatric labelling can be seen as acts of invalidation and misrecognition for people who have been sexually abused. To come back to Hacker's earlier formulation, what type of child sexual abuse survivor are we making up when we describe them as having a disordered personality?

There are signs that elements in psychiatry are moving away from these types of mis-framing and attempting to recognise and atone for past harms in a way reminiscent of public inquiries like IICSA. The position statement on non-recent child sexual abuse from the UK's Royal College of Psychiatry, states that, "for many survivors, their difficulties cannot be captured by a diagnosis" (REF pending) It goes on to acknowledge iatrogenic harm in mental health services and a failure to recognise problems like dissociation as central to responses to sexual abuse. This shift from a reductionist, diagnosis-based approach to understanding trauma, to one that recognises

past disciplinary failures and prioritises survivor perspectives as central is unquestionably a sign of progress and to be welcomed. However, it would be naïve to expect a statement in itself to signal wider change. Looking back at how institutions responded when confronted with their failures at IICSA, we can see a desire to distance themselves from the past, without always acknowledging the sedimentary imprint of tradition underneath fresh starts and learning the lessons. This historicism can only be fully addressed by a genuine recognition of past harms through a transitional justice type process, which has already been called for by some scholars and activists (Spandler & McKeown, 2017). Statements of change can be a harbinger of this type of structural change, but they should not be mistaken for a replacement for it.

## Hannah Arendt and the human condition

If we reflect on what the psy disciplines have done to shape, or make up, the identity of the child sexual abuse survivor, what sort of person would we see? They might be a person who lacks credibility as a witness of their own experience, someone who is fundamentally dysfunctional at the level of their inner being, not a human subject at all but an object that requires classification, measurement, and control. There is an obvious ethical challenge in this, or what we might call an Epistemic Injustice, that the person is not treated with respect in their capacity as a knower. I want to think about the exchange between the psy disciplines and our made-up survivor, to unpick the consequences of these disciplinary defences of clericalism, historicism, and exceptionalism using a different lens. A fuller understanding of how these defences produce this made-up person and a way out of its reductionism cannot be found in the psy disciplines themselves. We need to get on to fresh, higher ground to escape the tautological reasoning on offer within the fields themselves, which may recommend more and better science, more finely tuned diagnostic categories, or even a psychoanalytic interpretation of organisational defences. It is to the work of the German-Jewish political philosopher Hannah Arendt that I have turned for a broader understanding of the ways that scientific ways of thinking can limit the value we attach to people's understanding of themselves and their fellow citizens, and what a different approach might look like.

Hannah Arendt was born in 1906 in the German town of Königsberg. She studied with the phenomenologist philosopher Martin Heidegger. Her intellectual mentor and friend was Karl Jaspers, the psychiatrist and author of the phenomenological psychiatric text, General Psychopathology. Arendt fled the Nazis in 1933 and eventually settled in the US, where she lived until the end of her life in 1975. Her most famous works concerned the holocaust and Nazism, the Origins of Totalitarianism (1973), and Eichmann in Jerusalem (1964), making her one of the best-known political philosophers of the 20th century and a key intellectual critic of totalitarianism.

In 1958, Arendt wrote The Human Condition, a book which links the ancient Athenian acropolis and 20th-century politics, to examine the question of human agency and what can undermine it. One of the themes in the book is what scientific progress, in the form of technological innovation, does to our experience of the universe and how that shapes our ability to tell stories to one another and to engage in collective meaning-making leading to political action. Drawing on Galileo's 17th-century invention of the telescope, Arendt argues that his rediscovery of the earth seen from the vantage point of the universe led to a, "violent insistence … that they saw things never seen before, thought things never thought before" (p. 249). What this invention meant was that the way that humans had understood the universe for millennia, that the earth was at the centre of it and the sun revolved around us, was proven to be a fallacy, a perceptual mistake, our senses fooling us. In some ways, although Galileo was working in a philosophical tradition that dates to antiquity, this 'scientific' discovery through the eye of an 'instrument', the telescope, led to a break with the past and heralded a new age. Past attempts to explain the movement of the stars through Copernican philosophical speculation, ancient mysticism or religiosity were supplanted by 'scientific method' which led to objective discoveries by experts using instruments. Arendt was not bemoaning scientific progress on its own terms, rather recognising the triumph of a "demonstrable, ever quickening increase in human knowledge and power", while acknowledging, "an increase in human despair… specifically modern nihilism" (p. 261). For Arendt, the use of scientific instruments to understand the universe risked only an elite group of scientists having access to language and technology that can grapple with the complexities of true understanding. This leaves us alienated from the world around us; "Instead of objective qualities … we find instruments …, and instead of nature or the universe … man encounters only himself" (p. 261).

So what does this Arendtian vision of scientific dominance and human disempowerment have to do with the psy disciplines and child sexual abuse? Disciplinary approaches to understanding and intervening with trauma survivors have caused harms like those enacted by other public institutions. While in many cases they were, consciously at least, well intentioned, they nonetheless served to diminish the status of people's testimony of their own experience, history, and memory. Using scientific technologies of empirical methods, diagnostic categories, and models of mind, they have all at times undermined the ways that survivors have spoken about their abuse, questioning their reliability and using esoteric, specialist language to do so. In some ways, like Galileo's observation of the galaxy, it matters less whether these approaches are accurate or not. Instead, what we must ask, like Arendt does, is what are the unresolved conflicts within this progress? Who, and what, do we leave behind when propelling ourselves on to ever more audacious scientific progress?

Public inquiries are increasingly being used to address past institutional failures, in part through offering redress to victims. One form of redress is

the offer of testimonial justice, an invitation to affected people to share their experiences of abuse and its impacts with the inquiry so they can be treated with dignity and have their narratives validated and, often most importantly, believed. There is an emerging evidence base, suggesting this offer of testimonial justice to child sexual abuse survivors can be helpful for them in their ongoing recovery. Survivor testimony has another function to inquiries, it enables the sharing of lived experience as a valid, legitimate and respected form of knowledge that can help inquiries learn the lessons of the past from the people most profoundly affected by it. By 'lived experience', I do not mean the way this construct is currently used, in a vague, loose way to refer to anything a person says or does. Rather, I am using it in reference to its roots in philosophy of science, where it is an imperfect translation of the German, Erlebnis, with an associated concept of Erfahrung. Erlebnis as a philosophical concept dates back to Kant, and many philosophers have treated it as a unity of experience that precedes any analysis, categorisation, or crucially, verbal communication. Erfahrung, on the other hand, and according to the intellectual historian Martin Jay, is understood as a more, "temporally elongated notion of experience based on a learning process, an integration of discrete moments *into a narrative whole*" (p. 11, italics added) (Jay, 2005). The development of 'lived experience' therefore requires a translation of intense, immediate and unintegrated sensation, into something that can be communicated to and understood by others in a *narrative form*. This is similar to what Arendt referred to as the "subjective in between", the field in which personal experience is translated into public speech as a form of action. It is this type of lived experience, that incorporates both private pain and public action, that survivors contributed in testimonial form to the Truth Project, and that turned a procedural, legalistic public inquiry into a form of collective social action. Contrast this act of civic generosity and political potency from child sexual abuse survivors with the ways the psy disciplines have constructed them, and we can begin to see the potential of Arendt's version of storytelling as citizen participation and political action. The collective voice of over 6,000 Truth Project participants helped create a new, social world for themselves and other survivors, reclaiming the space from a narrow scientism, and embracing plurality of voice that valued rather than denigrated subjectivity.

From an Arendtian perspective then, talking about child sexual abuse is not wallowing in it. Enabling someone to be recognised as a victim does not condemn them to victimhood. The past must be recalled before it can be let go of. The purpose of learning how to talk together about child sexual abuse is so survivors no longer need to. It is the inverse of the story of the boy who cried wolf. If we listen to the boy, take his fears of violence seriously, he no longer needs to summon imaginary beasts to remind us to protect him from real ones. If there is not one boy, but 6,000 adults crying wolf, then surely, they are not all imagining something that is not there?

However, while Arendt had a vision about collective human action in a political sphere that drew on Ancient Greek models of citizenship, she was

not naive enough to think narrative storytelling could overcome state, or disciplinary, power. She had lived through the rise of fascism after all. It may be better to think of speech not as a replacement for other forms of action, but rather as, "a supplement, to be exploited when action is impossible or confounded" (p. 37). Finding speech in the wake of the speechlessness of trauma is not adequate to the task of justice, but it is where one must begin. What the collective voice of the Truth Project shows is that lone voices do not really exist, as Arendt argues, the storytelling occurs in an already existing "web of human relationships" (p. 183). The psy disciplines on the other hand have covered that collective storytelling in a veil of scientific innovation that is the preserve of an elite group who have access to technologies, such as theory, science, and diagnosis, that obscure both the uniqueness of our individual trauma and how it connects us to others.

There are risks with too much of a focus on trauma-based explanations in this formulation also, not least because it can trap us into an identity based on victimhood. Trauma is after all a form of technological scientific language itself. We can become trapped in our stories as easily as liberated by them, or more complexly, both at the same time. Many experienced survivor activists bemoan the focus on individual trauma stories as a gateway into understanding the field of child sexual abuse, their personal pain being used to 'humanise' the subject for the public in ways that can feel remarkable dehumanising. At the same time, storytelling can also be incorporated back into the psy discipline through the development of psychological therapies such as narrative exposure therapy for trauma, narrative therapy, and narrative-based family therapy. This is not to critique those approaches in and of themselves, but to notice what the psy disciplines share with capitalism, the ability to reproduce themselves by co-opting and commodifying other forms of human activity, while simultaneously distorting it into its own image. Arendt had something remarkable to say about this too, in relation to the dominant psychological model of her time, behaviourism. The science of psychology reduced human consciousness down to only what could be seen and observed in the behaviourism of the 1950s when Arendt was writing, treating subjectivity with even more scepticism than we do today. Her fear of humans engaging in "sheer automatic functioning … a dazed, tranquilised functional type of behaviour" (p. 322) was in stark contrast to her conception of them engaging in the polis as citizen storytellers. Arendt wrote that, "the trouble with modern theories of behaviourism is not that they are wrong but that they could become true" (p. 321). This automation of self would be assisted by models of human activity, such as behaviourism, that were uninterested in the internal world of Erlebnis, as it was irrelevant to the task of mindless labour. Similarly, if we take the social, political and crucially, "subjective in between" out of Erfahrung, by making it about story rather than storytelling, we risk stripping an innate human activity of its liveliness and potentiality. To extend the trauma-informed dictum, in moving from what is wrong with you to what has happened to you, there needs to be a further step towards, and what are *we going to do about*

*it now*? (Stubley & Taggart, 2023). This is where science and the consulting room cedes ground to the realm of action, if they can act as a gateway then they enable this; however, if they act as an alternative, they risk reducing storytelling to an atomised therapeutic activity devoid of its potential for transformational change. It is of note that the experiences shared by Truth Project participants were and are used as research data to develop our psychological understanding of the field of child sexual abuse, but this is not all they are, they also exist as a collective testimony to societal failure and demonstrate a generosity of spirit, alongside a public expression of private pain. As such they have broader purpose and greater power. Storytelling only has the potential for transformative effects if there is someone listening carefully and is prepared to act in response to what they are hearing. The denial and minimisation discussed in this chapter by psy disciplines is one example of how society defends itself against having to listen carefully to stories it struggles to integrate. The challenge for those of us working in the field of traumatic injury, is to lean into rather than turn away from these stories.

I want to return, at the end of the chapter to its title, "to think what we are doing". At the time I first became interested in Hannah Arendt, during the pandemic in 2021, when I was working in the Truth Project, I was struck by the publication of another book which drew on the German philosopher's work to examine violence, this time against women. The feminist literary and cultural critic Jacqueline Rose, cites Arendt's proposal at the outset of the Human Condition, "that we think about what we are doing." This deceptively simple prescription is taken up by Rose who says, in the context of writing about violence, "if we do not make time for thought, which must include the equivocations of our inner lives, we will do nothing to end violence in the world, while we will surely be doing violence to ourselves" (p. 33) (Rose, 2021). It has been my intention, in this spirit, to explore how my field of psychology and associated psy disciplines can think differently about the violence of child sexual abuse, to avoid perpetuating epistemic and other forms of violence against its victims. In order to do this, it has been necessary to leave psychological technologies to one side and to utilise other ways of understanding human action, in this case the action of storytelling so private pain can be understood in communal space. In thinking what we are doing in this case, thought is not something to be studied, codified, and integrated into existing psychological theory. It is an action we need to undertake together, to avoid mindlessly repeating the mistakes of assuming more of what we know is the solution to any problem, or that the best authority for the validity or rightness of our position can be found within our internal frame of reference.

I want to end with something which is based on a diary entry I wrote when I first joined IICSA in 2019.

> I stagger out of Liverpool Street station bleary eyed and stiff, already two hours into my day, joining the human swarm into the streets around Bishopsgate and on across the Thames towards Waterloo. As I

walk across central London I can't help seeing through my rural dwelling eyes the number of young men and women buried alive under cardboard boxes and stepped over unnoticed by busy commuters, all of us in a hurry to get to where we think we need to be. I chide myself for my naive sentimentality and tell myself 'this is London, you just have to get on with it'. When I arrive at the highrise office block where the Inquiry has its headquarters, I put my lanyard on, pass through security and into the lifts. I get out, at the top floor and make my way into the Inquiry office foyer. Looking in the window to the open plan office it occurs to me that the people inside could be doing anything, from the outside it looks like any other civil service department. The open plan desks, breakout rooms, soft furnishings and smartly dressed professionals hurrying around productively. I take a breath and a moment to remind myself what this is actually all about, before swiping my pass and going inside. I know that there are plenty of places where the Inquiry is witnessing the horrors of child sexual abuse as recounted by adult survivors. The public hearings where people take the stand and try to hold themselves together so that they can finally be heard. The Truth Project sessions going on in all corners of the country, where untold stories and hidden harms are finally bathed in some light. But it still strikes me as odd that I would be up here, in this office, looking out of the room high windows across London and thinking about something as earthly as child sexual abuse. As the incongruity of the situation registers I look down back into the streets I have walked across, tiny now from all the way up here and I think of the young people I saw lying, like discarded belongings in shop doorways. I think of all the research evidence on the impacts of child abuse across the lifespan and the strength of the statistical associations between sexual abuse, homelessness and substance misuse. I almost chastise myself once again for my emotionality but stop and think no, just look. Look at the distance between you and those bodies. What are we doing up here when they are down there, the living, breathing and forgotten proof of what this is all about? It is warmer up here and safer for sure. But what is it I am missing? What am I unable to see from my bird's eye view?

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# 4 Disclosure and recovery

*Laura Salter*

## Introduction

One of the things that I have increasingly heard over the last few years in mental health settings is a worry and wariness about asking about trauma and specifically child sexual abuse. This appears to be occurring at a time when the prevalence and impact of child sexual abuse is becoming more widely accepted. What I hear in my clinical practice is that clinicians are concerned about asking about child sexual abuse because of fears that this may be triggering and re-traumatising and would then be detrimental to the person's health, in fact cause further harm. It is certainly true that talking about experiences of child sexual abuse can evoke very distressing and powerful memories and emotions and may temporarily exacerbate symptoms of post-traumatic stress disorder (PTSD) and this certainly leaves clinicians with difficult dilemmas. What we know from research and our work with patients and survivors is that throughout history survivors have been silenced by societal, organisational and individual responses to their attempts to talk about sexual abuse, and this continues today. As clinicians, by not enquiring about child sexual abuse we risk the repetition of further neglect, a 'turning away from knowing', but to ask can feel that we are being too intrusive and re-traumatise the survivor. In this chapter, I want to explore more fully this dilemma drawing on psychoanalytic and trauma theory, survivors' experiences, and clinical practice. By doing this, I hope to shed light on how disclosure can be one aspect of a recovery journey for survivors of child sexual abuse and highlight the need for professionals and organisations to create a facilitating environment where conversations about child sexual abuse can occur in as safe a way as possible. As a psychotherapist and a social worker, I am interested in how different professional identities and settings intersect and how disclosure is distinct in different settings. I think this gives us an invaluable opportunity to learn from each other, to learn from the experiences of survivors and from different professional modalities and contexts.

Like in other chapters in this book, I am using the word survivor whilst being aware that the word survivor does not fit for everyone who has experienced child sexual abuse, and that for some the word may be triggering.

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The meaning of words and words themselves are enormously powerful and need to be treated with respect, but it is vital that worries about getting the right words do not act as barriers to talking together about child sexual abuse.

## Disclosure and barriers to disclosure

Disclosure is not just a telling of an experience, telling of a secret by one person to another, but is a complicated two-way process that involves both participants' unique histories and experiences and is located within a society and that society's history with child sexual abuse. As you will hear throughout this book, society has ignored, denied, and vilified survivors throughout history. Survivors have often faced many difficult experiences of disclosure to family, friends, and professionals which repeat earlier experiences of silencing, both by the perpetrator and the adults and organisations around the child who failed to protect and at times actively turned away from knowing. All of this will be in the room with you and the patient or client and talking about child sexual abuse can feel daunting. It can feel like walking a tightrope between asking too soon and too much, being 'intrusive', or not asking or communicating your openness to hear, thus being neglectful. Both positions often repeating earlier experiences for the survivor.

There are many different reasons why a survivor may disclose their experiences of child sexual abuse. These include disclosing out of necessity, for example when having a physical health procedure to ensure that clinicians understand their needs, disclosure as part of campaigning and educating others and in response to being triggered. In this chapter, I am focusing on disclosure in professional relationships, between the clinician and the patient or survivor. We know from research that disclosure to professionals is unlikely to be the first time someone will have disclosed (Brattfjell & Flam, 2019; Stige et al., 2022), and therefore, the previous experiences of disclosure both positive and negative will impact on the interaction and dialogue.

When we talk about barriers to disclosure, the emphasis is often on the barriers that the patient or client experiences, and these may be around disabling shame, worries about not being believed, worries about being judged and blamed, worries about the impact on you as the therapist or clinician and worries about the impact on the family and/or community. Concerns about families and communities may be more intense for some groups in society and an individual's social, cultural, and religious background as well as sexuality and gender identity will impact on disclosure in a myriad of ways (for a full discussion of these complexities see Kiki and Michael's chapters). There may also be worries about re-traumatisation, and that the survivor may remember more than they feel able to cope with. The literature tends to focus on the barriers that patients experience, and whilst these are important barriers to consider and attempt to navigate, the focus on the individual places the responsibility for disclosure on the survivor. For a disclosure to be part of a healing relationship, it needs to be contained within a safe and supportive

relationship and context, and I will look at safety later. This relationship is part of creating a facilitating environment for disclosure, a term used by Winnicott, to explain the importance of external factors in the parent-infant relationship (Winnicott, 1965), and shifts the responsibility for disclosure onto clinicians, organisations, and society more generally.

Therapy and particularly psychoanalysis has a difficult past with child sexual abuse (please see Danny Taggarts chapter for further information). In many ways, the pendulum swing from denial to outrage that has occurred throughout society, has also been played out in clinical practice and continues to do so. In my own practice, I have met many patients who will have been through a whole psychotherapy treatment, sometimes for several years, and not talked about their abuse histories. The reasons for this are complex and echo the barriers to disclosure more generally. Again, it is important to, as Winnicott (1965) suggests, consider the environment, rather than focusing our attention on why an individual has not felt able to talk about their abuse within therapy. Messler Davies and Frawley (1994) state that:

> Given what is known now about the prevalence of childhood sexual abuse in general and among a patient population, especially an apparent borderline population, and given the secrecy usually surrounding an adult survivor's childhood victimizations, it is incumbent on therapists to ask about sexual abuse just as routinely as they routinely query about any other potentially meaningful childhood experiences
>
> (p. 89)

They suggest asking for example:

> I wonder if you could tell me about any uncomfortable or distressing sexual experiences you may have had as a child or teenager
>
> (p. 89)

Another example might be "It sounds like you are telling me that you have been hurt in the past. Do you want to talk more about this?" Open questions such as these can communicate to the patient that this is a space where conversations about child sexual abuse can occur, even if the person is not ready or not able to put words to their experiences. Whilst it is not about having a check list of standardised questions that once asked are never returned to, speaking first about the possibility of child sexual abuse may also shift the responsibility of disclosure from the survivor to a more shared endeavour.

Research has shown that many therapists, like professionals in other disciplines, are concerned about the impact of talking about abuse, the potential for re-traumatisation and harm. (please see Emma Facer-Irwin's chapter for a more detailed description of research in this area). With the focus on short term work and management of symptoms in mental health services struggling with constant cuts and squeeze on resources, many patients fall in between

the gaps of increasingly restrictive referral criteria. Patients may have many experiences of being told that their difficulties are too complex for services and end up on a merry go round of referral and rejection, the message being that no-one wants to know.

In 'New Ways of Supporting Child Abuse and Sexual Violence Survivors' (2022), the authors, a collective of 'socially diverse survivors of child sexual abuse and sexual violence', state that

> We are frequently seen as 'too complex' for the few trauma/PTSD services that exist because we have often experienced multiple, severe and/or relational traumas that these services are currently ill equipped to respond to
>
> (p. 6)

Whilst the authors successfully challenge the use of 'personality disorder diagnosis' as traumatising, inaccurate and excluding, in my opinion this article also highlights the risk that concern about the potential for re-traumatisation when speaking about child sexual abuse, may add impetus to the argument for services to turn people away.

Talking and knowing about child sexual abuse is difficult and like society's struggle with fully acknowledging its existence and impact, it can be hard to totally comprehend the horrendous abuse and violation of children. Messler Davies and Frawley (1994) describe eight transference and countertransference positions involved in the work with adult survivors of child sexual abuse. Whilst both are terms commonly used in psychotherapy, they apply to all encounters and can help us understand further why disclosure, both the telling and the hearing, can be so challenging. Transference is when someone directs their feelings about one person onto someone else. For example, when a survivor meets a professional for the first time, there may be aspects of that person's role, or how they look, or speak which connect with earlier experiences. If a survivor has had difficult relationships with professionals or people in power in the past, feelings about these experiences may be transferred onto you as the professional. We can think about this as living the past in the present, and this is not always conscious, to the extent that the survivor may feel as if they are in the room with someone who is going to harm them. This can lead to a threat or trauma response, where the person moves into a fight/flight/freeze or fawn position, which you have heard about in other chapters, and I will come back to this later. Countertransference is then the transfer of a therapist's or clinician's thoughts and feelings onto a patient. This is also likely to be unconscious and will be influenced by the therapist's or clinician's history, attitudes, and experience. Messler Davies and Frawley (1994) state that:

> Analytically orientated clinicians are all products of a theoretical and clinical tradition that underestimated the frequency and pathogenic

> impact of childhood sexual abuse; they are also members of a society that only recently opened its eyes to the victimizations of children
>
> (p. 163)

They go onto say that therapists who have had their own experiences of sexual abuse may lead to further complicated countertransferential feelings that require careful and sensitive examination. In an online training that I have been involved in about disclosure of child sexual abuse, co-produced by the Tavistock Trauma Service, A Lived Experience Advisory Panel, and The Network for the Promotion of Change: NRCSA, Gail talks about her experience as both a health professional and survivor. She recalls the difficulty in working in a system that did not acknowledge the individual experiences of healthcare staff and patients nor allow sufficient time to process interactions with patients. Observing bad practice and powerless to challenge those in authority left her with, what she describes as an 'internalised sense of failure'. She states that:

> I saw this as my failure and not that of the organisation or the influence of a societal stigma.
>
> (2024, Tavistock Training on Disclosure)

Sadly, there was no 'careful and sensitive examination' of the impact of this work on Gail, and rather than being offered support and valued for the unique contribution that she could make to her profession, she felt blamed and silenced.

The transference and countertransference positions that Messler Davies and Frawley (1994) suggest may occur when working with survivors of child sexual abuse are:

- Neglectful parent and neglected child
- Abuser and helpless victim
- Rescuer and entitled child
- Seducer and seduced.

I recognise these positions and feelings in my work both as a psychotherapist and a social worker, and as Messler Davies and Frawley (1994) state, these positions are not fixed and shift moment to moment. But knowing about them can help us to be more aware of our own feelings and actions. For me, these transference and countertransference positions speak to the concern about re-traumatisation. For example, if by asking about sexual abuse, even if done in a sensitive way, risks re-traumatisation and thus further damage, and places you in a position of an abuser, someone who has done harm, then it is not surprising that you might want to turn away from knowing or asking.

These transference and countertransference positions are not however limited to the relationship between therapist or clinician and patient, but as we

can see in Gail's experience, also occur at an organisational and societal level.

She states that:

> The environment needs to be open to the possibility of CSA and committed to valuing and learning from those with lived experience whether that be the patients or healthcare professionals that exist in that service. And only in bringing CSA into the limelight can real change occur.
>
> (2024, Tavistock Training on Disclosure)

**Disclosure and re-traumatisation**

The Government's Guidance on Trauma Informed Practice (2022) defines re-traumatisation as "the re-experiencing of thoughts, feelings or sensations experienced at the time of a traumatic event or circumstances in a person's past. Re-traumatisation is generally triggered by reminders of previous trauma which may or may not be potentially traumatic in themselves" (2022. Gov.UK).

Re-traumatisation can lead to flashbacks and nightmares, increased anxiety and hypervigilance, difficulty sleeping and concentrating, and more generally an increase in trauma related symptoms. In a flashback a person is re-experiencing something of the traumatic experience in the present, this might be an emotion, smell, a fragment of an experience, and/or a more detailed re-experiencing of a traumatic event.

Sadly, many people who have experienced trauma face triggers and re-traumatisation in many aspects of their life. Going to the supermarket may involve a whole array of potential triggers that a person has to navigate. We know that professional settings often present the person with the potential for re-traumatisation and survivors describe many situations where their needs have not been met or considered and as a result treatment has been re-traumatising. In the Tavistock online disclosure course co-produced by survivors and professionals and researchers working in the field, survivors share their stories of disrespectful and sometimes just plain 'cruel' treatment by professionals and organisations that has led to re-traumatisation. Patricia Wennell, who contributed to this disclosure training and wrote the book – 'Because It Didn't Stop When It Ended' (2022), about her experience of therapy as a survivor of child sexual abuse, describes how her need to have an anaesthetic for a medical procedure was ignored and challenged. This led to a threat response and left her feeling like she was 'fighting for her life' (2024, Tavistock Training on Disclosure).

The threat or fight/flight response refers to the body's natural reaction to the perception of threat and is necessary for survival. Our bodies get ready for danger in a host of different ways such as rapid breathing, dilated pupils, tenser muscles. Certain bodily functions not required in moments of danger, such as digestion and the immune system, are reduced. Once the danger

is over, the stress hormones decrease and our bodies return to their normal position and equilibrium is restored, which Judith Herman (1992) describes as "alert but relaxed attention" (p. 36). However, as numerous studies have demonstrated, people who have experienced trauma, particularly when it has been prolonged remain in this heightened state of anxiety and alertness long after the danger has gone, with multiple detrimental effects on their physical and mental health. The freeze response, the escape when there is no escape, is referred to as 'attentive immobility' or 'reactive immobility'. Whilst the traumatised person is immobile, they continue to remain alert and ready for action. A fourth response to threat, coined by psychotherapist Pete Walker in 2015 is 'fawn', which is when a person limits a danger by appeasing the other person, typically dismissing one's own needs. In between these different threat responses of hyper arousal – fight/flight and hypo arousal – freeze/fawn is what Siegel in 1999 referred to as the window of tolerance, where thinking and developing is possible. Understanding these different states can help to recognise the movement between them and crucially when connection is more possible. In the example above, when Patricia's need for safety was ignored and she was faced with a potentially re-traumatising procedure, she was thrown directly into a fight/flight response, with all the emotional intensity of the original trauma.

Trauma-informed care is rooted in an understanding of the impact of trauma on the mind and body. As a framework for service delivery, it recognises that services and systems can be re-traumatising and through its' approach and principles seeks to prevent the repetition of this (2022, Gov.UK).

The Government's Guidance on Trauma Informed Care (2022) states that

> The purpose of trauma informed care is not to treat trauma-related difficulties, which is the role of trauma specialist services and practitioners. Instead, it seeks to address the barriers that people affected by trauma can experience when accessing health and care services.
>
> (2022, Gov.UK)

Trauma-informed care is about being sensitive to someone's experience and not for instance asking them to explain why they are anxious about having or cannot have a physical examination or a certain procedure. It is not asking them to give details or to justify their request, as in Patricia Wennel's experience, but accepting their statement and treating the person accordingly. Whilst I agree that we need specialist services for people who have experienced trauma and particularly child sexual abuse, I am concerned that the government's statement is open to misinterpretation, for example that disclosure and conversations about child sexual abuse can only occur in these specialist services, which we know are a scarce resource. Responsibility for talking and thinking about child sexual abuse then gets located within specialist services, which risks the de-skilling of staff in non-specialist services and essential training in child sexual abuse not being viewed as a priority.

Danny Taggart, a psychologist who worked at the Independent Inquiry into Child Sexual abuse states that:

> Typically, we have abdicated responsibility to certain groups to protect children from child sexual abuse, professional groups such as social workers. What we now have to realise is that there's a wider social responsibility to take care of people who have been sexually abused, to understand their current difficulties in light of the previous harm that they have suffered but also to be mindful of the way that child sexual abuse can infiltrate institutions that we see as trustworthy, such as schools youth care settings, and our religious institutions.
>
> (2024, Tavistock Disclosure Training)

A large part of my training as a psychotherapist and clinical experience as a social worker has been about helping the patient or client to put distressing experiences and feelings into words, as a way of managing overwhelming feelings. Graham Music (2022) stresses the importance of this ethos, but also identifies how new understandings of trauma and the effect on the mind and body mean that to do this important work, clinicians need to understand how "more positive or safe-feeling aspects of the personality develop and can be built upon" (p. 81)

He acknowledges the importance of not turning our back on what we know from our therapeutic practice, but instead integrating this with what we know now about the devastating impact of trauma. He states that:

> … most trauma therapists know the danger of re-traumatizing people by going to the trauma incident too early, and the importance instead of developing ways of feeling calm, even easeful, and the necessity of first developing some trust in the world and in one's capacity to have good feelings.
>
> (2022, p. 82)

When I look back on my career, I can think with some shame and regret about the times that I got this wrong. Whilst well meaning, my questions and responses were uninformed, clumsy, and at times misguided. At the beginning of my career, I was painfully aware of my inexperience and lack of knowledge about life. I was terrified of getting it wrong. My social work training had focused more on the safeguarding aspects of child sexual abuse and working with children and disclosure, rather than working with the traumatic effects of childhood abuse in adulthood; I suspect that I am not alone in this experience. I also know that I will continue to get things wrong, but I hope now that when I do, I will be able to reflect on this experience and my feelings both individually and with the survivor and apologise when I need to.

**Survivor's experiences**

Stories of survivors' experiences of working with professionals give us a unique insight in to understanding further this dilemma between concerns about re-traumatisation and intrusiveness, and neglect and a denial or disavowal of child sexual abuse.

Jean who was involved in the Tavistock disclosure training as a Lived Experience Expert, runs an organisation that uses portraits to facilitate survivors talking about their experiences. She described an incident with a professional where she was triggered by a word that was used. She states that:

> Firstly, language is important and with some survivors, me in particular, because of probably my generation and I didn't have anywhere to go and was really naive about all sorts of things. When I went to get some help from the only place where I can get help from, I was assessed and I was telling her my story and she announced that I'd been raped. Now, mine is within my family and it took me two days to actually process the fact that I'd been raped because rape and brothers, they don't actually connect with me because, maybe because of the length of the time. I think it's the tie that you have, your brothers are not supposed to do this. But if she hadn't have told me, I think I would've stayed stuck. But I think she could have asked it in a different way where she could have actually said something like, 'I believe it was rape. Would you like to have…? I can give you a link or some information on what the word 'rape' means'. So I can actually process that better because I found that I had two-and-a-half days or however long it took me to actually process that. I think that would've stopped that length of processing…. She was giving me a hand to understand why she'd said it was rape. And I think I needed to have that said because that did make me realise, yes, it was rape.
>
> (2024, Tavistock and Portman NHS Trust)

Whilst the word rape was triggering and potentially re-traumatising and could have been phrased differently, Jean acknowledges the helpfulness of putting words to this experience, of being able to process something in her mind.

In a podcast 'How Therapy Transformed me' (2024) Carolyn Spring, a survivor of child sexual abuse, an author and trainer, talks about her experience of therapy examining what has been helpful and why. She considers how moments of being challenged by a therapist, which were initially difficult and could be seen as triggering and re-traumatising, ultimately led to growth and development. She describes how her therapist had asked her why she stayed in a particular situation that was potentially exploitative, rather than leaving. In that moment she experienced the therapist as victim blaming and insensitive and this connected with a multitude of previous experiences of being

misunderstood and attacked. She describes how these past experiences were then transferred into the present exchange with the therapist, multiplying the intensity of the feelings. Carolyn describes this as 'misattunement', she states:

> That misattunement though can feel terrifyingly painful. It feels like I'm alone in the universe. It feels like I've not been seen, and I've not been heard and I've not been felt. That's a horrible place to be. And so over time I had to learn to notice that I was being triggered in that moment — that I wasn't just reacting to the therapist in that moment being misattuned, but that I was layering that up with all the years of misattunement of all the attachment figures and partners and friends and colleagues I'd ever had. And so there was this massive transference going on, of me reacting to a minor glitch in the moment but loading it up with decades of prior hurt.
>
> (Spring, 2024)

She goes onto say that:

> If the therapist always stays tuned into us on our frequency, then the danger is that we stay stuck on that frequency.
>
> (Spring, 2024)

It is a very difficult balance and one that as a psychotherapist I always have in the forefront of my mind, continually weighing up when feels the right time to talk and when to hold back until a greater degree of safety has been established. But with the conviction that ultimately putting words to experiences is a crucial part of the therapeutic endeavour. Carolyn Spring states that;

> In order to cope with challenge… we have got to believe that this person is for us and not against us, and that they are not shaming us when they point out how we have been impacted by trauma but that they are doing it so that we can stop being impacted by trauma.
>
> (Spring, 2024)

**Clinical example**

Jean and Carolyn highlight the importance of safety, the power of words, how the past can be felt in the present and the process of development and this resonates with my own work with adults who had experienced child sexual abuse. When working in the Non-recent Child Sexual Abuse team in the Tavistock Trauma Service I saw a patient, P, who had had experienced sexual, emotional and physical abuse and neglect from a very early age, before she was using words. Early in the treatment there was a particular word that I used, that was incredibly triggering, so much so that the very mention

of the word led to her re-experiencing the abuse in that moment. At the time I remember being both surprised at the response as it was quite a commonly used word, but also left feeling full of guilt and shame. In that moment, I became the abuser or perpetrator and the patient the victim. In the room, we were able to think about what was happening between us and I refrained from using that particular word, certainly for the time being. As the therapy progressed, there were many other instances of re-experiencing, just being in the room with me could evoke intense feelings of powerlessness and shame for P. P's mental health started to decline and both I and other professionals involved, questioned whether P was in a place where she could make use of therapy. However, with additional support, P continued to attend her sessions, never missing one, and we slowly began to put words to experiences that had previously felt unspeakable. Over time, her flashbacks did start to reduce although did not disappear completely, and she was able to hear the word that had initially triggered her, without re-experiencing her trauma. I was always in total awe of her determination and courage to keep moving forward, wanting to develop when I, filled with guilt at the damage I might be causing her, questioned our work together. This was a slow and painful process and looking back I wonder if I could have done anything more to reduce the re-traumatisation she experienced. Certainly, there are things that might have mitigated this experience, maybe as in Jean's case, I could have been more careful about the words that I used and the organisational setting would have benefitted from being more trauma informed, but I remain unsure if triggers and thus re-traumatisation could have always been avoided and if that should always be the ultimate goal. The transference and countertransference positions that Messler Davies and Frawley described helped me to understand and work with my intense feelings working with P. Psychoanalytic theory about symbolism has further assisted my understanding of the process of development and recovery and provided essential containment.

## Symbolisation and recovery

Symbol formation in psychoanalytic theory refers to the 'indirect or figurative representation of a significant idea, conflict or wish' (Spillius et al., 2011, p. 184). In Segal's seminal paper 'Notes on Symbol Formation'(1957), she describes symbolisation as a three-term relation, between what is being symbolised, what is functioning as a symbol and the person for whom the one represents the other. In other words, she states that it is 'a relation between the ego, the object and the symbol' (1957, p. 392). Segal suggests that symbolisation or symbol formation starts early, probably around the time of early object relations and is the process by which the early ego copes with anxieties about its relationship to the object, i.e. the parent or caregiver. 'Object relations' is a psychoanalytic term which describes 'the internal representation of figures and relationships which are emotionally significant, whether positively or negatively' (Waddell, 1998). Object relations, which has its beginnings in

Freudian theory, was more fully developed by Melanie Klein, through her observations of children's play. She observed that children played with objects, typically toys, and enacted dramas with the therapist (Spillius et al., 2011), and that the children had feelings for the objects or toys, which related to other relationships. From these observations she developed a theory of how the mind works, which was concerned with the relationship between the internal objects (the most important being the parents) and external objects, and the relationship between the internal objects and parts of the self.

In the very early stages of development, symbols are not seen or felt as symbols but are in fact experienced as the original object; the breast or bottle that the baby gets milk from is felt to *actually be* the mother or caregiver. Segal defines this stage as 'symbolic equation'. The baby copes with the anxiety of, for example feeling hungry by splitting between good (the mother who feeds and satisfies the baby's hunger) and bad (the mother who is not there to feed when the baby is hungry) in his mind (for the purpose of this explanation, I shall be using 'he' to describe the baby and 'mother' to describe the primary caregiver). Klein thought that this mechanism enabled the baby to survive and protect his relationship with the mother. For Klein, whilst this splitting goes on throughout development, it predominates in the first three to four months of life when the ego lacks coherence. Klein defines this state of mind as the 'the paranoid-schizoid position' (1959, p. 255) and it is characterised by rigid thinking and an inability to use symbols. This is very much seen as a phase and the development of the capacity to symbolise is also related to the development of a state of mind that Klein defined as 'the depressive position' (Klein, 1959).

So, the depressive position refers to the working through of early anxieties. For example, in normal development, the baby starts to be afraid of his destructive impulses on his loved object. He begins to feel guilt at the harm he has caused his object and wants to make amends. The baby is able to resolve this by gradually coming to terms with and mourning the mother who leaves him, because he has accepted that she also returns. The repetition of this is vital and the stability of the ego depends on the regaining of the good object (relationship with mother or primary caregiver) over and over again. During this developmental stage, the baby has to tolerate the loss of the idealised mother in order to integrate the reality of the imperfect mother (Klein, 1959). However, Klein also stresses that the persecutory anxieties of the paranoid-schizoid position exist throughout life and are a constant struggle to us all, particularly in times of stress. That is, when we are overwhelmed or distressed, we are vulnerable to viewing ourselves, others or the world in rigid terms. Segal (1957) maintains that the development of symbolisation occurs with the development of the depressive position, and that for the baby, there is a recognition of difference and separateness.

As the infant begins to see its mother as both the mother who provides food and love and the mother who withholds and is absent, he starts to develop the idea of being separate from his mother. This process by which the child

develops his sense of self can be understood as occurring through mentalisation, also known as reflective capacity (Bion, 1962; Fonagy & Target, 1996), that is, the child having experienced being fully taken in, thought about, and reflected on by a parent/caregiver. There needs to be sufficient 'good enough' (Winnicott, 1971) experiences of being mentalised for development to occur.

Like the movement between the different states of mind of the paranoid-schizoid and the depressive position, the development of symbolisation is a continuous process. However, when anxieties become too great, as in a traumatic experience, there is a regression to a paranoid schizoid state and symbols that have been developed revert back to more concrete thinking, symbolic equation (Segal, 1957). Caroline Garland (1998) proposes that when a traumatic event occurs a person usually responds in two ways, either by identifying with the object who caused the trauma, i.e. identification with the aggressor, or by identifying with the damaged or dead object (the lost object or relationship). Through identification with the lost person/relationship/part of oneself, the painful process of mourning that loss is bypassed and there may be a reverting back to a more fused relationship with the mother, where these painful realities can be avoided.

Garland (1998) suggests that some traumas are so great that they cannot be fully recovered from, and symbolisation cannot be fully regained. She describes how this breakdown in the capacity to symbolise can be partly responsible for the way in which a traumatic event becomes a 'foreign body in the mind'. She goes on to suggest that whatever help an individual gets later in life, there remains an area of the mind which is occupied by memories of trauma, a 'no-go area' or blind spot and for this part of the mind symbolic functioning is never completely recovered (1998, p. 121).

For P certain words were not experienced as words, but as the actual event, what Segal defines as 'symbolic equation'. Through the working through of this experience in her therapy, P was able to reclaim this word as a word to describe an experience, rather than becoming it, thus developing separation between the word and the event and the occurrence. It is likely that this would have to be repeated many times, and when she finished her therapy, there were still many aspects of her experience where symbolisation was not possible, and P would be thrown back into a world of rigid thinking and flashbacks. Jean had to work extremely hard to create a meaning for the word 'rape', that was rooted in her social, cultural and familial experience. The question, 'why did you stay?' transported Carolyn back to previous experiences and feelings of being blamed, misunderstood, and feeling powerless, that she experienced in the room with her therapist. It was only afterwards, like Jean, where she was able to think through her responses. She states that:

> It's such a fine balance to get right, to be able to offer unconditional positive regard and validation and empathy on the one hand, and then challenge on the other. I have always felt shortchanged when I've only received the first half of that equation, when there's been empathy but

> no challenge. Yes, I need to feel heard and seen and felt, but *so that* I can process the pain or the trauma or the suffering or the situation I'm in and move through it. Empathy has a point to it, and the point is to change.
>
> (Spring, 2024)

## Disclosure and recovery

Messler Davies and Frawley (1994) view disclosure as a "first step in a process of healing" (p. 86) and stress the importance of clinicians being able to know how and when to facilitate disclosure. They state that:

> It is the therapist's sensitivity to and comfort with derivatives and symptoms suggestive of a history of sexual trauma that can lead to disclosure and the beginning of healing.
>
> (1994, p. 87)

When disclosure occurs in a safe enough relationship and environment, it forms one part in the journey of putting words to experiences and moving from a terrifying world of symbolic equation and its associated identifications and flashbacks to a place where experiences can be thought and spoken about rather than re-experienced. Knowledge about the psychological and physiological responses to trauma is essential in this work and can help clinicians navigate the dilemma between asking too much or too soon and not asking, and the corresponding transference and countertransference positions. Being able to notice whether someone is in a hyper-aroused or hypo-aroused state or in their window of tolerance can signal when to intervene and make contact. However, the goal is also to increase that window of tolerance and I am reminded of Carolyn Spring's comments about the effectiveness of both empathy and challenge and that both are necessary for change. Similarly, Philip Bromberg (2003) in his work as a psychoanalyst with traumatised patients, talks about 'safe surprises' and states:

> It is that thin line between the anticipated but containable shock and the unanticipated but uncontainable shock what is perceived as potentially traumatic from what is perceived as safe but 'on the edge'. The goal is for patient and analyst to 'stand together, in the spaces between the realities' and move safely, but not completely safely, back and forth across the line.
>
> (p. 574)

Whilst the work that I have described has been predominantly within a therapy setting, I do not agree that this work can only be done by trauma specialists. Dr Johnathon Tomlinson, a GP in Hackney, London, on his blog titled

"A Better NHS", stresses the importance of all clinicians taking responsibility for patients who have experienced trauma. He states that:

> GP's are not trained therapists, but the work that we do is very often therapeutic. A compassionate curiosity informed by knowledge of the 'trauma world' enables empathy.
>
> (Tomlinson, 2017)

In his blog he draws on the work of the Tavistock Trauma Service, using the experience gained by psychotherapists in specialist trauma services to his work as a GP, and goes on to say that "Learning about trauma has completely transformed my practice, helping me to make sense of so much that has frustrated, worried and exhausted me for years" (Tomlinson, 2017).

It is vital that talking about child sexual abuse is not confined to specialist services or particular professional groups, where the danger is that it remains out of sight, but that facilitating environments are developed throughout our health and social care systems and within all organisations or settings who come into contact with adults who have experienced child sexual abuse. Reflecting on his experience with The Truth Project in the Independent Inquiry into Child Sexual Abuse, Danny Taggart talks about the therapeutic nature of the thousands of people who came forward to tell their story. When speaking about the worry that professionals hold that they will make things worse by talking about child sexual abuse, he states:

> One of the great things about The Truth Project that really challenged those anxieties and that belief is that it showed, that if properly supported, treated with dignity and respect, offered time, both before their Truth Project session and afterwards, that the majority of survivors who came forward were able to speak about their experience in a way that was not destabilising for them, that did not lead to a re-emergence of mental health problems. So, The Truth Project has challenged a long-held view within mental health services that you risk causing harm by talking with someone who has been sexually abused in their childhood.
>
> (2024, Tavistock and Portman NHS Trust)

## Conclusion

Knowing and talking about child sexual abuse has presented societies with significant challenge. It is natural not to want to know about the sexual abuse of children often occurring in families and in our institutions. The transference and countertransference positions described in this chapter experienced by individuals, organisations and systems help us to understand the temptation to 'turn away' or 'turn a blind eye'. But by doing so, we not only repeat earlier traumatic experiences for the individual, we maintain the swing between denial and outrage that has occurred throughout history. Recently there has been much in the media about individual paedophiles and the institutional

sexual abuse of children, supported by a system that did not only turn a blind eye but actively enabled the abuse. Watching the documentary on Mohammed Al fayed I was left questioning 'why does this keep happening and why do we not learn from history?' Freud's concept of the repetition compulsion can shed some light on this dynamic. Freud believed that some people, particularly those who had experienced trauma were unable to remember those events, but instead unconsciously repeated the experiences and their associated feelings in the relationship with the 'analyst', but also relationships outside of therapy. Freud felt that the key to stopping the repetition was in the working through of these painful experiences in the relationship with the 'analyst' (Freud, 1914).

Describing this 'working through', Pat Ogden states that

> Most therapeutic approaches help clients find words to describe the fearful experiences they have undergone, understand why these experiences remain so uncomfortably registered in their inner landscape, and develop new mental and physical actions that are adaptive to current reality.
>
> (Ogden et al., 2006, pp. 167–168)

Ogden also advocates the use of the body as a further tool in processing trauma, focusing on the connection between and tracking of emotional and bodily responses.

This 'working through' can also be applied to the systems and organisations within which clinical practice occurs. Historically the responsibility for disclosure has been left with the individual, rather than a focus on creating enabling and supportive environments where conversations about child sexual abuse can be co-produced. For disclosure to truly be healing it needs to be held with a society that is committed to knowing about child sexual abuse and alert to the temptation to disavowal. We need to learn from history and to be on guard to both the conscious and unconscious forces within ourselves, the systems that we work within and society more generally. The concern about talking about child sexual abuse being re-traumatising, may in quite complex and subtle ways discourage clinicians from asking or being curious about sexual abuse, give permission to services to turn people away and allow society to turn a blind eye. We need to take seriously the history of child sexual abuse and to be on guard to the possibility of repetition. In this chapter my aim has been to demonstrate how disclosure and talking about child sexual abuse is an important part of recovery for the individual, and that to be truly healing it needs to be located within a facilitating environment, one that takes seriously the sexual abuse of children. Survivor groups have been instrumental in putting and keeping child sexual abuse on the social and political agenda and through listening to the experiences of survivors, my hope is that we can, not only improve our clinical practice and thereby survivors' experiences in services, but also move away from the swing between the polarities of denial and outrage to a more sustainable and balanced position.

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## Section II

# Intersectionality

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# 5 Disclosure and difference

## Barriers based in minority experience

*Michael May*

### Introduction

For ten years, I worked with SurvivorsUK, an organisation supporting adult male victims of sexual violence, experienced both in childhood and as adults. In performing the campaigning and management work of the organisation, I spent time exploring the ways in which sex difference manifested in the victims and survivors we represented and supported, viewing these intersectionally through lenses of sexuality, skin colour, ability, culture and religion. As a representative of SurvivorsUK, I campaigned with others for the creation of an inquiry into sexual abuse. On the establishment of the Independent Inquiry into Child Sexual Abuse (IICSA), I applied for and secured a consultant position where I used professional and lived experience to guide the establishment of their Truth Project, before taking up a full-time operational role. In those positions, I led the Inquiry's efforts to understand and address barriers to participation in its projects experienced by people with various protected characteristics, shaping an inclusive practice that expanded the reach of Inquiry messages and take up of the Truth Project among people with these identities.

I am primarily addressing the experience of adults whose abusive experiences in childhood were perpetrated by another where the age and power imbalance is significant. The area of abuse between minors of similar age and power relationship is outside of my scope of experience and I hope that others will continue to examine this area and think about how those experiences replicate and/or separate from the ones I note here. Equally, I base my observations in work with a number of but not all groups and will of necessity exclude the experience of those I know little about. That does not signify their importance but my own limited exposure.

A few disclaimers before we commence. I write here as an individual who has worked in the provision of support to victims and survivors of sexual abuse for over 20 years. In much of that time, I have championed the needs of people from minority backgrounds who have trusted me to represent their views and experiences. I will try to do so faithfully and honestly here.

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We know that most victims and survivors of either sex struggle to disclose what happened to them for fear of embarrassment, misunderstanding, disbelief, exposure, issues of duty, shame (theirs and more systemically) or not being able to escape what may follow a disclosure. What I want to think about here are the additional barriers that aren't as near to our general understanding. I hope the following words will illustrate some of the challenges that non-majority identities place in the way of victims and survivors and the ways that their intersections can further complicate a desire to speak about their experiences.

Sexual abuse experienced in childhood cannot be isolated within the wider experience of growing up. Abuse experiences will be viewed and understood through the developing appreciation of economics, race, culture, ability, sexuality and gender (for example) that are part of children's daily lives. The shattering of boundaries, impact on trust (of self and others), secret keeping and manifestations of trauma that often accompany sexually abusive experiences sit alongside and within the child's on-going development. These children are members of the micro and macro societies that surround them, experiencing themselves in a world where they are members of families, of school, sporting, shared interest and social communities, of friendship groups and nascent romances. Their intersections are multiple and manifest. Where the child additionally experiences discrimination, dis-inclusion, racism, homophobia or other forms of attack, intersection with experiences of sexual abuse lend those experiences specific resonance and impact that must be looked at in the whole person. Available schemas around issues of minority discrimination can provide helpful contextualisation of what's being disclosed but also signal ways in which the abusive experiences may have been differently internalised.

In the pages that follow, I concentrate on the experiences of those who identify as male and those where skin colour, ability, cultural or religious difference are central in reluctance to disclose sexual abuse. I refer to specific people and experiences which are often composites of multiple persons and where direct quotations are used, I have worked to ensure the anonymity of the contributor. I also use the term 'survivor' and 'victim' interchangeably and mean no offence to any reader who holds specific views on the use of either of those descriptors.

So, let's begin…

## Why it's different for males

In thinking about how identity can impact victims and survivors of sexual abuse differently, I come first to the experience of men and boys. Not exactly a minority, I hear you say, but in terms of sexual abuse they have a stake in that group. Let's assume that the standard tropes about males remain true – not inclined to talk about feelings, to ask for help or to take direction, for example, seem irrefutable. These already form a potent recipe for self-de-selection and

account in part for the significantly lower disclosures of sexual abuse from male victims, but additional barriers present that it will be helpful to consider.

In developing a modern systemic response to child sexual abuse, the narrative has been framed with female victims in mind – an appropriate response given the significantly higher number of females that experience sexual violence and the inescapable fact that most sexual violence is perpetrated by males against females. We talk very much about "Violence Against Women and Girls" as the agenda that encompasses the whole conversation about sexual abuse and it is the focus of intervention design and service provision.

There is acceptance that males are a part of the cannon of victims but historically as "statistically insignificant" – most of the attention paid to males is in relation to issues of perpetration. The rape of males did not become a specific crime on the same footing as that perpetrated against females until 1994 and reports of sexual assaults against males of any age were not published in most official sexual violence reports until 2017 (CPS, 2017), even when they constituted more than 15% of the aggregate (Home Office, 2019). Promotion and awareness raising for victims has not until very recently included males as part of the victim narrative. So, males do not often get the opportunity to see themselves sympathetically included in or depicted as part of the community directly affected by sexual violence, those seeking solutions and/or the comfort afforded by solidarity in that shared identity.

This presents a barrier to disclosure in a fundamental way. If you do not believe that anyone is aware of the existence of your experiences (and sometimes deny their validity or importance) or that there are avenues for help and support, you are less likely to feel enabled to disclose. The emphasis placed on maleness as the cause, and males as the perpetrators of sexual violence often leads males to assume that their stories of victimisation are less welcome. There is also some additional measure of shame through association with the "abuser" group. This is compounded by fear (linked to ideas about societal judgement) that male survivors are more pitiable and somehow worse impacted based on the transgression against their masculinity. All of these disincline male victims from coming forward.

We acknowledge the ways in which sex and gender definitions have been constructed in our society and have been interrogating them for some decades now. Terms like patriarchy, phallocentrism and male privilege have become part of the standard lexicon of discussion around gender roles and take on evolving and multifaceted application in increasingly sophisticated (and sometimes sophist) dialogue about sexual abuse. Boys and girls across borders are raised with certain core beliefs about what should constitute the mainstays of their binary gender identities and children use these as raw materials with which they build perspectives and personality and against which they measure themselves. Common adjectives of masculinity include strong, protective, fearless, assertive and dominant – the things of which little boys and the men they should become are made. When sexual abuse is introduced to this formula of identification and identity construction, the sense

of masculine self undergoes a profound attack that damages and sometimes shatters developing definition of self – of masculinity itself.

Almost every male survivor I have spoken with over the last 20 years has expressed some form of the idea "What happened to me has made me less of a man", equally but differently where the perpetrator is male or female. This is both through the perception of the male child who wishes to have been more 'manlike' and the adult man whose wounded history makes a subjectively genuine experience of 'manliness' feel impossible or unknowable. The way this conflict presents is as multi-faceted as the individual affected but the common experience is in measuring the self against the fantasy 'man' of nascent imagination. In most cases, that imagined male is powerful (having preternaturally adult mental, emotional and physical resources not available to the child), able to fend off the assault and to seek retribution or justice for the enormous affront to his masculinity. He is fuelled by powerful primitive instincts that belong to undiluted and untempered ideas of maleness. This can make the reality of helplessness and power imbalance central to child sexual abuse unbearable.

I was profoundly moved by a man of Afro-Caribbean descent (let's call him Chris), abused over several years as a young teenager by a male relative, who said in a group session that

> …there is an important and noisy part of me that says time and time again that I should have killed him or myself rather than let that happen to me. That my whole life now is because I gave in, because I was too weak to do what a man should do.

Note carefully the use of the word 'let' in this expression and what it might mean to the adult version of the young boy who was not able to escape the power exercised by a perceptually more potent male. And the use of the word "man" to describe the feelings and actions that this adult survivor ascribes to his adolescent self, linked to a powerful sense of actual violence to match the internal assaults that his younger self was unable to contextualise or understand.

This man has fathered children with several women but been unable to settle into any significant and enduring romantic relationship from fear that his partner will "see" failure in his masculinity, be repulsed by it and, by extension, him. He cannot imagine himself as constituting a strong enough masculine object to withstand attack – insubstantial; a ghost of the self that should have died rather than surrender to sexual abuse.

This is an extreme expression of a sentiment common to male survivors – that not finding a way to physically stop what was happening negates their maleness in a significant and irrecoverable way. In addition to ideas of complicity that form part of most survivor experiences, this perception of having surrendered through weakness (ideas of survival can feel anathema to this conception) leaves a very specific scar in the psyche of male survivors. Ideas

about being able to protect themselves and by extension others are a powerful part of the social 'maleness' recipe. Beliefs about failing in this regard often act as a catalyst for bringing this fear of weakness into relief, whether that other be a partner, family member or child. It is worth saying here that in the vast majority of cases this is about a fantasised as opposed to real experience of protecting others. The primary pre-occupation is a thought like "I couldn't protect myself from the worst thing that could happen. How can I protect others I care for?" or more perniciously "How can others I care for ever expect me to protect them and can I endure failing in that expectation?". The idea in many males that they should be able to defend themselves even against feelings, that allowing themselves to be upset by or acknowledge the living impact of events "so long ago", is a further betrayal of masculine ideal and makes asking for help even more difficult.

The birth of a male child can be a very significant trigger for a male survivor, and I know of many cases where this was the catalyst of anxieties and counter-productive, painful behaviours directly linked to impacts of sexual abuse. James is a man I worked with who felt that he had overcome his experiences of child sexual abuse through therapy and introspection. He held down a good job, was married with a young daughter and expecting a second child which the couple recently discovered was to be male. From the date of that discovery, James (who had a relatively uneventful experience of the birth of his daughter) began to have stress related dreams. He started to obsessively childproof their already childproofed home. He frequently fantasised disasters involving the death of his wife and that of the baby. He began intermittently overexercising and overeating and became very concerned about his physical wellbeing. This put enormous strain on the couple's relationship and impacted his care of their young daughter. For James, the unconscious fear that he would be responsible for protecting a young version of himself was overwhelming, his anxiety presenting in hypervigilance, a desperation to create a certain and safe environment and to escape ideas of malign external intrusion. He struggled with a belief that he wouldn't be 'man' enough to stop what happened to him happening to his son because he had failed in "maleness" when he was a child – all this despite previous work to recognise what he couldn't or realistically could have done given his age, power and physical size at the time that he experienced sexual abuse.

Uncomfortable ideas about sex and sexuality are also areas of interest in thinking about the male experience of CSA. Chris, who I referenced earlier, talked a great deal about sex and the ways in which he used it to shore up his ideas of 'performing' masculinity. Part of the social conditioning of young heterosexual males is that they should be the leaders and instigators in sexual encounters, that the initial drive for sexual activity should come from them. That expectation is generally at odds with the experience of a male child who has been successfully groomed into meeting the needs of a perpetrating adult. Whether submitting to a more passive (feminised) role or being instructed to take up a more active one, the generative power lay with the perpetrator and

not the child, though this is sometimes obscured when in grooming ideas of the child wanting or encouraging the sexual abuse have been successfully implanted.

Erections and ejaculations are often used by the perpetrator to reinforce a narrative of mutuality in the experience but even without this explicit external reframing, most male victims and survivors experience their own sexual excitation during abusive events as a profound betrayal of self. The evidence of arousal is undeniable and physically difficult to ignore (tumescence and/or orgasm), and these physical manifestations may take on profoundly negative aspects to the male survivor. Many survivors believe that the events of sexual abuse should have been uniformly and consistently repugnant and abhorrent to them and that any experience of sexual gratification absolutely contravenes that belief, leaving only the opposite – that they "enjoyed" what happened and therefore were not damaged, whatever other evidence there may be of harm. The presence of a manifest erection or the sensations (and sometimes products) of orgasm act as strong confirmation in male children that whatever their emotional state, their body's response to (internalised as participation in) the abusive events means that they are complicit, the erection a clear physical signal of permission to the abuser to continue in the abuse, the orgasm a silent agreement of equal and shared exchange.

I have yet to meet a male sexual abuse survivor who hasn't questioned the impact of abuse on the formation of their sexuality and sexual identity. Where the perpetrator is male, it is common for the survivor to perceive the events of the abuse (between two or more males) as homosexual and to think about their own sexual responses as signifying homosexual identity. That requires a belief that the perpetrator is equally homosexual, whatever their presenting status, and makes the interaction 'a gay thing'. Where the adult survivor has developed a heterosexual identity, the question is often "Am I denying that I have homosexual inclinations because they're linked to abuse? Is my 'straightness' an avoidance and therefore not the reality of who I am?". That's a complex enough question but it's further complicated by issues related to their perceptions of homosexuality. Boys are often raised in an environment where homosexuality is seen as abnormal, dangerous and threatening. The on-going activism around recognition of LGBTQI+ rights and identities point to a society in which homosexual (or more broadly non-heterosexual) continues to be an outlying and second-class status. In addition to wresting with questions about the authenticity of his experience of sexual response and identity, the adult male survivor may see this feared 'other' sexual self as dangerous and less-than. It may represent acts that, through association with the legacy of abuse, may be perceived as even more shameful and disagreeable than the already negative ideas and stereotypes of homosexual sexual acts that may be part of their adolescent and adult beliefs.

Male survivors who identify as homosexual invariably question whether the abusive events in some way shaped their sexual identity – whether their 'gayness' is some legacy of abuse and not their natural orientation. The enjoyment

of consensual sexual acts may be complicated by memories and associated feelings about where they were first performed and what is attached to them in the way of shame, self-mistrust and on-going ideas of complicity and consent. This continues as a consideration in the male homosexual sexual exchange which is often linked to ideas of 'top' (dominant) and 'bottom' (passive) sexual partners (which on the surface my recreate some of the power imbalance of abuse) and the ways those roles ape heterosexual intercourse and ideas of traditional male and female role relationships. Think of the often-asked question of same sex couples – "Who's the man and who's the woman in the relationship?" and how these may already be internalised and working in the participants. Issues of masculine definition get played out here regardless of sexual abuse complications but for some survivors their history adds complexity. A male survivor may resist the more passive role, for example, as not sufficiently masculine or because it reinforces a negative experience of being subject to the dominant sexual desires and practice of the perpetrator. They may wish to take up the more assertive role as compensation for the feared deficit in their own masculinity or avoid it for fear of aligning with the idea of perpetration. They may mistrust a desire to 'bottom' as a legacy of abuse and not a genuinely held preference. In both cases, the central theme is one of mistrusting sexual instinct and the role that harms to security in sexual evolution play in acceptance of adult sexual identity and preferences.

In thinking about the impacts of childhood sexual abuse on masculinity, I am now going to risk a provocative question. We have thought a bit above (and more will come below) about the expectations masculine tropes introject in terms of sexual assertiveness and performance. We also recognise that in our existing social ideas and portrayals of sexual intercourse, powerful males penetrate, and less powerful females receive the penetration (think about the way we use those terms in plumbing supplies, for example). So, in an abusive situation where the young male has been penetrated by another – does he believe himself to have been made female, even only in those moments of penetration or only in the regard of the penetrating perpetrator? This is not a reflection on the desirability of male or female sexual or gender roles (and I am not suggesting that any events of sexual abuse are causative in defining or creating the gender identity of any individual) but about internalised ideas about identity linked to sex and gender norms and experience. For a young male determining what maleness looks and feels like, being perceived as female and treated sexually (in perception) as a female object by a more powerful (masculine) person is a profound negation of sexual masculine identity and its performance. In the situation where the perpetrator is female and performs a penetration the young male may not be cast or perceived as a 'female' object – the motivation may belong more firmly to the perpetrator wanting to inhabit a more traditionally male role than in changing the identity of the victim. But the experience of the victim remains much the same.

And what of the male whose perpetrator is an older woman? This coupling has been fetishised for generations as a devoutly to be desired rite of passage.

The idea that a young male may not be consenting is unthinkable – unnatural. For that young male, his experience is further complicated by ideas that he should be enjoying the sexual interaction, that he should see himself as lucky. Having negative responses suggests that he must be failing in his masculinity because 'real men' should enjoy sex offered by women regardless of the circumstances. Questions about what it means to resist being chosen while believing that others would devoutly wish to be the special object of choice leave the survivor with profound disbelief about the validity of their negative feelings. In this case, issues of power imbalance reinforce pervasive ideas attached to male and female roles in generating sexual intercourse that may leave the survivor feeling emasculated.

I am reminded of a young man who talked in a group about his feelings in relation to abuse by an older female relative. He talked with passion about the excitement and envy his contemporaries expressed when he revealed what was happening and how estranged their reactions left him from his own feelings of shame. Their reactions reinforced his own ideas that what was happening should be seen as a gift and not abuse, that he should be grateful to the woman who groomed and used him for her own gratification. This led to a profound sense of self-mistrust and hatred, and he abstained from any sexual activity until well into his thirties (further adding to ideas of estrangement and difference). It was only when he finally sought therapy for his sexual avoidance that he made an adult disclosure of what happened, and he talked about how shocked he felt when the therapist suggested that what happened to him as a teenager was both wrong and might have left a legacy of damage that could be explored without cancelling his ideas of what being a 'man' entailed.

Of the experience of adults of trans identity, I have significantly less direct knowledge (and of trans children none), but those who have spoken to me have raised similar questions about the role of abuse in determining their trans identities and sexuality, returning to conceptions of what is natural and what is imprinted. For these individuals (in this case trans women), there are further complications when the abuse happened to a child who they may not recognise as clear reflections of the adults they have become. Heather, a friend, talked about the abuse that happened to Ethan (her younger self) as something that happened to 'the boy' and that she could not successfully hold on to as an adult woman of trans identity. He was not just far away temporally but also so different from the person she now knows to be her true self that she struggles to empathise rather than sympathise with what happened to him. A protecting split is not uncommon among survivors of any sex or gender but her internal experience of recognising, accepting and manifesting her identity (in addition to the profound societal, legal and human rights negations common for trans people) adds a specific dimension to abuse experience that we must bear in mind.

As a final note, it would be remiss of me not to mention the pernicious "sexually abused boys go on to become abusers" myth. It has been so

prevalent over so many years that many male survivors struggle with a version of it in thinking of their own sexuality and ideas of sexual attraction. This encompasses fear of being branded with perpetrator identity, fear of their own feelings and hypervigilance about interactions with children. Hakim, a father of three, told me that he would never bathe his children as being confronted with any evidence of their developing sexual instinct in his presence made him feel that he was abusing them. He also feared that being confronted with that experience might awaken some dormant desire in him, despite having never experienced any sexual desire or curiosity in relation to children. Some research into sexual offenders suggests a higher rate of offending among men who report having themselves been sexually abused as children and it is a fact that most perpetrators that we know about are male. But no significant study has been performed to causatively discern what combination of factors (which may include a history of sexual abuse) come together to create a perpetrator identity. To suggest that simply experiencing sexual abuse in childhood leads to a higher probability of going on to sexually offend against children is as sensible as suggesting that if 30% of a similar sample of people committing murders read Shakespeare then reading Shakespeare predisposes people to commit murder. While the evidence remains so unreliable, I suggest it is beneficial to avoid the common assumption and consider instead what it might mean for those people living with the label and the fear of other's perceptions to experience themselves in living with it.

Males, of course, are not just a bundle of masculine projections waiting to be fulfilled or frustrated. And sexual abuse in childhood impacts much more than their sense of masculinity. But within the cannon of cause and effect, thinking about the role of maleness and how it is assaulted as part of sexual abuse may be fruitful.

## Race, faith and shame in sexual abuse

During my work with the Independent Inquiry into Child Sexual Abuse (IICSA), I met with hundreds of organisations and individuals working with CSA survivors with minority identities. My work was to try to promote participation in the public listening project (The Truth Project) from members of these communities and to understand why they were not accepting our invitations to join. "Why have you chosen us?" as an area of focus was often the first defensive response, an interesting one in the context of sexual abuse and what it means to be chosen. There was a belief that, whatever our intentions, the Inquiry would end up assigning blame and deflecting attention from the white majority to communities of difference as containers for universal anger, outrage and frustrations related to sexual abuse. One leader of a Jewish support group told me "Our history is of being made the scapegoat for societal unease across multiple areas, so why wouldn't we assume you'll do the same?". That sentiment reflected the views of many minority groups whose experience of majority culture is that its gaze on them has often felt

malign – judgemental and punishing. I discovered that there were profound anxieties about what participation might cost those who participated, not just personally but as representatives of their race, ethnicity, religion or culture. That anxiety was based in multiple and systemic experiences of disregard and continually being seen as threats to majority safety. As one community representative told me, "They (white society) already hate us. Why would I give them more ammunition to use against us".

Think for a moment now of the experience of a child of colour raised in a country where they are not part of the majority. It is likely that this child will have received from infancy conscious and unconscious messages that they should view the wider external world (outside of their family and community) as a possible threat to their identity, their culture, possibly their lives and wellbeing. The generational trauma of lived experience of racism and dis-inclusion will be alive in this child through early development and may be reinforced by their own experiences of how their skin colour and/or cultural identity are used as markers of difference, often in pejorative or disadvantageous ways. They grow and develop in a multicultural setting and this split between their native or historic cultural identity and that of their natal or adopted country is one they must negotiate on a daily basis to integrate the identities they hold as parts of different communities and groups.

These divided internal identities can impact their experience of sexual abuse in significant ways. Where, for example, this child experiences abuse at the hands of someone not of their own skin colour and/or cultural background, it is common for this child to entertain ideas (consciously or not) about the role their difference played in their selection as the object of the perpetrator. I think now of a young black man, abused as a child in clerical setting by a white pastor, who discussed this in a group session where he said (and I paraphrase)

> I know that I'm not the only one who experienced this abuse. I know that some of the others were white. But I can't stop thinking about whether he picked me because I'm black. I don't know if that's because of what he thinks about black people and families, or if he thought it was safer because people would be less likely to believe me or if it was part of some fetish he was living out – and I know I'll never know that – but I live with a belief that my skin colour played a role in what happened to me. That it was weaponised against me in some way and that I shouldn't be surprised about that given the other ways that white people treat black people in this country.

This observation opens the door to some important considerations about what may be present in and presented by the adult survivor of colour. In the case above, it is worth thinking about the ways in which these dynamics may be at play in the exercise of power by a white perpetrator over a child of colour. There is the already significant contemplation here of the role of

racialised difference in the direct experience of abuse, in this case in consideration of the selection of the child as a victim. But this may be more impactful in the context of our growing understanding of the ways that racial power imbalances across the social spectrum may be reinforced in this situation, where the abuser in addition to the imbalance of power between adult and child also represents the imbalance of power between white and non-white people in a global north society. There is also much to be said where the reverse situation occurs, and I explore this further on in the text.

I am drawn to thinking about the splits and re-internalisations of damaged objects that flow from considering racism and issues of discrimination in sexual abuse through object relations. I think here of the legacy of colonialism, the centrality of commodification of persons and identities and the rescripting of value, purpose and narrative that was required to justify and maintain it. This chapter does not propose to examine impacts or experiences of racism or colonial legacy outside of the context of CSA but there are clear resemblances to much of the commerce of child sexual abuse – the ways that less powerful people are defined by those more powerful to allow certain actions; the ways in which both sets of people unconsciously internalise and accept those definitions as a form of defence and survival; the desire of the coloniser (and sometimes the colonised) to impute mutuality and mutual benefit and to minimise the impact of their actions; and the desire that can be experienced in those subject to actions of the more powerful party to explain or contextualise the damage done as a consequence. Part of the impact of living with a legacy of racial disregard is an unconscious belief that it was justified or deserved, and we see a version of this time and again in victims and survivors who struggle to explain away the impact of their experiences, to accept responsibility and blame to make the unbearable more endurable.

Frank Lowe (2007) wrote about colonial object relations resulting in exploitation and degradation. It is powerful to imagine that which is alien or offending containing all the fear, insecurity and/or anxiety of the person or group projecting – that intolerant attitude, expressions and a reluctance to believe are an attempt to protect and keep safe a wounded psyche whose ego is unable to manage the ambivalence of what the 'other' represents. I bear this in mind when thinking about the many denials of child sexual abuse that historically and currently happen and the battle victims and survivors of colour face in navigating ideas of being believed.

Issues of belief are writ large in this recounting and while many victims and survivors wrestle with ideas about whether they will be believed or not (and by who) these are amplified in members of communities whose voices have often been historically silenced and where assumptions are made about the willingness of majority society to believe their experiences of and the impact of racialised disregard. In my own work with survivors of colour, there is often a heightened anxiety and determination to convince that the events of experienced sexual abuse both happened and have negative consequences. There is also a particular impact related to the fetishisation of black males as

sexually potent and assertive, an identity often taken up by black men and boys as a badge of honour, that frames sexual abuse as an assault not just on their heightened masculinity but also on their colour identity.

Faith also plays its role as a deterrent to disclosure. Over many years, we have explored the dynamics of religious belief that inhibited survivors of clerical abuse (primarily in Catholic and Anglican settings) from coming forward, hearing about the role of the priest as God's representative, invested with special ability to do good, know right from wrong and deserving of special forgiveness if delinquent. This aligns with the desire of many survivors of familial abuse to find ways to excuse the abuse perpetrated by family members and the struggle to reconcile ideas of loyalty, duty and love with abusive events perpetrated by someone not just trusted but invested by title (father, mother, sibling) and relationship with some greater authority and fantasied responsibility of care. In the accounts of Irish survivors, much has been made of a collective desire to protect the church from harm, a duty to shield its reputation and a reverence for those representing its power and beneficence – a desire to shield 'mother' Church and 'father' cleric. Much has been said about the cost to survivors in shame, rejection and diminishment through being forced to choose between a community of faith and a desire to seek justice or retribution, to be chosen again as secret keepers, but now for the greater good and not just that of the perpetrator.

Non-western religions also create barriers to disclosure. Ideas of Karma in Hinduism have commonly been interpreted to mean that you experience negative events in this life in payment for poor thoughts and actions in an earlier one (which is not what the Vedas actually describe). In that schema, sexual abuse can be set up as a deserved punishment that should be accepted to remedy earlier transgressions. The cosmic wheel ensures that the perpetrator will pay a price in bad karma and the cost of disclosure to those around the perpetrator may accumulate further bad karma to the discloser. Ideas of reincarnation to higher caste or position based on forgiveness and overcoming adversity also play a role in dampening the desire to reveal the abusive events.

Ideas like these are further complicated by conceptions of shame and a history of dis-inclusion. Shame in many societies is more systemic than the individual western response to personal experiences that we generally assign that word. In some cultures, ideas of "face", the mask of acceptability defined by cultural and religious norms are more pernicious and encompassing than in others. For some men and women from South, South-East, East Asian and Arab backgrounds (for example), the shame attached to sexual abuse is not confined to the survivor but impacts the reputation and prospects of all attached to them. Several women talked to me about not wanting to reveal what happened to them for fear that they would never be able to escape the assault to ideas of their purity and chastity, and the ways those assaults on ideals devalued and diminished them in the eyes of others whose opinion had a material impact on their lives. They talked about fears that they would

be hidden away to protect the family and community, or face expulsion for bringing shame on their religion or ethnic identity. They believed that being identified as an abuse survivor would negatively impact their chance of a full and unbranded life and inclusion in the wider social group. And not just their chances but the lives of those closest to them. One survivor told me

> If my community find out what happened to me, no one will marry me or my brother or sisters, my parents will never be able to hold their heads up in public again. I can't bear the responsibility for taking that away from them.

A similar experience was reported by many abused men from these backgrounds who talked about the stain of sexual abuse spreading wide and affecting everyone in proximity.

Let's think about the public discourse that has developed about the racial identification of men perpetrating organised sexual exploitation of girls in the UK. Attention has centred on events that involve men of South Asian heritage as perpetrators and adolescent white girls as victims (though the evidence suggests a significantly higher number of white perpetrators in the wider context of organised exploitation) and the headlines have condemned "Asian Grooming Gangs", centring attention on the ethnicity and religious identities of the perpetrators. In the public discourse around these prosecutions, ideas about sexual abuse as a form of revenge or retaliation against white society have been freely expressed alongside conceptions that sexual abuse is commonly more accepted and less important in the foreign cultures of the brown skinned perpetrators. There is much to be said about the systemic reinforcement of "othering" in national consciousness and about the avoidance of most sexual abuse perpetrators being white, but I am here concerned with the impact of these dynamics on victims and survivors coming from these communities.

In addition to the already discussed barriers to disclosure faced by people of colour, victims and survivors possessing this specific identity now face the additional burden of living in a society where a prominent and significant narrative about their sexual and psychological instinct is that of perpetration. While most male victims have at some point identified a fear that they may be seen as potential perpetrators, men of South Asian heritage now face a conscious or unconscious internalisation of anxiety that their entire identity is now inextricably linked with ideas that they represent sexual danger to children. This is likely to play a role in the way that they can consider grooming activities that may have preceded abusive events in their own childhoods, reinforcing and complicating splits between good and bad internal objects and threatening their ability to integrate victim and survivor identities in themselves. It is also likely to add to pre-transferential anxieties about engaging in a disclosure or therapeutic process that is not a recognised part of their cultural landscape and where they may have to do the heavy lifting of

contextualising the systems and rites of culture in which they have grounded beliefs about themselves and the abusive events of their lives.

The narrative affects the whole community whose minority status lends a tribal desire to protect itself (and its members) in the face of perceived attack on multiple borders. Female survivors with South-Asian or Muslim identities will be impacted by ideas about safeguarding the reputation of their entire ethnicity or religion and concerns that their abuse experiences may be framed in a context of what is perceived to be "normal" in their society. While I have recounted a specific example here, the dis-ease experienced is common in many societies (not just those of colour) that have faced negative societal assessment and disregard. Gypsy, Roma and Traveller communities face similar public conceptions about early sexualisation of children as part of their 'normal' cultural practices. Kevin McKenna wrote

> This is a people accustomed to living on the margins of society and wearily familiar with the lexicon of alienation and loathing that accompanies them on their travels. This has bred in them a suspicion and resentment of authority and a spirit of stubborn self-reliance.

A historical lack of compassion in the way that they have been depicted and described, experience of having unrelated social ills ascribed to them and a spate of lurid headlines about accusations of CSA in their communities act as profound negations of any desire to disclose and/or seek assistance.

Shame and belief of course are not just linked to ethnic, sexual or cultural identity and issues like those described above present across communities. In my work with sex workers (for example), a common thread of conversation encompassed conflicting beliefs – that disclosures would either not be believed or be seen as a form of manipulation, a justification or excuse for what society might consider poor adult choices. And a belief that work in the sex industry would lead the listener to judgements about abuse in the journey to sex work that overshadowed any other consideration or impacts of those events.

Language may also play a role for survivors whose native communication is not standard spoken or written English. In some cultures, the familiar words to describe sexual body parts and sexual acts do not exist and framing those experiences without these tools can cause distress in the narrator and confusion in the listener. Several workers supporting Asian survivors talked about a mistrust of interpretation, noting their experience of interpreters diluting content to shield culture or religion from what they (the interpreter) perceived to be shameful revelations. And interpretation brings significant anxieties about confidentiality and identification in societies where numbers are small and jigsaw identification commensurately easier. This was as true in deaf communities as in those of colour difference.

It's worth thinking about the role of 'specialness' and being chosen and the way that can be different for people whose lived experience of parts of their

identity already contain manifestations of that. We know that ideas about being made special and being chosen are often part of the grooming process and that these can be unhelpfully internalised by the survivor as part of coping. Children often seek special recognition to bolster developing self of sense and can competitively use the lack of it or its attachment to others as measures of their own value. Think of how it felt as a child to be recognised as clever or attractive or talented and how you may have yearned to have more of that feeling. Children who come from minority backgrounds have often experienced something about their physical, cultural or religious attributes as causing unhelpful notice in others and often receive messages that they must develop greater resilience as a standard part of managing life – they must learn to ignore uncomfortable incidents or manage their uncomfortable feelings as part of their place in the world. The message is often "That's the way the world is and you have to adjust yourself to overcome it". There is a straightforward imputation of self-care and taking personal responsibility for the biases and actions of others which is made easier by the widespread recognition that it's happening and that it's a shared experience. When this way of coping is active and endorsed in other areas of the child's life, it's not surprising that they might assume that sexual abuse falls into a similar category and feel a similar requirement for personal responsibility and a need to self-care. But this time without the shared identity reinforcement and support. This leaves these children in a specifically vulnerable state and can develop in the adult as a profound belief that seeking help is a betrayal of cultural norms and requirements.

Before I end, I think it would be helpful to think about how the issues raised above move into the consulting room which can represent a microcosm of the wider world to people of 'difference'. Much of the pre-transferential consideration of those who have experienced discrimination and sexual abuse will be unconsciously informed by dynamics of unknowing, fuelled by lived and suspected experiences of 'othering'. This client may have concerns about the therapist's ability to understand or empathise with their experiences. This potential barrier relates not just to cultural knowledge and shared experience but also to transferential and counter-transferential interpretation that goes beyond bias (conscious or not) and questions whether the therapist can recognise, interpret and fully experience culturally different unconscious communication. And it's worth noting that while some people I have talked to wanted to work with someone similar to them in background, perceived identity or skin colour who they thought would more easily contextualise and shorthand their recounting of experiences, at least an equal number wanted someone as different as possible to safeguard their identity and avoid unhelpful shared cultural assumptions.

Tension exists in some minority group survivors between wanting the ease of working with someone that might more easily 'get' their background and anxieties about what might come attached to that ease. The comfort that may lie in shared identity can easily be compromised by

significant fear of what it means to be discovered. 'Survivor' can be experienced as another minority status, one that carries real or imagined toxicity and shame on personal, community and societal levels – an identity which the survivor may not want attached. We invest a great deal in ideas of what it might mean to an individual to be seen with positive regard but 'seen' for many of the people I have discussed (where notice is often a far from positive experience) here carries higher risk and potential consequences that we must consider.

In summary, through the foregoing words and accounts, I have tried to illustrate the ways in which internalised ideas relating to identity and discrimination affect (and are affected by) experiences of sexual abuse. These attach to the whole person who experiences the impacts of sexual abuse globally both in and through all their intersecting parts. Each person is composed of sex, gender, race, cultural, ethnic and social elements acting both individually and collectively, all at the same time, all the time. Sex, gender, sexuality, race and culture have been my primary focus and I recognise that there are many other forms of discrimination and personhood that I have not highlighted here. I hope to learn and report more as time passes.

As I conclude, I want to recount something some deaf workers told me that I think applies across the groups I've mentioned above (again, I paraphrase)

> Sexual abuse isn't always as high on the list of priorities of our clients as it should be. It's not that they don't accept that it's wrong and has very serious impacts. But we're fighting every day just to have our existence and needs recognised, to negotiate a hearing world that sees us as inconvenient, problematic and inferior. It feels like we have to struggle to be heard and understood in ways that are far beyond just communication. So, opening up a conversation about sexual abuse just feels like another problem we have to present to a world that doesn't often want to see or recognise us.

Taking about personal experiences of child sexual abuse is always an act of bravery, but in the face of sexism, racism, homophobia, ableism and disregard, it becomes a profound and monumental act of courage that we must recognise and adjust ourselves to enable. I think about these issues in relation to every survivor who faces a world in which they struggle with ideas that they have to firefight on multiple fronts to be recognised, respected and included. I think about the many presentations of shame and expenditure of psychical energy linked to gender, colour, religion, ability and identity – the burden placed on these people and the daily compromises they must make to negotiate their lives. And I recognise that I have a great deal more to learn to enable me to hear not just what's being said but also what lies between the words.

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# 6 "I didn't think I had rights that protected me as a human being"

## Exploring the lived experiences of child sexual abuse in ethnic minority communities

*Kiki Hassen**

**Chapter summary**

Despite a substantial amount of research on child sexual abuse (CSA), there is a lack of understanding on experiences of child sexual abuse within ethnic minority communities. The Truth Project, conducted as part of the Independent Inquiry into child sexual abuse, heard testimony from victims and survivors, providing a collection of second-hand accounts. This secondary data qualitative study aimed to explore these accounts, focussing on the lived experiences of child sexual abuse in South Asian, Black and Afro-Caribbean, dual heritage, and Gypsy, Roma, and Travelling communities. This study examined how ethnicity and cultural background influenced the context of abuse, experiences of disclosure, support received, and their healing journeys. Utilising the Truth Project's database, 60 accounts were analysed using reflexive thematic analysis to identify themes within ethnic groups and explore similarities and differences across groups.

The analysis revealed distinct themes across ethnic groups. South Asian survivors emphasised cultural hierarchy and obedience, facing challenges in disclosing abuse due to fear of community rejection and internalised shame. Black and Afro-Caribbean survivors highlighted a legacy of systemic racism and intergenerational violence, while dual heritage survivors navigated troubled family backgrounds and racism intertwined with abuse. Gypsy, Roma, and Traveller survivors expressed confusion distinguishing love from abuse and faced societal stigma when seeking support. Across all groups, survivors encountered challenges in accessing support due to distrust of authorities and culturally informed systemic failures, yet they found resilience in empowerment and healing through community support and advocacy. The findings are related to theories such as collectivism, critical race theory as well as liberation and community psychology, to provide a framework to understand the influence of cultural factors, systemic racism, societal stereotypes,

* Statement of confidentiality: The Truth Project used pseudonyms to protect the anonymity of survivors. Participant pseudonyms assigned by the Truth Project were utilised to reference participant quotes in this study.

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and the healing process for survivors from diverse ethnic backgrounds. This study highlights the need for culturally competent interventions, recognising diverse narratives, and understanding cultural biases in professionals' perceptions and responses to abuse survivors.

## Introduction

While CSA is acknowledged as a widespread global health issue, there is no universally agreed definition because perceptions of childhood and definitions of sexual consent vary greatly between countries and cultures (Haugaard, 2000; Russell & Higgins, 2020). Ambiguity around definition influences the identification and prosecution of CSA cases (Mathews & Collin-Vézina, 2019). Additionally, if disclosure occurs, it is often delayed until adulthood. Cultural and situational factors, such as secrecy, compliance, shame, low likelihood of prosecution, and chance of not being believed, mean that many survivors and victims do not disclose at all (Augusti & Myhre, 2021). Consequently, crime statistics only capture a minority of cases and documented rates of CSA prevalence are unreliable and under-estimated (NSPCC, 2025). Prevalence in ethnic minority communities tends to be under-reported or not identified (Gill & Harrison, 2019).

Although there is a wealth of research investigating the psychosocial impact of CSA, as well as potential risk factors and experiences of disclosure (Blakemore et al., 2017; Laird et al., 2020; Lemaigre et al., 2017), there is a paucity of research which explores how these experiences manifest in ethnic minority communities (Gill & Begum, 2023). Ethnic minority is an umbrella term used to refer to ethnic groups considered to be a minority within the population; however, the term is widely critiqued for obscuring the fact that such groups may not constitute a numerical minority, but are instead minoritised through social, political, and structural processes. In the UK, this term covers all groups except White British, including white minority groups such as Gypsy, Roma, and Travelling (GRT) communities (Aspinall, 2020). This term, alongside ethnic group categories, was chosen from a limited selection, recognising that not all individuals may resonate with it and that these terms may carry stigma (Aspinall, 2002). The ethnic categories in this study were informed by the Office for National Statistics (ONS, 2019), as well as participants own words when referring to their ethnicity, alluding to physical attributes (e.g. 'Black') and heritage (e.g. 'Asian'). Furthermore, the terms 'victims' and 'survivors' are often used interchangeably in CSA research, respecting that individuals prefer to use the term that best fits with their experience of recovery and healing (Papendick & Bohner, 2017). This project mostly employed the term 'survivor'; however, it is recognised that research should ideally honour both terms.

An extensive literature review on ethnic minority experiences of CSA was conducted by Sawrikar and Katz (2017a, 2017b, 2017c, 2018), applying the findings specifically to an Australian context. They found specific

barriers to help seeking such as religious beliefs, reliance on intra-familial support, isolation from dominant culture and language barriers. They emphasised self-blame, avoidance, suicidality, and suppression, to manage cultural pressures alongside coping with CSA. They highlighted differences in how CSA trauma symptomology might manifest differently in ethnic minority groups, such as somatic complaints. These distinct needs were understood via a lens of collectivism and individualism (Bond et al., 2002). Collectivist (typically non-Western) cultures prioritise social order, community harmony, and family support in exchange for loyalty, while individualistic (typically Western) cultures emphasise independence, autonomy, and equality. They recommended that support services and structures should be informed by the importance of family reputation and collectivist values, rather than expecting ethnic minority communities to assimilate to individualistic ways of coping with CSA. These findings have been supported by other studies (Fontes & Plummer, 2012; Kenny & McEachern, 2000; Simpson, 2020).

While this research provides comprehensive insights, it is important to note that ethnic minority experiences in other Western countries (e.g. Australia or USA) or non-Western home countries may not capture the unique experiences that minoritised individuals face in the UK. This discrepancy may arise from distinct migratory and acculturation experiences, cultural influences, and geopolitical contexts that uniquely shape the experiences of minoritised communities in the UK.

In March 2015, the Independent Inquiry into Child Sexual Abuse (IICSA), referred to as 'the Inquiry', was established to investigate the extent to which statutory and voluntary institutions and public bodies had failed to protect children from sexual abuse in England and Wales. It was set up in response to societal fear and outrage, following the aftermath of high-profile cases such as the Rochdale abuse scandal and Jimmy Saville, as well as the 'Me Too' political movement. The Inquiry was established by the Home Secretary, under the Inquiries Act 2005 (Jay et al., 2022), and therefore was inextricably associated with the UK Government. Critical race theory (Delgado & Stefancic, 2023; Moodley et al., 2017) emphasises the systemic nature of racism and seeks to understand how it is embedded within institutions and everyday practices. According to this understanding, it is possible that the Inquiry represented structural oppression perpetuated through governmental policies which exclude and discriminate against minoritised individuals. This may have influenced whether ethnic minority survivors felt they could bring all aspects of their experiences and it likely influenced which survivors came forth from these communities. During the initial phase of the Inquiry, most Truth Project participants were of white British heritage. Therefore, in June 2017, additional efforts (the 'diverse communities engagement project') were devised to engage ethnic minority communities.

As part of this project, some research was commissioned and approved to gain further insight into ethnic minority experiences. Rodger et al. (2020)

explored experiences of disclosure and support discussed within focus groups with South Asian, Caribbean, and African survivors. Their qualitative analysis found that cultural stereotypes and misunderstandings of cultural differences hinders identification and response to abuse, while institutions lacking diversity are seen as unapproachable. Shame, fear of rejection, and concerns about family reputation contribute to a code of silence, with gender expectations affecting survivors' sense of identity. The IICSA research team also engaged community support staff in focus groups. They noticed that language barriers, religious taboos, and cultural norms complicate disclosure, compounded by professionals' anxiety about challenging cultural norms. These initial findings lay the groundwork for this project, which will thematically analyse individual stories of CSA collected by the Inquiry's 'Truth Project', from self-identified ethnic minority survivors. This information is anticipated to add further depth to the focus group data and contribute to existing research, specifically from a UK standpoint.

One limitation of current research is its tendency to group together distinct cultural norms, traditions, values, and practices under broad terms such as 'ethnic minorities' or 'BAME' (Black and Asian Minority Ethnic), falsely homogenising their needs and experiences. Fontes (1993) termed this practice 'ethnic lumping', which has appeared to occur due to small sample sizes in ethnic minority groups. While western minority groups may share some experiences such as language barriers, racism, and collectivist backgrounds, ethnic lumping overlooks nuanced details and ignores inaccuracy in generalising experiences from one culture to another. Another criticism of ethnic lumping is that it does not acknowledge intersectionality, referring to subjective experiences shaped by interconnected influences of race, gender, class, disability, and sexuality (Nash, 2008). This superficial understanding of ethnic minority experiences within the evidence base may contribute to a lack of cultural competency in UK clinical services (Sawrikar & Katz, 2017a, 2017b, 2017c).

To address this limitation, this project aims to analyse experiences of CSA in ethnic minority groups separately, highlighting themes unique to each group while also exploring commonalities and differences. By presenting these findings in this manner, it is hoped that a deeper understanding of intersectionality and diversity will be achieved, improving cultural competency, and guiding more inclusive practices in clinical settings.

## Methodology

The Truth Project was a research project set up as a strand of the Inquiry, alongside research and public hearings, to inform the final recommendations. The aim of the Truth Project was to hear and learn from the lived experiences of victims and survivors, to understand the long-term impacts of CSA and to

make recommendations for change. The overarching research questions of the Truth Project were (Jay et al., 2022):

- What have victims and survivors shared about their experiences of CSA and the institutional contexts in which it occurred and was responded to?
- What similarities and differences are there in victims and survivors' experiences of CSA across time periods, groups, and institutions?

Truth Project participants could share their experiences either through private sessions conducted over the telephone or in person, or by submitting a written account. Participants were encouraged to take a lead, disclosing as much or as little as they deemed comfortable. Private sessions were hosted by a facilitator, accompanied by an assistant facilitator who provided a written summary of survivor's experiences. Accounts were collected from June 2016 to October 2021. Although this represents a proportion of the total 5862 participants, a total of 1100 CSA accounts were summarised and documented. These condensed secondary summaries were anonymised and made publicly accessible through the 'Experiences Shared' section of the IICSA website. Since the publication of the 'Experiences Shared' database, a series of thematic reports were published examining the Truth Project findings in relation to various topics. This study aimed to contribute a thematic analysis (Braun & Clarke, 2006) of the unique needs of ethnic minority CSA survivors within this database.

This study analysed accounts consisting of written summaries documented by the assistant facilitator, rather than verbatim statements from participants. Henceforth, participant quotes included in this report are presented in both third person, when mentioning the participant, and first-person, when presenting direct quotes provided by the summaries. Participants are referred to using pseudonyms given by the Truth Project.

A limitation is that this dataset lacks demographic information for each participant, restricting conclusions about the influence of intersectional identities on ethnic minority experiences. Research has established the importance in considering intersectionality in exploring experiences of CSA as it allows for deeper analytical insights to be obtained (Armstrong et al., 2018). Therefore, it should be noted that understanding the impact of cultural background and ethnicity in isolation, without considering factors, such as class, religion, gender, and sexuality, does not offer a holistic understanding of lived experience (Phoenix & Brah, 2004).

#### *Data selection method*

The Truth Project aimed to be as inclusive as possible, inviting participation from survivors and victims from diverse backgrounds, cultures, sexualities, ages, and religions. It sought to collect experiences from individuals who

were sexually abused as a child, within an institutional or familial setting, who sought support from institutions and authorities.

The entire 'Experiences Shared' database of 1100 accounts was downloaded from the IICSA website and transferred into a Word document. Using the Word search function, the data was searched for any reference to 'ethnicity', 'cultural background', 'racial identity', and 'ethnic minority heritage'. Accounts were screened, and any which mentioned these terms or specific ethnic identities were included in the analysis. A total of 60 accounts (see Figures 6.1 and 6.2 for details) had some reference to ethnicity, cultural background, and ethnic minority status. This comprised the sample for this study, representing 5.5% of the total number of accounts within the 'Experiences Shared' database.

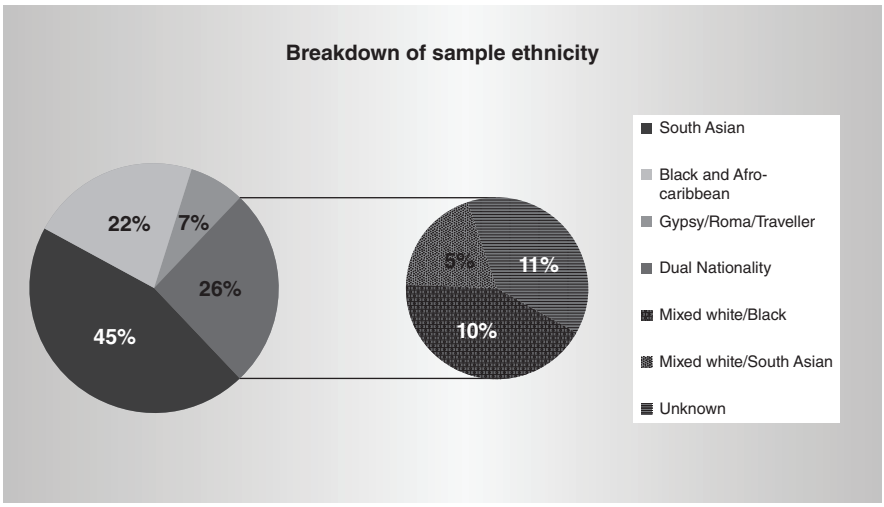


*Figure 6.1* Breakdown of Sample Ethnicity

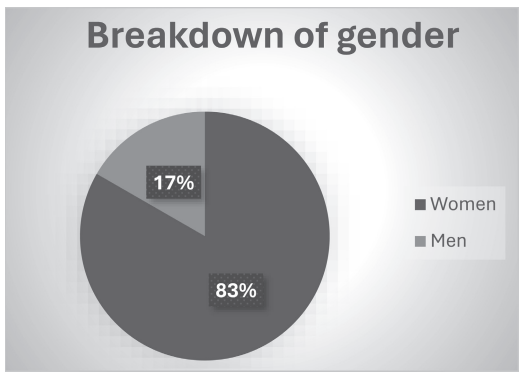


*Figure 6.2* Sample Gender

***Ethical considerations***

Truth Project participants were given the option to consent to the publication of their information freely available through the IICSA website's 'Experiences Shared' section, enabling its use for secondary research and public viewing. Therefore, the reuse of this data does not breach the initial research agreement, which is often a common ethical concern with regards to the use of secondary data (Tripathy, 2013). The Truth Project and 'Experiences Shared' database used pseudonyms to protect the anonymity of survivors, which was adhered to in this study, and participant pseudonyms were used to reference participant quotes. The Inquiry ensured that a trauma-informed approach was employed by the Truth Project to protect participants, with most reporting positive experiences of participation (Barker et al., 2023). They were offered a service by a team of trained counsellors/support workers who provided telephone-based support, preparation, debrief and follow-up for their private sessions. Participants could also bring companions and/or their support worker to their session and could take as many breaks as needed.

It is crucial to reflect on the broader ethical implications surrounding motivations behind the Truth Project's developmental context and the potential for exploitation of participants. While in theory, survivors were at the heart of the inquiry, the wider aim was to determine the extent of institutional failure and attempt to make amends for such failures. Therefore, the impact of bringing these issues to light upon minoritised communities may not have been at the forefront of the Inquiry. While support was offered to Truth Project participants, it is possible that this may not have been adapted to meet minoritised survivor's cultural contexts or considered how survivors have contended with acculturation, racial trauma, and internalised racism to share their experiences within a white-dominant space (Liu et al., 2023).

***Reflexivity***

When conducting reflexive qualitative research, it is important to state and incorporate the researcher's background and personhood, when approaching the analysis (Braun & Clarke, 2021).

*I am a 27-year-old South Asian woman, currently training to be a Clinical Psychologist. Growing up in a predominantly white environment as a second-generation immigrant, I have found it difficult to navigate my own identity within the context of acculturation and discrimination. Balancing connection to my heritage with a desire to belong has been a central part of my journey, while holding the tension between collectivist and individualistic norms. Witnessing the impact of female disempowerment among women in my community, I have rebelled against some cultural values. My passion for social justice and liberation has fuelled my clinical interest in marginalised communities, where I have worked with both victims and perpetrators of CSA within forensic settings, from a range of ethnic backgrounds. The personal stories of CSA that I have encountered, within the context of systemic failure and hopelessness, have drawn me to this research topic. Reflecting on this,*

*I've recognised my bias to focus on negative experiences of seeking support from family and institutions, potentially overlooking narratives of resilience and positive outcomes.*

## Findings

### *Perpetrators of abuse*

Demographic data on perpetrators of CSA appears to be lacking, particularly in ethnic minority communities (Kelly & Karsna, 2017). Therefore, during the coding phase, perpetrators were identified and categorised. Figures 6.3 and 6.4

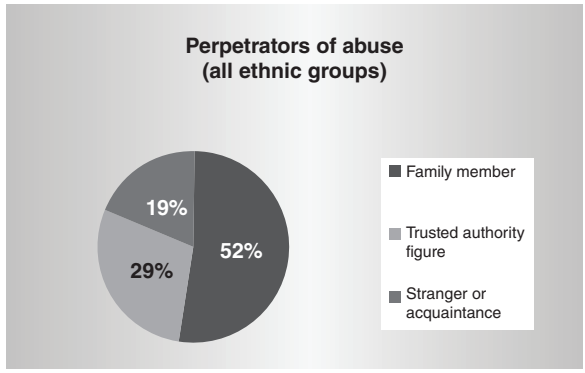


*Figure 6.3* Perpetrators of Abuse

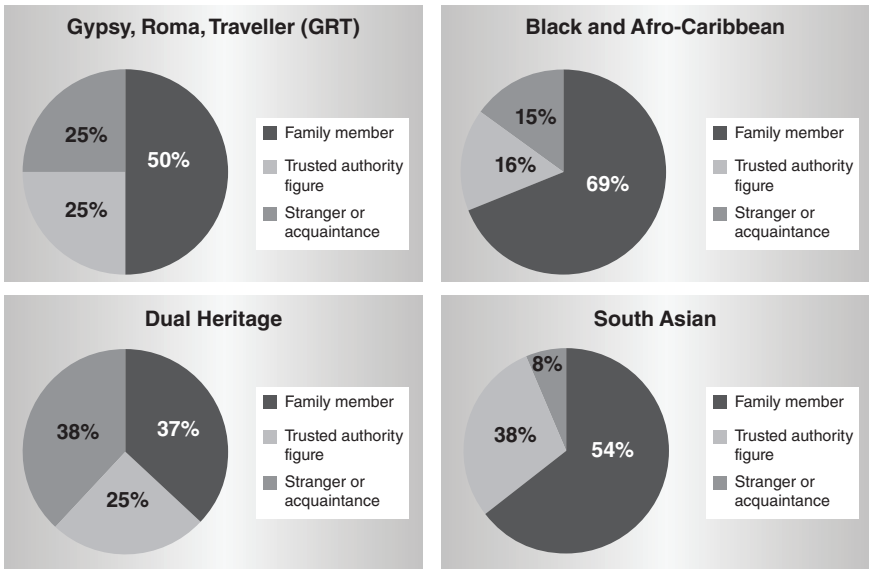


*Figure 6.4* Perpetrator by Ethnic Group

depicted comprise a brief overview of perpetrators of CSA within each ethnic group.

### *Introduction to themes*

In conducting this reflexive thematic analysis, personal reflections and reflexivity (italicised and signposted) which emerged during the analysis process will be integrated throughout this section. Quotes (italicised) will also be presented.

*This methodology analysed each ethnic group separately to avoid ethnic lumping, a decision partly influenced by my lived experience as a minoritised individual in the UK. Recognising the nuances of my culture and effects of intersectionality, I understand that my experiences differ significantly from those of other ethnic minorities. Experiences of being 'lumped' with other ethnic minorities has often left me feeling misunderstood or overlooked. I recognise that despite our diverse backgrounds, what homogenises us are our shared experiences of marginalisation and the impact of whiteness and power. This has driven me to challenge the concept of 'BAME' within this project, which often oversimplifies cultural and ethnic diversity.*

The following section details the themes unique to each ethnic group, in the order in which they were analysed. This will be followed by two themes which were common across all ethnic groups (Table 6.1).

### *South Asian*

#### *Cultural hierarchy and obedience*

Accounts from the South Asian group conveyed a cultural hierarchy and a patriarchal structure, whereby elders and men held positions of power: *"In Indian culture every adult is your aunty or uncle, and you have respect for your elders."* Survivors reported that disobeying their wishes was culturally disrespectful and would result in consequences from their family and community.

*Table 6.1* Summary of Themes

| | *South Asian* | *Black/Afro Caribbean* | *Dual Heritage* | *GRT* |
|---|---|---|---|---|
| **Distinct themes** | Cultural hierarchy and obedience | Legacy of systemic racism | Troubled family backgrounds | Confusion between abuse and love |
| | Internalised shame and community rejection | Perpetuation of intergenerational violence | Racism intertwined with abuse | |
| **Common themes** | Culturally informed systemic failure<br>Cultural resilience and diverse healing | | | |

Within this structure, survivors were often restricted and monitored by their parents. This dynamic appeared to foster an environment where emotional and physical forms of punishment were common. Therefore, survivors were accustomed to accepting control and lack of autonomy as well as normalised to obedience and fear. Survivors referenced that these experiences and dynamics made them vulnerable to manipulation by abusers: *"Our parents are right in all matters … I was unable to work out what was going on and whether it was wrong."* Perpetrators were often those higher up the hierarchy (e.g. adult men, sometimes a parent) and some reported that they would utilise the hierarchy to enforce silence and compliance. Therefore, survivors felt unable to speak out as they feared punishment and alienation from their community: *"She feels that cultural attitudes and a controlling hierarchy can mean that Asian families blame the victims for abuse."* Due to these cultural norms and values, survivors preferred to prioritise the reputation of their family and the wellbeing of their parents above their own needs to be heard, seen and safe: "*Total loyalty to family means abuse is not reported."*

*Author's reflexivity: While integrating British influences of autonomy and individual identity with my experiences of this societal structure in my culture, I rebelled against this idea of blind obedience and respect. However, the impact of disobeying elders was an isolating experience. It is possible that my personal experiences of this hierarchy may have biased my perception of this data where I may have been more receptive to stories of resistance and freedom and negative experiences of this hierarchy.*

#### *Internalised shame and community rejection*

The conservative nature of the culture means that discussions about sex are taboo and ladened with shame. This influenced how survivors made sense of their CSA experiences: *"She wishes that her parents had spoken to her more when she was young about what should and shouldn't happen in other people's houses."* Sex in the context of abuse was often viewed equivalent to consensual sex. Therefore, following abuse, many survivors felt impure, dirty, and tainted. Many abusers appeared to weaponise this shame. Disclosing the abuse to the wider community resulted in the survivor being deemed unsuitable for marriage as pre-marital sex is considered wrong and shameful: *"I'm afraid to be truly joyful because I feel tainted – like damaged goods."*

Survivors sometimes remained silent until marriage but disclosing the abuse to their partners led to marriage breakdown or further abuse, specifically for female survivors. Marital breakdowns and the truth about the abuse led to rejection or ostracisation from the community to preserve the family reputation. In some instances, survivors were instructed to marry their abusers to conceal the abuse: *"She says that it was even suggested by someone that she should marry the abuser, because he had taken her virginity."*

As a result of this internalised shame and community rejection, many survivors reported that they were not aware that the abuse was wrong or did not

understand the sexual nature of the abuse. Survivors reported that despite their efforts to avoid or suppress the memory of the abuse, it eventually caught up with them, manifesting as mental health symptoms. Internalised shame manifested as feelings of guilt, self-blame, unworthiness, and self-loathing, as well as difficulties with trust and intimacy in relationships.

*Author's reflexivity: It appeared that survivors had to endure the painful conflict between finding safety and healing from the abuse or rejecting and being rejected by their culture and family. Based on my experiences of witnessing female disempowerment in my community, I have witnessed how this rejection and isolation hinders healing. Equipped with my own personal experiences of the shame and self-blame that can arise from community rejection, I wondered how talking about these experiences during the Truth Project interview would have activated those feelings. If I had conducted the interviews myself, I would like to have asked how survivors navigated these feelings in the moment while telling their story.*

#### ***Black and Afro-Caribbean***

*Legacy of systemic racism*

Most accounts conveyed a sense that survivors believed their suffering did not matter to others and their experiences would not be heard. Survivors often associated these feelings and beliefs with a legacy of systemic racism. Illustrated by this quote: *"I didn't think I had rights that protected me as a human being."* These beliefs seemed to deeply impact survivor's abuse experiences in a range of ways. For example, many felt they were targeted or victimised due to their skin colour: *"Winnie says she felt the abuse was her fault because of the way she looked."*

Additionally, it appeared there was a culture of not engaging with authorities in the black community due to the belief that they would not care enough to intervene or support: *"She feels that institutions that should have protected her may have been less concerned about her because she is black."* Consequently, many survivors were reluctant or felt unable to disclose the abuse or seek support: *"She describes the additional difficulties she faced as a black child in an environment that was predominantly white. On a practical level, there was no one to help her look after her hair and skin. On an emotional level, she says, it added to her feeling of worthlessness."* Furthermore, many survivors reported experiences of disclosure where no action was taken, confirming their worldview of being uncared for.

*Author's reflexivity: Historical and recent events which I have witnessed in historical texts and in current media reflect the dismissal of Black individual's pain and needs. It saddened me to see how these world events had manifested into pervasive individual beliefs about survivor's place and importance in this world. It was also heart-breaking to read about how this had permeated*

*into their ability to access support and healing following horrendous sexual trauma.*

*Perpetuation of intergenerational violence*

A core pattern throughout all accounts was a story of intergenerational violence. Survivors often described childhood homes as chaotic or unsafe. Many were accustomed to harsh physical discipline or domestic violence, due to neglectful or aggressive parents who suffered from their own mental and physical health struggles. It appeared that these environments normalised abuse, violence, danger, and fear: *"Some years later when Anwulika tried to talk to her mother about the abuse, all her mother would say was that she had 'had it worse'."*

This cycle of violence appeared to be a core feature of abuse experiences, whereby physical abuse often preceded the sexual abuse and physically violent acts and threats were often used to enforce compliance. A large portion of this sample were sexually abused by members of their immediate family (e.g. stepfather, foster parent, father): *"He [father] started with physical abuse before moving on to sexually assault her. The abuse usually occurred when her mother was out of the house … Her father also constantly humiliated and threatened her."*

*Author's reflexivity: When reflecting on this theme, I wondered about how systemic racial trauma has contributed to an intergenerational need to fight for survival, hence the reinforcement of the use of violence and aggression. I wondered about how there may be an intergenerational pattern of unresolved anger stemming from decades and centuries of being made to feel not good enough due to their race, skin colour and ethnicity.*

***Dual heritage***

*Troubled family backgrounds*

A notable majority of survivors came from troubled family backgrounds or broken homes, due to parental separation, absence of one parent, or complications arising from one parent's ethnic minority heritage. This often led to rejection and placement in care or boarding schools: *"His maternal grandfather did not approve of the relationship [due to ethnicity] and forced his daughter to put her son up for adoption, although she did not want to."*

These challenging family circumstances were instrumental in exposing survivors to perpetrators, resulting in the sexual abuse they endured. Abuse occurred in various settings, including boarding schools with older children and staff as perpetrators, as well as in foster homes and households of biological parents.

The narratives suggested a cycle of abuse, whereby violence and anger were associated with intimacy and sex. In the aftermath of abuse and isolation, survivors in this group often engaged in self-destructive behaviour and promiscuity, which exposed them to further abuse: *"I think because I wasn't treated kindly by others it pushed me further into a cycle of abusing sex, drugs, alcohol."*

*Racism intertwined with abuse*

The accounts collectively depict challenges revolving around survivors' racial identity and the discrimination they faced. Survivors were often raised in predominantly white environments which lacked diversity. Due to their dual heritage, they were often marginalised, singled out and bullied for their skin colour and their unique features. This resulted in feelings of difference and isolation, which made them vulnerable to abusers. They often encountered obstacles which hindered the exploration of their cultural identity: *"The only thing she knew about her father was that he was black, and as the only non-white child in her rural community she was bullied and abused."*

Survivors often attributed the abuse and neglect they endured to their ethnic background and dual identity. Many accounts highlighted explicit racism intertwined with abuse experiences and many perceived that they were targeted due to negative attitudes towards them based on their ethnicity. Some believed that their abuse stemmed from standing out to abusers, while others mentioned that their eagerness to fit in exposed them to vulnerable situations: *"I had an urge to get to know people who looked like me'. She began chatting on social media and can see now that this is how she was groomed."*

*Author's reflexivity: Exploring this data made me wonder how these experiences of being displaced and disconnected from their home and heritage influenced their sense of belonging. This isolation and longing for belonging left them vulnerable to sexual exploitation and abuse. If I conducted the interview, I would like to have asked what it was like to connect with their ethnic minority heritage after having experienced loss and rejection because of their heritage. I would also have been interested in how reconnecting with their cultural heritage may have contributed to a sense of regaining empowerment and agency.*

## Gypsy, Roma, and Traveller (GRT)

### *Confusion between abuse or love*

All survivors in this group grew up in homes which exposed and normalised them to crime, violence, cruel punishment, and sex work: *"She grew up familiar with the idea that sex was used 'in exchange for things."* They conveyed being accustomed to feeling unsafe, angry, and fearful.

Survivors conveyed that these experiences predisposed them to difficulties distinguishing abuse from love, and to believe that sex was transactional. Physical abuse and violence were a key feature of the sexual abuse. Due to their upbringing, survivors perceived the abuse as normal and that compliance was necessary: *"I thought that was all right … he must like me."*

*Author's reflexivity: I recall a high population of GRT survivors in forensic settings who had learnt that violence and abuse were a method to communicate their needs and achieve psychological safety. I would like to have recruited more GRT survivors to uncover further details about their unique experiences. Although this group are of white heritage, I was struck by how their experiences appear to mirror non-white ethnic minorities more so than white majority populations. This raises a query around the intersection between whiteness and highlights the pervasiveness and influence of societal stigma with regards to discrimination and othering.*

### *Two themes common across all ethnic groups*

#### *Culturally informed systemic failure*

The Truth Project aimed to hear experiences of survivors who had been failed by UK institutions and authorities. This section refers to the nuances, similarities, and differences across ethnic groups within the theme of 'culturally informed systemic failure'; found to be common across all groups. This theme explores the cultural and ethnicity-related factors which contributed to lack of support and failure to protect survivors. It also explores experiences of support after disclosure from parents and families, as well as institutions.

Members in all ethnic groups commonly felt that they would not be believed, or their voices would not be heard. Almost all survivors detailed how the abuse affected their ability to trust others. With regards to familial support, survivors from South Asian culture were often blamed for inviting or causing the abuse and their distress was dismissed. Similarly, Black/Afro-Caribbean and dual heritage survivors described experiences of being dismissed and punished by their family when seeking help. In all groups, there was a prevalent pattern of family members choosing to ignore signs of the abuse and avoid intervention. South Asian survivors likened this to the consequences caregivers would face in their own lives if they were to acknowledge the abuse and support their children. Although, this was common in all groups, South Asian survivors specifically reported that they were frequently told to cover up the abuse or lie to authorities once an initial disclosure had been made, which led to investigations being discontinued: *"She thinks her mum must have changed her mind about wanting to report the abuse, because she later told Nadiya she should not talk about it. Nadiya obeyed and began to deny it."* Professionals were sometimes attentive until they informed parents, after which parents failed to adequately protect their children. Additionally, perpetrators of the abuse were sometimes

members of the family, which was most prevalent in the Black and Afro-Caribbean group.

In all ethnic groups, there appeared to be reluctance and fear to disclose the abuse to institutions and authorities. South Asian survivors were deterred from disclosure or support-seeking due to fear about the abuse being revealed to family. They experienced UK services as not 'truly confidential' due to policies specifying caregivers of minors must be involved. In the other three groups, survivors struggled with distrust of authorities which often stemmed from negative experiences, such as expressions of distress and efforts to escape being misinterpreted as delinquency, mental illness, or misbehaviour: *"…but her behaviour changed significantly. However, no one questioned this; instead, she was labelled 'the crazy one' by teachers at school."*

Survivors often believed that cultural stereotypes and societal attitudes towards their ethnic identity influenced the perception of these struggles. This was notably apparent among the GRT group, who believed professionals were concerned about potential repercussions, due to cultural attitudes about violence and crime in this community: *"Nataliya now thinks that the teacher may have been afraid of possible repercussions, as Nataliya's family were 'well known'."*

Consequently, no effective action was taken, and professionals overlooked or dismissed evident indicators of abuse. Some South Asian survivors suggested that this discrepancy might arise from UK safeguarding training, which may not adequately consider cultural nuances in identifying signs of abuse: *"Vayla believes that professionals need more education about cultural differences. She says that Asian people are expected to be totally loyal to family even if that means not reporting abuse."*

For instance, South Asian children might maintain high academic performance and compliance in school, yet still be victims of abuse. Overall, systemic failure was related to a lack of cultural awareness and stereotyping, reluctance to raise concerns due to fearing accusations of racism or explaining away abuse as 'cultural differences'.

#### *Cultural resilience and diversity in healing journeys*

Each group faced unique and distinct challenges, making it difficult to pinpoint a single overarching theme. However, narratives relating to healing and recovery were consistently mentioned across ethnic groups and individual accounts. This section explores diversity and cultural resilience within healing narratives across ethnic groups, with a focus on ethnicity-related factors.

Most survivors conveyed therapeutic benefit in positive and supportive interactions with others, specifically around speaking out and being heard. South Asian survivors often referenced empowerment as part of their healing journey. For example, gaining knowledge and understanding, resisting family pressure, maintaining religious commitments, achieving success in employment, or gaining autonomy. Despite the emotional burden, some survivors

found it necessary to sever ties with their family and community to reclaim their narrative: *"She resisted family and cultural pressure to get married, went to university and got a good job in a male-dominated sector."*

This contrasted with dual heritage, Black and Afro-Caribbean survivors who found healing in connecting with their cultural identity, which had been suppressed by society. Dual heritage survivors appeared to have more positive experiences with seeking professional support (e.g. therapy) and experienced more successful prosecutions than other groups. Black and Afro-Caribbean survivors often found strength in supporting and advocating for other abuse survivors: *"… I know a lot of black girls who've been sexually abused … that's why I want to speak up."* Many felt they were able to take power back through raising awareness or confronting their abusers.

These healing narratives juxtaposed with experiences in the GRT group, whereby all four survivors experienced exclusion from school or involvement with the criminal justice system due to behavioural challenges and substance abuse, stemming from unresolved anger. Societal responses to these behaviours led to isolation, severely limiting their opportunities for healing: *"Nataliya left home at the age of 16 and her mother disowned her. She struggled to support herself and began taking amphetamines so she could work two jobs."*

## Discussion

The previous section presented the findings, identifying both distinctive and shared themes among ethnic groups, pertaining to ethnicity and cultural factors. This section will explore how these themes (*italicised*) shape the context surrounding the abuse, experiences of disclosure and support, and the healing journey, while exploring similarities and differences between ethnic groups, referring to study aims.

### *Abuse context*

All ethnic groups described experiences that normalised abuse and power dynamics, leaving them vulnerable to manipulation and victimisation, shaping the context of their CSA. South Asian survivors were accustomed to control and *obedience*, while Black, Afro-Caribbean, and GRT survivors were accustomed to *intergenerational violence* and crime. Dual heritage survivors were often placed in care settings due to *troubled family backgrounds* which exposed them to neglect, racism, and sexual abuse. Normalisation of abusive dynamics resulted in difficulties recognising the abuse as wrong or being more inclined to tolerate it, which also impeded on their healing. For instance, GRT survivors found it difficult to distinguish between *abuse and love*. South Asian survivors *internalised shame* for losing their virginity, often due to limited understanding of sexual consent. Perpetrators often exploited these dynamics to enforce compliance.

Many dual heritage survivors were of mixed Black/Afro-Caribbean descent, therefore their experiences mirrored themes of the Black/Afro-Caribbean group. For example, both groups believed that *racism was intertwined with abuse* due to a *legacy of systemic racism*, believing that they were targeted by abusers due to their skin colour and heritage. This may reflect experiences of systemic racism and oppression which have been internalised, whereby the individual themselves perpetuates the belief that their skin colour and heritage reduces their status and importance in society (Panlay, 2016). The contribution of internalised racism in understanding the experience of CSA is an under-researched topic, therefore these findings provide a foundation to explore this in future research as this may hold clinical utility.

#### *Disclosure and support*

The analysis supported previous research (Hurcombe et al., 2023; Sawrikar & Katz, 2017a, 2017b, 2017c) as it found unique barriers to help-seeking and disclosure. South Asian survivors, influenced by a *cultural and patriarchal hierarchy*, thus they were afraid to disobey elder figures, including perpetrators of abuse. They prioritised their parents' wellbeing and family's reputation, fearing that revealing the abuse could harm their marriage prospects, leading to *community rejection*. Collectivism provides context to these barriers as allegations against older men can be perceived as allegations against their whole family. Allegations against religious leaders are perceived as a rejection of religious principles, which are detrimental family status and reputation (Payton, 2014; Sawrikar, 2017). Thus, parents often enforced silence to protect family status, while UK confidentiality policies regarding parental involvement further discouraged survivors from reporting abuse. Conversely, Black, and Afro-Caribbean survivors faced a higher prevalence of familial abuse, resulting in limited familial support. This group was often deterred from reporting abuse due to their belief that professionals would not care enough to intervene and due to previous negative encounters with authorities and services. Concepts highlighted by critical race theory (Moodley et al., 2017) were demonstrated in this sample, such as when beliefs about help-seeking were reinforced by professional reluctance to intervene following disclosure. This appeared to occur due to professional's fear of being perceived as racist or explaining away abuse as cultural differences. Similarly, previous research has found that professionals fail to investigate due to fear of disrupting community cohesion or appearing culturally insensitive or offensive (Gohir, 2013; Peach et al., 2015). GRT survivors also faced similar *culturally informed systemic failure*, stemming from societal stereotypes and fear regarding their community's propensity for violence. However, the validity of this observation is constrained by the small sample size of this group, potentially resulting in some themes not emerging due to the limited data generated compared to other groups.

This study also found that professionals often overlooked clear indicators of abuse, which impacted the quality of support offered. South Asian

survivors attributed this oversight to a lack of understanding regarding how cultural norms impact on post-abuse coping which contrasted with western cultural norms for identifying abuse. Black, Afro-Caribbean, and dual heritage survivors felt that signs were overlooked due to cultural stereotypes and institutional racism, leading to their distress being misinterpreted as misbehaviour or insanity. Davis (2019) similarly found that Black CSA victims in the UK were not provided adequate safeguarding as they were labelled, diagnosed with mental illness, and cautioned instead. Previous research has linked this to the adultification of black children; due to unconscious societal biases and racial stereotypes, black children are perceived as older and more mature than they are (Goff et al., 2014). Consequently, Professionals lose sight of their innocence and fail to identify the need for protection or support, as they would with white counterparts (Davis & Marsh, 2020). Similarly, GRT survivors believed their expressions of suppressed anger were misunderstood as criminality, possibly due to the dehumanisation of GRT communities (Rowe & Goodman, 2014). These findings add further depth to conclusions by Hurcombe et al. (2023), who found that survivors from ethnic minority communities are less likely to be identified as victims.

#### *Healing journey*

Survivors' *cultural resilience and diverse healing journeys* appeared to be shaped by the cultural context of their abuse and their encounters with support, isolation, and disclosure. South Asian survivors faced silencing and control and found empowerment, freedom, and reclamation in their healing process. Black, Afro-Caribbean, and dual heritage survivors, viewed by others through the lens of race and skin colour, benefitted from embracing their cultural identity, supporting similar individuals, and raising awareness. The dual heritage group had more positive support experiences, such as successful prosecutions and therapy, potentially influenced by their white heritage. While the four GRT survivors suffered from severe societal stigma and isolation, limiting their healing opportunities.

#### *Strengths and limitations*

As the Truth Project sampled survivors who had been failed by UK institutions, findings and conclusions do not capture positive aspects about collectivism in relation to abuse recovery and may allude to unhelpful cultural stereotypes. Families who respond supportively can provide powerful influences for the survivor's ability to address feelings of shame and isolation (Gill & Harrison, 2019). Liberation and community psychology cover the healing power of community and collectivism (Saul, 2022), referencing love, appreciation, and acceptance as integral in providing safety in youth trauma recovery (Johnson, 2022). Furthermore, it is important to consider that distinction

between collectivism and individualism is a western-imposed idea, based on generalised stereotypes. Instead, these exist along a spectrum and individuals occupy varying positions, irrespective of their heritage, based on their unique circumstances and intersectional identities (Owusu-Bempah & Howitt, 2000).

Taking a social constructivist perspective, survivor's experiences were filtered through multiple layers of meaning as the analysis utilised second-hand secondary data, based on the observations of the assistant facilitator (Chamberlain, 2015). Drawing upon the concept of double hermeneutic (Gangoli & Hester, 2023), the assistant facilitator would have interpreted survivor's stories based on their own cultural, social, and historical contexts and biases. This would have built upon the unique meaning the survivor had made from their experiences, based on their worldview and biases. This current analysis adds an additional layer of meaning, further influencing socially constructed meanings of survivors. Research has established the importance of reflecting on the interviewer's position in relation to being an 'outsider' to a marginalised culture (Bhopal, 2010). Agyeman (2008) posited that cultural background and ethnicity can impact interpretation of the presented information as an interviewer or researcher. Although the reflexivity element of this thematic analysis allowed for biases to be considered within theme development, the characteristics, cultural background, and past experiences of the assistant facilitator were not available to consider when evaluating the validity of this study.

The analysis of the South Asian group yielded a higher quantity of codes with greater depth compared to other ethnic groups. This could be attributed to the larger sample size in this group or to the researcher's South Asian heritage, potentially biasing them to extract more implicit codes and patterns due to their closeness to the data. This study's sample was biased towards South Asian females, also reflected in the broader CSA literature (Sawrikar & Katz, 2017a). However, this study highlighted unique cultural factors and provided preliminary insights into CSA experiences among dual heritage and GRT survivors, demographics that have been significantly under-researched within this field (Crawford & Alaggia, 2008; Marcus, 2019). Future research should delve deeper into the experiences of these groups. Additionally, East-Asian survivors were not represented in this sample, despite additional measures employed by the Truth Project to engage all ethnic minority communities. This highlights the significant and additional challenges in reaching and supporting this group, which has been supported by previous research (Roberts et al., 2016). It is also crucial to hold in mind ethnic minority survivors who do not disclose or acknowledge CSA, which are not accounted for in this study. Furthermore, this study's sample was heavily biased towards to those identifying as female, therefore, limited conclusions can be drawn regarding the experiences of male ethnic minority survivors. This is particularly significant for cultures where distinct gender roles are prevalent (e.g. Asian cultures).

***Clinical implications***

A key clinical implication emerging from this study is that ethnic minority communities should not be 'lumped' together as one. Professionals should receive cultural competency training which covers the nuances and differences between ethnic minority groups. Training should recognise how cultural norms and collectivist values surrounding power, discipline, and respect shape survivors' perceptions of abuse (Sawrikar, 2020). For example, the term 'abuse' might not be interpreted with the same nuances and contexts in non-Western cultures. Therapeutic models should acknowledge diverse narratives and experiences. A narrative therapy model may provide a useful framework to draw upon person-centred cultural values and language when supporting survivors to make sense of their abuse experiences (Gómez et al., 2020). Safeguarding training should include culturally informed signs of abuse and consider cultural differences in how trauma-related emotions are expressed and experienced.

Professionals should consider cultural biases which may influence their perception of children's behaviour. Professionals should also consider cultural factors that featured in survivor's journey to disclosure and the specific risks survivors have faced to break their silence. It is important to acknowledge how these risks may impact the healing process. For example, breaking silence and seeking support about abuse may come with therapeutic obstacles such as rejection from family or community and internalised shame. In collectivist cultures, families provide a sense of belonging and are central to identity (Sawrikar, 2017), and thus, grief and loss may accompany abuse disclosure. It may also be beneficial for white professionals to reflect on what they represent to ethnic minority survivors and how this impacts help-seeking. For instance, how their services might embody systemic racism and oppression, and the ways in which their whiteness could shape perceptions of power dynamics.

In conclusion, this study provides valuable insights into the experiences of ethnic minority CSA survivors and the role of ethnicity and cultural factors. It identified common themes such as normalisation of abuse dynamics due to cultural norms and systemic racism, as well as barriers to help-seeking and disclosure. However, it also highlighted unique challenges across ethnic groups. The findings emphasise the need for culturally sensitive approaches in supporting ethnic minority CSA survivors. Professionals should receive training that goes beyond stereotypes and incorporates cultural diversity into therapeutic models. Furthermore, this study highlights the value for professionals to critically examine their own cultural biases and influence of their privilege on therapeutic dynamics. While valuable insights were gained, limitations such as small sample sizes in some groups and overrepresentation of certain groups suggest the need for further research. Overall, this study contributes to understanding the intersection between ethnic minority heritage and CSA, emphasising the importance of culturally competent approaches in supporting survivors from diverse backgrounds and facilitating their healing.

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# 7 Shooting the messenger and the curse of Cassandra

## The impact of childhood and adult rape and torture on adults who report mind control, abuse by psychotherapists, homophobic and transgender abuse

*S. J. William and Valerie Sinason*

Cassandra was a daughter of King Priam and Queen Hecuba of Troy. She was a Priestess of Apollo and had taken a sacred vow of chastity for life. She was admired by the God Apollo who tried to entice her sexually with the gift of foresight. However, after resisting Apollo's sexual advances, Cassandra was given as punishment the capacity to announce truthfully all the dangers that were happening or about to happen but to not be believed. Each new catastrophe, that could have been prevented, happened because of this curse. She predicted the fall of Troy and during it was raped by Ajax by the altar of Athena. Taken by Agamemnon to be his slave concubine she was killed by Clytemnestra, his wife, who also killed him. She had foreseen her own death, but no-one helped her. Saying "no" to power is dangerous in all periods of history that we know of. Additionally, the one who speaks out is likely to experience further abuse and punishment in their lifespan. King Priam tried to keep her locked in her room as a mad woman – an early form of sectioning. She was seen as a mad liar.

"Shooting the Messenger" comes from the history of warfare long before modern means of communication. It was a messenger who had the ill luck to have to pass on the bad news and face being killed. The threat of being silenced and discredited and the inevitable repeat attacks, whether symbolic or literal, for breaking through societal denial are endemic in the field of sexual abuse. National Health Service Clinics, Hospitals and Units now expect all their staff to encounter abuse. They find it hard to recall that in the late 1970s, just 50 years ago, it was considered a minor subject that evoked unhealthy heat and interest. I (VS) was interviewed by a psychiatrist after expressing concerns about a graphic disclosure from a child with a moderate learning disability. "Could it be?", she kindly asked, "that you were imagining what the child might say if he was able to speak?"

Cassandra and The Messenger represent the experience of being disbelieved and discredited when presenting truth to power. They both have lessons

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to teach all mental health professionals in the field of trauma. Those of us who started to hear disclosures were seen as a source of shock with each new category of abuse we heard about. However, due to unconscious ableism, speaking about disability and abuse evokes less punitive and shocked responses than abuse or rape of children and adults without disability.

Abuse by a stranger was the easiest for professionals and society to face, followed by neighbours, stepfathers and then a worried pause. Mothers were an unbearable new addition, followed by siblings, family and others, organised ritual abuse, mind control, installed dissociation, bestiality. Whichever category of abuse slowly becomes accepted another becomes intolerable to consider. Professor Michael Salter, in a critical review of parental production of child sexual abuse material (2023), examines the societal denial of such organised parental involvement in the exploitation and abuse of their children. However, there is now a new addition to the toxic list of inhumanity – transphobic assaults and the societal response.

## Introducing S. J. William (not his real name)

S. J. William is an expert through lived experience of all the contemporary kinds of abuse we cannot deal with, which are part of the title.

He is a highly intelligent articulate professional man in his 50s. Lean and muscular he does more than "pass" as male. He was brought up as male by his parents from babyhood. His clothes, voice, main historical narratives are male, and he did not realise the cruel and monstrous deception he had been brought up in until his adult life. He had to face the fact that his total environment could be controlled and manipulated so that his body could be hidden from him. Only now can he realise the lies and betrayal that led to this situation. Trying to explain this to mental health professionals, let alone his experience of gender clinics and societal transphobic attitudes adds to his distress and concerns.

How could a post mid-life intelligent adult male not realise he lacked male genitalia? Sadly, all too easily when we consider he also has the experience of disorganised infanticidal attachment, (Kahr, 2007; Sachs, 2018) relentless childhood abuse from attachment figures, adult abuse from professionals, depersonalisation, de-realisation, identity alteration and confusion that led to a late diagnosis of DID, (dissociative identity disorder) with different self-states of different ages and sexuality and homophobic and transphobic abuse.

However, unlike many other individuals who have DID as a creative response to a mad world, who might also have both male and female self-states or parts (something seriously omitted in all the different discussions on trans issues), his DID was reported as being installed, encouraged and developed by a ring of family and others who used torture to establish it. Given the difficulties for Western Society to absorb the complex identity issues that come with multiplicity, consider the problems of such diverse self-states in a DID system that was not of their own making.

For professionals who are beginning to appreciate the power of Adverse Childhood Experiences (ACES – Felitti et al., 1998), how would we begin to consider the range of such experiences in this situation and how would we consider the trans issues in a DID system where most of the dissociative states were male and the females did not want to be female and gave their permission for the body to formally and scientifically be changed on the outside? How would we consider the current pain and heat around the subject of being trans for someone who has already had to face the problems of being seen as having a "cutting-edge" disorder?

S. J. William is also a painful example of a third problem, one that is equally unpopular. His abuse did not end in childhood. Even though childhood abuse can cast a shadow on adult physical and mental health, continuing abuse into adult life presents even more complex and severe issues. S. J. Williams' abuse continued into his adulthood. Survivors with DID can sometimes enter treatment or make a disclosure to police thinking they are now safe to speak only to find out abuse is still ongoing. Like Cassandra, S. J. William has been knocked at every stage of his life.

**S. J. William: The impact of abuse alone in adult life**

*When you've been a victim of child abuse your awareness of the power dynamic in every relationship you encounter becomes heightened, whether it's a 30 second meeting with someone or a more long term, intimate relationship like that with a partner or therapist. In a relationship with any professional the power dynamic is always perceived to be weighted in favour of the professional, (although I accept that this isn't always as simple or straightforward as this). It can be more equal in a non-professional relationship, but most abuse victims will usually default to feeling less powerful. When you add this default position together with the already (perceived) more powerful position of a professional in a professional dynamic, then it becomes clear that even contemplating speaking up, disclosing or voicing criticism against anyone in authority, or any organisation, can feel just too overwhelming and dangerous for an abuse victim. The risks are just too high and the barriers you have to overcome feel too great. Unfortunately, the familiar position of being mistreated, abused and/or powerless feels the safer, and often only, option.*

*I have lived my life being ruled and influenced by double-binds and my experience of thinking about standing up for myself or my selves replicates that dilemma. My DID system has been involved in disclosing details of former abusers to the police, as well as sexual abuse by a senior NHS consultant, a psychotherapist and transphobic harassment. I have also contemplated disclosing ongoing and historical abuse, going as far as meeting with the police together with a supportive therapist as well as starting an active participation in the Truth Project. However, I was unable to follow through on these procedures as they felt too risky and dangerous. I can't say that the process has ever*

*become easier to deal with, neither have the personal internal repercussions. It's easier to live with the abuse, the silence or the isolation rather than face the potential loss of hope if you discover the rest of society can be like your abusers.*

*People with DID also have another added dilemma and complication facing them and that is the fear of their own lack of continuous memory. I am very aware that there is widespread amnesia in my system and that I do not have access to an accurate and full system memory. This leaves me vulnerable. Vulnerable to being accused of lying and not always feeling or being able to refute those accusations. Even when I am confident and certain of my reality in a certain situation there are always doubts that I may have missed a few seconds or minutes. If my DID status is known, as in a therapy or GP situation, this vulnerability can feel greater because my amnesia could be used as another weapon against me. This fear is escalated if you are making a complaint against someone. How am I supposed to challenge someone who could be telling me I'm not aware of something someone else in my system may or may not have done or agreed to if I don't have access to their memories?*

*In any situation, should someone choose to use this against me, they can, and there's very little I can do to find out if they are telling the truth themselves. I am constantly aware that due to different personalities with different perspectives and agendas, I can often appear to be lying or contradicting myself to outside people who do not understand DID. Equally, I am also aware that those who do understand my DID could use this amnesia against me if they wanted to. DID, by its very nature, can leave you feeling vulnerable and defensive…and that's even before any issue of disclosure, disagreement or complaints are considered!*

*Deciding to make an official disclosure for example, is scary. Intentionally standing up against authority and power, in whatever form, is frightening for most people but when you have been abused by an authority figure that fear escalates and the possible repercussions for you personally are based on a known reality. Most victims of child abuse have been threatened to keep quiet about their abuse so when considering something formal or public you are immediately thrown back into a situation where you face breaking that silence and that is extremely hard to do. If you speak out against power you risk punishment, loss of help or potentially your life. These were very real fears for me and my system. They were the reasons why internal others/programs prevented me from continuing to speak out about my abusers before, both in the past and very recently. My very real fear of online and phone monitoring, with potentially dangerous repercussions, led me to withdraw from the Truth Project. Whether these fears were based on a current real level of risk isn't known to me – but it could be, and that is the point. This is how perpetrators, particularly those who are powerful and organised, control victims and much of my fear is based on my known lived reality, albeit a reality that only other similar victims and a few knowledgeable professionals could accept and understand. The groups of people I have been involved*

*with are powerful and powerful people have influence in many, many areas. Their networks run wide and go deep. To speak out against powerful people to people of power feels like a catch-22. In order for any complaint to be dealt with effectively, people with a certain amount of power and influence have to be involved, and as the person making the complaint this is the risk you know you are forced to take. Risk versus silence. Decisions are made depending upon which poses the greatest threat. This is a survival strategy that I have lived with my whole life, and it is behind all my decisions, big or small – consciously or unconsciously.*

***Valerie:*** *S*, you have powerfully shown us the long-term consequences of childhood and ongoing abuse in how much courage it takes to have any kind of voice. The nature of your childhood abuse also seems to have affected your safety in adult life and made you more vulnerable to professional abusers. Readers might find it hard to consider how a survivor could be abused by two professionals in their adult life.

I am very aware of the victims of domestic abuse who repeatedly return to the abuser. I found the work of ethologists very helpful here. Why do kudu like feeding in front of the lion, their main predator, in the South African bush? Dr Lazarus at Newcastle University revealed the obvious answer! The safest place to graze is when you can see your predator and know they will not be after you because they are well fed or tired. If they darted away they might well meet a pride of ravenous lions. The same is true for us animals. However, one thing I have seen in many victims of organised abuse whether they have DID or not, is a paralysis against daring to name family members. Even where people have bravely spoken to different police inquiries it is too terrifying for them to provide the linking information-how they got to be abused by X when it means speaking about their family who passed them on to X or indeed were part of X. This shows us the extra terror such abuse by family and others evokes and especially when the victim has DID.

We are also both aware of the real existential plight when someone has been abused by powerful figures. In many countries, we only hear something of the true extent of VIP criminal acts when they are dead-such as Jimmy Savile, Jeffery Epstein, Cyril Smith. A fearful paralysis sets in or a defensive identification with the powerful person. Seeing the angry media attacks on senior police officers who investigate the famous shows survivors only too clearly how poorly they would fare.

You also bring up the current dangerous climate in which to be called "trans" brings further dangers. Would you like to first speak about the abuse cases you succeeded in proving against NHS professionals and how difficult that was for you.

**S. J. William: Abuse by two senior psychotherapists as an adult**

*Before I do that can I just comment on the family issue regarding disclosure of abuse. I think many people struggle with understanding just how difficult it is to speak out against a family member, especially a parent or attachment figure. Normal attachment is powerful but when that attachment has been manipulated and reinforced by abusers the impact is huge. It makes any separation from them almost impossible and seeing any fault or failure, let alone abuse, in them is felt as betrayal and a threat to your very own existence. If, like with myself, there is concrete Infanticidal Attachment the attachment figure is viewed as a rescuer/saviour (the acknowledgement that they are only a rescuer due to the fact that they were the initial threat/attempted murderer is "ignored" as it too psychologically difficult to accept). The potential betrayal in exposing them as an abuser is increased dramatically. It is felt almost as an annihilation of both them and yourself. Attachment is survival based, but in abusive situations it can also be detrimental. In therapy or future relationships in which attachment plays a part this pattern can play out again, which is why future abusive situations like those I have experienced can* ***re-occur*** *in adult life. It's another way in which CSA can have a* ***long-term*** *impact on the life of a survivor.*

*Disclosing any abuse has always been difficult. The last situation I was in had an important difference to it. On disclosing a current abuse situation, by a psychotherapist within a therapy setting in which my DID was purposefully used to abuse (echoing my earlier comments and fear around amnesia and vulnerability), I was believed and immediate action was taken and this has enabled me to contemplate, and in some instances, carry through with subsequent disclosures.*

*Although there were feelings of betrayal and anger towards the* ***non-abusive members of*** *my treatment team that had to be addressed and worked through I gained psychological scaffolding which still supports me now even though I still feel vulnerable on a personal level and* ***it*** *has left me and my system unwilling to contemplate starting any new therapy with new therapists.*

*I admit that on hearing that the abusive therapist had stated to her supervisor that she was in a "relationship" with a client and that that information was not reported or acted on by the supervisor made me very angry and questioning of the whole safety of therapy. Knowing that this supervisor is now still successfully working with no obvious professional repercussions following full admission of the abuse by the therapist feels very unjust. Seeing her name on books and professional teaching days affects me to this day*

*After this disclosure I sold my home quickly at a lower price in order to escape to a safe space, because I was afraid the abusive therapist would return at any moment. She had manipulated home visits during our therapy, forced our friend to move out and had been living with us on and off for months – unbeknown to the clinic she worked at. The threat of her coming back when we lived there alone was very real, and I sold and moved within 6 weeks*

*of disclosing the abuse. That had repercussions financially, emotionally and internally which I still live with. I have no regrets in disclosing and was both encouraged and supported by my* ***treatment team****. An official complaint was a possibility but I was very aware of the possible implications this would have on the clinic* ***I attended*** *and all other clients and professionals, and this together with a system wide sense of shame and humiliation made the idea feel less than ideal. The abuser was being dealt with and that was the important thing. The experience wasn't easy for any of us involved, but it did give me an experience of speaking out and being believed, and that has been very powerful.*

*A previous situation in which I disclosed past abuse was validated in a slightly different way. An internal investigation into an NHS Mental Health Unit, (which I took an active part in), found numerous failings and I received an apology and an agreement to pay for my specialised therapy for 6 months (as I had left the area). I also received compensation after taking out a legal case which was settled by the NHS Trust. I felt I had to move from the area once I disclosed and investigations began because the abusive* ***professional*** *in this case was part of something criminal and dangerous in the area, and it remains something I feel less safe to speak about. The process of legal action and involvement in internal investigations was so lengthy, stressful and emotionally distressing I would never contemplate doing anything like it again. The cost to me both financially and emotionally, especially having to relocate, was huge. The connection between speaking out and disclosing abuse and the resulting loss of safety and need to relocate has been a recurring theme!*

*The very nature of my MC (Mind Control) DID makes disclosing difficult. My confidence in my own interpretation of situations is fragile. I have too many years of early conditioning and lies which have eroded myself belief in so many ways. I am unable to trust my interpretation of what is real and what isn't. I have little belief in my own power and minimal trust in being believed by others. So-called evidence and proof have been manipulated so much in my past that the things most people view as being important in evaluating what is real and true hold very little weight in my mind.*

*Whether it is disclosing or speaking out in the form of official complaints I have seen that one factor always makes a huge difference, both to me and also to the outcome, and that is the presence and backing whether directly, or indirectly in the form of support, of a trusted professional. The truth is I know I am more powerful and more likely to be believed and taken seriously if I have a professional willing to validate and confirm my statements, or in some situations to actually take forward the issue/complaint themselves on my behalf. I have experienced this on numerous occasions and it has had a dramatic effect on my self-confidence. It also makes it harder to feel safe once you leave therapy as you no longer have that "voice" backing you.*

*Would I ever make another complaint? That would very much depend on my reason for the complaint, who it would be about and to whom I would be making the complaint – but most importantly it would depend on what*

*support I had in my life at that point. The main factor for me when thinking about the possibility of complaining, or disclosing, is whether there would be any risk to my safety or the safety of those I know and care about. I have seen people, including victims, politicians, therapists and police, standing up and speaking out about the kinds of powerful people I have been abused by and the results have not encouraged me at all. I have seen people humiliated and blamed, jobs and positions lost, careers ruined and most certainly personal emotional and mental health impacted upon negatively.*

*The message that power protects power has been loud and clear and I am too small, even with support, to take them on and I know from experience that my own mental health diagnosis of DID would be used against me in a very damaging way. More importantly I don't want those in my life to be targeted and threatened. My past has conditioned and shown me that these are real risks and although I may choose to risk my own life I will never again risk other's lives through my own actions, if I can at all avoid doing so. That is the most powerful preventer of disclosing, speaking out or making a complaint about anything connected to my ritual abuse history*.

***Valerie:*** I quite agree with you. There are real risks. If we consider the way Tom Watson was treated as an MP speaking about VIP abuse, and the fact that the "fantasist Nick" was given a sentence longer than a murderer for wrongly naming VIPs or appropriating the history of others, has had a major impact on survivors disclosing abuse by powerful people. Indeed, I used the structure of a novel (The Orpheus Project 2022) in order to explore the powerful impact on a National Health Team when a disclosure names a powerful politician and a rock star. To be wrongly accused is an abusive experience, and although the figures are very small they count. However, we need to bear in mind the tiny percentage of truthful disclosures that do get to court or fail in court. (see Emma's chapter)

The brutal conditioning or mind control you mention has some features in it that would not be understandable for other survivors. For example, some groups and families succeed in isolating their children from the rest of society so they can control the reading matter This makes it easier to provide false backgrounds. One woman had a system that included all the characters in The Wizard of Oz, there was a man who was given Star Wars. In both these cases there was an unbearable sense of betrayal to deal with when film posters appeared advertising the films. I will never forget a quiet dignified man called Darth Vader who was utterly shocked to see posters of himself at underground stations. With torture, disinformation, virtual reality he was given the same background as the film Vader and all his genuine feelings went into those known scripts. That must add to shame and embarrassment. We also find ritualistic abuse is often in such backgrounds.

**How would you define mind control and ritual abuse?**

***S. J. William***

*I'm sure that part of my deep shame is connected to the lies I and my others were told about both our bodies and our histories. It's one of the hardest aspects of my DID to try to explain. How it feels when you discover as an adult that your life experiences and history – your memories, relationships, connections which you hold within your mind and body, indeed your very physical body and gender – are all based on fiction. That has such an enormous and profound affect. Trying to understand and accept the depth of the lies you have been told, which felt so real, is so very hard. I and others in my system had a lot of resistance against accepting these facts but given there was so much actual evidence available as many of our identities were taken from film and literature, denial is hard to maintain. As you suggested in your introduction of me, it is extremely embarrassing accepting you were lied to and tricked about your sex and gender, and you believed it all. Trying to explain that to others, particularly non-professionals, is both frustrating and humiliating.*

*When I did accept reality my world crashed around me and within me. All I held as the truth, about both myself and my surroundings, was suddenly blown apart. From that moment on I questioned everything and everyone. My sense of reality has never fully returned, and I don't think it ever will. By this I mean I do not take for granted that anything I see, feel or am told is real. It's a state of both fragility and fear. I live each day, each moment, constantly aware…expecting even….my perception of truth and reality to be exposed as lies and to change in a split second. It's hard to truly or fully live life when you exist in this way. I know there is much to be said about living in the moment, but what if you aren't sure if that moment is real?!*

*Initially I had a great deal of anger towards those who exposed the lies, in other words my therapists. I'm sure this was both a planned outcome from my Mind Control (MC) abusers but also an ingrained inability for me to place any blame and anger directly with those responsible, i.e. my abusers. Blaming my therapists for exposing the lies and deception is a huge issue to get past within the therapeutic setting and requires time, patience and a deep level of trust and attachment between therapist and client. It isn't easy maintaining a therapeutic relationship with someone who exposes you to deep and lasting emotional pain.*

**Valerie**

When we consider we have no choice as babies in choosing the parenting we receive and have to be attached for survival, it is not surprising the rage goes to the therapist in order to keep the attachment figures temporarily safer.

Many readers will know of the disorganised attachment that comes with DID in which the baby finds the caregivers frightened or frightening and has to try and shape its being and identity around that. Brett Kahr (2007) coined the term infanticidal attachment to illustrate the lethal nature of this and Adah Sachs (2018) showed the difference between a symbolic infanticidal attachment and a literal one where the child faces in a reality a life and death threat from the parent. This has a profound impact on identity.

***S. J. William***

*Fully accepting the lies of my past had, and still has, a massive and profound impact on my identity. I went from a solid sense of my self – my name, gender, family, role etc – to complete uncertainty and annihilation. I felt as though I had stepped off a cliff and was falling through the air without ever landing. I experienced a deep sense of loss and emptiness. I was aware that I still existed, I had a body and a mind, but beyond that I just felt like an empty black hole. All that I had been certain of was suddenly gone. My mind felt a strange and contradictory mixture of confusion and certainty. I felt the total destruction of myself and my identity but at the same time I still had within me my memory and lived experience of that past and the person that I was. I was falling through the air as the person in the lie!*

*Over time I think the acceptance of the lies becomes not necessarily easier to accept but more a concept which can be looked at head on and faced with less denial and avoidance. The feelings of humiliation and embarrassment are still intense and overwhelming, I think they always will be. I feel deep shame when I am with those people who are aware of the lies and deception that I believed. I have a reluctance, based in embarrassment and humiliation, in talking about myself as my former identity, for example in using names associated with fictional characters or referring to events that I now understand to be untrue. Talking about emotions and feelings connected to these events feels stupid. How can you talk to a therapist about an experience when both you and the therapist both know it wasn't real?! Belief is so fundamental to anyone who has been abused and certainly within the therapeutic relationship, but how does that work when you both know that something was simply a creation of a MC abuser? Can something be both true and yet not true?!*

*Discovering your true identity after MC deception on this level is an ongoing and soul destroying process. Personally, I don't believe I will ever fully "find" my true or real identity, or if that even exists. The impact of the lies and deceptions relating to identity are so pervasive and core deep. They affect your deepest concepts of self, as well as that of others and the surrounding world. They challenge and question the very nature of reality – both internal and external, and they attack your fundamental ability to trust yourself and your perceptions.*

*I frequently question whether I am actually still living in a fiction created by others. I constantly fear that my identity is being manipulated and moulded*

*by external factors. Not so much from intentional MC abusers any more but through a vulnerability and susceptibility that I am left with from my childhood MC. My identity feels so fragile and lacking in shape and solidity. I don't know how to defend something so lacking in concrete realness to me. I fear being overly influenced by books and films. I panic if I identify or empathise with characters in films or books. The result is a sort of self inflicted isolation. Like a blank slate I fear being imprinted on through exposure and my guard is up all the time. Sometimes the need for connection and overwhelming loneliness has led me to lower my guard in a controlled way by listening to music, a less triggering medium for me. However even in this I felt fear that my past was being recreated and I was once again losing my identity. My relief at finally finding a real, solid connection to something and someone – something different to the emptiness and nothingness of me – was filled with questioning, anxiety and fear. Fortunately I was able to acknowledge this was happening with my former therapist and in doing so discovered real reasons for my response. Nevertheless, it highlights the ongoing impact of MC abuse in adulthood.*

**Valerie: How do you define RA (ritual abuse) and MC (Mind control); These two areas that evoke such denial and fear?**

*Interestingly, I realised as soon as you'd asked this that they aren't subjects that I really think about in such a defined way. For me whatever has happened to me is just what's happened, it's just my life! However it has been important to me during my time in therapy and beyond to understand the specific type of abuse I have experienced and how my abusers used certain methods and techniques. This knowledge helps by empowering me as well as allowing me to find ways of dealing with it's consequences. In a strange way defining MC and RA also reduces their impact and hold over me.*

*My understanding is that MC is the deliberate attempt at controlling a child's mind by an abusive adult or group of adults. It involves control in an extreme way – control of attachment needs, memories, behaviour, emotions, environments. All and any needs a child has are deliberately used by the adult(s) in order to manipulate the child's mind. The key word here, in terms of MC, is deliberate. In MC nothing is done without purpose and intention, even if the outcomes aren't always predictable or expected. MC DID is therefore different to other forms of DID in that it is deliberately created by the abuser(s) and not just a natural defence within an abused child's mind.*

*In many ways I view RA as a way of achieving MC. The lies, tricks, training, torture, humiliation, pain, violence, deceptions etc which are used repeatedly over time that often involve set ideas or environments, sometimes of a religious/spiritual nature. RA is so deeply damaging because the effects in adult life are profound. So much of normal everyday life is built around rituals – daily routines, mealtimes, bedtimes, dates throughout the year, birthdays, Christmas- and amongst all these things there are objects and words that are*

*constant reminders of RA such as books, candles, food, drinks, clothing, animals, music, colours etc. What people who haven't experienced MC and RA don't realise is that these abuses pervade all aspects of a person's life and that extends into adulthood and it is ongoing. It can affect the adult in different ways, such as flashbacks, avoidance, isolation, eating and sleep disorders etc, but each of these can have a devastating impact on quality of life even if the actual MC and RA ended in childhood. I would go as far as to say that you never really recover from MC and RA, the strong and lucky ones may find ways of coping and dealing with it in order to live lives with any meaning and quality.*

**Valerie: To add to the other burdens you have carried, is the issue of being Trans, dealing with a gender clinic, NHS restrictions and delays, a shocking level of public rage, cancelling wars, how has this been for you?**

***S. J. William***

*It's been hard. Really hard. I found my initial dealings with the Gender Identity Clinic and their process really difficult and re-traumatising. I think I'm only now really understanding why that was. The approach of the consultants at the GIC when I first attended, and this is going back around 8 years so it may have changed now, was that I had to "prove" I was really transgender. They were not going to accept that I knew my own mind about my gender at all. It's very difficult, if not impossible, to actually prove you are trans! Their idea of proof was for me to provide documents showing change of name and gender markers and a detailed verbal history (preferably with photographic evidence) which I soon understood was required to be full of cliches such as "I always played with action men and hated wearing dresses" etc. At my third appointment it was compulsory for me to attend with a close friend or family member. At this appointment this person was questioned in detail about me and asked to give their own opinion as to whether I was really trans! In my assessment period with the GIC my appointments were filled with intimate and intrusive questions about my body, genitalia, sex life, sexual fantasies and masturbatory habits. For someone with a history of sexual abuse the nature of these questions felt inappropriate as well as triggering, and I still don't see the relevance to my gender status or potential treatment. The overriding sense that I was not believed about my own perception and understanding of my gender identity also mirrored the lack of belief I had repeatedly encountered around my abuse. Having your own sense of self and mind questioned by strangers is difficult for anyone to deal with and initially my response was defensive. I felt frustrated and angry because I felt these people were withholding help because they didn't believe me (and in truth that is exactly what they were doing). My defensive response actually resulted in my consultants prolonging my assessment period for a further 12 months. Ironically it was only when I understood how to "play the system" and left my former therapeutic support that I made any progress in being given the gender treatment I knew I needed.*

**Valerie: And how has that been going?**

***S. J. William hierarchy and the gender clinic: Transgender abuse***

*After attending the GIC regularly for nearly 18 months I was still fighting for their agreement to starting me on cross sex hormones, for me that was testosterone. Despite having the support and backing of two consultant psychotherapists, my GP and having lived and presented as male with name and title change for over 5 years, the GIC consultants were still reluctant. It was only when a consultant psychiatrist I was seeing in my therapy setting contacted and spoke to my GIC consultant on my behalf confirming her opinion that active treatment would be beneficial to both my physical and mental health that the gender clinic agreed to starting me on hormone treatment. Nothing I had said, nor anything my therapists (who had known me for several years) had said made any difference, but the first contact from a consultant psychiatrist brought immediate results!*

*One of the things I have found repeatedly frustrating about being DID, especially in health related situations like the GIC, is that I can be intelligent, capable and highly functioning but the moment I say something which others don't want to hear or find difficult to accept I am suddenly viewed as being mentally ill, and this was my experience with the GIC. The trauma that many deny even happening is suddenly weaponised and turned against me. The contradiction feels like gas-lighting by a society that in general refuses to take seriously or accept organised MC, RA and DID. The damage that results from these experiences are used as reasons why I am too unwell to be honest/trusted/believed/rational/sane/intelligent etc. It's a mind fuck created by the very people who are supposed to be the "safe" ones entrusted to look after and provide care for me. Sometimes this feels just too much to cope with.*

*I knew that gender treatment was what I needed – and I was right! Starting on cross-sex hormones (testosterone) had a huge impact on me mentally. Almost immediately I felt a sense of relief both internally on a psychological and physical level which has only increased over time. Physical changes take longer but were equally as positive. 4 years ago I had chest wall reconstruction surgery and it was the most positive and life changing experience I have had. Now I am on the waiting list for lower surgery which will probably be around a 4-5 year wait, (and I am lucky with that time frame given people being referred to GIC for a first appointment are waiting an average of 8 years with some clinics estimating a 35 year wait with the current services). My last communication from NHS England regarding delays to my lower surgery, due to the only surgical service provider's tender not being renewed, offered no support or help other than to include The Samaritans phone number.*

*The general attitude towards trans people which currently has the loudest voice is that we shouldn't be given help with gender care or help to transition within the NHS. I experienced this first hand at my GP surgery after my chest surgery when a nurse was shocked on seeing my scars, saying "they do THAT*

*on the NHS?!" This kind of feedback – that I and other trans people should feel lucky we are helped at all and shouldn't complain about the length of waiting time or lack of surgical providers, is internalised and instead of feeling able to voice frustration or anger at our treatment (or lack of) you keep quiet. You end up feeling grateful for anything, no matter how small. Even not being treated with disgust or distain feels a relief and not a basic human right or professional duty. This is yet another mirroring of past abuse and abusive situations, and I know I won't be alone in this. With being DID I also have internal personalities who are trained to never speak out as well as internalised abusers, the combination of which makes a powerful force against any form of self-advocacy or feelings of self-worth.*

*The "trans issue" has become increasingly toxic over the last couple of years. Politicians and media have seized on the "trans debate" and made it their main focus. It's interesting that many of the organisations and individuals who are claiming to be concerned about protecting trans children have been silent and missing around the issue of CSA. The number of children referred for gender care is minuscule compared to the number of CSA cases that are known about, and there will be many more that are not know about. Yet the focus is on the trans issue. The only time sexual abuse is referred to is when it is weaponised as a reason for a child or adult claiming to be trans, therefore making the trans status untrue. Even if this were the case there is little discussion about how to prevent CSA or help children who have already been victims, just as long as they aren't "transed"! Similarly, the current arguments and fear mongering around women's safety in single sex spaces are focused on a small minority of trans women and not the real risk of violence women are known to be at risk of from men.*

*It seems to me that the trans issue has become a convenient distraction from the deeper issues of both CSA and male violence against women both of which are known to be prevalent in society (as well as a political distraction from cost of living, housing, economy, health/NHS crisis etc etc). It's easier to make a minority group, especially one which creates discomfort in many people, the scapegoat for the seriously uncomfortable fact that CSA and MD are happening every day on a massive scale by ordinary people in ordinary families, schools, churches, institutions etc. As someone who is currently being targeted as being a threat to society by being trans as well as being a survivor of CSA, I find this rhetoric and situation extremely difficult. My abuse and its consequences have been ignored and denied by the majority of society, and yet my trans identity is focused on with microscopic precision and labelled as being sick/dangerous/predatory/criminal/mentally ill etc. My voice is being silenced as both a trans person and a CSA survivor with DID. My experience as both is being ignored, and I see misinformation everywhere. I feel back in a world of lies and abuse where my identity and safety are at risk.*

*Government rhetoric and suggested legislation around trans children is also concerning. Recent suggested guidelines for schools seemed to completely*

*miss the point of safeguarding. Safeguarding policies in schools are there to protect children NOT parents. Outing all trans children to all parents ignores the fact that for some children their greatest risk may actually come from home – from parents or primary care givers. It is already known that CSA often happens at home, by parents or primary care givers, and yet this knowledge has been completely ignored when considering the safety of trans children, both by government and by those people supposedly campaigning for women and children's protection.*

*I know myself that being transgender can leave you vulnerable to abuse. Having survived CSA which continued into adulthood for me, finding myself in a position where I was once again a victim just by being myself was so depressing. Before I started hormone treatment I experienced several instances of transphobia. When one of these instances threatened the safety of my home and my friend I decided to go to the police. I kept my DID status quiet through fear of being seen as mentally ill and thus not believed, but I did have to "out" myself as being transgender due to the fact I was reporting an incidence of transphobia! This created a lot of personal turmoil. For me being transgender is intensely personal and private, and I don't necessarily wish to share that fact with complete strangers! When I am forced to reveal this fact it makes me feel literally naked before that person, because I know their thoughts are probably focused on genitals. Imagining this (even if I am wrong in my assumption, which in my experience has usually been accurate), especially as a CSA survivor is extremely distressing and creates an immediate sense of vulnerability. In reporting a transphobic incident you also risk receiving a response of disgust or transphobia from the person you are reporting it to, which is exactly what happened to me with the police. I received no help or support and was told that if they got involved it "might make matters worse". If I experienced transphobia again I doubt very much whether I would even contemplate going to the police, especially in today's current climate regarding trans people.*

*In order to feel in some sort of control over the toxic situation I decided to try to understand why there is such animosity towards trans people, particularly trans women. In order to enhance my own understanding of others and their views I chose a selection of books encompassing a range of attitude and approaches to the so-called "trans issue". This is how I came to read Helen Joyce's book, "Trans – When Ideology Meets Reality", a book which has recently been recommended by the Home Secretary, Suella Braverman, as a summer read!*

***Valerie:*** I have been shocked at the level at which the hurt involved in transgender issues has led to huge professional splits, angry cancellations, and an enormous amount of heat and hatred. Books like Helen Joyce's have received a huge amount of publicity. You opened my eyes to worrying aspects of it.

***S. J. William Helen Joyce's book***

*Yes, the subject of trans people has become the new Brexit, creating polarised opinions resulting in divisions between friends and families and discussed everywhere constantly. I myself have nearly lost the one friend I have and now have to avoid the topic or risk losing the friendship completely. It really has become so deeply toxic, and people like Helen Joyce are key figures in this. She is now part of the organisation "Sex Matters" who are advising the government over changing the legal definition of sex in the Equality Act to mean biological sex. If this happens then it will have significant ramifications on the trans community.*

*Joyce's book wasn't an easy read for me, on any level, but aware of my own bias and potential lack of objectivity I tried to read it with an open mind. Unfortunately my open mindedness soon turned into disgust, dismay, anger and outrage. I expected to read about fears over single sex spaces, safety, the immutable nature of sex and the erasure of women, but what I wasn't prepared for was the rather strange and distasteful inclusion of Multiple Personality Disorder (the outdated term for DID) as a condition that could be compared to gender dysphoria, with both being viewed as examples of "social contagion" and "moral panic". It included deeply inaccurate statements implying that people with DID are only able to access their "split personalities or alter" by therapists use of "hypnosis, free association and sometimes psychoactive drugs" in order to "recover the forgotten memories, integrate the personalities and – supposedly – relieve the patient of all symptoms"! Joyce also predictably introduced "Satanic Panic" in her opinion against the reality of RA.*

*For me the worst, and most damaging, statements were still to come. Joyce went on from attempting to destroy the existence of both DID and RA along with the credibility of therapists and professionals involved with DID patients, to attacking directly those of us with DID (a double attack if, like me, you are both trans and DID). She writes:*

> there are many parallels between MPD and gender dysphoria. In both, a few therapists account for a large share of the diagnoses. The literature about both encourages patients to cut themselves off from doubters. Both offer people with nebulous malaise a striking label that makes them feel special – and promises the sort of complete cure that is unusual in mental health. The research base for treatments in both cases is of abysmal quality. And both depend on unfalsifiable theories.

*The language Joyce uses here mirrors the language and behaviour of abusers. Isolation of victims is something abusers do to gain control and survivors of CSA often impose self-isolation as a chosen response to not having been believed in the past and avoidance of such "doubters" or disbelief in the future. Saying a label makes someone feel "special" is language that so many abuse victims have heard from their abusers. To see an author with little or*

*no understanding or experience with abuse victims, (her background is in economics), using such words to attack and accuse wronged survivors is just cruel and inexcusable. There is nothing special about having DID. Living with DID is difficult, often intensely painful and most certainly not something anyone would choose. It is a result of trauma and extensive abuse. To suggest that a diagnosis of DID is something anyone would flaunt or be proud of shows a distinct lack of understanding or empathy. My memories have never been "forgotten", my personalities have never needed any hypnosis to engage with therapists and the only drugs I have taken were those needed and prescribed by psychiatrist and GPs before I entered into therapy or those given to me during me abuse.*

*Extreme abuse is a subject that always makes people uncomfortable, which is why DID is often difficult for people to accept and easy to dismiss as untrue/not real. If you accept its existence then you have to look at the potential cruelty of human beings, which is all of us. Similarly transgender people make others feel uncomfortable. Their existence forces people to look at identity, sex, stereotypes, prejudices, inequalities, violence, safety, politics and society in ways that they really would rather not do. People with DID and transgender people make "ordinary" people uncomfortable and discomfort, by its very nature, is something people want to avoid or get rid of. In a podcast recorded (and widely available) since writing her book, Helen Joyce has said;*

> every one of these people (trans people) is basically – you know – a huge problem to a sane world….whether they've happily transitioned…. every one of the people is someone who needs special accommodation in a sane world where we re-acknowledge the truth of sex….every one is a difficulty.

*She goes on to say "we have to try to limit the harm and that means reducing or keeping down the number of people who transition".*

*This "sane world" she refers to has been nothing but harmful, abusive and dangerous to me and others like me. My world has not felt "sane" because my mind has had to find ways of dealing with the impact and consequences of being the victim of others' sadistic abuse. Being transgender may or may not be a result of my past abuse, that is a whole different subject, but to have my identity, my existence and my happiness referred to as problematic and insignificant by someone who feels threatened and afraid of difference and theoretical situations and scenarios is dangerous and damaging to those of us who are already a vulnerable and targeted minority.*

*The impact of this discourse and rhetoric is that I, and other transgender people, (even those who "pass" easily), do not feel safe amongst society. The fears of violent attacks and rape that used to be attached to my abusive past and present are now added to because transgender people are viewed as dangerous and "other". My "otherness" is now two-fold, I am DID and trans. I am a double other who is a "problem" to this sane world, as decided by*

*a middle class, cis, straight, professional white woman with a platform that allows her voice to reach numerous people, including many in positions of power and influence, in order to attack, ridicule, humiliate and dehumanise a vulnerable minority group of people who she does not know or understand. People with DID make up around 2% of the world population, in the UK trans people are now estimated at around 0.5% of the population … we are not the problem nor the real danger to society!*

**Valerie:** Thank you for being willing to be a messenger in this book of something that has recently hit heights of toxicity. You are also being a messenger of everything that a peacetime country finds hard to consider- dangerous groups who operate outside of the law, deliberate theft and manipulation of a baby human's right to a life, organised scientific ways of hijacking identity and secure attachment. However, despite the huge burdens you have been left with and the professional and societal abuse that has come on top of the cruelty of the original life you were born into, you have voiced truth, you have been able to accept validation and been willing to help others with the most difficult subjects of all.

**I hope the process of writing here provides a home for your careful thinking and your willingness to think and debate. Working in the field of abuse and trauma brings attack from frightened colleagues and those in the mainstream who have not encountered these issues personally. One of the gifts we receive in doing this work is the meeting with some of the bravest people we will ever meet. I hope this book spreads your words and allows more thought to come to these painful subjects.**

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## Section III

# Words and silence

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# 8 Why language matters while talking about trauma

*Maria Podlejska-Eyres**

## The importance of language

While acknowledging that there is a lack of consistency of language relating to adults with a history of sexual abuse in childhood, for the purpose of this chapter, the words survivor and person who experienced sexual abuse as a child will be used as the most widely used by people with this experience. The words clinician, professional or practitioner are used to describe a person in a helping profession attempting to support them.

Why is language so important to us as humans? Language is a vital part of human connections – the bedrock on which babies and their relationships with themselves, others and the world develop, alongside visual cues, touch, taste and smell. Language, alongside bodily experiences, becomes the framework on which our comprehension of having, understanding and sharing mental states develops. Babies initially communicate through the mix of emotional expressions and emotive movements, creating first exchanges with the caregivers and initiating the process of attunement, a process in which our internal states resonate with those of another. Mother and baby, who are in tune with each other, are sensitive to each other and respond to them. A smiling mother evokes a smile on the baby's face, while a depressed mother brings about a very different reaction. A distressed baby elicits a caring response within the mother, who becomes curious about the reasons of distress, attempting to relieve it. Donald Winnicott's (1960) concept of maternal holding and the holding environment describes those processes beautifully. Malloch (1999) coined the term communicative musicality while analysing the pulse, quality, and narrative of those mother-baby dyad exchanges. Trevarthen (2015) wrote about the capacity of the infants to initiate and solicit contact and share their narratives with others. This primary language consists of shared rhythms in expressive, emotional and emotive movement. Those observations highlight the significance of the body in communication from the very beginning and how it assists language

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development. Bates (1979) describes how with time these early interactions become proto-conversations through which babies elicit nourishment, care and protection.

Motherese or baby talk, a phenomenon observed around the world, refers to the way mothers or other caregivers speak to infants. Motherese is slower than the usual adult speech, uses pauses and shorter sentences, word repetition and shortening, and modulation of the voice alternating high and low pitches giving it a sing-song quality. The infant learns to respond to it, initially with gaze, facial expressions and movements which evolve into exchanges, and turn-taking. The utterances which follow develop into words. The process of those exchanges encourages bonding between the mother and the baby and promotes language development further. Silence is a part of those exchanges, a way of making a space for another, creating patterns while taking turns. For the silence to occur, the presence of others is essential. It is the other who witnesses it, can be curious about it, and responds to it, emotionally and by naming it. Language becomes part of the context in which the relationships to the external world and those inhabiting it grow. They are in turn the building blocks of the developing internal world within the baby, and with it, a sense of self. Gradually, as vocabulary increases and words become phrases and then sentences, all the basic needs of early life for external and internal safety, sustenance and attachment figures can be expressed and responded to with language. Language becomes an important tool of caring and playful interactions with those around us, fostering the development of trust and stimulating brain development. As the language evolves, it allows us to communicate our thoughts and emotions more precisely. We learn how to describe our experiences and share complex ideas with others and to relate to them, allowing us to grow personally, educationally and professionally. This scaffolding of the language, alongside sensations and bodily experiences, creates an essence of what it is like to be a human being. This is what happens when language is used in the service of development, creativity and positive relationship building.

Conscious communication in the form of language can be understood as being thought through before being spoken, with the speaker being aware of it. It is important to acknowledge that communication also takes place in the sphere of the unconscious. Unconscious communication is omnipresent in all walks of life; it is subtle, not thought through and consciously unintentional. Every day examples include slips of the tongue, unintentional body language, facial expressions and the tone of voice. Emotions and desires can also be communicated unconsciously in other ways. Transference is a phenomenon in which we direct emotional states related to an important figure from our past to somebody else. Projection is an unconscious defence mechanism by which an individual attempts to get rid of unbearable feelings and desires. These unconscious phenomena form what can be called a language of the unconscious, uncensored by conscious thoughts. It is ubiquitous in human relationships and present throughout our lives.

The language of the body and the other senses also continues to develop, with touch being particularly important to human relationships, conveying meanings, allowing for the development of physical play, driving curiosity about the child, the external world and others. Human psychosexual development begins at birth, with infants getting to know their own bodies and discovering what brings them pleasure or pain, enjoying ordinary physical contact with caregivers and siblings, learning about intimacy and boundaries in relation to the body, how it differs from those of the others, how it functions and the need to respect it. This process continues into toddlerhood, through teenage years and puberty, leading to the development of adult sexuality. While adult sexuality grows on the foundations of child sexuality, its focus is entirely different.

Freud initially recognised the impact child sexual abuse can cause when he suggested that repressed child sexual abuse was a major root of hysterical neurosis, in a lecture he delivered to his colleagues in Vienna, later publishing a paper on it, Freud, S. (1896). Unfortunately, a few years later Freud changed his mind, suggesting that the seduction was likely to take place in the child's mind, rather than in reality, relegating it to the fantasy world. In doing so, he wound back the clock of progress in this area, contributing to the turning of a blind eye to this painful reality of child sexual abuse. However, Sandor Ferenczi (1949), a Hungarian psychoanalyst and a student and colleague of Freud, confronted the issue head-on. He presented his landmark paper on child sexual abuse at the International Psycho-Analytic Congress in Wiesbaden in 1932, originally titled "The Passions of Adults and their influence on the Sexual and Character Development of Children." The revised title, "The Confusion of Tongues, the Language of Tenderness and Passion" captures the disparity and separateness between child and adult sexuality using the word "language" in a symbolic way. Ferenczi's paper remains one of the richest and most profound writings on this subject, almost a hundred years later.

Child sexual abuse has a profound impact on children, which depends on many factors, including the child's age, duration, circumstances of abuse, closeness to perpetrator, as well as protective factors such as nurturing and trusting relationships with others, and resilience. The trauma of non-recent child sexual abuse is often held in a dissociated form, within the body, unformulated and without words. The trauma disrupts ordinary developmental processes, impacting on the development of the internal world, on the capacity to think and to process memories, and relationships with oneself and others. Depending on the child's age, it disrupts the development and use of language. Trauma experienced by young children may cause a delay in their expressive (what they communicate), receptive (what they understand) and social language (using language in social interactions). If not addressed, those effects carry into many aspects of adult life of the survivors, affecting trust and development of trusting adult relationships, including with care professionals. Conversations with those who

experienced such trauma require sensitivity to prevent re-traumatisation. This chapter considers the various factors which can facilitate or hinder such conversations.

It is vital that those working with survivors of Non-Recent Childhood Sexual Abuse (NRCSA) are aware of the role and the power of language, past and present, and use it in the service of healing and growth.

## Language and abuse

For survivors, the biologically imprinted aftermath of abuse lives on in their internal reality, altering their capacity to evaluate the current situation, which can be experienced emotionally as threatening, even if logically the mind knows that it is safe. When faced with various reminders of abuse, the survivors' brains can react by producing overwhelming emotional states of extreme fear and helplessness. They can feel detached from reality and unable to speak of their experiences. This in turn shatters the perceptions of the safety of oneself and others, severely disrupting trust in the world and in the safety of human relationships. Those reactions can be experienced by others as being out of touch with surroundings and the present and can be difficult for them to understand. It is as if the survivor finds herself a foreigner in a new country, unable to speak its language, a refugee from oppression of the abuse, unable to make herself understood. The survivors' capacity to communicate in such circumstances might also be affected as they continue to be on high alert, which in turn can profoundly affect their capacity to be present, to access their memories, to think and to use language in the ordinary way.

The aftermath of trauma of child sexual abuse is both complex and multilayered. Language is universally part of it, a part of the traumatic event and through its absence. Abuse and trauma affect language development, especially in young children. Childhood sexual abuse has profound repercussions on those who have experienced it, so it is not surprising that it is thought to be associated with the decrease of the capacity in receptive language learning and lower educational attainment in girls (Noll et al., 2010).

Psycholinguistic investigations of trauma narratives are another gateway to understanding the impact of trauma on language and made great strides in this work. The term "language injury" captures something of the nature of the trauma itself and describes its impact on language. Post-traumatic language injury is marked by hesitation of signifiers, intrusions and repetitive use of filler words, as well as "discursive disorganisation" such as tenses telescoping, reliving the event, lack of future references and incomplete sentences.

Childhood sexual abuse can stifle the development of language, which can be used as a tool in abuse and becomes corroded, affecting current and future relationships. The range of words to describe emotional states might become limited, and the balance between positive and negative emotional language altered and confused. The language of psychological and physical intimacy might become ambiguous and even frightening, with words used as

currency. The enforced secrecy around the abuse, using language to convey a threat if disclosed, equating being a good boy or girl with keeping it, can all have a long-lasting impact and lead to confusion between truth and lies which are expressed in language. There is some evidence that women who experienced sexual abuse in childhood use the word "I" less frequently in their narratives which might reflect the difference of power during the abuse and their perceived insignificance of themselves or lack of worth. The act of abuse taking place between a child and an adult of different generations in addition to power imbalance can narrow or even obliterate the generational gap. This can be particularly pronounced in the aftermath of incestuous sexual abuse when a family member who is a perpetrator might also be the one on which the child depends for material and emotional survival. It can impact the space where words are created, spoken and understood, making it difficult for them to acquire meaning and affecting the development of capacity to symbolise. Symbolisation in psychoanalysis (Segal, 1957) is understood as an unconscious mental process whereby one object or idea comes to stand for another through some part, quality or aspect they share, with the symbol carrying the emotional meaning invested in the original object or idea. The capacity to symbolise is a requisite for communication within one's own internal realm and with the external world. Without symbols as building blocks of communication, the ability to put words to our experience is decreased and one can revert to the infantile states of mind where survival anxieties predominate. The language in the aftermath of child sexual abuse can cave in, with words becoming hollow husks, like the shattered vessels that need to be painstakingly put together again repeatedly. It is as if the survivor must learn how to find a new language to describe their experiences as the pre-trauma one cannot describe it in full. Trauma of sexual abuse can severely impoverish the person's linguistic range, especially when occurring in early life, making it difficult to think, to find and to put thoughts and emotions into words and to process experiences. This difficulty to use language to describe abusive experiences is complicated further by other phenomena such as the fragmented nature of traumatic memories, dissociation and struggles with symbolisation. The initial stories when they start emerging are often fragmented, incomplete/incoherent and contradictory, there are time lapses. The survivor can present as emotionally frozen, seemingly forgetting or avoiding the emotions or emotionally overwhelmed and flooded by memories. Often when vocalising traumatic events, one can oscillate between having a fully contextualised, structured narrative and fragmented accounts characterised by gaps, hesitations and disruptions – between an obvious strong personal and emotional involvement and stance taking on the one hand, to a seemingly detached narrative that abstracts from the narrative self.

Silence is an integral part of communication in relationships. By making room for another and taking turns, a pattern of conversation emerges, and the space is created where things can be thought about together. Within the context of abuse, silence and/or the lack of it can become a tool of oppression,

a powerful and frightening presence. It is an inherent characteristic of child sexual abuse, both on the side of the child victim and the adult perpetrator. As the perpetrator sees the child as a target or an object to be used, the language often becomes a tool in grooming and perpetuating the abuse, acquiring different meanings as a result. Silence might convey that a child doesn't matter or is not worth speaking to. This denial of voice and the prohibition of speaking in the process of child sexual abuse takes place in the context of emotional/psychological and physical abuse, contributing to the cumulative trauma. The perpetrator needs the child to stay quiet in the course of being abused and afterwards, with the language used as a threat or a weapon to dominate and elicit secrecy. A warning of targeting a younger sibling if not compliant, being severely punished or sent away from home if the abuse is revealed can be used to warrant secrecy. The mockery of not being believed is very common, introducing doubt about one's own experiences, affecting the ability to trust that the world is a safe place and people in it are trustworthy. These can all cause immense problems with trust in relationships, for some, lasting a lifetime. Remarkably, the Adult Attachment Interview (Crittenden & Landini, 2011) captures the difficulties in language in unresolved trauma, picking up gaps, inconsistencies and incoherence in the narrative of people who experienced trauma in childhood. It is important to remember that some of the dynamics which occurred during the abuse are likely to resurface in the therapeutic situation, where the therapist might be experienced as holding all the power, where worries about trust might re-emerge and silence can have a threatening meaning. As one survivor said:

> Often after I had disclosed something difficult [and being suffused with shame] I would be met by silence. It felt really uncomfortable – not knowing what the therapist wanted me to say. I once asked her about the silences – and she told me it was to encourage me to come up with my thoughts about it. I found the whole experience traumatising. The silence made me doubt whether I should have disclosed and I could feel the shame creeping back. Without doubt it made further disclosure more difficult.

### On traumatic memory

Trauma profoundly affects the ability to lay down memories in a usual way, which is in turn reflected in language. Traumatic memories are very different to ordinary ones as they don't fit in with the person's pre-traumatic way of understanding themselves and the world. They are impossible to process and integrate into memory systems in a usual way, and therefore, they live on, unaltered and experienced in the present as they were in the past, dissociated from conscious awareness and not easily available for retrieval. As a result, traumatic memories are often described as incomplete, fragmented and incoherent because of the difficulties in encoding, processing and integrating

the traumatic events into the autobiographical memories. The overwhelming, unintegrated and unprocessed memories can be stored away from conscious awareness and often held in the body. The imprints of traumatic experiences are therefore not a coherent, logical narrative which can be recalled at will but raw and dissociated, fragmented emotional and sensory traces (Van der Kolk et al., 1996) and the language reflects it. Van der Kolk (2015) postulates that there seems to be a range of how much of such trauma-induced material can be finally transformed into a logical narrative of autobiographical memory. While some survivors experience only some small details of traumatic memories missing, a minority still retains mostly fragmented traumatic memories.

Traumatic memories can come to the surface uninvited and be triggered by various verbal, sensory and emotional stimuli. They can occur in the form of sudden and unexpected flashbacks, forming a visual language. They can give rise to intense emotions or bodily experiences and occur in dreams. Somatisation can be seen as another type of body language of the survivor, a tentative opening to gently explore. While they are all a valuable source of information, the memories can be initially non-verbalised or lack meaning and the work of decoding and processing them requires patience and sensitivity to what is being uncovered.

With NRCSA, this can be complicated further by the secrecy demanded by the perpetrator, the fear of revealing the truth, of not being believed or of being punished, and the deep shame attached to the abuse and sometimes guilt. One wonders how much Freud's expelling of child sexual abuse from reality to fantasy might have contributed to the societal difficulties to take it seriously. The Truth Project, part of the work of the Independent Inquiry to Child Sexual Abuse (2022), found that for 67% of participants, the abuse started before they were 11 years old, and for 42%, it took place within the family home (IICSA, 2022). It puts the abuse in perspective in terms of age and the level of power and authority the abuser holds in the child's life. As trauma also affects the capacity to symbolise, part of the work includes transforming the traumatic experience into something that feels less overwhelming and can be shared with another, spoken about and understood. The confusion about what happened might be apparent in the language and the language itself can become confused. The words used in abuse can acquire meanings that are different or even opposite to the way they are used in the ordinary world. For example, words relating to a positive emotional attachment such as love, care, support or looking after someone can become confused with words from the negative register such as abuse, neglect, anger, fear or hate. It is vital to be aware of the importance of nuance and difficulties in meaning making while helping to make sense of those experiences.

As trauma also alters the way the brain and body manage perceptions, it may impact the capacity to think and to communicate one's bodily experiences. It leaves the imprint of traumatic experience which can come to the surface when triggered and evoke responses from the past, such as the

fight/flight/freeze response or dissociation, even though consciously the mind knows that it is safe. It happens because triggers of trauma activate the autonomic nervous system which reacts extremely fast and whose goal is survival when facing extreme threat. They bypass a rational, slower thinking neocortex which is responsible for critical and rational thinking. The body might react in a way that is out of touch with the present, responding to triggers as if at risk and impacting the capacity to communicate.

Childhood sexual abuse and the memories associated with it concern violation of the body and therefore the words around this subject are inevitably problematic. The sensations felt at the time of the abuse can be experienced as present in every cell of the body, and the smallest of triggers can elicit an overwhelming body response by which the traumatic event is relived.

Similarly, the emotions linked to the past, including fear and even terror, a sense of being at the mercy of the other, feeling powerless, unable to get away or communicate the emotional states, can all re-emerge long after the abuse and affect the ability to speak. The closer the conversation to the core trauma, the greater those difficulties can become, leading, in extreme, to becoming speechless and unable to vocalise.

As a result, when attempting to speak about traumatic events, the oscillations between fully contextualised, structured narrative and fragmented accounts are common. The communication is characterised by gaps, hesitation, lack of certainty and disruptions, with fluctuating level of emotional involvement, from very intense to detached. All those experiences can lead to feeling out of tune with oneself, others, and the world, feeling alienated, ashamed, lonely and cut off, increasing the difficulty to verbalise the experience further.

Drawing is commonly used in work with traumatised children but less commonly with adults. It might be worth considering giving an option of journaling or writing about their experiences to adult survivors, as the act of putting words to paper over time might be easier than speaking them out loud. Sometimes, the language is so affected by trauma that other means of communication might be employed to start conversations. There are growing examples that creative arts-based interventions are a safe way to begin processing traumatic memories in those circumstances. They provide some emotional distance through the use of art materials (visual arts), musical instruments (music therapy), using the body (dance and movement therapy) or voice (drama therapy) to express what may feel impossible to express in one's own words. The presence of a benign mind of the therapist who pays attention to the process provides structure, safety and containment. Poetry or story writing produced in solitude or in the group setting might become another conduit of communicating what is not yet amenable to express in words. All of these creative arts communications can become a vital resource for coping and resilience for individuals, and a way of communicating their experience to others, would it be the professionals, loved ones or the wider population. The Arts can also be used to produce educational resources and the

Zine Breaking Silences produced by Network for the Promotion of Change (NRCSA, 2024) is a good example of such a publication.

**Language in the narration of trauma**

Child sexual abuse takes place in the context of an unequal relationship in particular settings. The setting is unsafe and uncontained for the child, all the power belongs to the abuser, while the child is unable to escape and completely powerless. Violation of the body is commonly accompanied by the overwhelming emotional states of fear and despair. The experiences shatter the perception of the world and people within it as a safe place as described above. What all abuse has in common is that the interactions are purely in the service of the perpetrator's desires with the child seen as an object or a tool to satisfy it. Language is a part of that setting. Words, phrases, a tone of voice, facial expressions, body language can all acquire meaning linked to the abuse and can become triggers.

Creating a space where difficult and distressing past events can be faced by the survivor and the practitioner together is a process which includes physical space. This is particularly important when words are not available and includes building the alliance from the start by providing a safe, confidential and supportive physical space, paying attention to the power difference and perhaps enquiring if the layout of the room feels safe. Traumatised patients are often more sensitive to the environment so lighting, colours and sounds from outside the room need to be addressed.

> I began seeing a new trauma therapist during Covid. By necessity there needed to be less potential for contact. I was not allowed to touch the doorknob or knock to let her know I was waiting. The seats outside had been removed which meant I hung around in the hallway until she was ready. My therapist, who was seated distally at the end of a long narrow room, had reserved body language and was not warm. The atmosphere felt cold and clinical, and I felt controlled over when I could come in and leave.
>
> Later I began to understand that the environment, and how you are met, are crucial factors in building trust and reducing power imbalance – essential to facilitate disclosure.
>
> Small factors can make a big difference, such as having two comfy chairs with no obvious height differential or desk in between, positioned not too far away from each other. Also a warm and empathic greeting, giving the impression you are wanting to listen, be curious, and help. It is important to emphasise confidentiality, and if necessary confirm the room is soundproof. It is also important to phrase the initial questions to invite dialogue so that it is centred around "what happened to you" rather than "what is wrong with you".

Safe space also means allocating enough time, being beside and benign, paying attention to the content and flow of the language, noticing when something is difficult and giving the choice to leave something out. It is important not to rush, allowing for things to unfold at a speed acceptable to the survivor, pausing or slowing them down if necessary while also remembering that prolonged silence can be traumatising and feel uncontained, or frighting, especially at the beginning. As discussed earlier, silence plays an important role in the process of abuse, so gaps in conversations need to be carefully considered. They can initially be experienced as traumatising, become a kind of torture, full of secrets, shame or fear. Fear arises with the threat of physical, emotional or psychological harm, real or imagined. Fear rooted in child sexual abuse is complex, especially if the abuser is someone the child depends on as an attachment figure, which might be lost if abuse is disclosed. The child might develop a deep sense of loyalty towards the perpetrator, which can feel at the time as genuine love and affection, meaning speaking about the abuse might feel like a betrayal. All those complex and potentially conflicting emotions might result in feeling differently from others, fearful of and alienated from the wider world, exposed, embarrassed, shamed, alienated, lonely and cut off. Those complex dynamics might be present in the consulting room too.

> Showing you are listening is so important. During my first few sessions of therapy on the NHS, I had to fill in a questionnaire at the end of each session. Despite emphasising that the main problem for me at that time was recurrent terrifying nightmares and thus being unable to sleep, this was never acknowledged or addressed. The emphasis continued to be focussed on improving communication which wasn't, I felt, a problem.

The process of disclosure of abuse is likely to take time and it starts with establishing a trusting relationship. The recent paper by Alyce et al. (2024) raised some very interesting questions about trust and trustworthiness, describing the process of building and repairing relational trust and advancing relational trust.

The disclosure might be slow and occur in stages, following the growing demonstration of trustworthiness. It might start abruptly, like a dam that has been broken, carrying with it powerful feelings and leaving the person in a very different state internally than the one they arrived in. Recognising and validating whatever emerges and giving time for the strong emotions to subside so the survivor feels they can face the outside world after the session is the work of containment. The words, tone of voice, facial expressions and body language of the therapist all play a role here. It is important to think of disclosure as a journey rather than one episode and not to rush it, taking cues

from the patient and slowing down the process if the survivor is struggling or time is running out.

> With disclosure, listen – and then validate by showing belief and if appropriate confirm what happened was not OK as they may not know it. Reassurance that they did well to cope with an extremely challenging environment is also helpful.
>
> It is important to be aware that every disclosure is likely to be associated with significant shame and humiliation, so reassurance that whatever coping mechanisms were utilised should be commended as they ensured survival at that time. It is also important to be really sensitive to the terrible corrosive nature of shame and guilt overshadowing any disclosure, choosing your words with care.
>
> The first trauma specialist I saw when my dissociated memories gradually began to emerge utilising EMDR was amazing. Truly curious, empathic and completely believing. The next therapist, in contrast was not trauma informed and the sessions were retraumatising, but I didn't understand at the time why. I didn't seek help again for a long time.

Identifying and naming the imbalance of power of abuse, while remembering there is also a difference of power in the clinical encounter, is vital. As language and/or its absence is present in the context of abuse, it can become saturated with memories and meanings which can be expected to be complex and reflect the imbalance of power which is always a part of the abuse. It is essential that this imbalance is authentically addressed while working with people who experienced sexual abuse in childhood. Genuine and active listening, being emotionally available and responsive but not forceful, being respectful of boundaries and believing the survivor is pivotal to encounters with survivors, wherever they are seen. Acknowledgement of the courage to disclose and a non-blaming stance, helping to shift the responsibility to the perpetrator, are key. Curiosity about how we can make the survivor feel safer, paying attention to their verbal and non-verbal communication, including tone, phrases and use of silence are all important, as is remembering that anything that touches the senses of the survivor, and can therefore bring about a link to the abuser, can be triggering.

It is important to remember that the act of telling the story doesn't necessarily alter the biological responses of the body as it remains hypervigilant and prepared to be assaulted or violated at any time. It is critical to acknowledge that despite training, experience and the best intentions, re-traumatisation in the clinical setting may occur. We are all human, carrying our own life experiences and we can get things wrong. Triggers for re-traumatisation can be verbal, including certain words and phrases, or the way in which they

are delivered. Asking for clarification rather than making assumptions about the preferred language around the abuse itself, attempting to mirror back the words used, not putting words in people's mouths, asking if we got something right and being prepared to be corrected are helpful positions to take. Other sensory triggers can include body language, parts of the setting such as the type of lighting, certain items in the room or scents – they can all be reminiscent of the abuse.

> It would be impossible for a professional to know what might trigger a survivor but avoiding anything reminiscent of mockery or power over is a good starting point.
>
> To this day I still struggle if anyone repeatedly points their forefinger to emphasise a point from a dominant stance.

Triggers can evoke images, physical sensations which formed part of the abuse and were unbearable, and affective or behavioural states which might not be picked up on immediately. When observed, giving the choice to pause, ask and acknowledge unintentional re-traumatisation is vital and can be corrective of the power dynamic during the abuse. The importance of noticing that re-traumatisation took place and the ability to reflect on it and make a repair is incredibly helpful as a small step towards restoring trust in others. The distress of re-traumatisation can sometimes be difficult to put into words and for some, agreed signals to communicate that this is taking place is helpful. Communicating that the triggering happened can give the clinician permission to be curious about what is happening, including dissociation, and bring the focus from the past to here and now.

> My therapist and I devised a hand signal during my initial EMDR which I would use when I had been triggered – it helped me feel safer that she knew exactly why at that moment I would then become overcome with uncontrollable grief and unable to talk.

Avoidance of the painful intrusion of traumatic memories can be seen as an attempt at self-preservation as there are likely to be consequences of it outside the clinical environment. Terror of knowing and not knowing and the fear of finding out are also likely to play a role when considering an attempt to disclose. Previous dismissal or disbelief when speaking about it, belief that others are not willing to lend an ear, and not wanting to burden others with one's pain can all be serious barriers to disclosure.

Child sexual abuse can still be perceived as secretive, a subject of interdiction and taboo. It is almost always associated with shame and guilt. The awareness of child sexual abuse, involving the violation and suffering of body and mind, has not yet been fully acknowledged on an individual or societal level. Previous experiences of attempting to speak up, especially if they were

ignored, moved away from, minimised, or glossed over, can add to confusion, anger and invalidation about not being believed. All can make the experience of abuse almost impossible to share with others again.

Like other intense experiences such as grief, pain and rage, trauma reaches the limit of what is sayable. Silence, which can be described as speechless dread, omissions, inconsistencies and the inability to speak intelligently, can be the closest one can get to conveying the experience of trauma in language, especially at first. The wish to protect the clinician from being burdened by the pain might also play a role in remaining silent. It is, however, important to remember that even without words, unconscious communication is still taking place and paying attention to the clinician's own feelings is crucial. The impression of something being wrong, a gut feeling, a sixth sense are all important to be attended to as examples of communication without words.

> Any disclosure, especially at the beginning of the journey, may trigger the survivor back to the place they have possibly spent their whole life – intentionally or unintentionally via dissociation – trying never to revisit. Disclosure can produce uncontrollable whole body distress, and at this point of outpouring of grief, the survivor simply needs to be held [not physically] with empathic bodily expressions, and at a suitable time vocal concern and reassurance, such as "it's OK, you are doing well, stay with it – this is normal, you are safe here". Some recovery time may be necessary before speaking again and the survivor may not be able to disclose further in that consultation. At the end of the consultation it can be enormously helpful to thank the survivor for sharing, and to reassure them that you understand how hard it must have been for them to disclose.

The end of the consultation is an important moment when some modifications of technique are needed when working with the survivors:

> One therapist always abruptly ended the session and became very clinical about the next appointment. It was a real change of personality from her empathic, caring persona during the session to something rather clinical. I think it was maybe her way of finishing the consultation and preventing any dependence on her – but it always felt wrong and cold – and a warm departure would have been much better.
>
> I can understand a therapist's concern to avoid dependence on them, but I wonder if this problem is less likely from a cohort of survivors? With childhood abuse you soon learn you cannot depend on, or trust anyone. This leads necessarily to a self reliance, and long term difficulty with trust and dependence on others.

Conversation about childhood abuse in a language that is not the mother tongue, or with sign language or an interpreter, introduces another level of complexity. Speaking about abuse in a different language, which might or might not be the language of the abuser, might add to the difficulty of finding the words to describe what has happened. Other personal characteristics of survivors and perpetrators such as their skin colour, culture, ethnicity, sex, gender, sexuality, disability, class, religion or age add another level of complexity practitioners need to be aware of and think about. The more characteristics which indicate a minority identity, the more complicated the picture becomes as they may bring another imbalance of power and therefore expectations. Working with interpreters, including sign language, introduces another level of complexity that can be hard to disentangle. It is important to remember that, while for some using an interpreter from the same community might bring a sense of familiarity and comfort, easing the disclosure, for others a fear of secrets being betrayed and shame brought upon oneself, and the family of origin might be a very powerful barrier to it. Equally, practitioners need to be aware of the impact their own characteristics can have on survivors.

### The written word

Written communication following the disclosure of child sexual abuse is incredibly important as words on paper have a life of their own and in the digital world we live in, they have a true staying power. Doubting the truth of what has been said in communication with other professionals, directly or indirectly, can corrode trust and delay attempts to disclose and seek help even further. While the amount of detail in written communication might be a matter of professional standards and clinical reasoning, it is important to reflect on the amount of detailed information disclosed. Words such as manipulative, attention seeking, engaging in dysfunctional or toxic relationships, being promiscuous etc are stigmatising and steeped in blame and judgment. The impact of such negative, emotionally loaded language on a person who might already be feeling ashamed, dirty, not good enough and worthless, through no fault of their own, can be devastating.

Similarly, some diagnoses associated with a history of child sexual abuse, such as emotionally unstable/borderline personality disorder, can also be experienced as stigmatising and re-traumatising for some survivors. They can be seen as labels, reducing a person and their experiences to a word. The injustice of wrong diagnoses can be experienced as a denial of the infliction of suffering and can strengthen a lack of belief in justice. They can be seen as suggesting there is something wrong with the person, rather than understanding the injustice and the crime of the child sexual abuse that has been done to them. The stance of acknowledging what happened, understanding the impact of it, and thinking about what is needed to address it is much more helpful. In a clinical situation, the difference of power is always present, with

the practitioners wielding most of it. Professionals are gatekeepers, being able to offer or deny access to help, support and other resources. This can be replayed internally between the survivor and the clinician, with various parts of the dyad taking up various roles and feeling pulled into complex dynamics which can end up reflected in the spoken or written language. The language chosen by the professional to describe the patient's experiences in the mental health system is also particularly important. Therefore, descriptive and matter of fact language is so much more helpful than a judgmental and blaming style, which recreates the imbalance of power present in the abuse and might become an obstacle to seeking and receiving help.

> It is a reflection of societal beliefs that my consultant wrote in his notes that he found it hard to reconcile the alleged history of childhood abuse with me having had had a successful career and family.

For some, grooming might have taken place online in the form of the written word and (usually) false images of perpetrators. While we are still learning about it, the exploitation of trust, changing expectations of what is safe behaviour, inducing secrecy and promoting fear to keep the child silent tend to follow a similar pattern as in the physical world. As a result, online communication is acquiring a different meaning altogether.

**Impacts on the clinician**

While working with adults who experienced trauma as children is a privilege and can be deeply fulfilling, it is also challenging. Witnessing the devastation of child sexual abuse comes at an emotional cost to the practitioner. It is important to acknowledge clinicians are likely to find it shocking and upsetting, despite their years of training and experience. This reaction might be greater if they were unprepared for it, there were no indications of it before the consultation, their own emotional resources were low for personal reasons, or they had not had good enough training to receive such a disclosure.

The unconscious communication described earlier is amplified by the milieu of therapeutic consultation. Survivors' painful or unacceptable feelings can be projected to and attributed to the clinician. The openness of professionals to this unconscious communication depends on their own life experiences, sensitivities and vulnerabilities, as well as their ability to recognise the communication as separate from their own internal lives. By taking in the projection, the clinician identifies with it, and by recognising it, can articulate something about the survivors' unspeakable experiences which are not yet ready to be conveyed by them in words. These unconscious processes add another layer of complexity to the work with trauma.

Practitioners might experience an unconscious pull towards taking a particular position in conversations around child sexual abuse. Those positions are often reminiscent of the dynamics of abuse and include taking up the

position of victim, perpetrator, rescuer and uninvolved observer. This is important to notice and reflect on as those positions can be reflected in the language. For example, taking up a position of a rescuer might include promising immediate personal help – promise of a perfect cure, underestimating recovery time or the reality of long waiting lists might exacerbate the lack of trust in authority. Asking detailed questions in an intrusive way while in the position of the clinician's authority might be experienced as violating by the survivor. Feeling powerless to contain the process and keep the safe boundaries of the session might result in being exposed to very detailed descriptions of abuse which might be experienced as breaching what the clinician is able to tolerate, with the professional ending up powerless, like a child experiencing abuse. Some clinicians might want to avoid witnessing a disclosure altogether which is likely to lead to re-traumatisation and possibly a withdrawal of the survivor and a further delay in seeking help. Unfortunately, there are still too many who might attempt to dismiss, doubt, or push the patients' experience back in various ways, by referring them elsewhere or finding a reason not to see them again. The following phrases have been reported as responses to attempts of disclosure: "If you say so." "You were too young to remember." "We have run out of time." "This isn't a place to talk about this." "I am not the right person to talk about it." "Why don't you speak to your GP about it?" Such reactions can have a profound impact on an individual, strengthening their distrust in the world and the authority figures who were supposed to look after them.

The reasons for such extreme reactions from clinicians are likely to be varied. They might include a lack of or inadequate training, fear they will not know what to say or do, or concern the patient might become too emotional and could become at risk. The reluctance to get involved in something that is likely to have an emotional impact on them or might lead to lengthy admin and liaison with other services due to safeguarding issues might also play a role. Practitioners who have experienced sexual abuse as children themselves might fear hearing about the trauma of another will trigger them and potentially lead to their own breakdown. This un-addressed issue of a professional's own abuse complicating encounters with survivors is still something of a taboo within health and social care. On the other hand, some clinicians feel sharing their own history of abuse can facilitate the disclosure, perhaps minimising its impact on the patient, who might consequently feel a need to protect or "save" the clinician from the distressing details of their own experience. We all have our own personal blind spots and are drawn to personal responses when facing powerful conscious and unconscious communication from survivors. Working in teams can amplify those phenomena potentially leading to conflicts and difficult team dynamics. To prevent possibly destructive enactments, it is vital to develop an understanding and awareness of our own limits, vulnerability and tendency towards taking up a particular role within a team and towards patients. Vicarious traumatisation is a term describing the negative cumulative effects of work with traumatised patients,

which can lead to secondary traumatic stress, compassion fatigue and burnout. This is likely to be communicated in clinical situations through direct or indirect communication, including words, tone of voice, emotional responsiveness or the lack of it, body language, etc. The other end of the spectrum is demarcated by vicarious resilience, increased compassion and satisfaction from the work. While the former may convey lack of interest, detachment and a sense of hopelessness and despair, the latter communicates genuine interest, hope and belief that regeneration and thriving is possible.

All professionals have a duty to safeguard themselves from the emotional aspect of the work and to protect survivors from re-traumatisation. They must ensure they present to work in an emotional state that is good enough, and if it is not, to take steps to address it. Without this, we risk traumatising patients further, with our thinking and language affected by our lack of emotional resources to process their trauma, failing to contain and support survivors in the way they deserve it. Continuing professional development and personal therapy for the therapist are cornerstones of providing a high-quality care. Reflective practice in its various forms is about being in contact with the emotional aspects of the work described above and finding the meaning of this experience with another. Examples include supervision, staff support, case discussion and Balint groups. In those confidential experiential safe spaces, the raw painful and difficult emotions experienced by the clinician in the consultation can be put into words and thought about, deepening the clinical understanding of the work, and enhancing creativity.

## The wider context

Silence about the abuse and language used in the wider world when the silence is broken can be equally traumatising. While there is a scattering of more balanced and thoughtful media discussions and programmes, much is to be done. Institutional abuse might feel easier to talk and hear about as it can appear faceless. Abuse that occurs at home, perpetrated by a family member or someone from the family's social circle, is more difficult to think and talk about, to understand and find the words for. One can feel pulled towards minimising and marginalising it, finding it embarrassing or shameful to talk about, pushing it away from one's mind, forgetting about it and, as a result, silencing the need to know about it. In that small way, we might all be contributing to the collective silence of the world turning a blind eye, which enables abuse and its aftermath to go on.

Sensationalist headlines with terms such as "child sex abuse," rather than "child sexual abuse," are likely to be re-traumatising, bringing back a sense of secrecy and shame, increasing the cumulative effect of abuse. The language around sexual abuse in childhood can become problematic too, with words like victim, survivor or person living with the experience of child sexual abuse all being used, often without understanding they are hugely personal and therefore not interchangeable. It is therefore good practice to ask a person

how they see themselves in relation to their experiences. Researchers, clinicians, policy makers and the survivors' movement are all influential in shaping the language linked to child sexual abuse. It is worth noticing that with time, all words can become labels, with some terms left behind when they are no longer trusted and replaced by the new ones. An example of this would be "historic child sexual abuse" being replaced with "non-recent child sexual abuse," with the former becoming unusable, not reflecting current thinking, proving lack of knowledge in this area, or even being experienced as wounding. This might be understood as words collapsing into symbolic equation in the aftermath of abuse, the past and present becoming the same and anything reminiscent of the trauma becoming the trauma itself. When it comes to accounts of abuse and its aftermath in the public domain, while some progress has been made, some still portray people with experience of childhood sexual abuse in unrealistic ways, portraying it as irreparable or idealising their recovery in a way that can feel unobtainable to others, potentially increasing their sense of failure or shame.

The Independent Inquiry into Child Sexual Abuse, which took seven and a half years to complete, initiated public discourse around child abuse in a brave and thoughtful way. It published its final report in October 2022. More than 7,300 victims and survivors responded to the call to engage with the Inquiry, with 6,200 of them sharing their experiences in the Truth Project, clearly wanting to be heard and listened to. The Inquiry can be seen as the first time the impact of child sexual abuse was discussed openly on a national stage, creating a space where it was possible to hear from survivors and making recommendations for the future. In July 2023, British Psychological Society published Guidance (Rouf & Waites 2023) on responding to disclosure on non-recent (historic) child sexual abuse and the Royal college of Psychiatrists is expected to publish its Position Statement on Non-Recent Child Sexual Abuse in 2025. While these documents are commendable and act as a foundation, it is vital they don't end up staying as documents, without further action. It is up to us to keep them alive by having conversations about this painful subject. We all have a moral obligation to want to know, speak about and contribute to the process of closing the gap between the private suffering and public awareness of child sexual abuse. It is the only way to address the trauma and injustice of it, so that we can all in our small way help to heal and prevent it.

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# 9 Silent, silenced, and silencing

## Understanding society's silences, how survivors are silenced, and why some survivors remain silent through memoirs of child sexual abuse

*William Tantam*

### Introduction

This chapter examines five memoirs of child sexual abuse published between 2018 and 2020 to consider the meanings of silences in relation to sexual abuse. Through looking at why survivors might choose to be silent, how they might be forced to remain silent, and how society silences sexual abuse, this chapter considers silence as a productive analytic lens through which to understand factors that prevent survivors from disclosing sexual abuse and the social stigmatisation of speaking about sexual abuse.

Although it is common to generalise the silencing of survivors and child sexual abuse as caused by shame and stigma, it is important for researchers, practitioners, and activists to begin to engage with the heterogeneity of silences and how these emerge. Survivors may choose to remain silent for many different reasons, just as the processes and experiences of being silenced are multiple and different. Remaining silent or refusing to speak can constitute a form of agency and taking control over what is said to whom, when, and how. The power to control our silences is central to personal, social, and political lives. At the same time, having one's voice denied or being made to feel afraid for speaking out about experiences consistently denies the agency of survivors and opportunities for justice and support.

This chapter draws out three themes emerging from memoirs of child sexual abuse in order to contribute to disentangling the meanings of silence and silencing: the speaking body; the disbelieving or rejection of survivors' experiences; and the inherited cultures of silence around sexual abuse. In these memoirs, survivors' bodies and actions spoke loudly through trauma responses and also through changes in behaviour but frequently were not listened to or those in positions of authority did not take opportunities to follow up. Where people did notice or suspect, there was sexual abuse they refused to hear or intervene. Within this maelstrom of placing responsibility on survivors to disclose something that people are deeply enculturated not to talk about, and with many survivors having experiences of disclosures –

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in body, action, or words – ignored or acted upon poorly, silence emerges in a new light. Silence is not a lack of voice but a refusal by those in authority to listen.

## Methodology

This chapter engages with five recent memoirs of child sexual abuse in order to analyse the emergence of silences surrounding abuse. The five memoirs were all published between 2018 and 2020 and include memoirs written by both men and women though with a skew towards female memoirists given that available data indicates that women are more likely to have experienced child sexual abuse (ONS 2020). All of the authors were sexually abused in England, and all of the memoirs were written reflecting on these experiences as adults. This was not a systematic approach and engaging with a much wider range of memoirs would be helpful to situate the particular insights offered in this chapter. Nonetheless, focusing on five memoirs offers the opportunity to engage with them in greater depth, and is helpful in attempting to understand 'silence' in its multiple nuanced, covert, and powerful emergences. Silences demand that we listen more closely, requiring us to hear past the noise into individuals' experiences.

Engaging with memoirs also serves to recognise survivors as capable authors of their own experiences. 'Listening' to memoirs can challenge power imbalances of interview formats and recognise the agency and ability of survivors to tell experiences in their own terms, and in their own ways. Zwerdling writes of the unique and fluid format of the memoir which gives them an indeterminate quality, saying: "it is not the anonymous story, nor the public record, but rather the idiosyncratic, private, anomalous version of an individual history, itself often inconsistent and full of unpredictable turns" (Zwerdling 2016: 2). Rather than requiring that survivors tell (and, in many cases, re-tell) their experiences to a researcher before becoming validated as research data, recognising memoirs as the truthful telling of experiences goes some way towards countering the epistemic injustice often inflicted on survivors (Fricker 2007). Engaging with memoirs recognises the agency of survivors' voices and is not predicated on what the interviewer is able 'extract' from the research participant.

This research aimed to explore the following questions:

i What factors contribute to silencing victims and survivors of child sexual abuse?
ii How do silences emerge around child sexual abuse, and what do these reveal about the impacts of stigmatisation on opportunities for disclosures?
iii How does the silencing of individual experiences of child sexual abuse relate to the broader silencing of sexual abuse throughout UK society?

**Theorising silence**

Silences hold particular importance to experiences of trauma. In Scarry's work on representations and experiences of torture, she writes that "pain does not simply resist language but actively destroys it" (Scarry 1985: 4). Kidron (2009) worked with the children of Holocaust survivors and particularly engaged with those whose parents rarely, if ever, spoke about the Holocaust itself. In spite of these silences, parents would 'talk' of their experiences through mundane, everyday rituals: a spoon in the cutlery drawer brought from the concentration camp; children's toys kept safely in a drawer; and shoes kept in easy reach of the bed (Kidron 2009). One review of anthropological literature relating to trauma and language argued that: "Brutal acts remind us of our species at its basest. The demise of language, or even the gaze, as forms of communication blurs the boundaries of the human and the inhuman. This inhumanity is nevertheless recognized but we may require a vocabulary outside the realm of ordinary language" (Pillen 2016: 99). Warin and Dennis (2009) worked with Persian women migrants in Australia who had been exiled from Iran after the Islamic Revolution. When working with these women, Warin and Dennis found that "when questions were asked about the circumstances of leaving Iran, conversations turned sharply to the weather or silences hung between us" (2009: 106). By contrast, as the researchers learned to 'listen' to non-verbal bodies and activities, they found that:

> the processes of remembering and forgetting trauma […] found presence in and through the habitual projects and processual activities of these women's daily lives.
>
> (2009: 113)

Researching silence in experiences of trauma therefore requires a different attunement and orientation to listening that goes beyond words and discourse. In Dragojlovic and Samuels' unpicking of opportunities for social scientists in engaging with silences, they write: "tracing silences demands that we raise more questions, invoke more possibilities and start considering silences as a presence 'on a continuum between articulation and non-articulation'" (2021: 418).

Although silence is often equated with absence, theorists have explored the multiple ways that silences 'speak'. Bruneau refers to overly simplistic understandings of silence and utterance (often raised as the counterpoint to silence) as similar to the relationship between ink and paper: "silence is to speech as the white of this paper is to print" (1973: 18). Such an approach views silence as an absent background against which speech stands out. This understanding of silence as "merely the absence of speech" (Saville-Troike 2003: 117) misses opportunities for engaging with the multiple meanings and analytic potentials of silences. It is the nuance and ambivalence to producing, sustaining, and interpreting silences that makes them so crucial and central

to communicative practices. Far from simply a backdrop, silences actively communicate.

Once the simplistic reading of silence as absence has been discarded, in its place it is helpful to consider the particular meanings and values of silence as a communicative tool. Jaworski goes so far as to develop the concept of "silence as a metaphor for communication" which enables us to view silence as a "unifying concept for tackling diverse communicative phenomena: linguistic, discoursal, literary, social, cultural, spiritual and metacommunicative" (Jaworski 1992: 3). Silence is therefore not simplistic but can convey different meanings and operate differently in different contexts. Complementarily, Scott argues that "silence speaks volumes: by saying nothing, a voice sounds all the more audibly" (Scott 2018: 14) and indeed we can "make our feelings known by saying nothing" (Scott 2018: 13). Silence thus has "many faces" (Jaworski 1992: 24) and its meaning and impact vary considerably over contexts and times. Silence carries communicative weight and is loaded with meaning and interpretive potential. Such potential extends beyond the capacity to be filled with words (as in the blank page metaphor) and instead suggests that silences might be better understood through different lenses.

Silence is not monolithic and can carry different meanings depending on audience, context, and speaker. Indeed, silence can draw positive outcomes for example enabling and encouraging someone to talk further or allowing someone the space to consider their words and responses. Silences might be defined by their length of time, as in the difference between a pause for breath or silence in an exam room. They can also be considered in terms of the interlocutors and context, such as the power differentials of judge and courtroom participant in contrast to between two friends in conversation. Context is similarly important, and we are highly attuned to those subjects that can be spoken about in different spaces at particular times, and when we are expected to remain silent. Silences, therefore, are far from impartial in producing social relationships and even a cursory reflection indicates how sensitive we are to knowing how and when we are expected to remain silent.

One consistent theme to emerge in the conceptualisation of silence is that it is fundamentally coproduced: "It only takes one person to produce speech, but it requires the cooperation of all to produce silence" (Pittenger, Hockett, and Danehy 1960: 88, quoted in Jaworski 1992: 18). The social production of silence is fundamental to engaging with its emergence and continued salience. The responsibility for producing silence and sustaining it does not reside in individuals but, rather, is diffuse and shared. This suggests that the delay for survivors in disclosing sexual abuse renders those around them complicit in this silencing either through directly silencing the survivor, or not facilitating environments in which the survivor feels supported to disclose. Complementarily, refusing to speak about the sexual abuse can itself constitute a form of agency for some survivors and indicates that they also have some power in these dynamics to decide when and if to break the silence.

Analysts of silence have pointed to the importance for children to learn when to keep silent, and what not to talk about (Jaworski 1992: 392). Dragojlovic and Samuels write that "silence is crucial to our social world" (2021: 417). Jaworski argues that "one of the most important uses of silence in every society is maintenance of a taboo" (2021: 392). Kidron talks of the silences around trauma as "a knowing without words" (Kidron 2009: 6). Silences surrounding child sexual abuse therefore entail unpicking the silencing of individual survivors and also the wider intergenerational transmission of knowing to keep silent about this highly tabooed topic.

Silence therefore offers a productive lens through which to understand the stigmatisation of survivors' experiences as well as the social (re)production of silences around child sexual abuse more broadly. In the following sections, I focus on the multiple ways that memoir writers have grappled with silences and silencing in order to view the close imbrication of child sexual abuse experiences with the emergence of silences and to understand more closely as to why experiences of sexual abuse remain unheard. The following section gives details of each of the five memoirs and draws out key themes that emerge in each of the works.

## Memoirs

These five memoirs offer insights into different elements of survivors' experiences. Four of the five were sexually abused by fathers or by mother's partners, which will certainly inflect the available insights. Also, three of the five (Bernard, Eveleigh, and Tucker) explicitly produced their memoirs as a product of, or alongside, counselling. This will also shape how these survivors reflect on the emergence of silences, given that they have both disclosed the sexual abuse and have taken steps to understand its impacts in their lives. One area that this chapter struggles to engage with is the continuing silence produced around those survivors who have not disclosed, and the sexual abuse that is not being spoken about.

*Paper Cuts* by Stephen Bernard was published in 2018 and details his experiences of being sexually abused by Canon T.D. Fogarty, a Catholic priest. The sexual abuse began at the age of 12. Bernard disclosed the sexual abuse to both the police and the church after Canon Fogarty had a major stroke, although he also details disclosures that were disbelieved and missed opportunities for the sexual abuse to be discovered. Bernard wrote the memoir in response to working with a therapist. The memoir is poetic, searing, and powerful, and gestures towards the limitations of written language in response to events that are both horrific and mundane. In his consideration of the memoir format in relation to survivor agency, Bernard writes:

> Biography is such a strange genre. It is often tacitly assumed that the subject retains full agency over the events of their life. What I have presented is a form of biography where the subject loses agency in a

> most violent way, and yet the act of writing allows him to take some of the power back. I see the piece as partly a comment on biography. One could describe it as postmodern, in that only the biography creates the agency for the subject of the biography.
>
> (Bernard 2018: 170–171)

This passage emphasises the memoir's potential to contribute to the process of reclaiming power in the act of writing and editing, and the memoir itself constitutes a demonstration of the reclamation of survivor agency once written.

Bernard's attentiveness to silences draws attention to the multifaceted ways that silences become inscribed in experiences of sexual abuse. He documents the ways in which the perpetrator silenced him, and of how when Bernard threatened to disclose the sexual abuse he was sent to a psychologist who "silenced the young men the Church brought to him" (Bernard 2018: 70). Bernard writes of the impacts of not feeling able to disclose the sexual abuse and having his attempts to disclose diminished or disbelieved, saying that "the truth's destructiveness was a cancer in my being" (2018: 145). This vividly indicates the physical toll of maintaining silence in spite of the need to speak out.

At the same time, control over silences emerge as acts of power and part of Bernard's reclaiming of his own agency. He says that in his memoir "almost all voices are silenced, to permit me to speak. The rabble of conversation dies and a simple truth speaks out" (Bernard 2018: 43). Choosing to silence others therefore becomes a way for him to find his voice and to enable the truth to emerge. Silence, in this way, is actually presented as a 'rabble of conversation': as noise silencing the truth of sexual abuse. Similarly, Bernard relates that as he proceeded with counselling and learning to cope with the impacts of the sexual abuse, he felt that he was "learning not only to speak, but also to hear" (Bernard 2018: 148). Hearing and speaking are therefore deeply entwined. Silence is implicit to listening, it can be learning to recognise cues to speak, or waiting to hear what someone else has to say. It can also give information about the relational aspects of the dialogue and provide opportunities in which to speak. For Bernard, silence, conversation, speech, and sound commingle and might come to take on new meanings – babbles as silencing, and hearing as a process of coming to voice.

Bernard's experiences of voice, power, and individual agency are further reflected in his processes of disclosing the sexual abuse. The perpetrator, Fogarty, lost his movement and his voice while in the process of dying. Bernard felt that "silenced, I could not accuse a dumb man before the courts" (2018: 137). By acknowledging the powerlessness of being rendered dumb, Bernard refuses to replicate the power dynamics of denying someone agency whose voice has been denied that he experienced when he was sexually abused. Remaining silent in this case in part indicated his own moral compass surrounding voice and agency that he himself was denied. Reflecting on these

silences, Bernard states: "what remains unsaid says a lot about us, as individuals" (Bernard 2018: 114). Staying silent rather than rendering speech enables society to avoid having to confront the difficult realities of child sexual abuse.

Sheila Tucker's *Rag Dolls and Rage* (2019) is an intimate memoir of Tucker's childhood and adolescence, and sexual abuse perpetrated by Terry, her mother's partner. Tucker wrote the memoir alongside therapy sessions and chapters are interspersed with experiences of her upbringing and exploration of these experiences with her therapist. Tucker was sexually abused when she was four, and also suffered physical, verbal, and emotional abuse. Although Tucker does not know the extent of her family's knowledge of the abuse and its multiple forms at the time, she knows that her grandparents were aware of the physical and emotional abuse and were likely also aware of the sexual abuse. She says that growing up in Manchester in the 1960s "people were just expected to be stoic and get on with it and this included children. Pick yourself up, dust yourself off and continue" (2019: 56).

Silencing and silences emerge repeatedly in the memoir, and the family's and wider community's silences around the physical and sexual abuse feel palpable. Tucker relates being directly threatened to stay quiet: "He needn't have worried. After his demands for silence and his threats, I was too frightened to tell [her mother] anyway" (Tucker 2019: 35). In spite of being threatened not to verbalise the experiences, she accidentally drew a sexualised drawing of Father Christmas when still a young girl at school. After being shouted at by her teacher, she was taken to see the much more understanding head teacher, who asked: "Why did you draw Father Christmas like this?" to which Tucker says she "was silent, thumb in mouth" (Tucker 2019: 57). While survivors can remain silent through not saying anything, nonetheless it is often apparent that bodies and behaviours can be speaking and shouting in place of words.

Gloria Eveleigh published her memoir, *One Small Word*, in 2018. In contrast to the four other memoirs used in this paper, Eveleigh's is a fictionalised memoir that draws upon Eveleigh's own experiences and develops them through the view of 'Frankie'. Frankie was sexually abused by her father from the age of four and lasted until she was 14. Eveleigh's catalyst to publish the memoir, as with others, was engaging with a supportive therapist while she was training as a social worker. Through the character of Frankie, Eveleigh writes:

> My father played with my head and took away my childhood, my innocence. That bit never heals. It just festers and festers. It amounts to a life sentence. […] I feel like my father set me up to attract abusers for the rest of my life
>
> (2018: 47)

The memoir is both a close look at the dynamics of her upbringing, and a careful reflection on the long-term impacts of sexual abuse.

Following the sexual abuse, Eveleigh considers the challenges facing her if she were to disclose the abuse:

> she wonders how much longer she can cope with this life. Can it get worse? Today, the pain was as much as she could take. What can she do? If she tells anyone, they won't believe her. If they do believe her, will her father get locked away? Will she and her sisters and brother have to live in an orphanage? Will she be the cause of breaking up her family? […] By morning she knows that she must keep her secret no matter what it costs her.
>
> (Eveleigh 2018: 88)

These candid reflections indicate the pressures that can discourage survivors from disclosing, particularly when the sexual abuse is perpetrated by a family member.

Eveleigh finds a way to stop the sexual abuse through challenging her father, however the seeming ease with which she prevents future sexual abuse becomes itself a form of self-critique. Eveleigh writes:

> 'I somehow plucked up all my courage and quietly but assertively said 'No'. I was shaking like a leaf both outside and in but I'd managed to say it. I was relieved that he didn't immediately fly into a rage. In fact, he didn't argue or get angry at all. From that moment on he never touched me again. One small word was all it took.'
>
> The silence in the room is palpable. Frankie's face is burning. She cannot lift her eyes. She sees her intertwined fingers fidgeting busily in her lap.
>
> The counsellor's voice breaks the silence, 'Frankie.' […]
>
> Shards of sound seem to bounce from wall to wall. […] The voices in her head start to whisper guilt. The whisper increases in volume until she is forced to cover her ears and screw up her eyes to protect herself. She begins to panic and hyperventilate.
>
> 'Frankie, stop!' says the loud, firm voice of the counsellor.
>
> Silence returns as the voices in her head cease.
>
> (Eveleigh 2018: 96–97)

Silence in this passage emerges as a quietening of Eveleigh's internal dialogue. Indeed, looking more closely it seems that speaking out loud leads to the silencing of the 'voices in her head'. The 'one small word' after which the memoir is named is the 'No' Eveleigh manages to say which puts an end to the sexual abuse. While this 'no' ends the sexual abuse, it by no means resolves the impacts and leads her to a sense of shame and feelings of complicity.

Alan Davies's memoir, *Just Ignore Him* published in 2020, begins with him driving along country lanes in Essex, unsure of what to do with a collection of what he believes to be (though the Crown Prosecution later dispute are) images of child sexual abuse that his father printed out. The memoir weaves between observations and reflections on his everyday life in the present and recollections of the death of his mother, difficulties at school, and the sexual and emotional abuse perpetrated by his father. He explains the purpose of the memoir: "I have set out to tell you the things you don't know about me, in the hope that, one day perhaps, you will feel able to tell someone what they don't know about you" (2020: 272). In this way, the memoir is presented as an encouragement to greater honesty, but also as a form of social pact in which the sharing of one person's trauma might generate the sharing of other people's trauma. In this sense, it is a promulgation not to maintain – which is tantamount to tacitly enforcing – the silence that surrounds issues such as child sexual abuse.

'Silence' and 'silences' emerge repeatedly throughout Davies' memoir. He often seeks refuge in being alone, and finds experiences of rejection by peers, siblings, and his father, reassuring. As he seeks to unearth and analyse details of the sexual abuse and its impacts, silences emerge repeatedly. He talks about the "unnatural silence in the room" as a component of the proof of his father's "sexual gratification" (2020: 249). Silence here emerges as an active presence in the production of the sexual abuse itself, it is 'unnatural' and generates a knowledge in Davies that what his father is doing is a form of abuse. His father also imposes silence, saying to him: "This is our special cuddle. You must never tell anyone about this cuddle," (2020: 34). His father therefore actively silences.

Alongside these forms of silencing that coalesce around the act itself, Davies also recounts how they are enculturated into individuals in ways that they do not always recognise. He writes:

> Somehow I knew not to say a word, to collude. I can be trusted with a confidence to this day. I never tell.
>
> I could keep this secret because I lacked the power to force news of it out of my person. Words to describe it adequately, or plausibly, were beyond me. I didn't want to tell anyway, not because I was consciously frightened, or even concerned that I'd be disbelieved, more that this new secrecy had gone very deep inside me, taken root so far within my being that to eject it was to risk self-destruction by somehow turning myself inside out and never being able to go back to where I was before. It felt, still feels, like a risk
>
> (2020: 35)

In this extract, silence becomes coterminous with remaining whole while vocalising the sexual abuse is to 'risk self-destruction'. Silence is therefore

an act of self-preservation and a way for Davies to manage the risks that take place along with disclosures.

In this way, it is possible to understand Davies' inability (not in the sense of a deficiency, but rather not being equipped) to disclose the sexual abuse. These structures are presented as engrained, that to narrate them risks self-destruction. From this perspective, Davies' innate knowledge "not to say a word, to collude" (2020: 35) was both a collusion with his father, but also a collusion with the social structures that silence victims and survivors. The production of these silences is therefore structured into victims and survivors and, also, structuring insofar as they find themselves unable to disclose.

Davies writes:

> I didn't speak up because the padlock in my mind was locked and I did not have the key. I did not have the power, I hadn't taken it, and it was still wielded over me in the form of a lifelong knot of silence.
>
> (2020: 78)

This 'padlock' in his mind was the process of a silence-production, produced from the 'unthinkability' of child sexual abuse in the cultural logic into which he was socialised.

*Coming Undone* was published by Terri White in 2020. The memoir begins with her institutionalisation in a mental health facility in New York following a suicide attempt, before returning to relate her experiences growing up. Her birth father was physically and emotionally abusive to White, her mother, and her siblings. After her birth father left, her mother had multiple husbands, boyfriends, and relationships, two of whom perpetrated sexual abuse against White. She concludes the memoir recounting a dream:

> The buildings, the avenues, the windows are black. Silence surrounds me. I'm screaming at the sky but no noise leaves my mouth; vapours that leave me collect amongst the clouds, filling the lid over my head. I open my eyes. It was just a dream. And now it's over.
>
> (White 2020: 247)

White's writing is visceral and powerful, and the turns of phrase she adopts intertwine the poetic and the violent.

Silence emerges here as something ominous, as an inability to scream, a voicelessness in a dystopian city. At the same time, freed of words the screamed silence becomes a form of release, a coalescence combining all of the trauma White experienced. Much of White's memoir reads as being caught in an impossible oxymoron, as she puts it: "This can't be my life. I won't survive it" (2020: 29).

White's first experience of sexual abuse at the age of five ended when she disclosed the sexual abuse. She recounts:

> I told someone who told someone else […] 'You fucked your "dad",' they said to me at school when my mother's boyfriend's name, our address, my age, ended up in the paper. I found it hard to disagree. The stain seeped inside me, thickened my blood, turned my bones to charcoal. It was part of me now. I'd never be free. He was me and I was him (2020: 57)

This experience reveals the social proscriptions against disclosing child sexual abuse. Not yet having been socialised into the silences of sexual abuse, White's disclosure met with social recrimination. Moreover, the experience points to the challenges raised when there is a focus on the perpetrator of sexual abuse (the 'boyfriend's name' but '[her] address, and [her] age); that the needs and requirements of victims and survivors are overlooked and can cause them harm.

**Analysis**

While each of the memoirs draws on very different experiences and contexts, themes nonetheless emerge regarding silences and disclosures. In this section, I am going to consider three themes in particular: the speaking body; refusals to listen; and enculturated silencing. 'The speaking body' concerns those experiences in which survivors had chosen not to speak verbally about the sexual abuse, but their bodies and behaviours communicated that something was not right. 'Refusals to listen' relates the multiple experiences related by the survivors of trying to disclose the sexual abuse but not being heard, whether through having their experiences diminished or not responded to appropriately. 'Enculturated silencing' deals with the experiences survivors relate of *knowing* not to speak about the sexual abuse without having been told. This final theme suggests that the silencing of sexual abuse occurs without people having been told not to talk about it: an intergenerational reproduction of stigmatisation that is pervasive and entrenched.

The speaking body relates to the examples of bodies which refuse to remain silent even when the survivor does not speak. Prior to disclosing the sexual abuse, Bernard medicated with ketamine alongside non-fatal suicide attempts. White was institutionalised after a significant mental health episode. Tucker instinctively ran to hide when hearing particular sounds, and shook uncontrollably when triggered by particular sensations. Eveleigh related how 'Frankie' had a series of destructive relationships with men and moments of dissociation. Davies reflects on how his behaviour and relationship to school were considerably impacted by the sexual abuse perpetrated by his father. In all of these instances, it seems clear that while each of these survivors did not

talk about the sexual abuse out loud, nonetheless their bodies and actions communicated on their behalf.

Without the necessary environments and support necessary for survivors to feel able and willing to disclose, the sexual abuse itself inscribes in the body. Each of the memoirs relates in different ways the deep embedding of trauma within the individual of the survivor. These are some of the most poetic, challenging, and searching elements of the memoirs as the survivors interrogate the ways that the sexual abuse contributed to shaping their being. White says that "the stain seeped inside me, thickened my blood, turned my bones to charcoal" (2020: 57). Davies describes that the sexual abuse had "taken root […] within my being" (Davies 2020: 35), and Bernard relates that not disclosing the sexual abuse meant that it became "a cancer in my being" (Bernard 2018: 145). These descriptions of roots, staining, blood, charcoal, and cancer convey the sense that the sexual abuse gets to the biological origins of life – the fabric of human beings and living creatures. In the way that they describe the workings of trauma and its impacts, the survivors did not speak about the sexual abuse yet the abuse nonetheless inscribed itself in their bodies and spoke 'through' them.

That trauma inscribes on the body is by no means a new finding, and indeed, there is a wide corpus of work detailing how trauma is held within the body and how it emerges (Herman 2015; Van der Kolk 2015). What is interesting here is that remaining silent prepares the ground for the trauma to inscribe. It is precisely the silencing of the sexual abuse that enables the bodily inscriptions to take hold, and the point at which society more broadly might facilitate better responses. Further, recognising that the traumatised body itself appears to act autonomously of the exhortation (from individuals or social contexts) to remain silent further entails recognising the complicity of society in refusing to listen appropriately. These memoirs demonstrate that while survivors did not speak about the sexual abuse out loud, there were many people who were confronted with survivors' bodies that were speaking (through changes in behaviour at school, panic and triggers, significant mental health episodes) yet refused to hear.

The second theme concerns the refusal of wider society to appropriately listen to survivors. While the topic of disclosures is often phrased as an inability of survivors, 'they were unable to disclose until…', 'it took them x years to disclose', this continues to locate the responsibility for the sexual abuse and its impacts with the survivors themselves. Instead, having already failed to appropriately protect the child at the time of the sexual abuse, society should take responsibility for facilitating the most supportive and receptive environments through which survivors might feel empowered to share a disclosure.

All five memoirs researched for this paper detail a number of attempts to disclose formally and informally, yet many met with poor responses or no meaningful response taken. Bernard relates being seen by another member of staff at school receiving money from the religious figure who sexually abused him. Tucker talks of running away to next door neighbours who

literally push her back out of the house as they refuse to listen to what has happened to her. When 'Frankie' draws a sexualised version of Father Christmas, the teacher calls her "a disgusting little horror" (Eveleigh 2018: 57). 'Frankie' is also examined by a doctor in preparation for the removal of an appendix, and he notices injuries to her thighs and groin, but there is no follow-up. White's disclosure leads to her family's house and details of the sexual abuse being printed in the local newspaper, leading to bullying at school. Each of these individual examples collectively lead to a broader understanding of the ways that society refuses to appropriately listen to survivors. From being literally pushed out of someone's house to prevent being told an uncomfortable truth, to being verbally abused, to having their family shamed and being name called at school, these institutions which come to represent society – neighbours, teachers, and the media in these examples – demonstrate that even when survivors speak, society reinforces the impression that it does not want to know or, when it does, will shame the survivor. The final theme develops society's complicity in silencing survivors further through paying attention to the enculturation of silence within children and young people.

Each of the memoirs considers how the survivor implicitly learned not to speak about the sexual abuse. These are not examples of being told not to speak about it, nor about having heard other people's experiences of disclosing. Instead, each of these examples points towards survivors having been unconsciously enculturated to know not to speak about sexual abuse. Tucker writes that "although I was only four, I intuitively knew what I was doing was very wrong" (2019: 26) and that she "simply couldn't put any of it into words." (2019: 31). Bernard knew that "the truth is something […] unwelcome and offensive, toxic." (Bernard 2020: 70). At the age of 10, 'Frankie' stays awake after an experience of sexual abuse and "by morning she knows that she must keep her secret no matter what it costs her" (Eveleigh 2018: 88). Davies writes that although he was not told to stay quiet, "somehow I knew not to say a word" (Davies 2020: 35). White remembers that: "I can't remember if he instructed me not to tell but he didn't need to. I felt ashamed, complicit, smeared with him and knew that I couldn't tell anyone about that night ever" (2020: 63). Each of these survivors' experiences indicate that even from a very young age they knew that they were expected not to talk about the sexual abuse.

The pervasiveness of silence around sexual abuse is therefore deeply engrained in UK culture, so much that even very young children know not to talk about it. This moves beyond the threats not to disclose, or the institutional barriers to disclosing, but to the enculturated understanding not to speak. Zerubavel argues that "the larger the number of participants in the conspiracy, the more prohibitive the silence" (2010: 38), and the silencing of sexual abuse implicates all members of a society in its conspiracies of silence.

## Conclusions

This research indicates that silence might productively be approached as elusive and multifaceted. These memoirs indicate that silence is not the absence of noise, lack of speaking, or communicatively empty. The experiences of survivors related in these memoirs clearly show that they were never silent in the sense of not communicating that something was wrong. Some survivors spoke about abuse but were not listened to. Survivors' bodies and behaviours clearly conveyed that something was occurring, but those around them – even when they openly recognised that they noticed the change – did not want to ask about what was happening. These observations suggest that there is not a silence around child sexual abuse but instead a reluctance to listen.

This understanding of silence reflects prevailing narratives surrounding child sexual abuse, and in particular, the repetition of claims that survivors did not speak out at the time of the sexual abuse. The reading of silence as an absence of disclosure misrepresents the power of silence to speak and the very silence of some survivors might itself form both a type of agency and also, importantly, its own form of communication.

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## Section IV

# Clinical perspectives

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# 10 Shame and neglect

*Sara Scott*

## Introduction

Earlier this year, I was running an analytic group for survivors of child sexual abuse and a member described being beaten, starved and left for many days on their own when they were very young. The adult asked to keep an eye on them, visited their home regularly and sexually abused them again and again. The question then arose which I have heard in almost every case I have encountered.

"What was it about me that made this happen?" I struggled to find the words. It felt nothing I could say would help and I feared sounding trite in my response or if responding at all would feel like I was closing them down. The group seemed to hold its breath until another group member leaned forward and described how they always believed what happened was their fault that they were somehow defective and deserved it, and in that moment, a connection linked to sharing the deepest pain was made and something unbearable was held.

At times, we must give up being the expert. No training however useful prepares and protects the clinician from the horror of the accounts of rape and physical attacks on small children and the terror which is often re-stimulated in the consulting room. Our role is to try and stay open to the experience being shared and not enact through our personal and institutional responses the wish to turn away. This is not easy because being in a state of confusion and not knowing quite how to respond can feel shameful for us as therapists.

Shame tends to be the most dominant emotion our patients experience. It is also frequently misunderstood, minimised and more prevalent in our clinical work than is often acknowledged. It is with this in mind that at the Tavistock Trauma Service, we have tried to develop a way of working informed by psychoanalytic thinking but adapted to help ameliorate shame rather than provoke it.

So often, it is shame that prevents people from connecting with one another, and so often, that shame is not recognised by others. As professionals, we can resort to seeing people as treatment-resistant, or destructive, if they struggle to engage with what we offer. At times when services are under

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pressure to see as many patients as possible, we can lose sight of the enormity of what we are asking our patients to do which broadly speaking is to face feelings which they have spent most of their lives trying to defend themselves against. If shame is not worked with and interpreted repeatedly, it gets turned into vicious self-blame which leads survivors to withdraw and hide.

Sexual abuse creates disgust in the mind of the survivor and the therapist, and there can be a wish by the clinician to both invite a disclosure and then sometimes an unconscious wish to move away from it. Many survivors have the experience of not being believed, and if they sense a reluctance in the clinician to engage with something that feels so unbearable, it can be interpreted as a rejection, yet another abandonment which they both expect and dread.

## Differentiating shame from other emotions

I have drawn on a previous paper (Scott, 2011) to inform this piece but have updated it to understand the experience of survivors of non-recent childhood sexual abuse. If we are to understand shame more fully, we need to set it alongside other emotions that are closely related. Shame is often confused with guilt. Psychoanalysis has in the past has been a tendency to focus on guilt rather than shame. Goldberg states that there can be an "overemphasis on guilt…… that compels the Analyst to discuss more superficial and often irrelevant material rather than the profound concerns we harbour about our own self-worth" (Goldberg, 1988, p. 342).

Morrison describes guilt as a transgression, followed by a sense of regret and a fear of punishment (Miller, 1985, p. 47). Piers and Singer characterise guilt as a feeling "one has violated some rule of conduct to which one attaches value" (Miller, 1985, p. 46). Guilt usually follows an act of will where there has been the possibility to take another form of action and there is a wish for reparation. Shame and guilt can be experienced together, two different responses to one situation. One can feel guilty about something one has done and fear reprisals and simultaneously feel shame because it has confirmed a negative view of oneself. Schrecter suggests that one of the goals of psychoanalysis is forgiveness of the self by the superego (Morrison, 1983, p. 303) which focusses on the relief of guilt. With shame, punishment is not the key anxiety, but the fear of being abandoned and rejected. "There is a pride in guilt". A guilty person can escape continued feelings by confessing and accepting punishment. In shame, there is no sense of pride or power (Goldberg, 1988, p. 341).

Miller describes shame as the experience of "shrinking away from others and pulling inward and downward". She believes that what is called shame is often embarrassment. She distinguishes the two by describing embarrassment as the wish to make oneself disappear when an aspect of the self is unexpectedly revealed. It is a transitory experience linked to an unexpected exposure, rather than the presence of a consistent negative self-image. Humiliation is

similar. It does not demand an ingrained negative idea about oneself, but it is a response to having control of one's actions taken away and put into the abusive hands of others (Miller, 1985, pp. 43–44). It could be argued that all these feelings can overlap, so we feel guilt, embarrassment, and shame all at the same time, and yet they remain distinct emotional states (Scott, 2011).

**Shame as a social phenomenon**

On a societal level, one can describe a key function of shame "is to encourage conformity to the prevailing group and culture" (Mollon, 2002, p. 139). One of our basic needs is to feel we belong to something larger than ourselves. To belong, we need to be accepted by others. To be accepted, we need to comply with a social order that accords us respect or shame, depending on our willingness or capacity to fulfil our designated roles. Gilligan argues that shame is the absence of self-love. Without self-love, we have no pride. Pride is linked to our sense of self-respect which is dependent on the respect we gain from others. Gilligan examines how patriarchal societies create social structures "In which men and women are each assigned radically different social roles, each of which is governed by a code of honour in terms of which members of each sex are accorded honour or dishonour, pride or shame depending on whether or not they behave according to the moral obligations of their code" (Gilligan, 1996, p. 287).

The codes of honour to which Gilligan refers are endemic in our cultural norms and rooted in our unconscious. If we are shamed, this connection with others is broken and our place in the group is threatened.

Pride and shame are close to the surface in gender, race and class issues; the dictionary definition associates shame to being dishonoured. Honour is linked to rank, which suggests hierarchy and the distribution of power. Structural power becomes destructive when it is equated with the idea that those who hold power are better than others. Norman Elias writes "the superior people may make the least powerful people feel they lack virtue-that they are inferior in human terms" (Dalal, 1998, p. 120). Elias maintains that this power "drives stigmatisation into the psyche" (Dalal, 1998). A stigma is a mark of disgrace which becomes part of the persons, self-image deeply ingrained and primarily unconscious. If people are stigmatised, they have been shamed so powerfully by others that they believe they have no right to belong anywhere accorded value or worth (Dalal, 1998, p. 118). This means they become outsiders never quite able to belong anywhere always needing to keep themselves at a distance from others to prevent their secret and the feelings of inferiority attached to it being found out.

Societal issues around race, ethnicity, culture, sexual orientation, and gender identity mean that many people often grow up experiencing disregard, misunderstanding, and discrimination. Shame acts as a powerful form of social control which is used to invalidate other "less powerful people" experiences and stereotyping functions to allow the powerful to project fears

about their own inadequacies into another group and make them embody the shameful characteristics they wish to avoid (Scott, 2011).

### Understanding our own shame

To work with shame, we need to understand our own shame, how it can make us behave, and what triggers it. Unless we do, we risk projecting the shame that belongs to us into survivors, enacting a childhood dynamic which has been so damaging.

Shame has always been with us. It is evident in one of the seminal stories in Judaeo-Christian culture: the fall of man. When Adam and Eve eat the fruit from the tree of life, they experience themselves as naked for the first time and they feel shame. They are exposed to each other by seeing that they are different. They hide themselves away and are then banished from paradise.

Shame relies on our ability to tolerate both being separate and different from others, yet also connected to them. In doing so, we have to face the anxiety that if we really show ourselves, we may be cast out into the wilderness.

In classical psychoanalysis, shame tends to be subsumed by theories of guilt or relegated to the role of a secondary emotion, a response to another more profound feeling. As Freud developed his tripartite structural theory (Miller, 1985, p. 9), he became increasingly preoccupied with guilt. The superego became linked to the processing of guilt, and shame was understood as a reaction formation against sexual exhibitionism linked to anxiety about genital deficiency.

In the 1950s, Piers and Singer (Miller, 1985, p. 5) described shame as a tension between the ego and the ego ideal, a set of goals to which the ego aspires. They believed that shame relates to conscious and unconscious confrontations that a person makes with some real or imagined authority figure. Shame, in their view, tends to be about a dialogue between aspects of the self and a powerful other.

Gary Thrane widens the psychoanalytic frame and writes that shame is linked to "one's body, the physical self …yet…shame is peculiarly social. It seems closely related to facing others" (1979). It is linked to a set of internalised ideals from our parents. If we fail to reach these ideals, we risk "the loss of love and the loss of a feeling of unity" (Thrane, 1979, p. 334). Shame is generated by the gap between who we aspire to be and who we feel we are. It can provoke envy, rage and sadness and make us attack others and ourselves for what we feel we have been unable to achieve. Therapeutic work may be aimed at the "progressive alleviation of shame" (Levin, 1971, p. 335), but the paradoxical quality of shame suggests that however painful it is to experience, leading us to temporarily withdraw, we need to be in touch with it to become intimate with others. Thrane believed it was the protector of individuation as it helps us (if not too acute) to develop a realistic image of ourselves in relation to others (Thrane, 1979, p. 335). Shame if not too severe allows us to reassess ourselves and change and develop.

The need to conceal our shame is one of its most defining qualities. There is a sense that the failures of the self are felt more deeply because another observes them. Shame does not always require an external audience, as it links all of us with an internal critical eye that bears witness to our hidden defeats. Phil Mollon points out that shame arises from failures of "connection and understanding, particularly when one person's need is not recognised by another. If this lack of connection is profound, then the shame response is more severe" (2002). Shame is shaped by our relationship with authority. It develops in our earliest relationships and in part emerges as a product of the dynamics between parents and children. Miller describes two different developmental shame states. The first is irreducible shame, which I characterise as an early and profound feeling of rejected love in the child; the second is secondary shame an experience common to all of us but more severe and disabling if we have been repeatedly subjected to humiliation as a means of control (Scott 2011).

## Early neglect

To understand this further, I want to explore Fairbairn's ideas on the development of schizoid states to understand the genesis of primitive shame states and early emotional neglect. He captures the complex emotional experiences of babies in their attempts to relate to their parental figure and illustrates the profound developmental effects of early shame.

If we are to understand shame, we need to locate it within the timespan of human development. Significant research undertaken by Stern exploring how babies interact with their parents in the first few months of life identifies an interacting pattern of face-to-face communication between parents and babies, each mirroring each other's responses (Ayers, 2003, p. 41). If the carers remain impassive and do not engage with the infant, the baby becomes distressed (Mollon, 2002, p. 26). Brouek describes this as an early shame response (Brouek, 1991). Winnicott believed that as babies look into their mothers' faces, they see themselves (because it is the mother who keeps the baby in mind). If the mother is experienced as a stranger, then the baby feels it has become a stranger to itself. For most babies, this is a momentary experience, and for some, it is a consistent pattern.

Fairbairn writes "The greatest need of the child is to obtain conclusive evidence that he is genuinely loved by his parents, and that his parents genuinely accept his love" (Fairbairn, 1986, p. 82). If babies' early demonstrations of love expressed by feeding and reciprocal facial mirroring are not responded to, the research reports, they become increasingly distressed and eventually retreat. I suggest that if a baby experiences its love as rejected, precipitated by a lack of recognition of their need to both receive love and to be allowed to give love, they will experience acute shame. Gilligan echoes this link between shame and the absence of love. "The person who is overwhelmed by feelings of shame is by definition experiencing a psychically life-threatening

lack of love" (Gilligan, 1996, p. 113). The shame lies not only with themselves but also with "the objects that have failed in their task to proffer a blessing" (Grotstein, 1994, p. 138).

Fairbairn describes the infant as wholly dependent on the mother the baby's identification with her is complete. The task of the child is to move away from a state of primary identification, an oral dependency characterised by the need to take in, to a mature interdependent state, based on differentiation from the object. Schizoid states develop when the mother is unreliable and experienced by the baby as absent. If the baby is unable to make a satisfactory link with the caregiver due to her lack of empathic care, its frustration increases to such a high level that the baby re-directs its libidinal energy inwards. The rejection is experienced as so profound that the baby defends against it by splitting the ego. This means the shame inherent in the process of separation is avoided and the child is unable to give up its infantile dependence. As Fairbairn writes "for such a renunciation would be equivalent to forfeiting all hope of ever obtaining the satisfaction of his unsatisfied emotional needs" (Fairbairn, 1986, p. 83).

Child psychotherapists have described how neglected children "have not been given a sense of themselves as continuing overtime in anyone else's mind, and have not introjected an object that is attentive to them" (Music, 2018, p. 11). Their internal objects are experienced as absent, distant and distracted. "in attachment and developmental psychology terms, such children lack a narrative sense of themselves or a developed autobiographical self, and they can live in an eerily timeless realm" (Music, 2018, p. 11). It is my belief that the experience of being turned away from, a central experience of neglect is a profoundly shaming experience for the child who feels they have been unable to create love and engagement in the parent. Many respond to this by adopting a compliant attitude which leaves them particularly susceptible to the paedophiles interest and preoccupation with them (Scott 2011).

### Secondary shame

Secondary shame describes the shame which is inherent in the struggles to reach childhood developmental goals. Some of this will be conscious and remembered. Spero locates (1984) shame arising between the first and second years of human life, in terms of anal organisation. The child becomes aware of themselves as a subject for outside scrutiny, and the self becomes penetrated by the disapproval of others. If the child behaves in certain ways, it may elicit a critical response often focussed on what it cannot achieve. The world outside can seem like a place of judgement with the desire for "autonomy versus shame and doubt" (Erikson, 1950, p. 251 cited in Thrane, 1979, p. 332). The child's wish to do something is limited not only by its abilities, but also by the atmosphere in which it attempts to do it. As Thrane writes, the child wants socially acceptable behaviour, mastery and self-control which he links to the power of the adult" (Thrane, 1979, p. 332). If children experience themselves

as wholly powerless, they are more susceptible to feelings of humiliation and the shame that accompanies it. If they feel they are too powerful, they become shameless and lose their capacity to relate to people authentically. Grunberger identifies early experiences of shame arising from a child's attempt to negotiate the conflicts inherent in the Oedipal situation. Shame emerges as the child struggles to negotiate the conflicts inherent in the oedipal situation namely exclusion from the parental couple. This is all part of the process of separation. In relinquishing this bond with the mother, the child is forced to reflect on its own smallness and feelings of inadequacy. There is a realisation there is someone bigger and better out there who fills a space the child cannot occupy. So, if we trace how shame originates, we see it goes far beyond the idea of poor self-esteem. Irreducible shame develops when a baby is unable to make a satisfactory connection with another, while secondary shame is linked with a desire to gain a sense of internal control, assert one's autonomy and still be loved and accepted (Scott, 2011).

**Toxic shame**

This is a term used by Mollon who referencing the work of Shengold who described the worst suffering of Child Sexual Abuse as soul murder. He writes this is never precisely defined, "but it seems to involve the deepest humiliation that a person can undergo, in which an attempt is made to undermine their sense of worth and to destroy the very essence of (their) identity for someone else's benefit" (Mollon, 2002). Shame arising from interpersonal trauma most especially when it involves a family member can lead to a persistent negative view of oneself.

"When the pain does not arise accidently but is inflicted as a punishment, the resulting persecution is much more difficult to bear. Suffering then is not simply a confrontation with pain or danger but something imposed with the intention to hurt and ultimately destroy" (Steiner, 2011, p. 7). This is what Peter Fonagy describes as ego destructive shame created by brutalised attachment relationships where neglect and a lack of containment prevail triggering terrible violent attacks on the self and sometimes on others (Mollon, 2002).

Shame in women is more likely to precipitate terrible self-harm. The need to punish is aimed (I am generalising here) against the self, and in men, it tends to be aimed at people in close either emotional or physical proximity to them.

It is well documented that shame in men can lead to violence against others as the need to locate their internal vulnerability elsewhere and then attack it can feel the only way to prevent themselves becoming overwhelmed by it.

Again and again, we see survivors take responsibility for the assaults they have experienced as children. Rationally, many know they were defenceless, but they are left with an entrenched belief that the fault lies with them.

The seeds of this belief are frequently planted by the abuser who justifies their actions by telling the child they asked for the assault, that they made

them do it and that the child would be punished if it was revealed. The shame children feel about being unable to protect themselves and the subsequent terrifying loss of control they experience often leaves them having to bear their own shame as well as identifying with the shame of the abuser who has split off the feeling and projects it into the child to rid themselves of it.

When the abuse is perpetrated by a caregiver, the child finds themselves in a terrifying position of fearing even hating the people, they depend on to care for them. Fairbairn describes the need of the child to take on the badness of the caregiver and identify with it as their own as a moral defence, a way to protect a good image of those they need to survive. To be able to do this, many children may appear compliant on the surface but live with a terror of being in touch, or anyone else seeing their rage and hatred and develop a set of defences to protect them from the intense fear and pain they have worked so hard not to be in contact with.

The Flying Child, a book by Sophie Olsen and Patricia Walsh (Olsen & Walsh, 2023) describes a relationship between a survivor and their therapist. The scenes which describe the sexual abuse she experienced at the hands of her father are written as a fairy tale to create some emotional distance for the author to enable her to recount the terrible attacks she endured. She writes,

The little princess felt different. She had been born, as all babies are, with love and loyalty in her heart and while she loved the evil king still, the more he captured her mind, the harder her heart became (Olsen & Walsh, 2023).

It is important to remember that any hope of being heard or helped by another is destroyed when the child takes the brave step of trying to tell someone, and then, they are not believed. This is a second profound trauma experienced by some as even more damaging than the abuse itself and confirms their fear that they are not worthy of the love and care they so desperately need.

We know that at moments of intense internal pressure, it can be impossible to evoke the presence of loving and protective internal objects to sooth and manage intense anxieties which emerge and dominate the mind through panic, flashbacks and a state of hyperarousal (Davies and Frawley, 1994).

A loving intimate relationship though longed for may feel too frightening as being vulnerable and open feels dangerous and the threat of another's judgement and potential abandonment too risky. The shame that accompanies trusting no one and the terror of all that is buried being seen, can lead to severe emotional isolation and attacks on the self. Self-sufficiency and withdrawal may help the person feel more protected from others, but loneliness and self-hatred can dominate their emotional world.

Stigma, blame, shame, denial, a fear of being retraumatised and a concern they may damage the relationship with the recipient of the disclosure often prevent survivors telling others about the abuse. The challenge for professionals working in this field is how we can communicate to our patients that we have the internal resources to bear and respond appropriately as they share these disturbing experiences.

We know that traumatic memories are stored differently to ordinary ones, so it is unlikely that there is a coherent story of abuse. The abuse may have occurred at a preverbal stage and the recovery of memory is unlikely to be through words but maybe more through actions and the body. This means that when a clinician hears a disclosure, they are not simply receiving information but become part of that disclosure and the discourse around the sexual abuse of children. This is all part of the breaking of the secret.

The fear of re-triggering trauma in the survivor seems to be the main inhibitor to actively engaging with the subject of abuse in the consulting room. It is true that this can happen, we know that breaking the abuse secret may increase confusion, the severity of symptoms, such as dissociation, increased flashbacks and risky behaviour. It can be helpful to warn a patient that they may feel more distressed during the work, but that it is a process that can be very helpful.

**What is so particular about shame?**

As helping survivors manage their shame is so key to our work in the NRCSA side of the service, I have become increasingly interested in thinking about its unique properties and why is it so difficult to shift. Fear, anger and sadness are profound and often intensely painful feelings and yet for most of us they lessen and sometimes pass and for many can be reflected upon. Shame feels different to me. It hangs around like a bad smell, an odour that however hard the survivor wants to rid themselves of it in phantasy, it lingers and pollutes the atmosphere around them. This paper explores how shame operates as both a powerful internal and external dynamic. As described earlier in the paper, shame has a powerful societal dimension to keep people in their designated place in the social order as well as its early and unconscious roots in a child's development. It is also a key dynamic in keeping victims of sexual violence silenced.

In her the Tavistock Trauma Service external lectures, Jan Hepburn-McGregor describes the difficulties in helping her patients process and be liberated from the shame states that inhibit them from living fuller lives. She suggests that for shame to be ameliorated forgiveness needs to take place. For that to happen, the perpetrator needs to own and take responsibility for the profound damage they have done to the survivor. We know this seldom happens as paedophiles in our experience remain invested in the belief that their acts were wanted or asked for by the child. The denial of the extreme violence of their acts, and their supposed ignorance of the dehumanising impact on children when they are used as sexual objects means they often remain shameless unable or most likely unwilling to own the shame and the pain that rightfully belongs to them.

In his chapter on Relational Trauma and Oppression (Stubley & Young, 2023, lpp132/33), Ariel Nathanson describes the psychological stages of grooming. He outlines how the child loses their capacity to resist the

demands of the perpetrator by complying with small and what might appear innocuous requests which represent a slow erosion of their right to say no. This usually happens very gradually initiated by a seemingly small infringement on their personal liberty where they give way to something small, but which opens the door to being unable to say no to other advances. He writes about the helpless "rage" that the child feels when they understand that they cannot resist participating in such a disturbing interaction. He uses the idea of mixing cordial in water as a metaphor to describe the impact of this oppression on the developing psyche which begins not only to colour their relationships but also distorts their growing sense of self (Nathanson, 2023, p. 132). He describes how once the abuser steals the child's authority to say no that they leave "a corrupt presence behind, an entity that would make sure the door would never be locked again" (Nathanson, 2023, p. 133).

If we think about the word corruption, it suggests that there is an experience of something rotten left inside the child, which they then identify with. The combination of the violence of the physical attack that accompanies the emotional intrusion means that the child's identification is so strong that it becomes a powerful structuring force which permeates the undeveloped psyche distorting the child's defences. These children are left with both a conscious experience and an unconscious phantasy that there is something so bad about them that they will need to remain outsiders, be punished and may deserve any future mistreatment. This means that many survivors will turn to addictive behaviours to try and dampen these intense feelings or become involved in abusive relationships partly because those power dynamics are so familiar and in an unconscious attempt to gain mastery over earlier abusive experiences. Once embedded shame remains like a stubborn stain which shapes how abused children define themselves. It lingers implanted in the psyche, a presence which may reduce with support but in my view never goes. The neglected child so often craving love and acceptance is aware that they have been unable to deny the demands of the perpetrator and the "passive part of the personality" has been unable to resist the attack and becomes an observer on the participating part of the self.

This is beautifully described in a passage from The Flying Child

> And the Little Princess felt the fear flood back and her body started to shake and shake. She hated the Big Princess for leaving her and not getting help and she didn't know what to do or what to say. She saw that she would have no choice She knew she would have to climb into the camper van and she knew there would be no cake and she knew that the Evil King would drive her far, far away from the kingdom, the butterfly queen, the big princess, her dog and her toys and she knew her life would be filled with abuse, although she didn't know the word for it.
>
> (Olsen and Walsh, 2023, p. 211)

Here, we can see the helplessness of the traumatised child whose passive self complies with a demand from a powerful other and illustrates how she observes herself participating in an action which she knows will cause herself irreparable harm.

## Conclusion

The basis of trauma-informed care is to assist the survivor to feel more control over the treatment they receive and to be allowed to be an active participant rather than a passive recipient. Nathenson outlines the importance of survivors taking action whether in their own care or as being part of a survivor movement. The scale of childhood sexual abuse means there is a pressing need to develop more specialist services which are open to engaging with the reality of sexual abuse and are designed to enable survivors to feel safe enough to articulate the most disturbing experiences without being shamed, pathologised and pushed away. As clinicians, we have much to learn from survivor's accounts not only about what happened to them but what they need from us to begin to come to terms with the terrible events from their pasts.

I want to finish with a poem by Patricia Wennel, a retired social worker, author and survivor and someone who has contributed to the online disclosure course that we are co-producing with survivors of childhood sexual abuse. The Poem appears in Patricia's book "Because it didn't stop when it ended" which details her experience of psychotherapy.

Deep within my soul
There's an unwritten rule
Don't Pass it on
I feel I am full of toxic waste
I am not sure if I feel toxic but I feel it is in me
Eve blamed the serpent
Adam Blamed Eve
They knew about guilt and shame
It caused them to hide
They made a choice and got it wrong
They chose to pass it on
Deep within my soul
There's an unwritten rule
Whatever was done
You don't pass it on

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# 11 What can we learn from children about the disclosure of trauma and abuse?

*Jess Chown*

Freud (1909) said, "In an analysis, a thing which has not been understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been resolved and the spell broken."

If we infer trauma here, as Margot Sunderland often guided us to do in my formative lectures as a trainee psychotherapist, it becomes a very useful metaphor. The word apparition can mean to see a ghost but it can also mean a memory so vivid it's like seeing a ghost. The longer the story is left untold into adulthood, the more apparitions will have occurred and more ways of coping with the encounters will have grown up and around it. This will include attempts to both tell and conceal what happened, to try to find some agency in this repeating pattern and to gain some distance from it and to numb it out. By adulthood, these well practiced responses and efforts to live beyond the trauma can bind the story up and make it hard for others to see and hear it. So, what can we learn from the instances when the stories have been disclosed earlier on in life? What can we learn from children and young people about the disclosure of trauma and abuse?

I have worked with many children and young people who appear to not consciously know what happened to them or the reasons why they have been separated from family members. Sometimes, there has been enough health in the child and the system around them that I have been able to piece together what has happened using social care files and by speaking to people who knew and know them well. In such instances, I have worked in therapy and supervision to co-construct a coherent narrative of traumatic events in their young lives to help them to integrate their experiences and continue growing and developing. Other times there has been only a void or negative space in the work which I can feel the edges of but can only guess the shape and contents. You may recognise this in relationships with people you see in your professional role, perhaps a mixture of familiarity and also something wordless that you both avoid as it feels risky to get too close to it. In ordinary day to day settings, this can be very subtle and it may need to be helped to come into awareness through reflection with colleagues, for example. In the context of therapy, this scenario usually gives me a feeling of walking on thin ice. It is the feeling that if we go too far and the ice breaks it will plunge

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the young person and possibly me with them into some unspeakable danger even though I may not know what any of it is about. From both experience and brain imaging research, we know this is because the unprocessed trauma cannot be recalled, reflected upon or learned from as trauma 'memories' bypass the parts of the brain which allow these things to happen when they are quickly stored. The unprocessed trauma therefore has no or little place in that person's conscious personal history. It can only be re-experienced as if it were happening again unless there is help to stabilise and regulate along the way (Van der Kolk 2014).

The stabilisation work required to create safety for trauma survivors can take years (Struik 2014). It also often happens that people collude with the unconscious assumption that the terrible thing is too awful to be known, and therefore, the best thing to do is avoid being curious about what happened, perhaps avoiding ever processing the trauma. The real and explicit responsibilities and distractions of adult life make it easier to carry on as if there is no ghost, no story waiting to be told. As discussed in Chapter 2, we know older adults that people can sometimes suppress traumas most of their lives until in later years neurological decline and reliance on care from others once more allows these ghosts to reappear. Having said that, it is also true to say that we are deemed to repeat these unprocessed traumatic experiences partially or completely as either a victim, perpetrator, rescuer or witness over our lives, so there is no real peace to be had by avoiding it. Children often tend to have more opportunities to show their implicit traumatic experiences because they are more regularly engaged with representational play and creative tasks than the average adult which is how implicit memory shows itself. Through their approach and engagement with play and creativity children can show us their implicit experiences, we just need to be ready to look for where it appears which like most things coming into consciousness, is usually on a boundary. Psychotherapeutic boundaries make it much easier to see the implicit memories and traumas of young people and adults compared to ordinary day to day encounters, but these types of insights are available to us outside of the therapy room and in less formal settings too. The principle aim of this chapter is to guide professionals in helping roles to see the apparition, the ghost that cannot be laid to rest and to support the story to be told whether that is to you or to someone else.

To illustrate, I recall a time limited piece of work with a young teenage boy, whose mother was in prison and had been for more than half of his life. I had been asked to do life-story work but my client could remember nothing of his early years and had never said anything about why he was in foster care to anyone except, "my mother wasn't able to look after me". He had never wanted to see his mother, refusing every type of contact that was offered without saying anything more. The only information I had about what he may have witnessed came from an extreme fear response he had had hearing a rowdy crowd cheering but that had happened soon after moving in with his foster family and he had since forgotten that too, never elaborating

on the experience and then recalling nothing of it when I mentioned it during our assessment. It was difficult to know how to begin the life-story work because the reason for his mother's conviction was a very violent, premeditated murder and no one in the social care system knew whether my client had indeed been present when it happened. If he had witnessed any part of it, he would have been 4 years old when it happened. The risk of re-traumatising and destabilising this young person's life was so real I found it hard at times to know how to proceed. However, through my holding the boundaries and space in the work he brought his implicit memory the day that he witnessed on his way to therapy, two older children from his school stamping on a nest of baby birds which had fallen from the bushes next to the path. When he arrived distraught and pleading for sense in what had happened, he showed me though his physical response and his words his response to the killing of innocence, untimely death, cold callous power and the fear of a person who could do such a thing. We stood side by side and drew together on a large sheet of paper and talked it through. He had so cleverly used this dreadful experience to show me what he knew about murder and the horror of it and the terror of those who can perpetrate it. By attending to the feelings as if we were talking about both the birds and the murder his mother committed, we began to process his experience.

At the end of the session, with the promise of the time boundary, he was able to make a leap in his progress in therapy. In psychotherapy, we don't move time boundaries to make more space for important things. Instead, we use the promise of the ending to open a space before it. I wanted to help him bring what he knew into consciousness more, to bring words which bring thought and therefore the possibility of processing. I was able to co-regulate him enough to take a risk, and also, we worked with his foster carer in the room who was ready and well able to help out if things became difficult. With thoughts of Arriane Struik's method (Struik 2014) of supporting young people to be able to tell the story of their trauma in a nutshell without becoming dysregulated as a precursor to trauma processing, I decided to take a risk. I suggested we design a vault that could be strong and trustworthy enough to hold the answer to "Why my Mum is in Prison". We constructed it on the page adding every kind of door and lock we could think of to keep it under lock and key layering them one on top of another. Paradoxically by going with the defence of how to keep this information away from people in order for it to remain unknown, he was able to write 'MURDER' in the blank space, shut the doors, turn locks and slide the bolts and left the room with his foster mum, relieved that the conscious knowledge hadn't destroyed anything and I would be there to see him again next week.

When I first began working with children who had experienced trauma and attachment injuries, I would read classic social work books based on play therapy which left me with an impression, although I don't know how much of this was just my interpretation perhaps because of what I wanted to believe at the time, that children would come into sessions and play out

their trauma with toys and then leave feeling unburdened and better. In most instances, this has not been my experience. It is more likely with simple traumas but because most of the trauma and abuse I have experience of working with has occurred in the context of neglect, traumatic loss and has occurred multiple times, I have mostly encountered developmental trauma in children and complex trauma in adults. I remember initially feeling disappointed that I wasn't able to facilitate the telling of what happened in the way that I had read in the books I was recommended by people I respected. It was later in my psychotherapy training that I came to understand that these insights come in on the boundary. Winnicott's writing on the client's inner and outer realities, how we meet those and the in-between spaces they create helped me to understand how to pay attention in the right places to hear the story that needs to be told (Winnicott 1971). To engage with this kind of way of knowing and way of telling whilst you are listening and taking time to think and understand requires us to get into quite a creative way of functioning where we can let go of certainty and the need for it. We need to receive what we encounter paradoxically as both profoundly important and at the same time easy to let go of or change. This is a difficult position to take and maintain because we are rightly concerned with the person's immediate physical and psychological safety and the safety of others when we first learn of trauma and abuse. The legal system and other systems around people who have been harmed often do not support this way of being and understanding because they are left brain dominated systems, preoccupied with objectivity and fact. This is not a criticism of the legal system or safeguarding systems, rather I am holding up the need for help and support to be offered by separate and clearly defined helping roles for victims and survivors so that the wisdom of the right brain function can be supported to tell us what happened (McGilchrist 2019).

If we change from our usual supportive role into a cautious, solemn professional concerned with gathering reliable evidence, preoccupied with procedure the moment someone begins to talk to us about their trauma, we will inhibit them. Traumatised people are so vigilant and so attuned to our non-verbal communication that we can easily lose their trust before we've even said anything just by the way we grab pen and paper and start writing down what they are telling us, for example. You may feel anxiously driven by the will to do your job well in the way that you were trained but they are driven by survival which is a stronger force.

We in health and helping professions must hold the tension between the need to receive and record the information disclosed to us in a way that is in line with the law on safeguarding vulnerable adults, supporting the gathering of evidence for a legal case and responding to the person speaking to us in a way that allows us to receive their implicit knowledge and memory. This is done well in my experience with children and young people by people taking different roles so that the child has clearly defined support roles which fulfil the need for communication of explicit memory (e.g. police) and implicit memory (e.g. therapist) and social worker who engages in both.

It brings to mind an experience of working with an adult client whom I increasingly felt was on the verge of disclosing to me childhood sexual abuse although I did not know for sure that it had happened. He arranged a meeting outside of the usual schedule which put us just on the boundary of our work – where we should come to expect these stories to emerge – and disclosed to me with much hesitation and difficulty a life-threatening incident that had happened to him as a child that was of a completely different nature. The feeling for me afterwards was like running for a bus and hailing it just in time, stepping on relieved and exhausted only to find it was the wrong bus. This sometimes happens when there is unprocessed trauma around, lots of affect or strong feeling that doesn't seem to fit exactly with the current situation. Sometimes, in my work with children, it can feel like if the play were a film at the cinema, the trauma story is told in the soundtrack which doesn't quite fit with what's happening on screen. Or we might be reading the script without the emotional soundtrack. This links with something that children do too, they experiment with disclosing parts of their trauma. They may play out a story to one person which details the feelings involved but the context is different. Or perhaps they recall a news story which recounts very similar events to what they have experienced but without feeling or self-reflection. We need to be patient and to be willing to gather the unintegrated parts of a disclosure piece by piece.

So, outside of psychotherapy, how can we use this knowledge to support adults with disclosure of childhood sexual abuse? Here, I am considering health and social care appointments, and residential settings.

Attend to your time boundaries – tell people how long they've got to speak to you and stick to it. If you sense that someone is working up to telling you something, carry on doing what you were doing and be very clear about your availability. Tell them when you're leaving for the day or you're finishing your shift. Remind people how long appointments are and how to book longer appointments. Book the patient in again before they leave so they know when you will next see them or offer to arrange a future time to spend time together. Making yourself available for long unspecified periods of time such as staying late or stretching appointments and making allowances for people does not help them to speak the so-far unspeakable. People need to know that they can and will be expected to leave and this can make it possible to speak up.

In the same way that children may play different roles in order to embody different perspectives, it may be necessary for an adult to resume a normal persona after they have told you something of their abuse history. Until people have had a chance to integrate their experiences, including their experience of disclosing to you, it is likely they may need to return to a way of being that is as if nothing has been said or you may feel a sudden change in their demeanour. This can be confusing and can put doubt in the mind of the listener about what was said and whether they did a good job of listening. It is important to follow that person's lead, allowing them to go into the next part of their day whilst also bringing one's own awareness to it.

I remember a time before I had trained when I was surprised when someone I didn't know chose me, a new young support worker, to disclose an incident where one of his young children had stripped off and waded into the pond whilst he wasn't watching them. His terror at what might have occurred fuelled him to shout and shame his little boy so ferociously that he had pooed in the pond. As I listened, he went on to tell me about his father's rage and violence in his own childhood and he was devastated that he might be to his children what his father had been to him. I could tell that he was not used to crying and there was an edge to the conversation because he felt so vulnerable, but we talked it through and began to make arrangements to support his family. I felt we had made a connection and I had done well being alongside him in his pain. As I opened the door to let him out of the building, he winked at me and said, "Alright Princess" and left. I was annoyed and disappointed. Speaking to my manager I expressed how in my mind this had devalued his experience and belittled me and I was unsure the conversation had any worth. Luckily my manager at the time was able to help me see the bigger picture – this man was not ready to integrate this experience with his everyday living and working in a hyper-masculine environment where tough exteriors were the norm. It is helpful to think about people being in different parts of themselves to get along in different parts of life in different moments. The part that is able to disclose may not be able to then be present whilst standing waiting for medication for example or having blood pressure monitored. We need to be flexible and stand by the disclosure whilst also allowing people to do what they need to do.

Because shame is so much a part of CSA survivors' experience, the defences people use to avoid shamed states are common around disclosure. People may use humour in surprising ways or come across as self-righteous, raging or grandiose when talking about it. You may be thinking about the person making the disclosure behaving in this way but these defences are as likely in us as listeners too if we are not used to paying attention to our unconscious process. By exploring how shame impacts people and getting to know how we carry our own shame we can be compassionate towards ourselves and each other for the things we wished we had phrased differently or awkward moments and in turn express ourselves better.

We can learn from children's use of play and metaphor to hold meaning whilst creating distance from triggering material to regulate shame in conversations. We can express what we want someone to know about our response to the abuse they have disclosed whilst talking about the case they have noticed on the news or in a film for example. By talking about another person or character's situation it may allow our words to be absorbed meaningfully.

We know from the Independent Inquiry into Childhood Sexual Abuse (IICSA) report that on average people sought help following childhood sexual abuse 19 years after abuse took place. If someone has begun to disclose to you and says they haven't told anyone before or for a long time, you can respond by being curious about how they have managed not to tell

people. Empathy for what it has been like to carry this untold story around will support people to feel their way through a disclosure more than direct questions.

An important aspect of why telling another person details which are distressing or horrifying is particularly difficult, is the sense that we are bringing something awful to this other person, putting it in their mind which may feel harmful in itself. Many children who have experienced sexual abuse either assume that the abuse that happened to them was normal or they are shocked that the adult they are speaking to knows that people do such awful things. If the person we tell has not ever imagined such a thing could happen, we also may have the sense in the telling that we are convincing them of something which is too awful to be believed. The shame people feel in having to ask another person to tolerate imagining something more perverse than ever before can be very limiting. This can lead to partial disclosure, where people sense that someone has already had enough and can't hear any more. Traumatised people have an acute sensitivity for the potential for shame and rejection and will often withdraw from people before the possibility becomes too likely. The helping professions need to engage enough in victims' accounts of the harm they've suffered to have an open mind to the extent of what may have happened. This is not to say that we need to appear un-shockable. Our genuine responses to a disclosure will communicate important information to a survivor about the seriousness with which you regard their experience. We have a responsibility to learn about patterns of behaviour and dynamics in abuse relationships, to know what is currently in the mainstream media which may be in the awareness of the people we help.

It makes sense to offer further opportunities for more to be said after a disclosure in case its only possible for them to say a little at a time for any reason. Children will often add strands together to build a picture at a pace which feels manageable. Sometimes, when we have heard something dreadful which has happened to someone, we can inadvertently assume it is finished because what we've heard would be enough to explain all the troubles they have and so we give the message non-verbally that the conversation is finished. Always check whether there was more they had wanted to say today and if possible offer another opportunity to follow up soon explaining that once these memories have been brought to mind and shared, there are often other associations or pieces of the story which emerge later.

What children are so good at is not trying to reduce and simplify things that need to be complicated and numerous. Through their play and image making they manage to express and convey complex thoughts and feelings that are unwieldy for words alone. The process of disclosure is always ambivalent, and there is good reason to tell just as there is good reason not to risk it. There are aspects of the memory or narrative which may seem contradictory to other parts and the memories may not hang together coherently –

these are all things that children are much better at being at ease with than adults. In thinking about children's experiences of showing and telling aspects of their lives, we can see that disclosure is not a linear, coherent narrative. Coherence is something that develops with regulation and time. Often, people can be coherent without being certain. Being alongside someone, helping them to be clear about what they are unclear about is a worthwhile endeavour.

To summarise, here is a list of considerations to prompt discussion or reflection.

When you have a specific person in mind;

- Consider what you know about this person – what is comfortable to speak about their personal history and what feels unknown or out of bounds?
- Do you get the sense they have a clear narrative of their life or do they jump around their timeline in ways you find confusing?
- Do you ever get the feeling you have strayed too far from safe conversation and feel the need to get back to familiar topics? Have a safe topic in mind and at the ready.

Considering your role and the context of your work;

- Become more aware of the boundaries of your role. Consider time, proximity, touch, personal information, place and context. Intend to be consistent with these boundaries and take extra notice when a boundary becomes relevant.
- If someone begins to disclose, welcome their words but keep your boundaries.
- Talk together about whether you need to bring others in to support with the next steps. Protect the listening role and share professional responsibilities if you can.
- Seek reflective supervision if you don't already have it. Working this way with colleagues can be very helpful and personal therapy can deepen your understanding.

With regard to disclosures;

- Commit to learning and developing your skills in this work but commit to self-compassion too- remember shame can be contagious.
- Use metaphor and fictional examples to help you speak about difficult topics.
- Read survivor accounts and Serious Case Reviews to practice self-regulation in the face of disturbing information and to keep an open mind.
- Follow-up with people, let them say when they have finished telling you what they need to say.

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# 12 Challenging the binaries in relational trauma

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## Introduction

The habit of thinking in binary terms, along the lines of victims and perpetrators, is well-established in our society, and even, potentially, among psychotherapists. Even when we accept that the capacity to sexually abuse children, for example, arises from trauma, we exhibit a tendency to set these experiences of trauma apart, as if the trauma experienced by victims and perpetrators were qualitatively differently.

In a sense, of course, there is an important distinction to be made: victims and perpetrators *do* trauma differently, in as much as individuals might enact their trauma towards themselves or towards others. Hence the need to always address issues relating to the super-ego when working with people who enact trauma through offending behaviour. Here, the term super-ego refers to an aspect of our own minds that is, 'self-observing, self-judging, and especially self-critical' (Barnett, 2019), which was central to Freud's thinking, but which was developed by Klein and post-Kleinians to encompass the potential for extreme hostility to the point of persecution (Nathanson, 2022; Rosenfeld, 1971).

Psychoanalysis has traditionally placed great emphasis on the super-ego in its consideration of, for example, sexual offenders, but an over-emphasis on the super-ego and a resulting failure to take reasonable account of the complex inter-relationship between the experience of early trauma and the impact this might have on the development and functioning of the super-ego, could lead to the centrality of the experience of trauma being overlooked. In the psychoanalytic account of 'perversion', for example, which is typically regarded as a problematic variation in the development of sexuality, and which Bion says contains a 'seed of healthy desire' (Long, 2007), the role of sexuality is highlighted and the possibility of that desire relating to safety is neglected.

## The distinction made between 'victim' and 'perpetrator'

The words 'paedophile' and 'child sexual abuse' hold particular resonance. People who have exploited vulnerability in this way, flouted what is considered natural, and done long-lasting damage to susceptible others, are

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understandably regarded with anger and disdain. The sort of headlines that follow any disturbing incidence of abuse testify to this as well as to a strong desire to keep the categories of victim and perpetrator as far apart as possible. Even where one might anticipate greater understanding, it can be absent: one study conducted in Essen, in Germany, found that 95% of psychotherapists in outpatient settings were unwilling to work with patients designated as paedophilic due to holding negative beliefs (Stiels-Glenn, 2010).

Preserving distance between the categories of victim and perpetrator – feeling confident that the boundary between them is solid and clearly defined – prevents empathic confusion and leaves our internal and external sense of morality untroubled. At the level of society, it avoids the anxiety that we are 'going soft' on perpetrators and defaulting on our responsibility to keep communities safe. This is true of people convicted of crimes relating to child sexual abuse but also of people convicted of crimes more generally: there are the perpetrators and the victims, the traumatisers and the traumatised.

It is important to note that this insistence on separateness is understandable when viewed from the perspective of survivors of sexual abuse, not least because of the immense effort required to alleviate the shame associated with childhood sexual abuse and the painstaking emotional work required to move towards the status of survivor. In light of this, it seems unnecessary – or even unethical – to challenge the distinction between the two categories.

On a societal level, bringing victimisation and perpetration into a shared orbit seems counter to the great strides achieved by, for example, political narratives concerned with violence against women and girls, as well as the huge amount of time and energy it has taken to move society on from victim-blaming (a still unfinished business).

And yet there also exists in society a general understanding that when someone abuses, they have experienced some form of abuse themselves. Something has gone wrong, typically at the hands of others. We may even be aware there is consistent evidence for the fact that those who criminally abuse others have themselves been victims. This evidence emerges from both research (Campbell et al, 2016; Ford et al, 2019; Gray et al, 2021), and from clinical experience: some people defend against their own *victimised* vulnerability through acts of perpetration towards vulnerable others. While the so-called cycle of abuse is relatively unsupported by evidence (Lambie & Johnston, 2016; Wanklyn, 2012), it remains the case that victimising others remains one possible response to victimisation.

These individuals could be said to be dialoguing externally with some some aspect of their own, internal, experience. Gilligan writes, 'different forms of violence … are motivated, or caused, by the wish to ward off or undo feelings of shame and humiliation, inferiority and impotence, and replace them as far as possible with their opposite – feelings of pride, honour, superiority and power' (Gilligan, 2009, p 244). Even a brief period of time spent in a prison should convince anyone of the profound levels of traumatisation

(and re-traumatisation), contained within these institutions, and there is now a significant amount of research to substantiate this.

### The link between offending and childhood trauma

While acknowledging that the overly systematic Adverse Childhood Experiences (ACE) framework appears to make comprehensible individual experiences of trauma that, Woods (2016) writes, 'stretch the use of language' in their quality of overwhelm, it has nevertheless proved a useful tool for measurement and thereby supported a growing body of research.

Such studies have demonstrated that not only are a higher number of ACEs more prevalent among offender populations (Baglivio et al, 2016; Craig et al, 2017; Malvaso et al, 2018), but that the greater the number of ACEs, the greater likelihood of individuals participating in, 'serious, chronic, and violent' offending (Malvaso et al, 2022, p 1677). These figures remain consistent across research conducted in a variety of countries, including the United Kingdom (Ford et al, 2019). A 2019 study, for example, into the prevalence of ACEs in the extant male prisoner population in Wales demonstrated that 84.1% of participants reported at least one ACE, while nearly half reported four or more. This is almost three times the level reported for males in the general population in Wales and England (Ford et al, 2019). Similar high ACE levels have been demonstrated among justice-involved populations in Scotland (Carnie, 2017). The findings confirm a link between ACE exposure and offending, regardless of age, but point to other demographic factors associated with ACEs and similarly linked to offending behaviour, including levels of educational attainment and levels of unemployment. High ACE levels also linked to prolific offending and recidivism, involvement with violence, and drug and alcohol use (Ford et al, 2019). Studies utilising the ACE framework have also been applied to the specific category of sexual offending (Naramore, 2017; Ramirez, 2015), and within that, of offenders convicted of crimes relating to child sexual abuse and paedophilia (Freund et al, 1990).

A consideration of evidence in the specific category of child sexual offending requires the caveat that research in this area is subject to a confusion of terms: particularly a lack of distinction between what constitutes childhood sexual abuse and what might be labelled paedophilia, and between paedophilia and inter-familial abuse, or incest (Fry, 2020). Research is also frequently framed around the issue of the so-called cycle of sexual abuse (that is, that people who have been sexually abused as children have a greater likelihood of perpetrating sexual abuse against children as adults), rather than around the more general relationship between adverse experiences in childhood and paedophilic preference or sexual offending against children by adults.

Both adults with paedophilic preference and child sex offenders have been shown to have histories of adverse childhood experiences, but there does exist some evidence for a greater incidence of childhood sexual abuse among

those with paedophilic preference (Freund et al, 1990; Glasser et al, 2001). As above, however, Marx (2020) has highlighted the tendency for researchers to overlook other forms of childhood abuse among these adults and has pointed to the higher levels of emotional abuse evidenced in this population, when compared to psychotherapy outpatients and the population in general. Gerwin et al (2018), meanwhile, suggests it is the onset of sexual activity, the experience of sexual dysfunction, and associated paraphilias that are significant when distinguishing those later identified as paedophilic, rather than simply exposure to experiences of childhood sexual abuse. Similarly, Lambie and Johnston (2016) point to other markers that distinguish adult offenders with a history of childhood sexual abuse who go on to sexually offend against children from those within the same population who don't: the presence of empathy, a sense of morality, a lack of sexual desire for children, or a combination of all three have been identified as potential barriers to child sexual offending.

So, while there exists a relationship between the experience of adverse events in childhood and both paedophilic preference and child sex offending in adults, it is hard to point to the specific experience of childhood sexual abuse as causative in this regard. It remains the case that the vast majority of people who have an experience of childhood sexual abuse, do not go on to sexually offend against children and that while experiences of childhood abuse might increase the risk of child sex offending in both people identified as paedophiles and those who are not, experiences of childhood sexual abuse are unlikely to turn the latter category into the former. Rather, the experience of childhood sexual abuse must be set within the context of multiple other potentially contributory factors including general neglect, and emotional and physical abuse (Wanklyn, 2012).

### Trauma is trauma

The concept of ACEs looks backwards in that it seeks to establish a relationship between traumatic events in the past that influence present-day wellbeing and functioning. When that functioning includes offending behaviour, however, the ACE concept reaches into the future, in as much as offending behaviour has the potential to transmit trauma to a victim. In the case of the so-called cycle of abuse, and despite the reservations about this concept expressed above, this process of transmission is particularly evident, given the traumatised individual who perpetrates sexual violence against a child is in all likelihood influencing not only the present wellbeing and functioning of that child, but is also exerting a longer-term impact, potentially far into the future (Hailes et al, 2019; Saladino et al, 2021).

The concept is helpful, therefore, in that it serves as a particularly clear example of the way in which the impact of adverse events in childhood does not come to a halt in the present or within a particular individual; it moves through time and between people. Offending behaviour is an example of this,

but so is transgenerational trauma or the way attachment difficulties manifest in parenting. Here, trauma has the potential to become a cycle that spans generations or relational networks. Trauma is, arguably, and to greater or lesser extent, always passed on.

The potential long-term impact of childhood sexual abuse is well documented, including increased risk of depression, anxiety, difficulties with learning, dysregulated eating, body image issues, risky sexual behaviours, and issues relating to physical health (Lo Iacono et al., 2021). But again, in as far as these are all symptoms, they are largely thought of as contained within the individual, rather than as a characteristic of relationships, both intra- and interpersonal.

The film, *The Railway Man*, released in 2013, tells the story of Eric Sutherland Lomax, a Japanese prisoner of war between 1943 and 1945, who was helped by his second wife to confront and overcome the traumas of his past. Lomax is portrayed as stoic in the face of his struggles with depression and, overall, the film is powerful and affecting. What the film omits, however, is the story of Lomax's first wife and two daughters who suffered immeasurably due to his emotional absence and erratic behaviour. His daughter succinctly states: 'What happened to him, happened to us too'. ('The Railway Man's forgotten family: we were victims of torture too', The *Guardian*, 28/12/2013) This is less an example of Hollywood-style airbrushing, than of the way in which trauma is not contained within an individual but, via relationships, is passed on.

Trauma, including that imposed by childhood sexual abuse, is less a discrete event or symptom, and more something that is transmitted. I use this word to imply both the way in which trauma is passed on, and the attribute of communication contained within it. These complex traumas are rooted in our ordinary potential to become internally and chronically overwhelmed by external events, as well as the fact that as human beings, we are designed to resolve such overwhelm through relational proximity. When we are distressed, we seek out and place our trust in others who we hope will help; if our past experience has taught us, however, that far from helping, other people will ignore us, exploit us or themselves become overwhelmed by our distress, the situation becomes unworkable. Even in the case of extreme withdrawal, we are communicating something of our trauma – through our behaviour – to those around us. At the same time, we are communicating our lack of faith in a relational solution. This is true of all trauma, whether identified within the victim of childhood sexual abuse or the perpetrator and yet, we persist with an idea that the ways in which victims and perpetrators are traumatised is markedly different.

## The role of gender

It seems obvious to say that while recognising vulnerability and victimisation in the perpetrator when we meet them in the context of psychotherapy

is helpful, labelling destructiveness in the victim – saying there is a capacity to enact destructiveness – is obviously more sensitive. And yet it seems nonsensical to label the significant levels of self-injury enacted by people with complex trauma, simply because it is perpetrated against the self, as anything other than violence. Similarly, the vague descriptor 'relational difficulties', frequently applied, obscures the potential damage done to others.

While the assertion may be complicated, from a clinical rather than a moral perspective we are saying something quite simple: people who have been victimised can be highly destructive, either towards themselves or others. This is not a statement about the ordinary way in which we all struggle with destructive impulses, it is referencing the enactment of destructiveness that is a consequence of our efforts to manage when something bad has happened to us.

One of the mainstays of the binary distinction between victims and perpetrators is gender: from a statistical point of view, more women are identified with the former category and more men with the latter. But this may amount to saying something quite simple about socialisation, or about the way our societies are structured according to socially sanctioned power relations: when we feel that our power is compromised, when we feel victimised or humiliated, do we simply turn to someone perceived as less powerful than us and victimise them in turn? Men to women and children, women to children and their own bodies, the exploitation of culturally maintained racial hierarchies and so on.

The rather neat alignment with gender is challenged in a number of ways, including the high incidence of self-injury among men in the prison population (ONS, 2023); these are widespread and yet go relatively unacknowledged outside of these institutions. Related to this is the increasing use of trauma-based psychological therapies in prisons (though with both male and female populations), as well as the adoption of trauma-informed practice within the criminal justice system (McAnallen & McGinnis, 2021).

And yet, challenging these well-travelled, socially reinforced categories need not detract from the way in which some people, at distinct points in their lives, can unequivocally be designated as victims (Richardson & May, 1999); rather, it acknowledges that, through the workings of trauma, destructiveness fans out beyond the immediate experience of the individual.

## Victim and perpetrator: A shared orbit

A young woman hopes to build a relationship with a man and start a family. She compulsively scrutinises dating apps, identifying potential partners, only to conclude there are too many red flags. Occasionally, she arranges to meet a man for coffee and, perhaps, meets him again. Initially, the encounters seem positive: perhaps this is the one? But something warns her against him – she can't put her finger on it, but she knows deep down she cannot trust this man and impulsively blocks him. Eventually, she grows despairing of the whole

process: she'll never meet anyone, and her dream will remain unfulfilled. She gives up on dating apps, only to find herself resuming the whole process several weeks later. Her efforts to understand the 'red flags' lead nowhere. She despairs – she loves children and desperately wants a family of her own.

What can be made of this cycle of hopelessness in light of this person's history? She was sexually abused by her oldest brother (several years her senior) as a child. He orchestrated elaborate and sometimes menacing sexual games and, on occasion, her parents very nearly discovered them. These experiences evoke feelings of shame that cause her to grow detached in sessions. Her remote, listless manner is betrayed by an obtrusively shaking foot, or constant sipping from a water bottle. In mid-adolescence, several years after the acts of abuse had ended, and when memories of it already felt distant and unreliable to her, she discovers her brother was being sexually abused at the time by a member of the wider family. She stumbles on this information while overhearing a conversation between her parents but, as far as she is aware, nothing is ever explicitly said or done.

As an adult, she pursues a career with vulnerable children. This starts promisingly but comes to an end when she is suspended due to complaints about her, at times, unsympathetic treatment. She is swamped by feelings of remorse, despite being cleared in a subsequent investigation. Simultaneously, there is an incident – this time with sexual overtones – while she is minding a friend's child. Again, nothing material comes of it, but she feels horrified and struggles to recall or understand her state of mind when these events occurred. She drifts from job to job, with no clear sense of purpose other than to one day have a family.

These slow, obsessional cycles of promise and hopefulness collapsing into disorientation and failure run through this person's life and through our work. Optimistic feelings – that we have made sense of something, that there is the possibility of something different happening – alternate with a seemingly hopeless repetition of thoughts and actions, an endless going over of vague events. The notion of red flags crops up again and again, more often than current popular usage might allow for. This, set against a backdrop of vagueness and silence: her own abuse was never disclosed, her elusive, numbed state of mind makes it hard to think about it, as well as to explore and make sense of the self-harming behaviours she engaged in.

A version of red flags has come up in other work, most concretely with a troubled air traffic controller who, while leading a manifestly stable life, made several uncharacteristic and life-threatening errors at work, which resulted in the activation of actual red flags within an automated safety system. This idea of a warning system that both detects grave danger (notifying all of its existence, including the protagonist, that is, bringing it to awareness) while also setting safety procedures in motion, felt helpful in thinking about this young woman, given her red flags – whatever other function they served – acted to prevent her from taking further steps along the path of realising her dream of having children. Her fear (rather than any real possibility) of perpetrating

abuse may have activated them, but it is fair to say that she could not access thoughts and feelings about the complication of being both abused as a child and, in some way, desiring to exact punishment on children.

The case study demonstrates not only the proximity of the experience of victimised vulnerability – that is, the way in which the inevitable vulnerability of childhood has not adequately protected – but also the way in which experiences of trauma are hard to delineate from apparent conflicts at the level of the super-ego.

## Trauma and the super-ego

In as much as the young woman has been both, unequivocally, a victim, as well as someone with manifest potential to enact abuse, her experience highlights the acknowledgement of trauma and the emphasis on super-ego (dys) function apparent in psychoanalytic accounts of perversion (Yakeley, 2018). She bears all the hallmarks of trauma – the dissociation, the embodied responses, the shame and despair – while the red flags can be regarded as pointing to the compromised functioning of an aspect of mind best described as the super-ego system (Barnett, 2019).

It is possible to emphasise with the young woman's predicament, and yet at the same time adopt a moral position: should this person have children? Such a response in the context of a clinical session might constitute an ordinary anxiety about risk, or an auxiliary super-ego functioning that emerges due to the apparent absence in her mind of any connection between her experience of abuse, the near misses and allegations made against her, and her desire for children of her own. The red flags are suggestive of Freud's watchman (1914c), who has fallen asleep on the job and scrambled to avert crisis by activating a rudimentary alert system; the air traffic controller spoke of a 'break glass' function that served to prevent truly calamitous acting out.

Central to trauma is the failure of the good internal object (Garland, 1998), which, inevitably, also impacts the development of the superego system, both in the sense that the ideal object may be defensively distorted (for example, idealised) because too little actual protective care was available in the early environment (Barnett, 2019), as well as with regards the social dimension that comes into view as the child grows and which may be experienced as, for example, perverse or chaotic. Trauma, therefore, creates the conditions for both defensive dissociation (Bromberg, 1996) and a super-ego that cannot enact good, protective care.

When defensive dissociation is prominent, there is the potential for a return to a state of anxious remorse, as was the case with the young woman described above. But what of the apparent lack of remorse following an act of violence towards another, for example, when instances of child sexual abuse are in some way justified by the perpetrator: the downloading of images does no *real* harm, the perpetrator was appreciating the beauty of the child, the child was seductive, and so on?

Armstrong references Bion's notion of the 'true lie' (Armstrong, 2005, p 19). This is not a straightforward deceit, one where we know the truth of the matter, but opt to misrepresent it. It is known but defended against and serves as a barrier to knowledge that would upend or catastrophically disturb a state of psychological or emotional equilibrium. In other words, it is a barrier to knowledge that would both 'outrage [our] moral system' (p19) and change us. To allow knowledge – to give up our lies – relies on a capacity to not feel it is disastrously unsafe to reconfigure our super-ego system.

Abuse towards children could be regarded as simultaneously a consequence of an imbalanced super-ego and an enactment of the absence of protective care for the vulnerable; the product of a fragile good object and the accompanying inability to protect that object from attack. Seen from both sides, there is the experience of the absence of safety, both in relation to ourselves and to others.

### Working with super-ego impairment as a consequence of trauma

Another example of the interplay between trauma and the functioning of the super-ego system, as well as an attempt to modify the latter, is a man in his 50s who arrives for an assessment following his release from prison for the prolific use of illegal images of children. He is watchful; his language is stilted and precise. When he discloses a few details about his childhood, I gain the impression of its barrenness, an emotionally arid environment with little sense of protective care: a violent, domineering father, a mother too frightened or preoccupied to intervene even when the man is sent away at eight-years-old to a school for children with challenging behaviour where he is exposed to sexualised behaviour on the part of staff.

As an adult, he has a partner, a big man – even bigger than my patient, who towers over me. The man describes an occasion where he became so angry at home that he started to smash plates and break furniture. His partner – who could physically restrain him if he chose to – simply sat nearby, talking to him from time to time, until the man calmed down. I suggest to the man that his partner's behaviour helped him feel safe; he seems stunned by the word. Later, when I use careless language to describe his offense, he stiffens and corrects me: he is at pains to alert me to the harm he has done. Despite feeling anxious of my judgement and subject to his own, he is trying to keep his offenses as real as possible in his mind. He is walking a tightrope, abandoning lies in an attempt to maintain a reconfigured super-ego system that relies for its effectiveness on an increased experience of safety, which has the capacity to transform catastrophic experience into something more ordinary and manageable.

Again, what is apparent in both the clinical cases discussed is the proximity of victimisation and the capacity to perpetrate. It is not that psychoanalytic accounts of perversion fail to recognise this, but rather that the latter

is sometimes emphasised, while the former is not worked with directly. If impairment of the super-ego system is recognised as proceeding from trauma, it seems reasonable to address the latter in a more direct fashion, allowing for the potential reconfiguration of the former. The psychoanalytic frame has great potential to contribute to a sense of safety and, provided the discourse is not, 'predicated by categorical binary thinking – what is right or wrong, normal or abnormal, healthy or pathological,' also has the potential to, 'open up spaces where confusion, conflict and blurred boundaries can be explored' (Yakely, 2018, p 170).

## Conclusion

If we understand trauma as a relational system, established and perpetuated both internally and externally, we are able to recognise phenomena such as self-injury, enacted by people identified as victims, as acts of violence. We are also able to recognise the levels of self-harm enacted by people identified as perpetrators that proceed alongside the enactment of abuse. Both can be regarded as attempts on the part of the individual to find a relational and, at some level, communicative solution to an experience of psychological and emotional devastation in the past.

A more binary division of victims and perpetrators can lead to an emphasis on super-ego functioning in the treatment of the latter. The way in which an experience of protective care – of safety – impairs the development of the super-ego could be clinically overlooked. As with any other traumatised individual, it would be challenging and potentially counter-therapeutic to address issues relating to the super-ego if, in treatment, past trauma is activated, and the individual does not have recourse to the experience of feeling sufficiently safe.

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## Section V

# The professionals

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# 13 Communications from the edge of disclosure

## Responses in art from psychotherapists working in a NHS specialist service for adult survivors of child sexual abuse

*Maggie Schaedel*

### Introduction

The sexual abuse of children speaks through the confusions of many tongues. It is an open secret which is commonly known and disregarded.

The way that disclosures are heard is complex. When the process of *un-knowing* is in the ascendant, a silencing force settles into the space between such knowledge and its subsequent disavowal. Survivors carry the continuing impacts and many live with the dread of what disclosure might mean for themselves and for those whose help and support they need.

When psychotherapists are approached for help, they become witness to the pain, conflict and uncertainty. This becomes communicated to them within the lived space of the therapeutic relationship. I interrogate their responses and the ways that some have used art to explore challenges found in their work. I use material initially prepared in the summer of 2022 for a conference hosted by the Tavistock Trauma Service. The focus is on silence, silencing and the use of art.

Despite their prolific and rich creativity, I did not risk confidentiality by exposing the poetry and art of the patients involved, each of whom I knew throughout their time in The Woman's Service: I conducted the initial assessment process and all subsequent reviews until they were discharged.

While the needs of survivors form the focus of our commitment, the work of the psychotherapists involved is relational and needs to be seen and understood. In this chapter, I concentrate on their counter-responses as they take inside and explore the significance of clinical experience which is at once both shared and intensely personal.

Each art object discussed is associated with the need of the psychotherapist/artist to search for meaning at times of impasse. I have each therapist's permission to publish each piece of art while the narrative construction and meaning ascribed to these works is mine.

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## Current situation

The cultural pull to populate the gaps and silences of historic narratives with disclosures and evidence is backed by powerful research. The findings of The Independent Inquiry into Child Sexual Abuse (2022) suggest the extent to which our human context continues to be shadowed by the widespread sexual abuse of children. The Crime Survey for England Wales estimates that 7.5% of adults aged 18–74 experience sexual abuse before the age of 16.

Parallels are drawn between recent reports of sexual abuse by high-profile predators and those governing the early work of Freud from more than a century before. Made explicit in a short documentary *Hysterical Girl* (Novak, 2021), links are found between the recent and archaic narratives that silence and shame survivors. It is clear from this film that the human struggle to accept this atrocity haunts the psychoanalytic field.

Despite advances in understanding, the grip of denial is sustained at many social, political and cultural levels. Historic "pendulum" shifts in societal perceptions are noticed by Rouf and Taggart (2022) who identify the need to "shockproof" institutional structures towards responding in ways which are socially just and ethical. Such swings are also mirrored in cycles of numbing and hyper-arousal for those survivors who remain isolated and alone in their struggle to bear the unbearable (Schaedel, 2015). Group solidarity is significant in the movement towards change as is the need for support and appropriate longer-term psychotherapy. A collective of survivor groups has articulated such need in a lobby report to NHS England (Lomani et al, 2022). Nonetheless, countless survivors self-censure, remain hidden, silenced and erased from history. Arendt describes the process whereby taboos become secrets which potentiate lethal outcomes: "*The facts I have in mind are publicly known and yet the same public that knows them can successfully and often spontaneously, taboo their public discussion and treat them as though they were what they are not- namely secrets*" (Arendt, 2000).

Within a toxic environment, hope is denied to those who are powerless and lack agency. Many have taken inside the shame of humanity and made it their own.

## Psychoanalysis: Brief background

Psychoanalysis is implicated from its inception. Freud believes the stories of survivors and recognises the impact of incest (Freud, 1905). For a brief time, the newly emerging profession rests on his findings. The serious provocation that this exerts on existing social norms results in an immediate backlash. Freud turns away, concludes that this work is unsuccessful and dismisses the challenge of Ferenczi (Ferenczi, 1949) who becomes ostracised. The psychoanalytic world then goes largely quiet for much of the rest of the 20th century with a few exceptions who dare to challenge the hegemony

of silence (Masson, 1984). More than a century after Freud's earliest discoveries, the prevalence and impact of child sexual abuse begins to receive recognition.

### *The woman's service*

Formed at the onset of the millennium The Woman's Service is an outpatient National Health Service (NHS) specialist psychotherapy service for adult survivors of child sexual abuse. It is a time when global movements of solidarity with survivors is gathering momentum and historic denials are challenged. This trend is reflected in the work of a committee at *The Department of Health* whose subsequent publication Psychoanalytic Psychotherapy After Child Sexual Abuse (McQueen et al, 2008) breaks through the long-standing ambivalence about naming the scale and impact of child sexual abuse within NHS mental health services. A substantial population of women is found to be affected, and advice and guidance policy issued (Into the Mainstream, 2002). All NHS trusts are encouraged to establish women-only specialist services for survivors and the provision of longer-term psychotherapy is key to the recommendations. This call is taken up by only one UK NHS Trust and The Woman's Service comes into being.

As founder and Consultant Lead Psychoanalytic Psychotherapist, I develop a unique service model which deploys many of the insights and recommendations described by Herman (1992). The clinical emphasis is on empathic resonance and validation within phased and bespoke psychotherapy programmes. An ongoing support service is offered to all while the bulk of the clinical work is conducted in group and individual psychodynamic or art psychotherapies. The ethos and environment reflect the protocols of a teaching and learning clinic: the collective witness of a whole team approach and high levels of supervision. From its earliest days resources are drawn from a wide community of support as many visiting experts come to work, teach and learn with us. The strength of the service' community and cohesion is frequently recorded verbatim within many patient reviews:

> From the minute you enter the building to the moment you leave you feel that you are part of a family.

Such encouraging feedback suggests a sense of connection and acceptance which fuel our hopes for change. Our early audits suggested high levels of patient satisfaction with few returning to the ward or other secondary mental health services and this trend has continued.

I was interested to understand this, and in 2018, I arranged to meet a group of survivors all of whom I knew from their time as patients within The Women's Service. Having been discharged some years previously they formed a

self-help group which meets weekly. After more than a decade, none of its members has returned to mental health services. While the reasons for this are likely to be complex and individual, it is clear that a unifying experience is the completion of a psychotherapy programme from within The Woman's Service. This group continues to offer empathic witness, compassion and support. Regular reviews of each other's progress are instituted from the start and forms one of several protocols drawn from our service norms. From this conversation, I sense an intimacy and trust which has evolved over many years and also a shared understanding of the ways that unconscious dynamics of abuse may still be operating within the wider organisational and relational world.

Survivors develop concerns for each other and for those unknown others still isolated and unable to be reached. This is frequently recorded in feedback and reviews. The potential fragility of a much-needed service is also often mentioned as is the desire to have this resource made available to "*others like me*". Reflecting a solidarity common among survivors, the current UK context presses for understanding. A seriously depleted NHS is struggling with the destabilising cuts imposed by "austerity" measures. Stubley (2023) notices how the isolation of the pandemic together with policies which fragment and cut resources impact heavily on a population *"whose inner worlds are already shattered and fragmented by trauma"*.

The need to feel safe is Herman's first principle of recovery (1992). If a service is to be found trustable by those who have experienced significant collapses of holding and security, then appropriate programmes of care are likely to be neither short term nor appropriately governed by one-size-fits-all models of recovery.

The Woman's Service is situated within the secondary mental health services of a large NHS Trust in London. Most survivors seen within this service have journeyed through psychiatric routes, having accrued various diagnoses. Their symptoms and suffering would also fulfil the current criteria for complex post-traumatic stress disorder. The diagnostic pathway reflects a particular and unique context and should not detract from the nature of the insights gained in working with this population. Taggart and Bromboszcz (2024) refer to the results of the ICCSA (2022) report and suggest the need for all professionals to recognise the complexity of the survivor's relationship to care, emphasising the quality of radical empathy needed as part of the process of healing.

Each survivor has a story, unique and unfolding, and I have met many in my working life. While a few may move forward needing no further professional help, for all those seen within The Woman's Service, the traumatic impact continues, remains formative and weighs heavily in the mind and body.

Many of the maxims of The Woman's Service are illustrated in the testimonies of patients and psychotherapists and recorded in a short documentary film *Hidden* (https://youtu.be/kZEGEnHsWHk). The film opens with the

words of a survivor who is describing the dissociative state of "non-being": a residue of the trauma she suffered as a child.

> For the past 41 years I have existed with the devastating effects of being physically, emotionally and sexually abused as a child. There are no easy words to describe that devastation which caused a self- loathing, forcing a part of me to exist in a non- place, a place so bleak and scary that I could never imagine finding the courage to visit what was locked inside, and wouldn't have, but for the support of The Woman's Service.

By the time, a survivor asks for help a vital step forward has been taken. Courage is found to face the risk and danger of breaching a collective silence and this needs to be met within the empathic resonance of a psychotherapist who is witnessing the impact of a primal crime.

### Journey relationship and voice

At the outset of a psychotherapy programme, neither survivor nor psychotherapist can anticipate the dimensions of traumatic experience which may open up. Their commitment is to stay together and to find ways back into an authentic and alive connection.

An adult survivor may take on the guilt of the perpetrator and feel responsible for an attack in which the child's ordinary need for tenderness becomes sexualised. This is described by Ferenczi (1949). The child knows what has happened but has never found a way to bear the unbearable burden which such knowledge carries. When shame and self-blame become consolidated over many years, a long-standing dissociative mind-set continues to limit what may be imagined or felt. Where there has been little or no past experience of empathy, the challenge is to learn to trust a psychotherapist and draws from both current and historic contexts of denial.

The obligation of the psychotherapist is to bear witness and to refuse the disavowal so often inscribed into the survivor's previous attempts to disclose. For this, they need to identify and find meaning within their own counter responses to the work. That this is a moral responsibility is discussed by Herman (1992), while Boulanger (2012, p. 210) furthers this argument, urging the imperative of an imaginative response "This painful leap of imagination necessitates the acknowledgement of horror that is beyond recognition and beyond words. It requires the courage *to join someone whose self has collapsed in the aftermath of interpersonal destructiveness and hatred and to make our psyche available to be invaded by that horror"*.

This task is daunting and at times feels hopeless. As survivors let us know what helps, it becomes clear that at critical moments two minds are better than one. Winnicott D.W. (1971) observes the genesis of hope which *arrives* as infant and caregiver find creative ways of coming together. This idea

reverberates within the accounts of those for whom psychic movement and change has evolved within a psychotherapeutic relationship.

The testimonies of patients seen in The Woman's Service following the conclusion of their psychotherapy programmes are recorded in the research findings of Williams (2017) who organises their responses under three overarching themes of significance to them: *the journey, the therapeutic relationship* and *finding a voice*.

The longing for experience which feels real is termed *finding a voice*. Sexual abuse once forced the child away from imagination and dreaming. At the time of the attack survival meant being psychically absent and *out of mind* while remaining physically alive. These dissociative ruptures of time and space may persist into adult life at times of perceived threat. Time stands still in the dissociative attempt to "escape when there is no escape". This is discussed by Van der Kolk (2015) who asserts that it is the body which *keeps the score*. The paradox is revived "*if I am to live I must die*" and it is impossible to witness an event at which nobody is psychically present.

Now as an adult survivor, body-based pain and multiple fears can make everyday life feel full of threats. Shame is ubiquitous. Nightmares and flashbacks are common and for some the option of suicide is hard to relinquish. Paradoxes abound: the desire to feel fully alive is also feared. Hope and optimism can disappear in an instant as memories become triggered. When all that can be desired is that time turns around and returns a stolen childhood, the present becomes haunted by unreality. Self-accusations follow and rage rises at the injustice, the sheer wrongness of events which changed everything.

At the heart of this anguish is a silenced isolation, a psychic absence for which reflective and empathic witness is sought. On the psychotherapy journey traumatic memories surface within the lived space of the therapeutic relationship. An opportunity may then be found to move beyond shame and toward finding meaning and hope.

*"One important time was when I told my therapist that she didn't understand me and I walked out. When I came back she was still there and we both knew that I was finding myself and my voice"* (verbatim feedback).

This survivor recognises familiar relational patterns. She understands her defensive withdrawal as a legacy of non-recent abuse. It has rippled into her present, threatens her future and magnetises to close and important relationships. Now she anticipates the ways she might defer to someone she needs, especially when feeling threatened with loss or abandonment. She recalls this moment when she managed to bear the anticipation of rejection. In deciding to not "suck it up", her growing capacity to re-imagine herself outside the terms of a groomed reaction is clear. She works at unlearning her fears of retaliation, of rejection and of being forgotten. The way ahead is beset with uncertainty but as she discovers a growing aliveness, she challenges her own internal silencing norms with important refusals. Every move towards disclosure will become an act of courage whenever the shattering impacts of past abuse reverberate within. According to Herman "Certain violations of

the social compact are too terrible to utter aloud: this is the meaning of the word *unspeakable*". Herman is asserting that "the conflict between "the will to deny catastrophic events and the will to proclaim them aloud "is the "central dialectic of psychological trauma" (1992, p. 1). A survivor who speaks with heartfelt longing voices her conflict "I have spent so much of my life trying to forget but now I need to remember". Complex internal and external forces have converged and pressed toward her shame and her silencing. She remembers the moments when she began to "learn to forget" and the loss of liveliness and spontaneity.

If the way forward is to be made safe, the need to reach a shared, emotional connection with a psychotherapist whose authenticity may be trusted becomes vital. Within this intimate context conversations move towards the edge of disclosures. A seeming impossible choice confronts the survivor who faces the risks and uncertainty ahead or of once more surrendering to a silencing invisibility. When an avalanche of rage and terror is feared self-harm or compelling thoughts of suicide may flood. These are raw moments of *agony* (Winnicott, 1974) and hard to bear alone. In recalling non- recent sexual attacks survivors frequently describe a death-like sensation, "*Something inside me died and nothing ever felt the same again".*

Traumatic experience is also communicated wordlessly and inhabits myriad ways that trusted therapists are allowed to know something of what has happened. The desire to *find a voice* reaches into the heart of the work as much distress lies outside of language. As the meaning of a life-long silencing is becoming called out this may be sensed initially in dissociative absences or timeless states of non-being. An adult survivor may still be drawing from the residues of grooming repertoires which once silenced the child. This may now become shared with a psychotherapist.

### The psychotherapist's response

In describing The Woman's Service as a *"model project which learns with and from its patients",* Susie Orbach discusses the complexity of the patient-therapist conversation. Crucially *"the therapist hears the patient and is also able to hear herself AND hear herself being heard*" (Orbach, 2023).

An awesome responsibility is described. Professionals are challenged to calibrate their attunement to the moment-by-moment tensions held within the therapeutic space. This can carry risks for a traumatised patient who may feel overwhelmed by a too direct or short-term approach. Conversely, a life-long legacy of denial may be revived should a therapist fail to respond empathically to important cues. It is not only the weight of unwitnessed personal trauma that survivors carry but the historic reality of more than a century of professional and social denials (Masson, 1984). Many do not expect to be heard and sometimes can hardly bear to believe what they also know to be true. The emergence from emotional isolation becomes a shared journey which is uniquely personal for both survivor and

psychotherapist. Neither really wishes to believe in the dehumanisation which lies at the heart of the abusive act. As they struggle at the interface of thinking the unthinkable, the work stirs strong responses. The personal resonance of the psychotherapist witness becomes imperative and involves an intuitive receptivity. As a survivor finds ways to allow a trusted person to begin to understand what has happened these communications are often unconscious, un-worded and sometimes silent. They may be sensed in non-sequiturs or the rifts within conversations which take an unanticipated turn. At critical moments, the insidious paradigms of sexual abuse become sensed. As the drive towards openness and understanding meets an internal pressure to close down and withdraw, an impending impasse becomes signalled. When the transgression of mental space becomes identified as an intrusive block to reflective thinking the search is on for lost reverie and a missing imaginary. At such times, some psychotherapists turn toward using art.

**The psychotherapist's use of art**

The psychotherapist who can tolerate the paradoxes of working within such dissociative breaches may find certain iconic images of violation deeply unsettling, unable to be either accepted or forgotten. In the gulfs between lived experience and the limitations of training or supervision, the myths of invulnerability become exposed. Sooner or later the impact of the sexual attack makes itself known. The eclipse of spontaneity and the loss of inner expressive freedom is a significant communication. Reciprocal tensions may become refracted within the psychotherapists' own counter-responses and some use art to try to break through the impasse.

Much as a transitional object functions for an infant (Winnicott, 1971), the use of art helps to contain and explore dynamics linked into relationship and to deepen understanding. Milner describes the use of art as a "temporal-spatial plane" (1952, p. 183)), an idea picked up by Rogers (2021, p. 687) who refers to the creative potential of the psychotherapist's art. In describing the creative process, she compares "*the emotions of the therapist, the patient, the patient and the interior of the therapist's room, with the inside of a painting. It also collapses time, place and history so that reality can blur …".* Links are observed between the therapeutic process and the psychotherapist's use of art which holds a vitalising potential for clinical work.

Survivors who are already attuned to sudden ruptures, become convinced that when abuse enters the relationship that this will then hurt or destroy the therapist whose commitment is so needed. Remaining open and present while at the same time feeling cut off and haunted is disconcerting as the *absences* of dissociation and the anticipation of disaster become viscerally sensed. The ways in which such tensions are worked out within and between patient and psychotherapist will become critical for psychic growth.

**The unthought known**

Experience which is held within yet remains unbound by language is termed *the unthought known* (Bollas, 2018). When the active presence of a silencing force is sensed, the challenge is to reach through its deadening hold and to find an alive and resonant emotional connection.

There are many kinds of silences, some generative, alive, holding meaning and uncertainty. But the silenced state in child sexual abuse is affectively deadening and marks an immense and unworded loss.

"What happens when the flood of feeling from the patient makes the analyst unable to think or contain the experience?" Sinason and Conway (2021, pp. 127–129). This question is posed by Johns who writes of those times when the analyst is unable to think. She reflects that her own bodily based countertransference is "a communication from my patient of the extreme overwhelming by fear of death, guilt and horror" (pp. 127–129). In the same volume, Mollon (Sinason and Conway 2021, pp. 105–108) describes forms of consulting room terrors, noting that for some the empathy required "can be too much to bear". Both psychoanalysts suggest that the psychotherapist witness who takes inside an entrenched loss of vitality is tuning into a sensed and deadly force. When the terror repeats, it may be associated to *mind rape*. It becomes hard to think as the imprints of past sexual attacks make their mark and an enforced and insistent entry is felt to collapse the worded narrative.

The links between artistic creativity and clinical work is discussed by Rogers (2022, p. 679) who describes her use of painting as a psychoanalyst in training. She grapples with the seeming impossibility of reaching beyond the scars of her own anxious, internal struggles. As an artist and also a psychotherapist, she discovers an adaptive reciprocity. From fragments of experience held within her experience of painting she learns more about herself and her patient within her clinical work. She notes (ibid) that "deeply attentive states of receptivity and listening" are required to receive this important communication.

The idea that art reflects shared experience which is both internal and external draws from the concepts of creativity and transitional space developed by Donald Winnicott (1971). In describing an intermediate area (1971, p. 14), he refers to an experiential intensity which is retained throughout life, and belongs to art, imagination and scientific creativity.

The parallels able to be drawn between the artist and the psychotherapist rest on the creative potential able to be harnessed within and between both patient and psychotherapist. There are times when it is clear that there is a disruption to spontaneity, when something is felt to block an inner creative resource and an impasse is reached.

In considering the traumatic sequelae of incest for an adult survivor, Bollas cites as most pernicious the impact on the child's psyche in which the capacity for dream, reverie and playfulness have become overwhelmed and the survivor "cannot get back inside her own mind" (1989, p. 180).

He suggests that the psychotherapist's response in such situations is both "regressive and generative", attesting that it falls to the psychotherapist to bear the "fact of transgression" which is identified in the termination of the imaginary.

How a therapist bears and moves through this raw and devastating "fact" draws from uniquely personal creative resources. When the reflective interplay needed for movement and growth is lost, some turn to using art to explore the complex dimensions of relational work.

## Angela

The interface between Angela's work and her canvas is opened up by the worded imperative of its title: *Remain Open* (Figure 13.1).

In a wavy, dreamy space, a melancholic face turns away from the open beak mouth. Thickly drawn lines separate the part which meets the world from a more primitive, darker place where time is suspended. This painting frames important aspects of work in the clinic. We commit to listening for the silenced voices which echo behind smiles which fail to disguise.

That psychotherapists meet up with disturbing states comes with the working territory of empathy and receptivity. This is discussed by Davies and Frawley (1994) who suggest that while making links to past traumatic events is

*Figure 13.1* Remain Open

important, it may not be as essential to clinical work as is the empathic resonance and relationship within

> … the moment-to-moment interpretation and negotiation of an illusory reality shared between patient and therapist that ultimately provides the second chance for…developmental achievements … As patient and analyst work together to interpret the illusory world they have cocreated, a kind of sorting out process ensues, whereby the experiences of each mind come together, commingle, ultimately assume a clearly differentiated integrity.
>
> (pp. 224–225)

Angela is deeply engaged with her patient. She has painted a message to self (illustration 1) to both remain open *and* to reach into the deep where a terrified creature lies shadowed. She listens for the heartbeat of an evolving inner life and while remaining separate yet acutely attuned she symbolises the silenced scream.

**Karen and Jess**

Karen finds ten words returning over and again in her head in a repeating refrain. She can neither digest nor evacuate a sentence which churns inside. Her patient Jess has just described a traumatic childhood event of immense significance concluding with the words "It was going to be a bit of a bother".

Jess had been raped by a "family friend" when her mother was out of the house. She was recounting the moment when her mother told her that she had to go into hospital for a while during which time Jess would be cared for by this same man. As a breezy aside she tells her psychotherapist that at the time she thought *"basically it will be a bit of a bother".* Karen listens to her patient and hears the child in the adult's voice. She catches a glimpse of the way this then seven-year-old girl once tried to minimise her fear and at the same time reassure her sick mother.

Jess hides within a chilled demeanour. She is cool, deploying certain phrases as airy nothings which trivialise and disguise. The word "whatever" often signals her expertise in disguising tension and pain. She also needs her psychotherapist to know the meaning of her anxiety, her despair and her loss of dream. Jess lives with an utter isolation of being. As she details an account of the raw fact of rape, her capacity to move into reflective space becomes overwhelmed. She wanders into a moment of dissociation and her psychotherapist begins to realise the terms of her impossible choice. Jess is frightened by the intimacy and trust of their relationship but without it she remains trapped in a two-dimensional timeless world. Jess is unconsciously cueing Karen to understand that these mindless refrains hide her longing for change. In sensing that these belong to her patient's past, Karen makes this state her own.

Jess believes that she can destroy the one she needs and fears that this may already have happened. She is reaching through the silencing with an important message which Karen tries to decipher (Figure 13.2). She has received the distress signal and needs her art to help her stay psychically alive. She makes a breast from clay, wire, screws, nails and bits of text on paper and explains "*This reflects the way my patient often distances herself from her emotions. I often sense an explosive rage and fear underneath an outwardly-controlled persona".*

An insistent chorus is chiming as hollow and distancing. Karen is wrestling with what feels like an intrusive and controlling domination of her mind but she doesn't give up at trying to work it out. In a solitary place, she cuts the sentence into word-pieces and continues to sculpt. She neither shows her art nor discusses the personal meaning with Jess who needs her to remain open and to be neither taken over nor taken in by a groomed and silenced veneer.

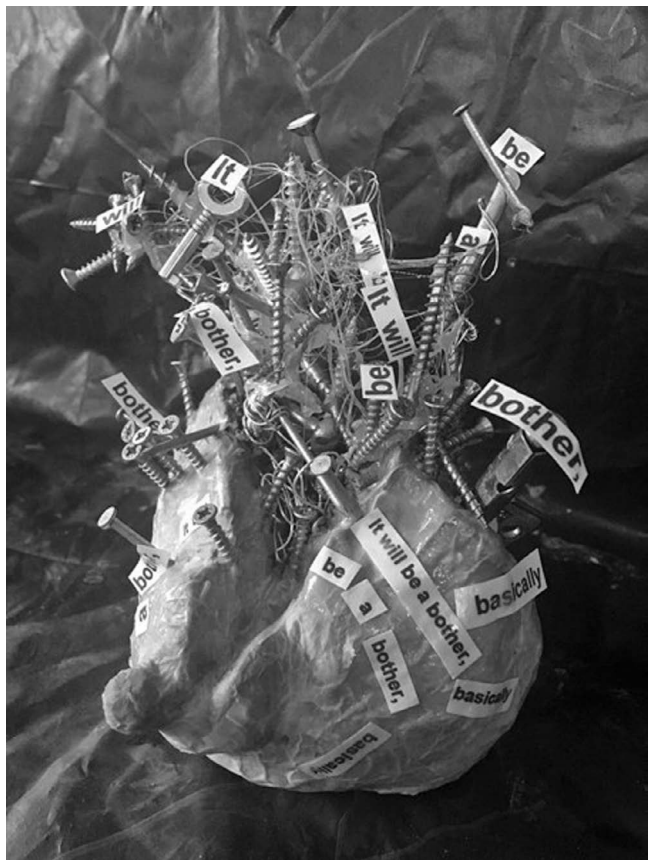


*Figure 13.2* Karen

As she shifts through states of incomprehension, Karen realises that for Jess the longing for intimate contact with the mind and body of another human being holds dread. She cuts to dismantle a deceptive sentence of its power to violate her own mental processing and in doing so repudiates the threat to her own imaginative vitality.

An unspeakable catastrophe is represented within the fragments of a dissonant narrative. What hasn't broken down is the commitment to stay the course and as patient and therapist return to each other they work it out.

Karen has glimpsed the violation of psychic space within the wording of a monstrous truth which transmutes instantly into a numbed denial, "*Whatever … bit of a bother … no worries…",* familiar catchphrases which mark the place where loss and shame collide. Now they combust in the crucible of her art. Karen is navigating through a fake and flimsy narrative and reaches beyond the futility of attempts to graft words on to an essentially mute exchange.

The impossibility of the wish to return to a time before the catastrophe, when the fabric of feeling and thinking became shredded is heartbreaking. Karen is symbolising the trammelling of the play spaces of infancy and childhood which for Jess have left both desire and dread. Karen's response is compassionate. The less her patient fears retaliation for the attack on her holding and nurturing, the more she will eventually be able to bear her own vulnerability.

I meet with Jess for her final review. We notice together how her sense of shame has begun to dissolve. She no longer feels alone in bearing a wordless horror. She has found courage to risk a close relationship and understands this as an achievement of mourning and of love.

**Mandy and Asha**

Some years ago, I assessed and offered a programme of therapy to Asha, the survivor of an appalling atrocity about which little had been recorded. When details reach media headlines with more victims announced daily "*new evidence is emerging…"* the reports corroborate our patient's bleak accounts with a deadly accuracy.

The sheer scale and force of the human atrocity of child sexual abuse feels overwhelming. I watch without seeing as a stream of mediated material explodes the limits of my capacity to process the horror described.

I know what is being said but can't quite take it in and yet I am enslaved to the story, returning compulsively to the screen. Sleep is elusive, and memories return me to the times when Asha made serious efforts to kill herself. For a time, my world feels clouded by a sickening uprush of dread and culpability which threatens every waking moment.

In the days that follow, Asha continues to come to the clinic and her psychotherapist Mandy lets us know what is happening. While Asha is troubled by the headlines, she is holding herself together. I settle into some relief and trust that our clinic life continues. Our evening service is in a dedicated and

secure building which is warm and well-lit. I call to mind our receptionist whose familiar welcome Asha has come to recognise as personal. In a matter of moments, I can inwardly register the whole history of The Woman's Service woven through with collective courage. In my mind's eye I see Mandy with Asha in the art room, heads together, paint on their hands. As I begin to feel less powerless, less alone, I go into my garden and the fields beyond. Here I find the canvas and clay for my own creativity. The small promises of re-creation are breaking through the illusory stillness of winter.

All of us who know Asha are affected. Mandy becomes concerned that the media reports might stir the self-retroflection of her patient's rage. On returning home from work she describes herself in a state, "*a mess of insatiable rage*" and records a sequence of events (Figure 13.3).

Mandy goes outside with paper and paint, her anger and frustration escalating because there "*didn't seem to be enough paint*". In her verbal narrative, she is collecting visualised images, noting that she has *"used up all the squeezy bottles and all the wallpaper lining roll"*. As she pulls the *mess* together, she notices that it resembles the shape of a heart and recoils at the thought of putting this into the recycling bin. She makes a fire, and as it burns, she experiences an inner transformation. *"A powerless and unwieldy rage gives way to a sense of empowering and tender fortitude"*.

*Figure 13.3* A mess of insatiable rage

Subsequently, she turns towards psychoanalytic theory, feeling shored up by the work of important theorists. She feels inspired by the writing of Joy Schaverien and the possibility of bringing the unconscious to a form where it can be seen understood and reintegrated through the use of art.

In "The Revealing Image. Analytical Art Psychotherapy in Theory and Practice" (1992, p. xi), Schaverien suggests the use of embodied image-making as a way to understand and reintegrate aspects of experience lost to consciousness. This is in the service of more fully understanding the therapeutic relationship for the benefit of the patient. It is the embodied (as opposed to diagrammatic image) which offers "a means of understanding the significance of the aesthetic impact of the transference embodied in the art object" (p. xi).

While accepting that she has found herself in the grip of a traumatic paradox, Mandy explores her own need to manage and contain this *mess*. She is consumed by a visceral disgust at the thought of recycling and subsequently links this as a metaphor for the ways in which her patient's night terrors become "*recycled, returning over and again as raw shame".* In reminding herself of the compassion needed to stay and listen she wonders whether Asha might be able to offer this to herself.

Recently, Asha has begun to reflect on the strength of her own survival. A memory has returned from an earlier and desolate time when she found important resources from the land. Mandy writes "*Asha wonders with awe how Mother Earth kept her alive*". Alongside her longings to re- find the experience of earth mother, Asha lives with a terror that were she to find this and lose it *again* then chaos would lie in its wake. She links a raw existential terror to the break-down of an early environment and relationship in which she had once been held.

In referring to such dread as *primitive agony*, Winnicott (1974) interrogates the *fear of breakdown* as a torment which essentially belongs to a past catastrophe and which leaves those who live in its wake in fear of its revival. Paradoxically they are also driven to search for the realness of this lost self-experience.

Survivors allow us to know about the longing for what *might have been,* how the past has never really passed and the ways that abuse continues to reside in their fears and the realness of body-based pain (Van der Kolk, 2015). They long to reclaim life and living. That this can also become a source of shame and fear is now shared with a psychotherapist who remains actively present.

Mandy's concerns for her patient have led her to locate the *fear of breakdown*. Meaning becomes shaped when language arrives, and while pain and fear are identified, there is also hope and empowerment.

> *So I burnt the work as an offering back to the elements. I offer up the suffering of my patients, the ones I hear of in supervision and the others The Woman's Service holds, as well as wishes for myself and all those who work within the Woman's Service to the deities of my personal spiritual tradition*.

Mandy does not know precisely what she is making but remains open to its impact, sensing that it is reparative. As imaginative connections evolve and with Asha held in mind, she realises that without a nurturing and reflective mind the transformative potential of reverie is impossible (Figures 13.4–13.8).

*Figure 13.4* Mandy

*Figure 13.5* Mandy

*Figure 13.6* Mandy

The rape of a child is an act of brutal possession which leaves no space for play. The adult survivor longs to find voice and vitality, but there are times when staying alive to truth and memory becomes impossible and the pulse of progress slows to the pace of hibernation.

In the context of the work discussed, the psychotherapist who works with compelling bonds of empathy senses a helpless passivity within the impasses of ongoing work. When located within mind-numbing repetitions, it is identified as the psychic replay of violation.

The therapist's task is to contain and to help transform the ways that the sexual abuse of the child has become psychically embedded within the adult's continuing vulnerability. As internal landscapes of dream and imagination fragment, the psychotherapist is both witness and participant. The transgressive *fact* has become identified as an intrusive block to reflective thinking.

*Figure 13.7* Mandy

According to Benjamin (2004), the shared therapeutic space is always being lost and found, breaking down and becoming restored. She writes of an increasing integration of previously dissociated self-experiences which become introduced into the therapeutic relationship and from there into the self. She suggests that the central active movement of psychotherapy is between "*rupture and repair*".

Within the art-making processes described, fragments of disconnected experience not yet assimilated into a coherent narrative are shaped and framed. The psychotherapist-artist is not so much speaking a different language as grappling for insights able to be wrested from ruptures and confusions.

Angela is listening for the voice of someone for whom silence means being forbidden to speak. She paints through the symbolic impoverishment of language and barely audible sounds, finding words for the courage she needs to stay present: *Remain Open*.

*Figure 13.8* Mandy

Karen realises that her patient's bleak storyline flags a sub-symbolic and traumatic event. In her art she pursues the intelligibility of an off-guard quip, the gravity of whose undertones she senses. She is holding her patient's despair while forming the shapes of unthinkable loss. As she claims space for the imaginary and for mourning, she asserts the continuity of existence.

Mandy responds profoundly to states of mind in which time and memory are occluded. She allows herself to become immersed in a sensory immediacy as she creatively explores the turmoil of a feared psychic collapse. As she takes a reflective step back, she can hear her art speaking back to her. Mandy is learning about regeneration and containment as her patient is connecting with what has bound her to life and living.

## Conclusion

Adult survivors of child sexual abuse may struggle to move beyond a numbed and haunted inner world as the longer-term impacts of traumatic early experience becomes represented in dissociative blocks to symbolic mental processing.

The fear of becoming pulled toward the annihilation of the creative, dreaming mind is identified within the counter responses of the psychotherapists

whose work is described. They bear witness to what survives when words fail or are forbidden.

Within the shared space of the clinical setting, a sensed mutuality of need evolves: to more deeply understand unprocessed experience and to find symbolic form for expression and emotional integration.

Through the psychotherapists' use of art, an embodied form of witness to unworded suffering becomes imaginatively inscribed and a transformative potential discovered.

Resting on powerful dynamics at play, vitalising connections and shifts occur as new states evolve in a growing capacity to refuse the silencing norm. A temporary symbolising potential becomes held on behalf of their patients as psychotherapists work to imaginatively capture the depth and living presence of the *unthought knowns*.

Clearly, an account which privileges the psychotherapist's response has shadowed the unique perspectives of the patients involved. In the final frames of the film *Hidden a* survivor describes the impact of psychotherapy. She chooses a visual metaphor to describe a deeply transformative process

> … being able to see colour through the eyes of someone who feels colour is so different from looking at colour for a person who just feels grey inside". I don't really understand how it works (psychotherapy) but I just know it does.

This survivor is describing new possibilities, a changing relationship to self and other, one built on connection, realness and trust. This process is not without risk. As survivors and their therapists move through states of bewilderment and uncertainty, trust and hope are hard earned.

A powerful paradox is embraced: while the trauma of sexual abuse invades mind, body and soul, courage also grows from creative acts of repudiation. As new connections are formed there is movement and growth which reaches beyond history simply repeating.

When faith is lost in the validity and complexity of personal experience, the transformative potential for a rich re-imagining is found in the use of the creative arts.

We have drawn inspiration from those survivors whose courage and creativity have formed the matrix of all our work. We have discovered an immense privilege, becoming more known to ourselves in our vulnerability and our humanity.

This chapter is dedicated to all those who have found a sense of belonging and a home within The Woman's Service.

Thank you to all those who have shared their art within our team and given the whole community of The Woman's Service an opportunity to think together.

I am especially grateful to Mandy Bruce, Angela Haren and Karen Stevenson whose work is represented in this chapter.

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# 14 The importance and struggle for teams to think reflectively when working with people who have experienced childhood sexual abuse

*Louise Allnutt*

It is widely recognized that reflective practice in the workplace can provide a helpful environment for making sense of challenging emotional experiences. A foundational example of such is the Balint group in hospital settings. In specialist trauma settings, a space for teams to come together as a group to reflect on their experience while often viewed as essential, can also feel daunting. Work that consists of supporting or treating people with abuse related traumatic injury carries risks of vicarious trauma and an emotional impact that can include feelings of shame, anger, and exhaustion. This can be challenging and distressing for team members whatever their level of training and experience. The proximity to the relational dynamics, such as abuse of power, breaches of trust and fear and intimidation, that can be left in the wake of abuse can lead to work relationships becoming saturated with feelings of distrust, fear, betrayal, and loss. Reflective practice is one way to ensure that staff groups have opportunities to process and digest their experience in the hope these relational dynamics and emotional stirrings can be 'worked through' (Brenman Pick, 1985) together in a safe space. For Pick, the process of working through in the counter transference, refers to the importance of acknowledging our feelings and responses in the service of getting to know the deeper impact of a relationship. 'Working through' in reflective practice, therefore, is an opportunity for deepening our understanding of the predicaments of our patients and clients through our greater awareness of the emotional impact these relationships have on us.

In services that work directly with childhood sexual abuse (CSA), there are some specific dynamics that emerge for staff groups and individuals while supporting people with experiences that disturb the very depths of basic trust and care. The kinds of feelings that can be stirred up in settings such as these can be distressing and can illicit complex defensive behaviours for clinicians and workers at all levels of the hierarchy. Childhood sexual abuse is deeply shocking, socially taboo, frequently misunderstood, and quite naturally something we all retreat from in our minds. The recent increase of more open public forums for discussing CSA has led to greater appreciation of the extent of CSA and the institutional processes that have led to its prevalence. With the publication of reports such as IICSA (2022) and public exposure of

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chronic institutional denial of offending, there is a growing social agreement that CSA is something we all need to be in psychological contact with and an understanding that without being such, CSA will be perpetuated.

In psychoanalytic terms, the emotional stirrings and reactions to CSA can be understood as part of the countertransference responses we have to any human relationship or emotional experience, but perhaps for CSA in particular, these are more pronounced, disturbing and are perhaps less familiar. Brenman Pick's (1985) task of working through in the countertransference then, while it can deepen our understanding, can also leave us with disturbances and anxieties that feel out of place and uncomfortable. Reflective practice, if facilitated to draw on this experience, can make good use of these complex feelings at the same time as bring about greater resilience for managing this kind of emotional burden. Countertransference is a technical concept that refers to all aspects of experience and communication. These are the kinds of emotional experiences that are not perhaps as available to our conscious minds and emerge somewhere on the threshold of the sensory level of experience and the perception of such. Coming to some kind of realization through making sense of these experiences can feel quite uncomfortable at times and can demand us to tolerate not always immediately knowing what has come to life within us. There are heightened levels of 'countertransference' responses in clinicians responding to patients who have experienced sexual abuse. As Trowell and Kolvin (1999) points out, this may be distress, despair as well as revulsion, in response to hearing about people's experiences. As one member of a reflective practice group in a service that supported young people who had experienced childhood sexual abuse put it:

*I have sometimes been so taken aback by the way children can tell you things almost in a matter-of-fact way that it takes a moment to register what they are saying. They are often more worried about upsetting others by disclosing what has happened and fearful that somehow, they have done something wrong.*

*These are painful things to hear and often there is no time to begin to process them. Reflective practice is so important in helping me to have the time and space to do this and to express my feelings in a safe and contained place and where those feelings are attended to, and I am able to release them.*

## Models, approaches, and context

The use of a psychoanalytic lens for understanding organizational life has been well utilized in public health settings. 'The Unconscious at Work,' edited by Anton Obholzer and Vega Zagier Roberts (1994), is a collection of essays focused on teams that were supported by consultation with a psychoanalytically trained eye. Many of these chapters deal with the specific nature of challenging workplace environments such as hospital nursing, or caring for older people, through which we are introduced to the powerful mechanisms of unconscious processes and their manifestations in work relationships.

While this collection doesn't look at CSA in particular, there is much to learn from these chapters that is applicable to a setting where the emotional impact of the work is such a significant part of the context. Within this frame of reference, the processes of transference and counter transference in making sense of the emotional level of experience that may not be so accessible to thought at the surface can be helpful, as well as a relief to workers, particularly when perhaps there may be conflict or heightened levels of feeling. This kind of focus on a team can also help the team to pull together and create a container for the feelings that otherwise put great pressure on individuals. The experience of working in a highly complex family assessment service often gave me a sense that the team held a containing function not only for the individual families, but also for the clinicians. The emotional impact of our close experience with the families was shared within the team in honest, frank, and open ways, although this was not always straightforward and could be difficult to bear. We were fortunate to have the support of a highly skilled psychoanalytic consultant – someone who could help us digest and share the experience of our work. Now as a group facilitator I often refer to the difficulty to digest and the struggle to be in in touch with the feelings stirred up by the immediate impact of cases we hear about – supporting the group to steer away from the pressure to reject this emotional experience and turn too quickly to intellectual activity. This can be particularly acute in groups who work with CSA as there so often pressure to push the task into the level of management, outcome processing, and model development – all of which of course need to have a place but are perhaps sometimes turned to when the emotional impact can feel a burden and a threat to the wider functioning of the team.

While the psychoanalytic lens helps to bring otherwise unconscious processes to the surface, attention also needs to be paid to the system and social context. Without this, the intense focus on the emotional and unconscious content can feel like a burden for a team and lead to feelings of stuck-ness and helplessness. In this sense, the 'purpose' and 'task' need to be identified and supported in the reflective process. CSA has a social and relational context and choosing to work in this field is often marked by understandably strong feelings of hope in supporting recovery alongside a need for justice. In reflective practice and organizational support terms, this level of investment is important to acknowledge in this work. Without acknowledging the social motivation and the task of the system, the trauma and its impact can feel overwhelming and threaten to undermine the task, which in turn can alienate staff from their core values and purpose. In the 'Unconscious at work' (1994), Mosse acknowledges, 'We view organizations as social systems to be studied using the established methodologies of the social sciences, but with an unconscious life to be studied psychoanalytically and we also believe that the social and the psychoanalytic perspectives must be deployed together if real change is to be effected in those aspects where structure and unconscious function overlap' (p. 1). I think this is particularly essential with regard to abuse-related trauma. Power relationships and hierarchies are both present in

families and teams and it is often along these axes where abuse takes place. In my experience, it is also across these axes where one tends to see most of the challenging dynamics emerge in services attending to this kind of abuse. As Trowell points out, 'Whenever clinical work, training or research focuses on child abuse, in particular sexual abuse, it is highly likely that issues of power and gender will lead to conflict.' (Trowell and Kolvin, 1999: 82). This can manifest quite easily between managers and staff, particularly when there is some distance between the two roles. In the clinical domains, empathy and emotional understanding of someone who has been significantly harmed by another person in a position of trust, can lead a clinician or support worker to feel somewhat sensitized to the emotional manifestations of these dynamics in other settings. In the work context, disagreements can easily arouse such emotional responses and an otherwise expected part of hierarchical relationships can easily lead to an idea that the feelings aroused by such relationships are evidence of abuse and neglect.

Without due consideration of the system, there is also a risk that these dynamics can feed into further enactments. Examples of this may include powerful feelings in more junior staff that senior management are being manipulative or neglectful, mirroring abuse dynamics whereby the abuser exploits the victim and disregards their needs. Narratives along these lines may involve complaints around workload expectations or feelings that managers dismiss the emotional impact of the work, invalidating the importance of abuse and our emotional responses to it. There are times when of course these kinds of complaints need to be investigated; however, it is interesting how often these narratives emerge in those services where the client groups are similarly haunted and disturbed by breaches of trust in dependency and hierarchical relationships.

The dynamics that frequently emerge in CSA focused services are perhaps more acute in multi-agency settings. The models of care that are frequently referred to as best practice for CSA are those that bring agencies together in ways that allow service users to feel better held and heard (e.g. Barnahus model). However, they also pose some pitfalls and potential fault lines, which can play into dynamics of power, if not explicitly explored in a reflective way. A common example is an overarching sense that relationships that are underscored by differences in power are at best competitive, at worst abusive. Multi-agency settings are perhaps at greater risk of replication of such complexity in the dynamics if there are, for example, differences in the funding arrangements between the agencies, or indeed differences in practice as one might see between the role of an agency focused on advocacy, compared to perhaps the medical interventions required for assessment through a healthcare agency. While most of the time these differences may not cause too much conflict, when the kinds of dynamics emerging in the clinical context are emotionally challenging, it can be more difficult for professionals to fully appreciate the source of emotional burden in the system. At these moments, these differences can become fraught with anxieties about power and

distrust. In this context, these complex dynamics are a possible replication of the abuse of power frequently experienced by victims of CSA, in which a parent or trusted adult has breached the boundaries of the hierarchical relationship and have abusively undermined the needs of the child. In the workplace, it isn't necessarily a reality as such that exists within the hierarchy but a sense or an expectation that emerges when faced with an experience of disadvantage or emotional distress. However, if this experience is not disentangled and understood, it can start to feel quite concrete, 'as if' there is a reality to the emotional experience. This can happen institutionally as well as between individuals. The complexities of bridging the disclosure of CSA between the social care system and the criminal justice system as well as the contrast between the investment in a workforce to support people with current and non-recent CSA and the limited public funding available to support such work are all examples of the kinds of complex fault lines through which abusive dynamics can become active and take hold institutionally. In my experience of facilitating reflective practice groups, these issues are frequently raised within a group and need repeated attention, to fully guard against further negative influence in the functioning of the system and a repetition of abusive dynamics across the system.

## Reflective group experience

It is not uncommon in reflective practice groups for staff who work in the field of sexual abuse-related trauma to reflect that their work is not something that is easy to share in their external social relationships. Themes around feeling the world 'outside' wouldn't get it or would withdraw from hearing about this area of work come alive in team discussions, further emphasizing how important the team is felt to be. Many group members refer to the experience of shock and silence at the dinner party when talking about the nature of their work and workplace. Staff members report feeling a sense this work should be hidden and not talked about, almost perhaps as if even thinking about it could lead to some kind of contamination for a group engaged in socializing.

Alongside these social responses and the taboo-laden resistance to hearing about this work, are the complexities around the experiences within the workplace itself. One of the primary tasks in this kind of therapeutic environment is to create a safe and supportive space, in which someone can feel held enough to begin the process of putting a narrative to their experiences. Clinicians and social care staff can work incredibly hard in creating such a space, however, even with all their best efforts, unconscious processes can lead to unintended enactments of dynamics that regularly emerge in relation to CSA. As highlighted above, countertransference responses are heightened in these contexts. Hearing about terrifying and deeply disturbing experiences can understandably lead to high levels of sensitivity to the ordinary pressures of working relationships. Should these emotional experiences not be possible to contain or manage

through support networks and positive relationships at work, staff groups can develop defences that serve to block out and deny the reality of the experiences that have led to such levels of feeling. For many survivors of childhood sexual abuse, the emotional impact of living with the memory of abuse has a similar quality and the experience of bringing abuse into the present can inevitably re-traumatize; disturbing an individual's sense of security and requiring the manifestation of defences to keep disturbance at bay. In the workplace these dynamics put great pressure on even the most effective therapeutic service.

During a reflective practice group with a mixed group of staff, working in a setting supporting families with histories of childhood sexual abuse, a group member brought a clinical situation in at the beginning of the meeting. They described a parent contacting them to let them know they wouldn't be able to attend a parent support group. The parent explained that they had just heard some previously unknown distressing news about sexual abuse that had happened to a relative and felt unable to attend the support group. They feared this might re-ignite painful memories for other parents present if they were to come and talk about their experience. The group facilitator explained to the other staff members that the group had recently moved into different territory where hope could be held a bit nearer to the surface. When the reason for the parent's absence was relayed to the parents' group by the group facilitator at the beginning of the group, little was said, and the group of parents appeared to ignore this new information about the absent parent, which the group facilitator thought was odd. The parent who was absent had been attending this group for a while and seemed to have taken an important role in the group.

As this scenario was introduced into the staff reflective space a lengthy period of heavy silence ensued and the individual who had brought the scenario started to wonder aloud if perhaps, they had taken too much space from the group – they had in fact not attended for a while and wondered if they should have brought this in at the beginning or perhaps waited until others had spoken. It was suggested to the group by the facilitator that perhaps, like the parent group, this group was now ignoring this new information and the individual who had brought it was picking up the projection from the group; perhaps they too should have cancelled and not turned up today – should they have kept this difficult experience away from the group – had they now contaminated the group in some way. On thinking about this for a moment, another member of the group dismissed this, claiming they were in fact 'enjoying' the silence. It felt to the facilitator that the group were struggling to manage the painful experience of silencing, claiming in fact this was part of their enjoyment and not to be negatively reflected upon. The introduction of the sadness about the parent who felt unable to attend their group with their acute current concerns, despite knowing this was usually a supportive group, was a reminder of a propulsion to silence trauma in the wish to hold onto hope and enjoyment. Silencing the arrival of the abuse in memory can be a re-enactment of the silencing experienced by the child or young person who

is living with the knowledge of the abuse and not being heard – an experience referred to by many survivors of abuse in their reflections.

The fear of contamination brought about by the new knowledge of non-recent abuse, while wasn't felt possible to be brought by the parent, was brought to the staff group by the group leader. The re-enactment that emerged was perhaps an opportunity to reconsider the issues around silencing and intrusion. The reflective practice group in this instance, once the enactment had been somewhat acknowledged, was able then to turn their attention to their ideas around what would constitute a safe space where all aspects of the group's dilemmas could be heard. While important for staff, this experience was also potentially beneficial for the adults, young people and families who were relying on them in the service. This experience of 'working through' was also alerting staff to the importance of addressing this in the system and the way it can operate dynamically to deny unwelcome information, knowledge, and emotional experience. In these circumstances, it is ordinary to resist knowledge or awareness of complex dynamics in the workplace – sometimes in relation to the families and at other times in relation to the team or system. The pressure to 'turn a blind eye' is experienced in several ways, which of course if enacted reduces the impact of the therapeutic space significantly for people using the service. The circumstances that surround child sexual abuse can feel as damaging as the abuse itself, such as the silencing and disbelief in families and institutions that can lead to its perpetuation as well as place the survivor in a state in which disclosure feels almost impossible.

As mentioned earlier, dynamics and conflict often emerge across hierarchies and power relationships. In less integrated teams, the expression of upset or having a perceived lack of emotional containment can sometimes be identified as complaints or a lack of professionalism by those in management positions. In my experience, the difference in services where this is not as problematic, is less to do with management having more professional experience, and more to do with management being in greater proximity to the interface between service users and the service. In services where management do not have proximity with the impact of the work, inevitably leads to a sense in staff on the ground of not feeling their relationship to work is understood. In services with a CSA focus, this perhaps comes to the fore more easily than in other environments. There is often a pull in two different directions being enacted, the wish to understand on the one hand, and the wish to forget on the other.

The split can also become quite stuck if the resistance to hearing about the experience of those undertaking direct therapeutic work and its impact can't be worked through. This is one of the important reasons why staff and management need, in my view, to share reflective spaces together. In a reflective practice group, I facilitated in a multi-agency setting there was often a struggle to ensure that both those who had direct engagement with their service users and those who worked in management roles regularly attended the group and shared the space together. On those occasions when this was

achieved the outcomes for staff in feeling heard and having the opportunity to make sense of the tasks preoccupying managers were far more effective and positively experienced.

On one such occasion, a group member reflected on a change to the program being piloted by the service, owing to some pressure on funding and time management. The staff member reflected on this experience. It had been incredibly challenging. Their memory function had been significantly impaired following the change and they had felt overwhelmed by the content and in particular the feeling expressed in the additional conversations she had with the service users. They struggled in the group to disentangle the narratives of the assessments, failing to remember the country of origin of one of the young people and the family background of another. They were visibly upset by this and started to express deep dissatisfaction with the management. They felt they were 'out of touch,' with this experience and felt the idea of overwhelming them with this kind of experience was abusive. While they talked, my sense was that this group of managers who were piloting this model, were felt to be cold and heartless, faceless figures who had little care for the emotional experience of their staff but were primarily motivated by power and money. It was immediately relieving for the group when a manager spoke to this phantasy, describing in detail the experience of sitting in a funding meeting and needing to find solutions to the realities of funding pressures. The dynamic that had surfaced in the emotional distress felt by the staff member was one of an abusive authority undermining the emotional lives of a less senior worker who couldn't say no. While in this state of mind, they had a narrow view of the role of the manager and a two-dimensional sense of an abusive dynamic, in which there was an abuser and an abused. The manager helpfully and openly acknowledged the emotional experience of the staff member as well as openly discussing the role they were taking in their ordinary management of a complex service with limited funds. It was encouraging that by the end of the group, there was some lighter more open communication between the staff member and the manager about how they had not been able to 'trust the parent managers, because they had felt so burdened.' It was important for the staff member to understand the manager and vice versa, particularly in relation to the emotional impact of the work and the reality of even the most experienced minds, needing space to do this kind of thinking.

## Conclusions

Work with families, children, and adults who are struggling with complex and challenging emotional responses to CSA, demand us to reflect deeply upon ourselves in sometimes uncomfortable and frightening ways. Reflective practice can be a helpful context for making sense of this emotional burden, experienced by individuals and groups in the workplace. It also offers a unique and facilitative context for deepening understanding of the dynamics

of CSA, including silencing, distrust, and fear, with the aim of a team learning from experience in a safe environment.

As a breakdown of the ordinary and expected shape of experience, trauma undermines trust, as discussed in Susanna's chapter. The dynamics and complexities that emerge in the workplace in relation to trust are more pronounced in the context of CSA. It is therefore even more imperative that reflective spaces are given their full weight in supporting teams to explore their relationships to each other as well as those with their work.

A common characteristic of CSA is its hidden quality. This is something that permeates into the experience of CSA as a 'taboo' in society and to work in this field can often feel like you're somehow involved in something you should keep quiet about. The feelings of isolation and concern about one's relationship to work can be supported and strengthened by a sense of belonging to a team. Reflective spaces in this sense are team containers for the emotional challenges that this work can arouse for individuals and therefore can contribute to the creation of therapeutic environments that feel more nurturing and supportive for both a staff team and the client group they support.

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## Section VI

# Systemic and social perspectives

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# 15 Repetitions and re-enactments of NRCSA trauma within the mental health system

*Joanne Stubley*

In this chapter, I will describe how aspects of the current mental health system may potentially reflect, replicate, reinforce and repeat different components of the traumatic experience of child sexual abuse (CSA) for adult survivors. Understanding why and how this might occur at both an individual and a systemic level is essential for all mental health staff to prevent or at least reduce, re-traumatisation of survivors and vicarious traumatisation of staff. It is also the necessary beginnings for truly trauma-informed care in the context of compassionate and relationally driven mental health systems. In working therapeutically with CSA survivors, it is vital to recognise the broader societal issues that contribute to the traumatic experience and may impact upon the professionals and institutions offering care.

Trauma surrounds us. The world is facing a climate crisis, an existential potential for annihilation that has never been seen before. This brings with it the growing mass migration of peoples as their environments become increasingly uninhabitable. The impact of the Covid pandemic on social structures is ongoing, despite a societal wish to place this firmly in the past. Neoliberalism and capitalism leave their destructive mark on communities with growing inequality and social and economic injustice. The Black Lives Matter movement helped to highlight the centuries of oppression trauma which continue to be transmitted down the generations whilst the #MeToo response drew attention to the pervasive and ongoing gender inequality and trauma as a part of the patriarchal systems. Hardy (2019) describes the interlocking of sociopolitical oppression and trauma that is systemic, pervasive and protracted over time. He includes in this description impoverished peoples, women and racialised minorities.

And whilst this oppression trauma might be considered as impacting these kinds of specific groups within society, this view fails to register that the reality is we are all affected and that the aftermath of traumatic injury is in the social and cultural fabric. The definition used by Argenti and Schramm (2009) for cultural trauma is:

> A tear in the social fabric, affecting a group of people that has achieved some degree of cohesion.
>
> (p. 4)

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The pandemic may be viewed as one example of cultural trauma. The New York Times in April 2023 quoted the US Surgeon General describing an epidemic of loneliness, an epidemic that is killing people as surely as cigarette smoking or the Covid virus (Murphy 2023). What does this mean in a world more densely populated than ever before and how do we begin to understand it? With this loss of connection and disruption in a sense of community comes a loss of compassion for others, a greater division in society between "us and them" and all of the prejudice this othering provokes. This leads to alienation. The rise of conspiracy theories seen so clearly in the pandemic is linked to a greater sense of institutional betrayal by our governments and leaders, fuelled by the psychology of mistrust and isolation.

The epidemic of loneliness is perhaps the clearest evidence we have that the tear is the social fabric has been so profound that we have lost cohesion, our communities are fractured and perhaps the most important survival requirement for human beings of social connection has been diminished.

Judith Herman, the American psychiatrist who originally used the term "Complex Trauma", said:

> The core experiences of psychological trauma are disempowerment and disconnection from others (1997).

This emphasises the helplessness inherent in the experience of trauma, as conceptualised by Freud in his notion of a protective shield that is breached by experiences of extreme helplessness (Freud 1920). It also highlights that trauma impacts upon relationships, straining if not shattering the bonds that facilitate our social connectedness. Trauma is thus an internal experience and inevitably a relational experience as well. It leads to disempowerment and social isolation and therefore any therapeutic intervention needs to recognise the impact of trauma on the individual's psychic life and on their relationships. Interventions need to be aware of the broader societal issues that are further contributing to the traumatic experience in relation to the cultural and collective traumas described above. And interventions need to hold as central the necessity for a relational connection, which may be required over a considerable period of time.

All trauma involves loss, and it is the work of mourning which supports movement out of the closed trauma system, out of trauma time, to occur. And yet trauma, by its very nature, means mourning may be experienced as difficult if not impossible. How does one begin to think about what is unthinkable when symbolic capacities have been impaired by this unthinkable experience? How does one remember when the memory is not held in one's narrative but rather is in the body as somatic flashbacks, intrusive images or nightmares? Or else has been dissociated so that it is no longer available to be remembered and without memories how does one mourn? How does one begin to bear the affective experiences of grief when they have been felt to be so unbearable that attempts to manage the guilt, shame, rage and pain, to

find a "solution" may instead have been employed? What I mean by this is that the emotional states are dealt with through these activities and the trauma is hidden away beneath them. Solutions such as addictions, eating disorders, gender dysphoria, self-harm, extreme sports or overwork. Tolerating uncertainty and not knowing is part of the mourning process and can so effectively be bypassed by these kinds of solutions that offer certainty and shut down thought and curiosity. The solutions found in this way then become the symptoms the mental health system assesses for, bases its organisation around and focuses on.

Even before the COVID pandemic, the mental health system in the UK was an overwhelmed, resource-depleted, struggling health service which somehow has still managed to hold the hearts of most of the population with its central descriptor of "free at the point of entry". The growing sense in the NHS, and perhaps particularly in mental health services where parity with physical health has still failed to appear, is a system which is broken.

Re-organisations abound, often cloaked in terms of transformation which has become a by-word for further cuts and limitations of services. To attempt to cope with growing numbers of referrals and less resource, the system tends towards offering briefer interventions, moving more people through treatment in whatever form this takes with a firm focus on specific symptom reduction as the desired outcome. This is firmly linked with the primacy of the medical model of evidence-based interventions derived from the gold standard of randomised controlled trials (RCTs) of treatment delivering the evidence base. For some, this focus on symptoms and specific interventions aimed at symptom reduction may be sufficient but there are problems with this approach for any who have some level of complexity to their problems. This is particularly true for those where the roots of their difficulties are located in interpersonal harm such as CSA. Indeed, these are often the very people who are excluded from the RCTs due to their co-morbidity, high risk and complex presentations and thus the evidence base skirts around the people most in need.

Brief interventions aimed at specific symptoms can cause a kind of merry-go-round on the treatment cycle with each presentation, leading to a brief intervention followed by discharge which then leads to re-presentation of another difficulty. Fragmentation of care and the inability to view a person holistically results, with the over-riding outcome being an absence of a sustained therapeutic relationship. Repeated hospitalisations, repeated crisis team interventions, multiple brief therapies increasingly offered exclusively in groups and a growing list of medications are the likely result, with a label of "treatment-resistant" by the end of the merry-go-round ride. And somehow the merry-go-round, because it treats the symptoms which are often linked to the "solution" rather than addressing the underlying trauma, keeps everything standing still despite so much activity, as it twirls round and round.

With scarcity of staff resources, one sees a growing emphasis on the biomedical approach to psychic distress. A questionnaire is administered, a diagnosis given, and quite often a prescription is then written. Acknowledging

the psychosocial aspect of formulation requires time to recognise and attend to the reality that a patient's distress may be understandable in the broader context of their lives. But perhaps more than this, the system itself turns away, disavows, the reality of trauma, focusing instead on the symptoms, the defences and the solutions that have been used to not know, thereby preventing the acknowledgement of trauma.

CSA is a particular kind of trauma that often occurs within the context of other childhood adversity including physical and emotional abuse and neglect. It involves a violation of the body boundaries with potentially profound repercussions on the functioning of the mind. It is often a process which evolves and changes over time, beginning with grooming, then the abuse and the possible experiences of disclosure. Most cases of CSA are committed by perpetrators known to the victim (Snyder 2000), often within the context of a caregiving attachment relationship. The Truth Project, part of the Independent Inquiry into Childhood Sexual Abuse (IICSA), estimated that 48% of sexual abuse was perpetrated by a family member among Truth project participants. Inherent in this experience is the operation of a power dynamic, with the oppression of the child's safety, security and freedom curtailed by the violence of the adult, often caregiving, perpetrator.

The hidden societal systems, including patriarchal structures, which allow for this mistreatment of children, deny them their basic human rights. Herman (1992) highlights that the essence of complex trauma arises out of an experience of captivity, and it is the helplessness inherent in the developmental attachment needs of the child which perpetuates this state of captivity as part of CSA. One may consider CSA within the context of an attachment relationship as a form of domestic tyranny.

CSA, as with all traumas, profoundly impacts on the capacity to trust and this is further heightened by the oppression and tyranny inherent in this form of abuse, especially when any new relationship brings with it a power differential. Simply through the process of help-seeking, the survivor is required to engage in a power dynamic with the care provider.

Alongside the reality of the power imbalance that is an inherent aspect of seeking support and help, there may be other forms of oppression which are also operating for the survivor which further impact on this situation. The concept of intersectionality highlights the interconnected nature of social categorisations such as race, class and gender and these create overlapping and interdependent systems of discrimination, disadvantage and systems of oppression. These systems are likely to increase the inequality within the therapeutic relationship, beginning with issues around equity of access to services.

The current reality within most mental health services is that the diminishing resource and anxieties about unmet need create a system of gatekeeping as a way of managing waiting lists. The survivor is required to request help, navigating often complex and unclear pathways where certain criteria are required, often based on diagnosis but also attending to issues of complexity, co-morbidity and risk. They must fit the requirements of the service to be able

to be offered help. This will often mean they are required to seek help in several different services before, hopefully, the "right" one is found. Determining "suitability" is often the purpose of an "assessment" whereby the survivor needs to be able to tell their story to a stranger, meet all the criteria required to be accepted and to manage all of this often within a single meeting. Many services will also have a limited or sometimes only one form of treatment they offer so the question of assessment is often around whether the survivor is "suitable for this therapy" within the limited parameters of the treatment model. All of this increases the perceived power of the clinician and reduces the power of the survivor. Of course, for many clinicians, this situation can increasingly feel ethically problematic and may even lead to moral injury. There is little capacity within the system to co-construct a treatment program or often even to acknowledge the power imbalance that forms a part of this interaction. Waiting lists are so long, and choices so limited that the survivor is often given the experience of being made to feel lucky if they have been offered anything at all, even if it is not what feels right to them, and they do not feel they have had a choice. This perpetuates a sense of powerlessness, helplessness and silencing.

Highly stretched and poorly resourced services may also struggle to offer a culturally competent engagement such that space can be created for the differing needs according to cultural and intersecting identities. More broadly, the narrow definition of health within a medical model, one-person psychology further restricts and confines the survivor to one mode of understanding the difficulties, structured through the medicalisation of distress.

The anthropologist Marlovits (2020) suggests that:

> Re-encoding socio-material problems of homelessness, food insecurity, differential abilities, immigration, structural unemployment and violence as matters of "mental health" is a radical practice of dematerialization and de-socialisation, a slight of hand that substitutes the reification of mind in the place of provision of social and material necessities, not to mention medicalizing innocuous forms of otherness.
>
> (p. 90)

The "medicalizing of innocuous forms of otherness" as described by Marlovits also highlights the potential for epistemic injustice, which Auestad (2012) describes as occurring when someone is ignored, disbelieved or eliminated due to race, sexuality, gender, disability or social identity. Failure to recognise issues of intersectionality is more likely to occur within the one-person psychology model which remains within the current mental health system as the dominant mode of thinking in our neoliberal age.

This is in keeping with the growing challenge to the medical model and its evidence-based practice by alternative models which move the overarching question of "what is wrong with you?" with its implicit blame and shame, to a question of "what happened to you?". This has the potential to locate the

experience of the survivor in its socio-cultural context, broadening the reach beyond the individual to understand the potential consequences of past and present adversities, as well as highlighting potential strengths and resilience. It is captured in the psychiatric notion of a biopsychosocial formulation and in models such as the Power Threat Meaning Framework (Johnstone & Boyle 2018) and is one of the basic tenants of trauma-informed practice.

The Adverse Childhood Experiences research (Felitti 2002) has served to effectively demonstrate that the artificial divisions of physical and mental health, social and psychological impacts need to be re-formulated. Childhood adversity has the potential to increase risk of cardiovascular, respiratory and autoimmune disorders alongside an increase in a variety of psychiatric diagnoses. Relationship difficulties and psychosocial difficulties are also more likely to occur. Findings from IICSA also support this (IICSA 2023). Our current health and social care systems tend to perpetuate the denial of this important link with CSA and increase the fragmentation of care.

The issue of the power dynamic inherent in experiences for survivors in seeking help within the mental health system also plays a role in questions around trust and trustworthiness and issues around engagement in services. The reality of life for many survivors is that trust has been broken and a hypervigilance to the trustworthiness of another, especially someone "in authority" is an appropriate survival mechanism. Professionals need to earn their trustworthiness (see Susanna Alyce's chapter) and this may impact upon the capacity to fully engage in the process of seeking help. A system which has policies of discharge after two failed appointments which is common in mental health, brings a power dynamic and a failure of understanding the issues around engagement that perpetuates a sense of once again being failed.

A 2011 meta-analysis of 217 studies placed the global prevalence of CSA at approximately 12%. On average, 1 in 12 boys and 1 in 5 girls are victims of CSA worldwide (Stoltenborgh et al. 2011). However, variations in estimates of prevalence range from 0% to 68%, reflecting the heterogeneity in study design, socio-cultural contexts, modes of data collection, sample size, study populations, and operational definitions of non-recent CSA (Wosu et al. 2015).

Cutajar et al. (2010) found that HCSA victims were 3.65 times more likely to have had contact with public mental health services than the general population, and a later study by Guha et al. (2019) found that individuals who had experienced CSA had significantly increased contact with health professionals for mental health care and increased use of psychopharmacology of all categories.

A longitudinal birth cohort study of over 1,000 New Zealand young adults studied to age 25 showed that exposure to CSA was associated with increased risk of later depression, PTSD, anxiety disorder, conduct/anti-social personality disorder, substance dependence, suicidal ideation and suicide attempts between the ages of 16 and 25. After adjustment for social, family and individual factors, those exposed to CSA including attempted or completed

penetration had rates of disorder that were 2.4 times higher than those not exposed to CSA (Fergusson et al. 2008).

These studies tell us that CSA is much more common than we would want to believe, that it is over-represented in the mental health population, and this is across many different diagnostic categories, suggesting a lack of treatment validity and diagnostic reliability. This is an issue that has a significant impact on the mental health system, and yet, CSA is barely mentioned in treatment guidelines, there are few statutory specialist services that specifically work with adult survivors, and there is limited training for staff in this area. Research remains patchy and difficult to interpret when the methodological problems described above can give such wide variance even in the basics of prevalence rates.

Judith Herman (1992) says:

> The ordinary response to atrocities is to banish them from consciousness.
> (p. 1)

The defences of denial, disavowal, dissociation and silencing operate within the individual and within society. The experience of adversity becomes traumatic when there is no other mind to help to bear the reality of what has happened, to symbolise it through thought and words, to contain the emotional experience when the experience feels so overwhelming and uncontainable, and to be present and connected as another human being. When this is not possible, the experience becomes traumatic. It is a significant risk factor for the development of post traumatic distress if there is a perceived lack of social support. If, as a society, we are already in a state of collective traumatic disconnection, then the capacity to support and contain each other is significantly reduced. This inevitably enters the realm of mental health care.

If society operates, as Herman suggests, to banish this atrocity of CSA from consciousness then I would contend this is replicated within the mental health system. The powerful forces operating to turn a blind eye to the reality of CSA begin in the process of grooming. Nathanson (2023) writes of CSA as a relational trauma which is a form of oppression and tyranny. He suggests that it is at the time of grooming that victims begin to lose their capacity to resist. He says:

> It is as if the abuser subtly breaks in, steals the authority to say no and leaves a corrupt presence behind, an entity which would make sure that the door would never be locked again.
> (p. 133)

It is this corruption that is central to the oppression, stealing away the freedom to say no and to reach out to others, to disclose and to break the silence, asking for help and companionship as an essential step in any struggle for freedom. This

silencing is one way to understand why disclosure often does not occur until adulthood, and indeed for some survivors, many years later. (see Emma Irwin-Facer's chapter) Mental health services serve to perpetuate the silence when they fail to ask about abuse, to ask the essential question of "what happened to you?".

Read et al. (2016) describe how less than 25% of service users report being asked about their experiences of trauma and abuse in the mental health services and that this had not improved following their original audit in 1997. Survivors are therefore unlikely to be asked about the experiences of abuse, but the reality of what has happened to them also makes the question, if it does arise, often difficult to answer. This is part of what makes disclosure so problematic – the very nature of CSA attacks the mind of the victim, through the corruption and oppression of grooming through to the reality of the act itself. As Campbell (2014) describes:

> Incestuous sexual abuse causes doubt of three distinct types: (1) honest doubt that is essential to the pursuit of knowledge; (2) inherent doubt that can result from a trauma that leaves the victim's mind fragmented and confused; and (3) the sadistic imposition of doubt intended to deceive, disorient and attack unbearable knowledge in the victim or another person familiar with the abuse.
>
> (p. 441)

Campbell (2014) also emphasises how paedophilia causes doubt about what constitutes reality through attacking the sovereignty of generational difference. Sexual barriers are breached, and oedipal relationships are turned upside down. It is a betrayal that causes confusion, doubt and disorientation.

> The victim is left without a trusting orientation to the mind of the other within which to find a representation of itself; the mind of the other that has inflicted pain is now viewed as split between loving and hating parts.
>
> (p. 447)

One might also understand this in relation to the isolation of the victim from important other relationships so that the forgetting or indeed the denial of what is occurring or has occurred is also denied by others. In thinking about the traumatic scenario in terms of the positions of victim, perpetrator, rescuer and bystander, all roles are implicated in doubt, confusion, forgetting and denial.

Ferenczi, in his description in "Confusion of tongues" (1949/1998) says the following:

> When the child recovers from such an attack, he feels enormously confused, in fact, split—innocent and culpable at the same time—and his confidence in the testimony of his own senses is broken.
>
> (p. 202)

Ferenczi describes powerfully the defences employed by the child to bear the pain and betrayal of the abuse. He describes how the child uses dissociation so that the mind is wiped clean of desires, emotions and thoughts to introject the abuser in what he calls identification with the aggressor. This allows an attuned compliance, unconsciously attending to what the perpetrator needs as a survival tactic. Dissociation as the escape when there is no escape is strongly linked to the freeze response, the next step on from fight and flight when helplessness and terror is overwhelming and physiologically the body shuts down. The mind then detaches from what is occurring with the consequence that the experience is compartmentalised, separated off from the rest of the mind in what Stern (1997) describes as "unformulated experience", a kind of psychic chaos which lacks symbolic representation and so cannot be shared with others, or even oneself.

Sexual abuse thus relies on, and compounds, secrecy and silence, creating profound emotional isolation and loneliness, and sometimes compliance, which hides deep hostility and hatred of self and others. It is an arena of disorientation and confusion in which truth is lost. The perpetrator's cloak of invisibility, the evacuation of the victim's mind and the bystander's refusal to acknowledge the reality.

In Freyd's (1996) theory of betrayal trauma, abused children can separate the trauma from their consciousness in order to preserve the relationship with the needed caregiver. This may occur during the trauma (i.e., the child does not recognise that his parent is hurting him), after the trauma (i.e., the child is unable to remember what happened during the abuse), or both. This dissociation from the abuse facilitates the child's survival by helping him remain connected with the important attachment figure.

These dynamics of forgetting, denial, dissociation and disavowal inevitably come into the arena of mental health. A wish not to know, to turn a blind eye to the reality of unspeakable atrocities inflicted upon vulnerable, helpless children is, as Herman tells us, the ordinary response. Individual clinicians may enact this through a failure of curiosity, focusing on symptoms rather than being available to an authentic enquiry of what has happened in someone's life that has contributed to their current help seeking encounter. Systems perpetuate this through the fragmentation of services which fail to provide a holistic view of someone's difficulties, mirroring the fragmented state inherent in severe trauma.

One example of this is in the response to dissociative identity disorder, a diagnosis which has a strong associative link to CSA (Brand et al. 2009). Despite a growing body of evidence for its validity both neurobiologically (Reinders & Veltman 2021) and epidemiologically (Kate et al. 2020), the presentation of DID will often provoke disbelief, denial or even contempt and ridicule. Its fictionalisation by Hollywood serves only to facilitate this kind of response. Salter (2023) suggests:

> Where it is represented at all, dissociation often surfaces within inverted or indirect symbolic registers, as something that can only be

> acknowledged through processes of denial, splitting or projection ("DID does not exist," "I'm a rational sceptic opposing the hysterical believers," "this so-called victim is actually a perpetrator of false allegations"). (p. 2)

The wish not to know is further strengthened through the recognition of what the listening clinician may have to bear if they fully take in the emotional experience the adult survivor of CSA must carry. Sinason (2020) suggests that a paedophile is someone who hates children and through the abuse projects the hated vulnerable child-self onto the victim.

Grand (2000) adds to this by describing the impact on the survivor:

> In her core, the trauma survivor remains solitary in the moment of her own extinction. No one knew her in the moment when she died without dying; no one knows her now, in her lived memory of annihilation. This place where she cannot be known is one of catastrophic loneliness; it is a solitude imbued with hatred and fear and shame and despair. (p. 4)

Sinason and Grand emphasise the hatred and violence at the heart of the attack which serves to annihilate the survivor. Although the act involves sexual gratification of the perpetrator, it is an act that is not primarily sexual but rather one in which the violent projection of helplessness, vulnerability, shame, disgust, hatred and despair is at its core.

The emotional response to CSA is thus imbued with hatred, helplessness, shame, disgust and despair. Laub (in Greenspan et al. 2014) suggests that trauma therapy involves the communication of testimony to a witness willing to be totally present to the survivor, and to receive as well as experience what he/she wants to transmit.

I would broaden this to suggest that for any professional who is truly available to the survivor, receiving testimony requires being open to receiving these emotional states.

Trying to bear what is being communicated, without action or attempts to be rid of it, is the beginnings of containment. Wilfred Bion (1962) described this notion in terms of mothers and babies when in the normal course of development, a baby is filled with the early, powerful anxieties, and employs projective identification to communicate what is unbearable to mother. It is her role to try to take this in, to think about it and attempt to understand what might be going on in the baby's mind so that she might relieve him of his distress. Over time this gives the baby the experience of someone who can bear what they feel is unbearable and thus can lessen the need to rid oneself of distress.

> Where Freud and Klein made love and hate central to psychic life, Bion adds knowledge, particularly the inability to know. The inability

> to know results from the failure to have found someone, generally in early life, willing and able to contain unbearable feelings, feelings that cannot be put into words, but have more the quality of fragments of feelings. It is only by encountering another mind willing and able to hold these unbearable pieces of feeling that one can learn to put them together for oneself.
>
> (Alford 2018, p. 46)

Traumatic experience may be understood as a rupture of the container so that knowledge is attacked, the ability to link associated experiences is destroyed, and the capacity for thought which allows an experience to be recognised and owned is lost. As Alford describes, love wants to know, and hate would break what we know into pieces to save us the horror of knowing. Not knowing empties the world of the connections that give it meaning and life its vitality.

Bion's (1962) model of containment highlights the need for another mind to know, to be open to recognising, feeling and thinking about unbearable experiences. Frontline staff in mental health services are now taught principles of trauma-informed care, and to practice "active listening" but all too often this fails to capture the reality of what it means to really engage with the emotional states a survivor of CSA may bring to the work. All too often there is a failure in containment, the professional is unavailable or unwilling to engage in a relational response which is what is required to contain the emotional experience that is usually brought with considerable distress to the encounter.

One might also think of these failures of containment in relation to difficulties within the health system. A good manager allows frontline staff to do their job by containing their anxieties activated by their work and preventing them from being overwhelmed by anxieties from their patients or from higher up the system. A struggling public health service might reflect a management structure that is beginning to be overwhelmed by anxiety and defends against this through projecting the anxieties back into frontline staff. When they no longer feel able to hold the anxieties of the patients because they themselves are not contained within the system, then fragmentation, confusion, action rather than thought and an increasingly phobic avoidance – even "othering" of those in psychic distress may occur. Burnout, moral injury, stigmatisation and loss of compassion are likely results.

Watts (2023) describes this in relation to patients labelled with the diagnosis of borderline (or emotionally unstable) personality disorder (BPD) with what she calls the Personality Disorder (PD) Shield.

> The "PD Shield" metaphor represents a practice where mental health professionals utilize the notion of BPD as a protective barrier, effectively safeguarding themselves against the emotionally gruelling reality of their patients' traumatic experiences.
>
> (p. 6)

Hailes et al. (2019) in their umbrella review of outcomes of CSA found that one of the most strongly associated psychiatric outcomes of abuse was a diagnosis of BPD. De Aquino Ferreira et al. (2018) report similar results from their systematic review of 40 papers examining the link between BPD and sexual abuse. The authors concluded that CSA played a major role in the development of BPD and that it also predicted a more severe clinical presentation and poorer prognosis. Watts, like a growing number of clinicians alongside survivors of CSA, is calling for a paradigm shift, to stop using this diagnosis because of the inherent shaming, stigma and othering that has arisen within services due to the functioning of the PD shield – what I would call gross failures of containment.

The message in the PD label can easily be heard as "there is something wrong with your personality, with you", and this is particularly problematic when childhood trauma can so readily cause a child to feel blamed, guilty or somehow bad. Although initial research (Cloitre et al. 2014) suggests there may be differences between the diagnoses of EUPD and complex PTSD (such as level of impulsivity of degree of experiences of abandonment), there is also a broader question to consider in relation to the impact of the personality disorder diagnosis on traumatised individuals. With the advent of the complex PTSD diagnosis finally reaching the psychiatric classificatory system of the International Classification of Diseases (ICD) 11, there is a real opportunity if one needs to use a diagnosis, to consider this one instead. In this way, traumatic experiences are less likely to be disavowed, denied and re-enacted.

Of course, this is only one step and to truly attend to this significant failure within the system, staff need to be valued, supported and sufficiently trained in understanding the impact of traumatic experiences such as CSA in order to be able to take in, think about and contain the distress of survivors. This might better be understood through Benjamin's (1998) description of intersubjective recognition:

> to affirm, validate, acknowledge, know, accept, understand, empathize, take in, tolerate, appreciate, see, identify with, find familiar, … love. … What I call mutual recognition includes a number of experiences commonly described in the research on mother-infant interaction: emotional attunement, mutual influence, affective mutuality, sharing states of mind.
>
> (pp. 15–16)

As Benjamin (2004) describes, the alternative to intersubjective recognition and relating is complementarity: the sadomasochistic, domination–submission dynamic of "doer – done to." Relating in this mode, each party insists on the supremacy of their own subjectivity, and each becomes locked in to the conviction that they are the victim of the other.

For me, this highlights the potential for re-traumatising of survivors through a failure of recognition, containment and validation. Without this relational

meeting of mutual recognition, there is a serious risk of a repetition of the victim – perpetrator dynamic that made up the original abuse. One sees this is the kind of vocabulary that may get employed with those given the BPD diagnosis – terms such as manipulating, hysterical, attention-seeking. As Watts (2023) describes, there can also be a misuse of psychoanalytic terms to accuse the survivor such as splitting or projecting, as a way of shielding the professional from an intersubjective encounter that would face them with the painful reality of atrocities committed on children. The staff may feel "done to" by the survivor, victimised by them which in turn causes more action in the doer-done to dynamic. Describing this is not to blame staff but rather to emphasise how the system needs resource and support to attend to this complementarity, to give staff sufficient space to think about the work without being overwhelmed by anxiety from higher up the management chain, and sufficient skills and training to recognise the inevitable failures of attunement that occur.

The reparative processes that are a part of any relational mental health work-acknowledging fallibility, being accountable for doing harm, apologising, forgiving, expressing and receiving gratitude – are shame diminishing, "subjectifying" processes. This is not easy by any means but is essential in working with trauma survivors. It requires the professional to be aware of their own emotional states, to attend to them through thinking and to thereby reduce the propensity to use action as a defence.

One emotion that is worth acknowledging in this context is rage. In a system which is often so strained, the capacity to work with an angry patient can at times be limited. This often gets tied up with the BPD diagnosis and can be an important aspect of why survivors may struggle within the mental health system.

There is a moment in the television adaptation of Margaret Atwood's The Handmaid's Tale that captures a central question for those who have been abused, violated and oppressed by a cruel patriarchal system. June, the main protagonist, asks a group of traumatised women who have been talking about how to find a way forwards after such violence and degradation. She says:

> Why does healing have to be the only goal? Why can't we be as furious as we feel? Do we have that right?

June's suggestion that survivors may need to feel the fury – to have the right to do so – alongside the healing, brings in a broader question than the therapeutic treatment of traumatised individuals. To feel, the rage is to allow this aspect of the necessary grieving that is a part of the healing process, to allow the feelings that were cut off through dissociation when it was too dangerous to feel. It is also empowering, and this is a vital aspect of its function when disempowerment is so central to oppression trauma.

Psychoanalyst Beverley Stoute (2021) describes Black Rage arising out of repeated acts of injustice without opportunities for redress that is at the heart

of racism. This form of oppression leads to moral injury – inhumane behaviour experienced as a betrayal of what is right. Stoute suggests that indignant rage – in this case Black Rage – is an appropriate response to such injury, that it is an adaptive mental construct and a powerful and necessary defensive psychic force which serves to preserve dignity and self-worth and mitigate the impact of racial trauma.

This concept of indignant rage is what, I believe, June was suggesting was also needed. At an individual level, it protects and empowers and may promote psychic growth and resilience, but there is also an important aspect to this rage at a societal level. Oppression trauma such as CSA will not end until society feels this rage and addresses the socio-political oppression that is systemic, pervasive and protracted over time. Denial and disavowal of the stark reality of CSA must be challenged.

We have seen glimpses of this in the setting up of the Independent Inquiry into Child Sexual Abuse and their Truth Project, initiatives campaigned for and co-designed by survivors enacting the rage over many years through lobbying and activism. Rage needs to be felt by all members of society to challenge the oppression, to offer services that are truly trauma-informed and empowering and to change society.

Herman (2023) emphasises the necessity of a political movement alongside the practices of studying and treating psychological trauma. She argues that:

> advances in the field occur only when they are supported by a political movement powerful enough to legitimate an alliance between investigators and patients and to counteract the ordinary social processes of silencing and denial.
>
> (p. 9)

The thesis put forward in *Trauma and Recovery* is that the process of healing from trauma is essentially embedded in a wider socio-political framework that must always be taken into account.

> What human beings cannot contain of their experience – what has been traumatically overwhelming, unbearable, unthinkable – falls out of social discourse, but onto and into the next generation.
>
> Gerard Fromm (2012)

The concept of trauma invites us to consider the implications of atrocities committed on the individual and this inevitably requires the recognition that it is also a matter of social justice. We need to shift between the acknowledgement of the impact on the individual and to also understand this within the broad context of social movements for human rights. As Fromm suggests, trauma has to be a part of social discourse, to be given words and to be contained. In a world in which trauma is a constant backdrop in our everyday

lives how do we truly allow acknowledgement of this violence? Within our mental health system, how do we hold a space in which we can, with our patients, begin to think about what is unthinkable, or as Bollas (1987) describes to become fully aware of the unthought known.

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# 16 Interrupting silence

## Tuning in to the movements calling out for change

*Khadija Rouf*

### Introduction

This chapter explores the harmful silence that exists around child sexual abuse and how we might break it. Abuse occurs in a societal context and as part of a continuum, bound up with inequality, erasure and misrepresentations of victims. It is impossible to divorce the experience of interpersonal violence and trauma from wider systemic power and human rights. The latter is the matter of being recognised as a human being of equal value to other human beings. Psychology as a discipline has played a central part in knowledge production which has then been used to suppress the stories of victims, such as through 'false memory syndrome'. This knowledge production was not via co-production. Oppressive stereotypes about survivors exist, intersecting with other forms of discrimination, meaning many victims of abuse never receive appropriate help. As clinicians, researchers and practitioners, we have an ethical duty in helping to highlight this silence, and to join with those engaged with truth telling and demands for justice and survivor rights. This has the possibility of radical re-design and co-design of social systems, which could lead to real prevention and proportionate intervention for children and adult survivors.

There is now an imperative for change after national and international inquiries into organised child sexual abuse and organisational failures to protect children. We need to equip ourselves for the push backs we will face as we move forwards to act on the findings of these inquiries. We need to make more than superficial change. Harmful forms of power do not surrender themselves easily and understanding potential dynamics when working in survivor centred/victim focussed ways is vital. We may face various forms of shut down, isolation or hostility. Freyd (1997) has named this the dynamic of DARVO (deny, attack, reverse victim and offender). This can work at an interpersonal level and institutional levels. These are the dynamics which victims of trauma must face regularly. Despite this, many survivor movements are gathering momentum and are demanding to be heard, seen and to be treated with humanity. The Centre for Institutional Courage which Freyd has founded, is now developing measures and researching how to prevent institutional betrayal.

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Such seismic shifts demand that we go from the traditional confines of 'therapy rooms' or 'therapy spaces' and outwards, aligning with survivor movements. We need to consider means of healing which extend beyond some traditional notions of individual therapy and understand that aspects of our institutions and what we've been taught, are part of the problem. There is growing international recognition that we must move toward trauma-informed care within mental health services (see Sweeney et al, 2016, 2018 for UK examples). Breaking silences is a fundamental of becoming trauma informed and moving towards the transformational changes needed for people who have suffered abuse.

**Why the silence?**

Silence can be a noun, but also a verb. To be silent or to be silenced, can be active states, which require intention and effort. A state of being silenced implies power imbalance and coercion, the crushing of expression.

Silence in the context of abuse is complex. Abuse can be horribly difficult to think about, but part of this has been the lack of language to talk about it. Therefore, responses to abuse are multi-layered and complicated. To be simplistic about this means that we will continuously fail to respond with the nuance, time, care and systemic interventions which are needed to respond to and prevent further harm.

There are, inevitably, massive pressures to erase and silence those who talk about abuse. These pressures operate on a continuum of experiences associated with sexual violence (Kelly, 1988) and intersect with power, particularly harming black and minoritised people (Sosulski et al, 2010; Wilson, 2001). Systemic models can help us to recognise that abuse happens within an ecology, and systems support this culture through multiple means (Bronfenbrenner and Ceci, 1994; Pearce and Cronen, 1980; Reason, 1998) which create physical and mental distress (Hagan and Smail, 1997; Johnstone and Boyle, 2018). Vera-Gray and Fileborn (2018) talk about how the disruption of 'being in the world' caused by sexual violence '…reveals the relational and situated nature of the self, enabling a relocation of the problem, and the solution, from the individual to the social world' (p. 85). It is here that it seems impossible to address child sexual abuse without thinking about structural and intersecting inequalities.

There are pressures to keep the world a safe and happy place, and to put up our fences and defences. As T.S Eliot wrote, 'Humankind cannot bear very much reality' (Four Quartets, 1943). There are pressures, subtle and otherwise, to require the performative display of happiness in public (Vera-Gray and Fileborn, 2018). In our contemporary idealised image saturated society, families in adverts assemble around abundant dining tables in perfect kitchens. The atmosphere is affable and calm, and ultimately there is a product to be sold by pairing it with this idea of happiness. Many children's lives are very far from these short soundbites. The children who somehow find the courage

or means to speak of the unpleasant things in their lives are often labelled as 'bad', or 'mad' individuals. They risk not being heard because they disturb the peace. History has put them in institutions out of sight, to be treated, corrected and corralled. Sometimes those institutions have exacted further abuse on them 'for their own good' or enabled further secret abuse because these children are seen as of 'less worth'. The secrets are kept, half open, half closed. Hush, shush, silence please.

For children who are abused, silence may become a necessary way to try to survive. This harms childhood experience, diminishing play, interrupting reverie, suffocating imagination and isolating the child from others. To be chronically abused is to experience an injury which is potentially so profound that it can rupture one's sense of personhood, one's spirituality, and the ability to feel safe in relationship to others. These injuries, without access to traditional or other forms of healing, can radiate out far beyond the end of the abuse. Especially, if it is not safe to speak without being called a liar or blamed, shamed for what happened to you.

How abuse impacts can be beyond the reach of usual communication. It can be almost impossible to express through everyday language, because normal language is an inadequate vehicle to carry the weight of this hidden harm. This interiority of experience is then lost, and the internal reality of abusive experience can be shut down. The visible impacts of this harm ('symptoms', 'behaviour') can then be misinterpreted by others, often men in positions of authority. Notions of a 'safe world' are held intact, and power remains uninterrupted. Impressions are managed to claim that abuse doesn't happen often, and if it does, it is really the victim's own fault. In the past, it's been claimed that abuse doesn't do much harm, if any. It has been claimed that it can be positive. These lies distract us away from the reality. They are sedative. We carry on, sleepwalking about the scale of harm that children and young people are enduring.

There are searching questions to ask about knowledge production, truth telling and the void that has existed in understanding context and history. It's hard to look for something that appears to be absent. Absence implies non-existence. There is limited inclusion of the perspectives of victims and survivors in mainstream textbooks, particularly of survivors who are from minoritised backgrounds. Where are these voices, in their own words, and not reduced to numbers, percentages and rating scales?

The academic Sara Ahmed (2023) offers reflections on what happens in the understory around organisational performance around power and equality, around raising complaints and challenging norms. She notes how not all relational spaces are mapped. She examines what happens 'in real life', when we get close to dominant beliefs and power, and what is absent from discourse and academic understandings. For us as clinicians, these are the stories which don't make research, or the pages of academic texts. We don't hear about them in training, we miss them in clinical practice. We are unaware of the

void, because it is hard to listen for silence and it is hard to see something which is not visible.

How does silence look on a page?
Does it look like this?
Does silence look like this?
[redacted] *The state* [redacted] *No case to answer.*

*We will redact that which we do not wish to see. We will cloak it and screen it off from public view.*

Speaking or communicating about what threatens powerful societal norms can be a precarious business. In legal settings, we have a right to silence, in recognition that speaking can cost us freedoms, can lead us into self-incrimination and peril.

For people who are already minoritised, there are hateful stereotypes which lurk everywhere, like snares and traps. The IICSA report (2020) found that racism, including the impact of cultural stereotypes, could lead to institutional failures in identifying and responding to child sexual abuse. People from black and minoritised backgrounds faced particular barriers to telling, such as fear about community repercussions and worry about feeding into racist stereotypes held by the majority culture. The stories held about us in collective consciousness and unconsciousness, can cause harm. They highlight longstanding issues with inequality and vulnerability for minoritised children (Fox, 2016).

**Family trees and disconnected stories**

Who has told the stories about victims of abuse? This requires an examination of the surrounds of silence. There are profound questions about the foundations of societal structures and the services within which they are built. What are the founding beliefs about who gets to be seen as a citizen, who has rights? This is an uncomfortable ask, like how looking at a family tree can be uncomfortable. What is the story about beloved professional ancestors, the icons of our work and deeply held beliefs?

There is a growing recognition that some of the foundations of mental health were built on patriarchal, ablest, white norms. However, there is dispute and heat about this, accusations of 'wokeism', sensational headlines. Naturally, there may be fear about hearing too much, about interrupting the sense of 'safe life'. After all, it is hard to see these norms, like trying to see snow upon snow. There is a blankness, an invisibility.

The deprivation of power and not having access to the resources to have your story heard is central to being silenced. Thus, trauma goes un-recognised, under-recognised and viewed as unconnected to wider societal inequalities and injustices. So who gets to be at the tables where decisions are made?

Who is missing? Whose trauma is heard and seen – which traumas are going undocumented?

Kinsey's work on sexuality in the 1950s was hugely influential in shaping societal understandings of sexual desire and response. However, he also held the view that children were not harmed by being used for the sexual gratification of adults. He did not recognise paedophilia as abusive and argued that it should not be criminalised. He did not address the reality of rape, abuse or consent, and his work was influential in revising legislation to be more lenient to sexual offenders (Goode, 2011).

Perhaps such 'research' makes society feel safe, and it certainly gives a safe screen for abusers to hide behind. In the 1970s and 1980s, there was active political lobbying by paedophiles through the Paedophile Information Exchange (PIE, established 1974 and disbanded 1984) for the abolition of the age of consent for children. This organisation used the notion of civil liberties and human rights to argue the case for sexual 'relationships' between adults and children. It established links with the National Council for Civil Liberties (now known as Liberty), the Albany Trust (a counselling and psychotherapy charity), lobbied parliamentarians and created a link with the British Psychological Society. The Truth Project, one arm of IICSA, has heard and reported on evidence of this activity (IICSA February 2020). We must learn to be alert to the corruption of ethical frameworks, by those who appear to be arguing for liberties which destroy the wellbeing of children.

We must also remain critical about the context in which experimental research is conducted and applied. In the 1990s, memory experiments around being lost in shopping centres were conducted (Loftus and Pickrell, 1995), and the findings of these studies were then developed into 'false memory' theories. The findings of these small-scale experimental studies in shopping centres were quickly applied to real-life cases of child abuse in court. From shopping centres to sexual abuse seems rather a leap, and there is evidence that the studies went beyond their evidence base with these claims (see Sinason and Conway, 2021). Once again, the findings of these studies were used in court rooms and influenced abuse cases.

This knowledge production is powerful, and it disappears into the walls of our institutions, no longer visible, but present. This blankness is like a 'white out'. Snow upon snow can look idyllic, hypnotic. This metaphorical snowdrift happened under storm conditions, subjecting victims to a blizzard under which many find themselves trapped and smothered. The drift may appear glittering and bright. But sound is muffled and smothered. Stories of abuse are engulfed, covered over and erased.

Abusers are helped by societies which privilege certain people over other people, so that citizens who are of certain genders, certain skin colours, certain abilities, certain sexualities and certain classes, will be chosen to be part of the landscape. Others will be shunned, cast out or smothered underneath. They are then more vulnerable to harms, because they are unseen, anonymous. People's experiences of being minoritised and powerless are

not voiced, because people's inner lives are silenced and excluded from the canon of research.

### Power, minoritisation, trauma, exclusion and silence

We are moving. We are beginning to have better understandings of abuse and trauma. It is evolving. Trauma is a little word for a huge topic. Our understandings of what is experienced as traumatic need to expand, while also becoming more nuanced. We need to increase our understanding of what causes trauma without locating it within an individual as sickness, using it as a byword for all adversity and without losing its meaning for particular groups.

People can be exposed to trauma as children or adults: occupationally, relationally or because of disasters. Increasingly, there is a (contested) public discussion about identity-based trauma; that some groups are exposed to violence and abuse simply because of who they are – for example, because they are a woman, because they are black, because they are gay. For example, the IICSA Lambeth report which highlighted the 'adultification' of black children as one of the reasons they were not safeguarded (IICSA, 2021). The report also highlights that the 'progressive' culture at Lambeth and left wing/right wing political polarisation does not always work in relation to the prevention of child sexual abuse.

Again, traumatic experiences exist within a context and are often relational and are part of a continuum of experience. Child sexual abuse creates a particular imprint of traumatic injury, one where shame, a loss of social connection and a sense of entrapment are often at the centre of the experience. Inequality in power is so often central to the trauma experience. We need to recognise harms which appear 'everyday', 'normal', unseen and unheard.

So, what happens to the person who has multiple minoritised identities? Vulnerability to trauma intersects with social exclusion. Social inequalities can intersect with each other. Aspects of people's social and political identities intertwine to create nuanced and multi-layered experiences of discrimination and privilege (Crenshaw, 2017, 2018). We can fall into simple ways of seeing, which fail to address complexity and acknowledge the importance of story and narrative. We are not binaries, none of us has a single identity – we contain multitudes.

People who do not fit privileged norms have had to fight for equal rights – to be recognised as humans of equal value. Often these injustices are exacted upon the body. The body becomes a site of trauma (Lorde, 2017). Hooks (2000) argues that gender, race and class interlock, and that hierarchical rule and coercive authority are root causes of violence, as they raise expectations of 'male supremacy and power' in intimate relationships (p. 121).

The provenance of the body, where bodies have been owned and seen as property, still lurks as an understory, often erased or unacknowledged. Bodily

autonomy is a human rights issue. If we have rights, then issues of consent, dignity, choice, access to resources, belonging and justice become normal.

While social privilege matters in recovery from CSA, it is also important to recognise that it is a crime that does not operate on a social gradient and impacts children from all backgrounds, including 'privileged' ones.

Within colonialist hierarchies, it was often black female bodies which were seen as the least powerful within racialised hierarchies. It is important to understand experiences of people with the least rights, to ensure that equal rights are there for everyone. We are hearing a much wider discussion about recognising racism as having a toxic impact on people's health (Williams, 2016; Kinouani, 2021) and seeing how structural practices are threatening to minoritised people, especially black people, coming into systems that are supposed to be there to help (Gayle, 2017, 2019).

The experiences of minoritised people have not historically sat within academic settings. The production of knowledge has othered people into subjects, sometimes objects of study. People have been gazed at, done unto. The experiences of victims and survivors of harms have been shut out of many forms of public narrative, and the places where the healing stories are being told have come through literature, poetry, art, song.

Those power dynamics can be repeated in our services if we do not actively try to change this.

### The relational dimensions of silence

Many survivors will have suffered profound attachment injuries.

All of us exist in relationship to others. It can cause huge psychological cost to be 'erased' and silenced. It can be very damaging to have *embodied* parts of us (which we cannot hide) attacked, shamed or othered, such as ethnicity, disability and gender.

To encounter blankness in services, the blank canvas of 'neutrality' is like confronting victims with the Still Face. The Still Face experiment (Tronick et al, 1978) is when an attachment figure (aka someone beloved), gives no response to a small child. Children quickly become distressed, that their attempts to interact and be in relationship with a loved one are met with blankness. It leads to dysregulation and distress.

Is this what we do to survivors when we meet them with blankness around their stories. Do we frame this blank as 'neutrality', when 'neutrality' isn't neutral?

Like the infant experiments by Tronick and researchers, we must not be still faces, particularly not in the face of suffering. If we remain blank, we risk amplifying distress and suffering through our mis-attunement with victims and survivors of abuse. We need to tune in, attune, hear and respond in survivor centred ways.

For children who are abused, silence is oppression. It is can also be a means of survival. To try to survive shame, to try to pretend that things are

okay, to cope with unspeakable and unnameable experiences. It is also a form of creeping death. It is a destruction of the self.

For society and institutions, for the state, the silence allows stasis and the illusion of a 'safe' or 'just' world. Noisy victims are labelled as mad or bad, and encounter the power of the state, or become derecognised as citizens, falling outside of societal structures. This is what neglect looks like at state scale.

So how shall we disrupt this silence as clinicians? How do we protect ourselves, as by association with working with victims and survivors, we also become vulnerable to attack, just as Freud did. What will we do when it is us that becomes caught in a blizzard? Who will we be, what will we do?

## Finding voice and breaking silence as survival

Audre Lorde wrote 'Your silence will not protect you' (2017) in which she urged people, women, particularly black women to break silence to find each other, and to find strength.

In interrupting silence, survivors risk much – how safe is the space victims-survivors tell into?
How much can society hear how victims-survivors communicate or what is communicated?
How much will those more powerful try to silence, discredit, discriminate against those who attempt to break silence?
Are minoritised victim-survivors made to feel they do not fit into looking like the 'right kind' of victim?

Prejudice and discrimination are reductive and entrapping. The move to manualise what help should look like for victim-survivors, in all the multitudes of experience they have, can also be potentially reductive and dehumanising – it can compound invisibility if they do not fit into 'getting better' in the prescribed ways.

Our intersecting identities connect to vulnerability and how we access help in the aftermath of trauma. The Truth Project in England and Wales was part of IICSA and has listening to victim-survivor testimony in order to address issues of justice and prevent the further abuse of children and young people.

## The truth project

One of IICSA's terms of reference was to engage with survivors as part of its investigation into institutional failures relating to CSA. They developed on a model of survivor participation based on the South African Truth and Reconciliation Commission (TRC), foregrounding victim's testimony to offer justice to those harmed by historic injustices.

The Truth Project and its findings are described in more detail in Chapter 3. What is key is the link between the South African process of moving beyond

Apartheid while taking account of human rights injustices and structural racism at the heart of the state, and how societies are dealing with non-recent child abuse through offering survivors testimonial justice.

While the circumstances are distinctive, the TRC's model of victim participation shares some features with how CSA survivors at the Truth Project which demonstrates the civil rights violations they both share, alongside human rights and criminal infringements. The TRC and the Truth Project both emphasised the importance of communicating belief in testimony, after institutional injustices of undermining, dismissing and covering up previous survivor testimony.

In communicating belief, they both also made space for Erlebnis, often translated as Lived Experience, a form of knowledge often treated with suspicion in the legalistic world of inquiries and truth commissions. This meant making room for a, 'deeper level of interiority involving volition, emotion, and creaturely suffering, a level that suggested a more subjective or psychological truth, which was irreducible rational workings of the mind' (Jay, 2005).

This meant that the facticity and probabilistic reasoning of inquiries needed to make space for emotionality and trauma-based narratives. While this tension between survivor knowledge forms and legalistic fact finding is not without its tensions (Taggart et al, 2025), it means that a previously discredited, stigmatised group were recognised as having valuable knowledge to impart and an attempt has begun to acknowledge their value also as participants.

In this respect, the Truth Project at IICSA shares much with the social movements described in other parts of this chapter. However, as we will see below, the Truth Project is only the beginning of offering CSA survivors' justice, in some ways the work has just begun.

## Moving forward from IICSA – be prepared

Systems love homeostasis. They may often appear to change, but that change will potentially only be at the surface and give the collective reassurance that a 'box has been ticked', the work is complete. Deep culture change is often messy, continuous, hard to measure. This can be very unsettling, even dysregulating. There will often be both subtle and visible resistances to giving up power and privilege.

Systems will often only change if they *have* to adapt to new circumstances, and even then, this may only be surface change. Systems may not see their part in perpetuating minoritisation in the 'business as usual' culture we have. They will often only change if they have to adapt to new circumstances – and even then, power will often use tactics to preserve itself. Ahmed (2017, 2023) writes about how organisations will essentially be in a dialectic where they appear to want to change, whilst simultaneously not wanting change. At worst, they may obstruct change, and simply preserve systems, which facilitate harassment and abuse (this time in the context of universities). What she has to say gives us important insights, so we may be prepared for what

might come and how to survive it in ways that maintain our values, even if this might mean leaving an organisation in protest. Any large-scale inquiry and justice processes should not be seen as the end of the work but its beginning; we need to be more vigilant rather than less when it looks like the work has been done. Social movements, led by those who have been unvoiced, can cause interruption, disruption and change. Feminist and survivor activism critiques power and places survivor testimonies centrally. It is through these efforts that there is change, because why would change come from those who don't see or hear what needs to change?

Systems which are purely symptom focussed do not tend to focus on context. This can mean that holistic care is not offered, and that our services do not focus on wider contextual issues. They may say they are trauma informed, when they are not, often pushed in directions of rapid interventions. This focus can mean that some of the phenomenology of trauma is missed, such as the need for extra time to build trusting relationships, extra time to create a safe space for disclosure and subsequent responding, and service session limits which often do not reflect the need for proportionate care. Once again, a 'one size fits all' is not appropriate to fit the diversity of experiences and suffering which victim-survivors have often faced. People harmed by sexual abuse should be offered proportionate and personalised care, with adjustments which are reasonable in the context of the kinds of relational injury they have suffered. If this is not done, then the texture of the impacts of abuse can be missed, and services can inadvertently behave in ways which chime with past abuse. For clinicians who work in proximity with victims-survivors, failing to offer personalised care can create a context which can become territory which is ripe for moral injury, as clinicians may have to end work based on rationing decisions rather than clinical decisions.

It is important to name these dynamics and how they will intersect with many forms of hierarchical power. It is vital to engage in anti-discriminatory practice; otherwise, other forms of oppression will be replicated in the dynamics of protecting children from child sexual abuse. For instance, which children are seen as victims or as making life choices (see IICSA, 2022), which children are adultified (Gamble and McCallum, 2022) or completely marginalised because of disability (IICSA, 2022).

## Human rights, activism and social justice

As the psychiatrist, Judith Herman has written, 'All the perpetrator asks is that the bystander do nothing … The victim demands action, engagement, and remembering' (Herman, 2015).

It has been the efforts of activists which have led to societal-level change. It is activism at all levels of society that has led to the improvement in children's rights. It is not enough to be aware and hope for change. We have to push for change in whichever ways we can. Here, we need to be aware that

we do not fall into 'rescuing' those we serve, but to work together, listening carefully and using privilege strategically, to ensure that we are making space to include the most minoritised people.

We can look at trauma-informed care through a human rights lens and consider making this part of our therapeutic offer. We can help understand history, and work in anti-discriminatory ways. Our work with victims and survivors can expand to have discussions about bodily rights, consent, human rights, drawing for example, on the UN Convention on the Rights of the Child (1992) and the Equality Act (2010). Co-production, co-design and survivor led change is essential and a key pillar of trauma-informed care. This co-production must be pluralistic and include the most marginalised people, to prevent a replication of already existing power structures in victim and survivor services.

The move to co-produced, co-designed services must address power inequities and be based in local communities. Some examples are considered here.

## Social action models of therapy

We have a responsibility to understand the patterning of state violence against minoritised groups historically, to resist repeating that same violence in the here and now. This is impossible to achieve though a passive position. It requires us to move into positions where we help to advocate, demand change for the people we serve and to 'move out of the way', so the people we serve have access to space where they can influence the change directly.

We can engage in therapeutic work which helps those impacted by violence to connect, form new narratives, to re-member what has happened to them and to lobby for better. There are respected examples of feminist models of social action-based psychotherapy which have led to improvements in the conditions which cause distress (see Sue Holland's work, 1992, 1995 about the White City Project).

More contemporary examples include professional bodies centralising safeguarding within their professional responsibilities (for instance, see the British Psychological Society, 2018). The Association of Clinical Psychologists UK (ACP UK) have also made a commitment to anti-racist practice, showing how we cannot be silent about racism (2022).

The Power Threat Meaning Framework (Johnstone and Boyle, 2018; Boyle and Johnstone, 2021) has brought a refreshed discussion about power into academic and mental health. Influenced and expanding on the work of psychologists such as David Smail (2015), this work has put a fresh lens on to psychiatric diagnoses, looking at contextual causes of distress and the meaning of symptoms. It is leading to new understandings within mental health, to tell more accurate stories about psychological injury, to join the dots. This is the basis of trauma-informed care.

### Community-level prevention and challenging harmful narratives and stereotypes

To reiterate, sexual abuse and violence occur within a particular context. They are occurring at a scale that requires us to take an ecological view on remedies, and to work at public health scale. There is growing research evidence that violence connects to harmful narratives and stereotypes about gender, ethnicity, class etc. This requires community-level prevention, and the work of the academic Michael Flood can be seen as an exemplar of trying to engage men and boys in allyship around reducing harmful masculinity and preventing abuse of women and girls (2019). Flood argues that it is vital to make the experiences of women visible; to insist that an intersectional lens is used to nuance and widen the category of gender and to take both global and local perspectives on gender. He argues that it is vital to engage men and boys in recognising, preventing and working with other men to end violence against women and girls. This must extend to people of all genders.

Within an ecological model, it is impossible to disconnect child sexual abuse from the wider treatment of women, girls and minoritised people. Reducing inequality needs to be part of this work. This includes helping to lobby for human rights. It is not so long ago that the marriage bar in the UK, meant that women had to stop working if they got married. Within marriage, it was not recognised that rape was possible, nor a crime, until 1992. For children, seen and not heard, The Children Act (1989) established a legal framework for child protection in England and Wales. The smacking of children was banned in Scotland in 2020.

### Rights, restoration and reparation

The importance of justice, legal and in its 'kaleidoscopic' forms, is vital. Judith Herman has written about the impact of complex trauma and sexual abuse over several decades. She has talked about the importance of phased approaches to recovery and healing from childhood trauma. She talks about the harms having taken place in relationships which were meant to be intimate and trusting. For this reason, it is important that healing and repair also take place in relationships, so that victims might experience something which can help them connect with their own natural healing processes. She writes about helping victims and survivors have a period of safety, stability and validating their experiences, something which many may never have experienced before. This may be followed by relational processing and re-storying what has happened in ways which reduce shame, blame and responsibility from the victims. There may then be opportunities for survivors to connect (or reconnect) with a sense of community and belonging in society, without shame or fear.

In Herman's newest work, Truth and Repair (2023), she has moved into recognition of a fourth potential phase to healing for victims and survivors, that of justice; this involves community recognition of harms done to victims

of abuse, and abusers becoming accountable for the harms which they have caused. Sadly, we know that all too often, this is not the case, and victims of abuse can end up suffering multiple layers of trauma and abuse, and all too often are unable to access adequate or proportionate services to help them heal.

We cannot talk about trauma without talking about justice. Survivors need to be seen and heard (recognition) and have fair access to appropriate resources (redistribution) as outlined in the work of Fricker (2007). Activism can lead to healing at a community level, and it is the relational power of being heard, believed, included and given proportionate help, which can do so much to repair the injury of abuse. These are part of what can be termed 'kaleidoscopic justice' which involves thoughtful, dynamic and expanded forms of justice, involving hearing; access to help; equity and humanity (McGlynn and Westmarland, 2019).

The seeking of justice *is* a political issue, but we should not be afraid of this. To pretend that the abuse of children is depoliticised is to do a huge dis-service to victims and survivors. When we are confronted with an adult who has been harmed, we are forced to hear that within each adult is a child who was abused. When we acknowledge the scale of these experiences, then if we are truly committed to the prevention of such harms and healing for those who have been hurt, we must ask meta-questions about the societal systems which are meant to protect citizens, when they are children. Recognising children as having rights and citizenship.

### Safety culture

Reason (1998, 2000) has written extensively about safety culture, starting in industry with catastrophic events in aviation, he identified that seemingly small, unchecked errors can gather momentum and have catastrophic consequences. This is a particular risk in 'command and control' cultures, where there are big differentials in power. He has outlined that safe cultures have five features – they are informed; they facilitate safe reporting (without fear of blame); they learn from positive and negative feedback; they are just; and they are flexible. Safe cultures depend most of all on trusting relationships, with a non-blaming attitude to unintended mistakes, shared values and a sense of individual responsibility. Other features are being mindful of human errors, needing space to reflect, promoting altruism, and ensuring that there is a socially just and inclusive culture. There should be an imperative on all leaders to ensure that our institutions are able to create safety culture for the benefit of people we serve, across all sectors of society.

### Social movements

It is social movements with clear demands for change, in law and in society, which have gained ground, hard won rights. Social movements as the vehicle for change, implicitly tied into social justice and human rights and bodily autonomy. They often carry within them the demand to be free from abuse and

fear. These rights should not be taken for granted, even once they are seen as 'mainstream'. The links between abuse, trauma and the need for human rights need to be more explicitly acknowledged. Broader human rights struggles provide exemplars of how activism following the IICSA could build.

Recently, refreshed activism has sparked against gender-based violence and racism. The #Me Too Movement went viral following allegations about Harvey Weinstein in 2017. Originally founded in 2006, by Tarana Burke to highlight the scale of harassment and abuse, the expansion of movement has led Burke to call for improved legal frameworks around all forms of sexual violence and abuse, and access to healing resources. In 2013, Black Lives Matter was also established by three Black women – Patrisse Cullors, Alicia Garza and Opal Tometi – in response to the acquittal of Trayvon Martin's murderer. The movement has highlighted police brutality and called for wider rights and protections of black people from state violence and racism.

Here in the UK, there are hugely concerning reports about police brutality, involving racism, sexism and the use of violence against children and young people. The murder of Sarah Everard led to huge social protest. The use of tasers against children, particularly against children from racially and ethnically minoritised backgrounds (Gayle, 2019), and the police misconduct against Child Q (Gamble and McCallum, 2022) also mean we need urgent reform and scrutiny of policing at an institutional level. We must ask how the public, particularly those from minoritised background are meant to feel confidence in state institutions. How are survivors of abuse and rape meant to feel confident to break their silence and come forward for help and justice, when so many cases do not proceed to court or successful prosecution (BBC, May 2022).

Social movements demand seeing and hearing. They demand emotional labour and cultural change at all levels, human and symbolic. In recent years, there has been much debate about the cultural significance of statues, who they speak for and who and what they present historically. The 2020 Minneapolis Memorial to Survivors of Sexual Assault in the USA is believed to be the first-ever, dedicated to survivors of sexual violence and inspired by their stories. It intends to break the silence around sexual violence and demonstrate community solidarity towards changing the culture around sexual violence. It was built through the efforts of Sarah Super, herself a survivor of rape, and allies, through donations. The monument has words engraved into three columns, stating simply, 'You are Not Alone', 'I Believe You' and 'We Stand with You'.

> Sarah Super spoke at the inaugural event, saying, *'When I first spoke out about being raped, a lot of people said and did nothing. Their silence taught me that there is no such thing as a neutral response to sexual violence. A response will either be hurtful or healing. Silence is not neutral. Silence supports the perpetrators and never the victims,'* (9 October, 2020)

Such public monuments show the power of allyship and survivor activism, and what can be done together. Other forms of public witnessing and healing

can take place through the medium of the arts. For instance, Viv Gordon's powerful 4 minute animation, *She Walks*, conveys the impact of trauma and survival in a way that many textbooks could never do, using music and poetry (Gordon, 2020). This is part of a 'Restless Project', to increase the visibility of survivor experience, which then connects with other movements and build critical mass for change. Sophie Olson is also a survivor activist and has founded The Flying Child, which is training and campaigning around the prevention of child sexual abuse. Again, this is part of a critical mass for change in public understandings of child sexual abuse and her organisation is also employing creativity as a means of increasing understandings and breaking silences around abuse, see https://theflyingchild.com/

Lucy Johnstone is helping to create a similar social movement in her A Disorder for Everyone (https://www.adisorder4everyone.com/), which is demanding a look beyond diagnosis into the causes of distress. Trainer and activist, Beth Filson has made powerful films about her lived experience, most recently '*Telling the Story, Untelling the Diagnosis*' (2023, https://www.youtube.com/watch?v=K4sdIUao5tM). Such forms of creativity connect with storytelling and truth telling in a way that can be of therapeutic value, and connects into more traditional methods of community cohesion, present in every culture. Whilst not therapy, the power of the arts should not be under-estimated in its ability to foster positive health and wellbeing (APPG, 2017).

These forms of silence breaking are a powerful means of building a momentum for change and can spark in the most difficult and hostile of environments. They are vibrant and hopeful, and they demand that we do better.

## Opening thoughts

We are in challenging times. There are incredible conversations happening about human rights, restorative justice and institutional change. There are greater public understandings about child abuse, hearing victims and state commitments to hear victims and survivors. This is superimposed on a very difficult ideological landscape, one which is leading to climate emergency, the reduction of state provided services and a cost-of-living crisis. On top of this, we are still in the aftermath of a global pandemic, which is now moving towards a predicted wave in mental health needs, which a chronically underfunded and wilfully neglected mental health system is overwhelmed by.

But are we in the darkness before the dawn?

We have opportunities to become a trauma-informed society. This will take political decisions to ensure that there is real levelling up, and a fair distribution of resources. If we are to have true access to prevention and healing, then we need political decisions to enact evidence-based research on what works around violence reduction, drugs and alcohol policy, child protection, social housing and to ensure that there is a commitment to well-resourced health service, which includes psychological trauma specialist services.

We need an overturning of harmful narratives which have led to victim blaming, ostracism, denial or the active shaming and silencing of those who have suffered abuse. And we need to be clear about this being everyone's business, not a private affair, but a public one, to which the whole community makes a collective commitment.

Activists have been raising demands for justice for decades. We cannot turn away from the harms that happen to people every day, because of racism, sexism, ableism, homophobia. It is the social movements and activism of those most minoritised and most traumatised that has sparked change. Victim-Survivor activists such as those from the Lambeth Children's Homes are acting collectively to demand better rights and protections for those harmed by child sexual abuse (see https://www.shirleyoakssurvivorsassociation.co.uk).

To fall out of step with societal movements and shifts in public understandings, means we are not attuned or aligned with resistances against violence and abuse. The context we live in can and should come into the therapy room. It is already in therapy room, after all.

As clinicians, academics, researchers and supervisors, we need to understand the complex relationships we inhabit with power and relative privileges. This is hard emotional labour, but it is full of learning. If we are really committed to prevent the harms of child abuse, particularly of child sexual abuse, then this is necessary work. It is complicated and messy, but if we use the principles of trauma-informed care, then there is an ethical beacon to illuminate our way.

All victims and survivors of child abuse deserve to be seen, heard, believed and helped in ways that allow relational healing.

In the aftermath of major national and international inquiries into child sexual abuse, let's be upstanders, active witnesses, humble allies and change makers. The interruption of silence can cause shifts. When there is snow upon snow, sometimes it only takes a few shifts to cause an avalanche.

Let's tune in, stand up and help to end the silence around abuse.

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# 17 Contagions of shame, dignity and connection

## Working in the field of childhood sexual abuse

*Daniel Taggart and Katie Wright*

At the end of an academic conference, after the first author of this chapter had finished speaking to a large audience of clinicians and researchers about childhood sexual abuse, including his own lived experiences, a senior professional took the stage to close proceedings. The senior professional pointed to the theme of trauma as a feature of the final presentation, and noted that conference delegates had "heard a lot about trauma" over the past few days. She then shared an anecdote in which she had been talking with a patient who began to disclose his experiences of childhood abuse. The senior clinician confidently recounted how she had interrupted him, saying, "You don't have to tell me about this if you don't want to". She went on to say that the patient nodded, and quickly spoke of something else. What this exchange taught her, she said, was that while sometimes it is good to talk about trauma, at times we can talk about it too much. In making this comment, was the senior clinician agreeing with those social commentators who lament that society is now are awash with trauma-talk? Did she ever wonder if her responses may have shut down a rare opportunity for her patient to share his experiences and have those experiences affirmed? And did she consider the possible effect that her comments may have had on the final speaker of the conference, whose presentation had sparked her reflections, and engendered in him a sense of shame? Did she notice his facial expression, his bowed head, as he sat alone in the front row and waited for her to stop talking.

Encounters like this will be familiar to people who speak about child sexual abuse in their places of work. It will be familiar to victims and survivors who talk of their experiences when trying to have their needs met. It will also likely be familiar to people who think that there is now too much openness and would prefer people stop focusing on their trauma. In beginning this chapter with a personal experience at an academic conference, in which a senior clinician's response to a presentation on child sexual abuse sparked shame in the speaker, we aim to tease out some possible meanings and use this as a starting point to reflect on the wider circulation of shame and notions of contagion. It is tempting to set up a drama triangle to interpret this scene; the victim of abuse shut down from disclosing, the professional as unintentionally abusive in the act of turning away because she could not listen,

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and the rescuing presenter trying to valiantly articulate uncomfortable truths about a topic that remains very much taboo. While this neat distribution of moral responsibility is tempting to invoke, it tells us little about what might be underlying the roles each person plays in the story and why these roles may appear to be fixed.

In this exchange, there are three protagonists who speak directly or whose speech is reported. However, there are another hundred people in the room watching and listening. The social nature of the scene binds the three in that their roles are observed, indirectly in the case of the patient, and crucially, open to judgement. We can speculate on what might drive a senior clinician to relate a story about suggesting someone might stop speaking about child abuse just after a conference presentation focused on trauma. We can wonder what it was like for the patient to be invited to speak about something else, given the evidence from survivors, in this book and elsewhere, about the impact it has on their recovery when they experience being shut down during a disclosure. We can even think of the parallel between the patient and presenter, two men speaking about child sexual abuse to a woman who implied that maybe it was "too much". It is this social context, the audience of witnesses and their speculations and judgements, that may help us understand what connects these three people, despite their preassigned roles. It is our contention that underneath this and other conversations around child sexual abuse, a shared affective experience, albeit experienced and expressed differently, is *shame*. In this chapter, we explore how shame can both frame how conversations about child sexual abuse take place, how shame can push us into ways of being we may not recognise, and how shared affective connections and disconnections around shame can inhibit and shut down everyone's attempts to grapple together with a difficult but critically important subject. Crucially, we also consider how shame can work in other, often unexpected, ways, not only through what we might conceptualise as a kind of negative contagion, but also by fostering new connections, creating new meaning and purpose, and by galvanising hope about alternative futures.

Shame has been proposed to be a central affective component of the complex trauma that arises from child sexual abuse (MacGinley et al., 2019). Part of the complexity of living with this type of trauma is that the chronic shame that can develop in response to the abuse, makes connecting with others and speaking about one's own experience painful at a visceral level. Therefore, chronic shame in the context of abuse can both be something that people need help with, but which makes help seeking especially challenging. Complicating this are the shame-based responses of others to the topic of child sexual abuse, for example, when a clinician shuts a person down if they attempt to disclose, we can see how the interpersonal context – even in a therapeutic setting – is not conducive to straightforward dialogue and connection. In this volume (Chapter X) Sara Scott eloquently talks about the concept of shame related to child sexual abuse from a psychoanalytic frame, how it gets projected between people unconsciously and clogs up our ability

to connect with one another. Much of that understanding fits with what we would like to think about in this chapter, but to complement and develop our understanding of shame beyond the interpersonal and psychological, we will consider other disciplinary approaches to shame, specifically drawing on queer theory and the work of Eve Kosofsky Sedgwick.

In Sedgwick, 2003 book, *Touching feeling: Affect, pedagogy and performativity*, she grapples with the embodied relationship between texture and affect (touching and feeling) in a way that both draws upon and subverts more conventional approaches to the study of emotions. Sedgwick explores the irreducibly phenomenological quality of shame by emphasising the word's ability to confer the feeling it refers to, "Shame!" Given the evocative texture of the word used to refer to a particular affective state, she goes on to challenge the dominant psychological paradigm that shame is inherently reducing, shrinking and diminishing of the person in a shamed state. This is a helpful launching point for considering the ways that shame can, as well as diminishing our sense of self, have a peculiarly constituent influence on the development of survivor identity in the context of child sexual abuse. An identity that can be, simultaneously, isolating and socialising, atomising and conjoining. Examining this paradoxical affect, using Sedwick's framework, can, we believe, illuminate the strength of the bonds that victims and survivors form through collective action and advocacy work, while also understanding the ruptures and splits that can occur in survivor spaces. None of this is to minimise the painful feelings of annihilation that chronic shame often induces in victims and survivors of child sexual abuse, but rather to explore how generative elements in shame responses to abuse can help us understand the development of survivor identity in all its complexity.

Drawing on the work of the psychologist Silvan Tomkins, Sedgwick outlines how at the heart of shame is a developmental need for *recognition*. In this sense, our need for recognition in the face of others, we can draw on the example of Edward Tronick's 1978 "still face experiment" in developmental psychology. In this groundbreaking study, after engaging and connecting with her infant child through smiling, making eye contact and talking, the mother disengages and greets her infant's attempts at connection with a blank gaze. This leads the child to initially experience confusion and exhibit increased cues that would ordinarily provoke a maternal response. As the mother keeps a "still face" the child experiences distress at failed attempts at connection, turns away and, in withdrawing, exhibits a "hopeless facial expression" (Tronick et al., 1978). In this example, a child needs to find recognition in the face of the other. When they do not, they lose the ability to connect, withdrawing into themselves. In Tomkin's analysis, this is a scenario in which shame can be provoked, as, "one wishes to look at or commune with another person but suddenly cannot because he is strange, or one expected him to be familiar, but he suddenly appears unfamiliar, or one started to smile but found one was smiling at a stranger" (Tomkins, cited in Sedgwick, 2003, p. 35). We highlight this example because of the stark parallels with the dynamics of child

sexual abuse. A child looks to a person in a position of trust for connection and warmth but instead experiences betrayal and abuse. They expect the caregiver to be one thing and suddenly find them to be something else entirely. We can see here the potential for the abusive encounter itself to be shame provoking because the child is left with a failure of recognition.

Sedgwick develops the roots of shame as a difficulty of interpersonal recognition through her observation that the affect is both, "peculiarly contagious and peculiarly individuating" (2003, p. 36). When we are in a state of shame, we find ourselves completely isolated, abandoned even by ourselves. However, it is also an affective state that is infectious, to be with someone in shame is to viscerally feel a reaction to it. Again, this can read across to the field of child sexual abuse in reference back to the anecdote from the beginning of the chapter. The shame of talking about a shameful subject, such as child sexual abuse, has a contagious effect on both the speaker and the listener, rendering them caught in "the double movement shame makes toward painful individuation, toward uncontrollable relationality" (Sedgwick, 2003, p. 37). So, while a survivor talking about child sexual abuse may feel waves of shame in response to a lack of recognition in others, it is equally possible that they have become "infected" by the shame-based responses of their listeners. We can see the feedback loop that can develop from this contagion, leaving the survivor carrying all the shame of the system around them and identifying it as entirely their own. Clearly this contagion can also include, and begin with, the original abuse, where the child victim takes on the shame of the perpetrator and is silenced by it.

However, it is the next step Sedgwick makes that has the greatest explanatory power in understanding the function shame might have in the development of survivor identity. Again, drawing on Tomkins, she says that "shame effaces itself … shame and pride, shame and dignity, shame and self-display, shame and exhibitionism are different interlinings of the same glove" (Sedgwick, 2003, p. 38). In this formulation then, shame is not only foreclosing and diminishing but creative and characterised by *performance*. Performativity in this sense links to Judith Butler's work around gender and their argument that it is, "performative, that is, constituting the identity it is purported to be" (1990/2006, 24–25). In describing oneself and expressing preferences, there is a construction of identity through language, one that is not linked to an essentialist essence, but is brought into being and constituted through the language that has been taken up by the speaker. So, in this way, the construction of a queer identity may draw in elements of shame, but not simply in a reductive or diminishing way. A key difference between identity construction as elaborated in queer theory, and identity in the field of child sexual abuse is that in the case of the latter, identity is often violently imposed upon victims and survivors. The absence of agency is crucial in understanding the inscription of a traumatic injury. Yet importantly, for some victims and survivors, embracing an identity linked to their experiences can be both agentic and an empowering antidote to the diminishment that often results from this type

of abuse (Taggart et al., 2025). Therefore, to understand the impacts of child sexual abuse on our ability to talk about it, we need to also consider the ways that both victims and survivors, and those who have not experienced abuse themselves, have developed particular forms and patterns of speech on this subject, how that links to people's identities as a survivor, how this feeds into wider survivor politics, and how it shapes broader language around child sexual abuse more generally.

It is helpful to return to Sedgwick and her view that "performativity in terms of habitual shame and its transformations opens a lot of doors for thinking about identity politics" (2003, p. 62). If early experiences of shame relating to child sexual abuse are constitutive, in the sense that they are the affective driver of distress and dysfunction, but also in shaping aspects of a person's relational strategies, then they may become structural. This structure can be understood in terms of a psychiatric presentation, such as complex post-traumatic stress disorder, where shame is seen as a central organising feature (Salter & Hall, 2022). However, it can also be seen in the emergence of a survivor identity that seeks connection, empowerment, speech and visibility to counteract the diminishing impacts of shame. This is often constructed as reactions against shame, with the affective juxtaposition being pride or dignity (Moran & Salter, 2022). What Sedgwick is arguing, though, is a qualitatively different type of dynamic. Rather than eradicating or "moving beyond" shame through the development of a survivor identity via involvement in activism and through connection with others, it is, paradoxically, from the very shame-based experiences that these generative processes can arise. Therefore, instead of excising toxic elements of shame, these processes are instead constitutive transformations, occurring not only in reaction to, but also in synchrony with, shame in ways that form identity while also creating new political and social potentialities. While seemingly counterintuitive, even contradictory, in the way we typically formulate and conceptualise trauma-based shame, in this formulation we can consider the idea of "shame creativity" as not only generative, but of being of central importance in survivor identity and activism.

Why does it matter whether survivor identity is an attempt to overcome shame, find an antidote to it, to "unshame" or to see shame as instead having generative capacities leading to the performance of identity? From a phenomenological angle, these subjective experiences may not be easily disentangled, distinguished and categorised anyway. To try to do so may also run contrary to existing survivor frameworks that have managed to find new ways of discussing child sexual abuse and risk being jeopardised by "a sterile journey through theory" (Spring, 2019, p. 8). One of the motivations is simply to offer another entry point to the seemingly insurmountable task many victims and survivors describe when facing the shame generated by their abuse experiences. If the task is to overcome shame and yet people find themselves continually bedevilled by it, does that signal failure? Shame is widely understood as an affective barrier to service access, in that people living with

chronic shame spend a lot of their lives trying to avoid situations that can give rise to it, including the risks associated with seeking social connection, and the very real possibility of failed attempts at recognition described earlier in the chapter. What if, in being sensitive to shame, services were also able to recognise its inevitability in victims and survivors, as well as its circulation in the organisational systems – and indeed in the wider culture – around them? What if therapeutic approaches to traumatic shame, that place a premium on shame as a symptom to be reduced or ideally removed, instead recognised its generative capacity? Of course, the risk here is that this becomes another way to resolve and overcome shame, with the pretence that its constitutive properties can simply be transformed into positive affective experiences. This would deny the other side of shame and reinscribe a form of therapeutic thinking which seeks to distinguish between healthy and unhealthy shame, a return to polarities that Sedgwick's approach nimbly circumvents.

The primary motivation to reconsider traumatic shame arising from child sexual abuse is to find another way in to understanding how the affective politics of survivor identities and activism can lead to collective progress, hope and connection, while also being beset by painful ruptures. While intragroup ruptures are potentially an inevitable feature of any social movement, it has a particular quality in survivor politics due to the abusive nature of the differential but commonly held, underlying injuries. The chapter will now turn to considering some of these challenges in context, as well as the achievements of survivor activism, before turning back to Sedgwick's work on shame to understand some of the affective drivers underpinning ruptures. It will then conclude with some consideration of how the generative capacity of shame in survivor identity and more broadly, can be safeguarded against destructive conflicts.

Nancy Whittier describes the process of survivors becoming visible as a form of "coming out" (2009, p. 10), one that has parallels with Sedgwick's ideas in queer theory. Whittier identifies survivor activism as a form of visibility politics, whereby previously stigmatised identities are brought into the public sphere to provoke awareness of a taboo topic. From the survivor perspective, this has both individual therapeutic potential and serves a broader social and political purpose. It is similar in some respects to larger-scale mental health anti-stigma campaigns such as the "Time to Change" movement in the UK which featured celebrities "coming out" as people who suffered from mental health problems (Evans-Lacko et al., 2014). The underpinning principle is based on Allport's (1954) social contact theory, the idea that for members of the public the stigma attached to people with marginalised experiences such as being survivors of child sexual abuse will reduce on contact with real people as opposed to stereotypes. Whittier found evidence of the effectiveness of these strategies for both individual survivor recovery and as a tool of wider social and political action. Many of the survivors she spoke to said that coming out, "increased their sense of belief in themselves" (p. 176) as a form of action rather than in the context of a therapeutic intervention.

Like many others writing in the area, she describes the process of coming out as an antidote to the shame of silence (see Rouf Chapter XX in this volume). However, what happens when coming out as a survivor of child sexual abuse not only increases shame in some contexts, but can also lead to shame-based interactions with other survivors?

The Victims and Survivors Consultative Panel (VSCP) was a group of people with relevant professional expertise, as well as lived experience, appointed to the Independent Inquiry into Child Sexual Abuse (IICSA) in the UK in 2015. Their remit was to offer advice to the inquiry on the needs of victims of child sexual abuse interacting with IICSA. There is evidence that they made a significant contribution to the work of IICSA and made a material difference to the experiences of other survivors (Barker et al., 2023a) and staff (Barker et al., 2023b). However, their work was not without challenges (Taggart et al., 2025), including criticism from survivors outside the VSCP. In one research study, members of the VSCP described being attacked by external survivors on social media and portrayed as "obedient poodles" to the inquiry. While this could be narrowly viewed as evidence of an envious attack by people left out, not "chosen" or conferred special status as a survivor, it could also be interpreted as reflecting something deeper. The largely female VSCP group being described as dogs on a public forum has a particular shame-based quality. One of the understandable responses on hearing about this type of attack, is to say, "But how could another survivor not understand how hurtful that would be?" Surely, we think someone who has been shamed themselves in such a profound way would never willingly do that to another person who has suffered something similar. Within conventional psychological understanding, one way to resolve this paradox is to focus on Karpman's (1968) drama triangle that identifies three roles: persecutor, rescuer and victim. This model can explain the shift from a victim to a persecutor position through the roles people are assigned based on power relationships when the subject matter is conflictual and traumatic. From a psychoanalytic perspective, we might think that the external survivors have internalised some of the abusive feelings of the perpetrator, leading to a reaction formation whereby it is better to identify with a dominant, albeit abusive role than acknowledge one's vulnerability by taking a less powerful position (Freud, 1937).

While these are helpful intrapsychic and interpersonal explanators, they lack a wider social framework. Returning to Sedgewick's notion of shame as a failure of recognition, of expecting to see commonality but instead finding alienation, we can begin to see how the objectification and dehumanisation of VSCP members by other victims and survivors can be understood as a social phenomenon as well as a psychological one. The French writer Annie Ernaux says that "the worst thing about shame is that we imagine we are the only ones to experience it" (2023, p. 71). However, in this case, we would suggest there is something worse than the isolation of shame, it is the connection that is offered by people with similar traumatic experience, only to be betrayed through a false promise of social connection that is replaced with

public humiliation. The outraged riposte towards survivors who attack other survivors in this way feels familiar in an age of polarised identity politics and political correctness, which Sedgwick suggests can be understood as, "a highly politicized chain reaction of shame dynamics" (p. 64). If survivor groups are to challenge some of these circular outrages, ostracisms and moral purges, there may need to be a full reckoning with the potentialities of shame to both bring together and alienate survivors from one another. To paraphrase James Baldwin, while this dynamic may be difficult to change, it must first be faced. While it is among the worst roles that a survivor of violence can be put in, that of abuser of another survivor, it is important to think that problems of recognition between survivors can lead to shame-based responses and feelings of ostracism.

While difficult dynamics between survivors can be used as a rationale to shut down participation, as it is seen as too difficult to manage, there are many examples of the other "interlining of the glove" – instances of social connection and change that emerge through survivor identity and collective action. While psychoanalytic literature contends that defence against shame involves splitting (see Chapter Sara), which inhibits social connection, other disciplines and perspectives offer different angles onto shame. Rebecca Moran and Michael Salter's work, for example, underscores the ways in which the conferring of dignity not only works to ameliorate shame, but that it is also "at the heart of therapeutic politics" geared towards social change (2022, p. 972). If there is a common message to be drawn from highly disparate survivor voices and people "speaking out", it is that survivors don't want what happened to them to happen to others (Wright & Swain, 2022). Drawing on interviews with victim/survivors who gave evidence in public hearings of the Australian Royal Commission into Institutional Responses to Child Sexual Abuse, Moran and Salter (2022) illuminate the restorative power of being heard and the benefits of having lived experience validated. The Royal Commission provided formal and public acts of recognition, affirming that survivors' experiences were fundamental, both to securing justice for those who had experienced abuse in the past, and to improving child safety in the future. What mattered was not only being listened to and being believed by people in positions of power (i.e. the Commissioners), it was also the small things – the provision of comfortable rooms and refreshments, survivors being seen, cared for, and treated with dignity throughout all their interactions with inquiry staff. Sadly, for many, this sat at odds with either their previous life experiences in general, or more specifically, instances when they had tried to speak about their experiences of child sexual abuse in the past. Rather than responses that minimised the abuse or blamed them for what happened when they were children, feeling seen, heard and valued – being treated with dignity – was described as "a powerful antidote to shame" (Moran & Salter, 2022, p. 977). From our reading of Sedgwick's work, the notion of antidote, implying counteraction, may risk setting up shame and dignity as in opposition and therefore not capturing the shared origin of the two states. While this

might seem like a semantic distinction, we think it enables dignity conferring processes to coexist with shame-based responses, in a way that does not negate one or the other but rather shows them to be co-constituted and that both have generative potential.

A more personal example, and one that serves as a counterpoint to the anecdote that opened the chapter, is both of our experiences of participating in a collaborative workshop for an Australian research project, led by the second author, that is investigating new approaches to raising awareness of child sexual abuse. The workshop brought together 24 people: eight survivor advocates, eight young people, six academic researchers, and two professionals from the creative industries. The project is investigating awareness raising and the central question the research is grappling with is how to safely engage people with the topic of child sexual abuse when the urge is to turn away. Over two days, there was warm, respectful, engaged dialogue between highly experienced survivor advocates, socially engaged youth, researchers from sociology, psychology and history, a filmmaker and researcher, and digital designers and storytellers. The workshop aimed to develop the foundations of an online storytelling experience, one that draws on survivor advocate experiences in ways that will connect with young people and increase their knowledge and understanding of child sexual abuse. Across the two days, existing relationships were strengthened, and new connections were formed. Shame was mentioned as an element of the survivor experience and, importantly, is sometimes also experienced by non-survivor researchers because of working in the field, suggesting what could be described as a type of shame contagion. Yet, the overriding affect over the two days was its opposite. Judith Herman's concept of the "survivor mission" captures the mood of the room, but during the workshop this mission transcended survivor status. Herman suggests that, "a significant minority, as a result of the trauma, feel called upon to engage in a wider world" (1992/2015, p. 207). In so doing, the meaning of trauma is transformed, with personal misfortune sparking social action. If the senior clinician mentioned in the opening anecdote was present, she may have reflected that we "heard a lot about trauma" during the workshop. But rather than invoking shame, there was a collective experience of connection, and a vision that drove the collaborative work – a deeply shared belief that child safety mattered, that we cared, and that we wanted to improve on the failings of the past. The advocates were recognised for their deep knowledge and contributions, and there was a collective feeling of hope and, critically, that change is possible.

Despite the work of activists and advocates, major public inquiries in many countries across the world, and changing social norms around openness and disclosure, child sexual abuse remains a taboo topic (Wright & Swain, 2022). In this chapter, we have reflected on shame from our perspectives as researchers – and from our experiences of working in this field as a survivor and a non-survivor. The shame that circulates around child sexual abuse is not limited to the affective experiences of survivors; it permeates more broadly. We do not

know how much of our own inhibitions, concern about upsetting people, or shame, even, in talking about our research shapes other people's reactions to it. At times, we sanitise and employ euphemisms to avoid the discomfort of others. We know that shame plays out in complicated ways. But what we see in our work – and in the work of others, is that when social connections are facilitated, dignity conferring environments fostered, and collaborative action aimed at social change mobilised, shame's antidote – dignity – can come to the fore. So, while we return to Sedgwick's formulation that survivor identity may be forged in the smithy of shame, that it is not fixed there, but is amenable to reshaping through connections of solidarity and social action. We thus conclude our reflections by offering some fresh insights into the duality of shame and its antidotes, as well as their contagions.

There is a paradox in working in the field of child sexual abuse. How do we enable and foster meaningful collaboration and participation without fixing people in a position as a survivor, for example, by repeatedly asking them to share their stories? We now know that collaborating with people with lived experience expertise is important to conducting ethically, socially engaged research that has real impact. Drawing on lived and living experience and expertise is not only essential in working towards social change, but our research has affirmed that centring and valuing that experience and expertise can generate warmth and connection in a group setting, including amongst people who don't share common lived experiences. In combating the corrosive effects of shame and stigma, we conclude this discussion by noting an aspect of our individual and collective research and personal experiences. While working in the field of child sexual abuse (either as a survivor or as a non-survivor academic researcher) can be painful and difficult, our experience is that it can also be incredibly joyful and optimistic. The possibility of being at the vanguard of social change, of improving the lives of others, is deeply meaningful, and connecting with those who share these values is both sustaining and life affirming. These elements of working in the academic field of child sexual abuse are rarely discussed. Yet for us, they keep us going when, like the young adult audiences we are trying to reach with our awareness raising project, sometimes the urge is to turn away.

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