

**Working with Adult Survivors of Childhood Sexual Abuse: Mental Health
Professional and Survivor Perspectives**

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Abstract

Childhood sexual assault (CSA) is a prevalent societal issue that can have long-term negative effects on the survivor. Adult survivors of CSA frequently seek therapy from mental health professionals. However, mental health professionals are not necessarily aware of, or trained, in working with CSA. This lack of knowledge can result in considerable negative consequences for the survivor. This study aimed to explore the experiences and needs of CSA survivors who engage in therapy, and identify helpful and unhelpful mental health professional practice. This was achieved qualitatively, with data gathered by a semi-structured interviewing style and evaluated via thematic analysis, guided by a social constructionist epistemology. Three survivors of CSA, who had previously engaged in therapy with a mental health professional, as well as 13 mental health professionals, participated in the current study. This study found that despite mental health professionals' lack of education and training about CSA, they did not need to be particularly knowledgeable to be considered effective. Specifically, the ability to listen was crucial, as this indicated the professional was comfortable with the disclosure. However, an inability to listen was commonly cited and demonstrated to the survivor in a variety of ways. The issue of referral upon disclosure of CSA was identified as problematic, as well as considered a professional ethical dilemma. Whilst mental health professionals are bound by a professional responsibility of working within their realm of expertise, it could also be perceived as negative in terms of the messages it sent to the survivor. An ideal solution was suggested to circumvent this problem. The implications of mental health professional practice on CSA survivor wellbeing is discussed.

Doctor of Psychology Declaration

“I, Alison Barber, declare that the Doctor of Psychology (Clinical Psychology) thesis entitled **‘Working with Adult Survivors of Childhood Sexual Abuse: Mental Health Professional and Survivor Perspectives’** is no more than 40,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work”.

Signature: _____

Date: _____

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Chapter 1

Introduction and Overview

1.1 Background

Childhood sexual abuse (CSA) is a prevalent societal issue, affecting girls and boys in childhood or adolescence (Fergusson & Mullen, 1999). A variety of factors prevent children from disclosing at the time of the abuse, with delayed disclosure or non-disclosure being common (Alaggia, 2005; Hunter, 2011). If children do disclose, it is often met with negative social reactions, deterring future attempts at disclosure (Jonzon & Linblad, 2004). The listener's negative reactions may exist due to the perpetrator being known and trusted by the listener, as well as society's general discomfort with sex and the victimisation of children. Negative reactions to disclosures of CSA can detrimentally affect the survivor's wellbeing and mental health (Ahrens, Stansell & Jennings, 2010; Campbell & Raja, 1999).

Experiencing CSA is associated with long-term negative effects that can last into adulthood, and include relational and mental health issues (e.g., Abdulrehman & De Luca, 2001; Neumann, Houskamp, Pollock & Briere, 1996). These associated effects may prompt adult survivors to seek therapy from a mental health professional with a 'disguised presentation' rather than for therapy about their abuse experiences (Gelinas, 1983). Therefore, mental health professionals will be likely to encounter survivors who seek help for issues associated with symptoms and issues associated with experiencing CSA, rather than for the CSA itself (Herman, 1992a).

While diagnosis may be helpful, Judith Herman (1992a; 1992b) cautioned that traditional diagnostic criterion for disorders is neither designed for, nor fulfilled by, survivors of repeated trauma experienced in a child's developmental phase. Therefore, therapeutic guidelines used to treat associated mental health issues, such as depression or posttraumatic stress disorder, may not be adequate to address the unique symptoms developed from childhood trauma. Research indicates mental health professionals lack training or knowledge about the link between CSA and associated symptoms or issues, or are reluctant to ask about childhood trauma due to lack of training around how to handle a disclosure (Lab, Feigenbaum & De Silva,

2000; Read, Hammersley & Rudegeair, 2007). It is unlikely the survivor will spontaneously disclose their experiences of CSA to a mental health professional (Zaidi & Foy, 1994).

Disclosure of CSA is considered to be helpful to the survivor's mental health and wellbeing (Murthi & Espelage, 2005; Ullman, 2007). Available literature indicates helpful and unhelpful practices employed by mental health professionals when working with survivors of CSA (Dale, Allen & Measor, 1998; McGregor, Thomas & Read, 2006). These practices can assist a survivor's wellbeing for either better or worse, with the latter often resulting in 'secondary victimisation' and further silencing of the survivor (Ahrens et al., 2010).

1.2 Aims of the Study

This project's aims were twofold. Firstly, it aimed to explore the experiences and needs of adult survivors of CSA when consulting a mental health professional. In particular, the experiences surrounding disclosure, or non-disclosure, of CSA in therapy, what the adult survivor found helpful or useful about the disclosure, how satisfied they were with it, and what, from their invaluable perspective, could have been improved were all investigated.

Secondly, this project aimed to explore mental health professionals' knowledge and experiences of working with adult clients of CSA who have disclosed historical sexual abuse in therapy. In particular, opinions about disclosure of CSA in therapy, what they believe is helpful and unhelpful practice for working with survivors of CSA, as well as adequacy of the training and education they received were all explored.

1.3 Significance of the Study

As Section 1.1 indicated, CSA survivors tend to seek therapy with a 'disguised presentation' (Gelinas, 1983) rather than for the abuse experience itself. In addition, diagnostic criteria for commonly presenting mental health issues such as depression or posttraumatic stress disorder are inappropriate for sustained trauma experienced in a child's developmental stage (Herman, 1992a). Therefore,

subsequent treatment guidelines for these mental health issues could also be inappropriate for treating survivors of CSA. Authors such as Astbury (2006) and Herman (1992a) have also asserted that guidelines established for adults who have experienced recent sexual assault may not be applicable to adults seeking help for CSA, due to the more complex and problematic nature of experiencing sexual trauma in childhood. Information to date indicates that mental health professionals could improve their knowledge and practice to provide optimum treatment for their clients (Lab et al., 2000; Read et al., 2007). At present, guidelines for mental health professionals who discuss childhood or adolescent, historical sexual assault are scant and not readily accessible. Therefore, this study was conducted to address the gaps in literature regarding disclosure and therapy experiences of CSA survivors, as well as helpful and unhelpful therapeutic practice employed by mental health professionals. The current study achieves this in three main ways.

Firstly, existing qualitative research has been particularly useful in exploring people's experiences of therapy and working with a mental health professional regarding their experiences of CSA (e.g., Dale et al., 1998; McGregor et al., 2006). Employing qualitative research and employing semi-structured interviewing enables participants to discuss their experiences and elaborate on their interpretations. Gathering this type of data allows for a deep and rich understanding that is unable to be gained via quantitative research methods. It also provides an opportunity for unanticipated material to emerge. Therefore, using a qualitative approach in this study was thought to contribute to the existing and emerging knowledge in this field.

Secondly, disclosure of CSA has been explored, but largely using quantitative research methods (Ullman, 1996; 2003) or concerning disclosure to informal support sources and the listener's subsequent reactions (Ahrens et al., 2010; Filipas & Ullman, 2001). Qualitative research about disclosure of CSA in therapy is underexplored. Therefore, this study explored crucial aspects of disclosure of CSA to a mental health professional, including factors facilitating and inhibiting disclosure, as well as the consequent discussion about the survivor's CSA experiences with mental health professionals.

Finally, while research tends to focus on either mental health professionals' knowledge and opinions of working with CSA (Munro & Randall, 2007) or CSA

survivors' experiences in therapy (Dale et al., 1998; McGregor et al., 2006), this study incorporated the perspectives of both adult CSA survivors as well as mental health professionals. By obtaining subjective perspectives of both populations, more comprehensive, constructive and balanced conclusions could be reached. These insights and resultant recommendations may increase knowledge and understanding when working with adult CSA survivors.

1.4 Structure and Overview of the Study

Chapters 2 and 3 review the current, available literature regarding the associated relational and mental health effects of experiencing CSA, as well as mental health professional practice when working with adult survivors of CSA. Chapter 2 provides background information about CSA, including its definition and prevalence rates. A theoretical framework accounting for common difficulties survivors may experience, as well as possible neurobiological mechanisms underlying such trauma is described. Relational and mental health issues are then explored, highlighting moderating factors and gender differences. Chapter 3 focuses on mental health professionals asking, or conversely, not asking, about CSA. It also explores factors that facilitate or inhibit disclosing CSA in therapy, and whether disclosure is beneficial. Finally, helpful and unhelpful therapeutic practice is examined, as well as the consequences on the survivor. Chapter 4 outlines the qualitative methods and procedures used to gather data, as well as details how this information was analysed. The findings are presented and discussed in Chapters 5 and 6, with the first chapter focusing on the difficulties survivors present with when seeking therapy, and their experiences of disclosing CSA to informal supports, such as family and friends. The second chapter highlights the experiences of disclosure or non-disclosure of CSA in therapy, as well as what is considered helpful and unhelpful practice from the perspectives of both CSA survivors and mental health professionals. The final chapter of this study includes the conclusions made based on the findings, the implications for practice, as well as its limitations.

Chapter 2

Literature Review Part One:

Childhood Sexual Assault and its Effects on Survivors in Adulthood

2.1 Introduction

Available research exists concerning the therapeutic needs of adult survivors who disclose experiences of childhood sexual assault (CSA) to a mental health professional. This chapter begins by providing background information about CSA, including its definition, prevalence rates and other key information. A theoretical framework accounting for common difficulties survivors may experience, as well as possible neurobiological mechanisms underlying such trauma is described. Common relational and mental health difficulties survivors may experience, as well as a supporting theoretical framework is then explored. It is noted that survivors of CSA may be affected to varying degrees by their experience of sexual abuse due to a range of moderating factors, with possible gender differences existing.

2.2 Childhood Sexual Abuse

Childhood sexual abuse is commonly defined as any “sexualised behaviour” between a minor who is generally five years, or more, younger than the perpetrator (Russell, 1986, as cited by Monahan & Forgash, 2000). However, this definition is controversial as it excludes peer-aged child sexual abuse, where the perpetrator has an age or maturational advantage over the victim (Finkelhor, 1994). Sexualised behaviour can range from non-contact experiences, such as exposing the child to pornography or exposing genitalia, to contact experiences, such as fondling, oral sex or rape (Monahan & Forgash). The majority of literature reviewed in Chapters 2 and 3 either explicitly adopt Russell’s definition of CSA, or a variation of it, or does not define the abuse experience at all.

Prevalence rates of CSA also vary according to the sources from which the statistics are derived. For example, it had been reported that approximately one in three (33.3%) females and one in six (16.7%) males will be sexually victimised by

the time they reach 18 years of age (Fergusson & Mullen, 1999; Najman, Dunne, Purdie, Boyle & Coxeter, 2005). However, other research suggests that approximately 19.7% of females and 7.9% of males will experience CSA (Pereda, Guilera, Forns & Gomez-Benito, 2009). Regardless of these estimate discrepancies, it is clear that CSA is a prevalent societal problem.

Approximately 90% of perpetrators of CSA are male (Finkelhor, 1994), although recent research increasingly recognises the incidents and damaging consequences of female perpetrated child sex abuse (e.g., Beech, Parrett, Ward & Fisher, 2009; Duncan, 2010). For example, in a large-scale U.S. study, male survivors of CSA reported that females perpetrated abuse 40% of the time, compared to only 6% of female perpetrators reported by the female survivors (Dube, Anda, Whitfield, Brown, Felitti, Dong & Giles, 2005). Perpetrators are likely to be known to the child, with more than 90% of girls and 80% of boys reporting they were abused by a person they knew (Australian Bureau of Statistics, 2006, cited by Tarczon & Quadara, 2012). The most frequently reported perpetrators are fathers, stepfathers and other male relatives, including siblings, consisting of over half the perpetrators against girls and one-fifth against boys (Australian Bureau of Statistics). Abuse perpetrated by fathers and stepfathers is more likely to be severe, intrusive, frequent and prolonged (Fergusson & Mullen, 1999; Romans, Martin, Anderson, O'Shea & Mullen, 1996). Family friends, acquaintances or neighbours constitute of approximately 16% of perpetrators for both boys and girls (Australian Bureau of Statistics). Boys are more likely to experience sexual abuse by a stranger (approximately 1 in 5), compared to girls (1 in 10) (Australian Bureau of Statistics).

CSA is a prevalent and insidious phenomenon that has been viewed from many perspectives in order to make sense of it, and the effects it has on survivors. The following model provides a theoretical framework to conceptualise CSA.

2.3 Traumatogenic Model of Childhood Sexual Abuse

Various theoretical frameworks have been proposed in order to describe how the nature and dynamics of CSA affect an individual. Of the available frameworks, Finkelhor and Browne's (1985) 'traumatogenic model' appears to best

account for how experiencing CSA may result in particular consequences for the survivor's wellbeing. This model asserts that experiencing CSA can be understood in terms of four traumagenic, or trauma causing dynamics: traumatic sexualisation, betrayal, powerlessness and stigmatisation. It is thought that experiencing these combined dynamics during one's developmental history affects how a child views and experiences the world and themselves, resulting in negative psychological and behavioural issues.

2.3.1 Traumatic sexualisation.

Traumatic sexualisation is a "process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse" (Finkelhor & Browne, 1985, p. 531). Traumatic sexualisation occurs in three identified ways. Firstly, by the child learning that sexual activity is a commodity that is exchanged for receiving attention, affections and gifts. Secondly, the inevitable confusion the child develops about sexual morality, behaviour and norms based on their experience, and finally, via memories of the abuse itself. The result of being exposed to such traumatic sexualisation may continue into adulthood and is associated with issues concerning sexuality (e.g., Holmes & Slap, 1998; Mullen & Fleming, 1998).

2.3.2 Betrayal.

Finkelhor and Browne (1985) define betrayal as "the dynamic by which children discover that someone on whom they were vitally dependent has caused them harm" (p. 531). Generally, a child learns that adults are to be trusted and provide guidance and protection. The abuse experience effectively destroys this perception as the child becomes increasingly aware that the perpetrator was manipulating and lying to them to protect their own interests. This betrayal may be further reinforced by a lack of support or protection from other trusted adults, who deny or ignore the child's disclosure of abuse. The result of such fundamental betrayal may continue into adulthood and is associated with issues concerning the formation and maintenance of all attachments, including intimate relationships (e.g.,

Abdulrehman & De Luca, 2001).

2.3.3 Powerlessness.

Powerlessness, or disempowerment, refers to “the process in which the child’s will, desires, and sense of efficacy are continually contravened” (Finkelhor & Browne, 1985, p. 532). The child’s boundaries are repeatedly violated by the perpetrator and may feel as if they are unable to stop this from occurring. Feeling unable to stop the abuse can exacerbate fear and reinforce their sense of powerlessness over the situation. The result of disempowerment may continue into adulthood and is associated with issues such as anxiety and revictimisation (e.g., Barnes, Noll, Putnam & Trickett, 2009).

2.3.4 Stigmatisation.

Finkelhor and Browne (1985) define stigmatisation as “the negative connotations (‘badness’, shame, guilt) that are communicated to the child around the experiences and that then become incorporated into the child’s self-image” (p. 532). Stigmatisation may occur via the perpetrator blaming or shaming the child for the abuse, or conveying it covertly through secrecy. Such stigmatisation may be reinforced by societal attitudes and subsequent negative reactions to the abuse, thereby increasing the child’s sense of guilt, shame and isolation. The result of stigmatisation may continue into adulthood and is associated with issues around self-concept and self-harming behaviours (Mullen & Fleming, 1998).

Finkelhor and Browne (1985) stated these four traumagenic dynamics exist amongst all CSA experiences to a greater or lesser degree. Due to the uniqueness of each abuse experience (e.g., use of threats, quality of support from family, number of incidents) a child, or adult survivor, may encounter a particular dynamic more or less than another. Particular mental health issues, such as depression, may be attributed to a combination of traumagenic dynamics, such as stigmatisation, betrayal and powerlessness.

Other frameworks were considered for this study. For example, Sigmund Freud’s psychoanalytic theory pioneered work on ‘repressed memory’, where the inability to remember abuse was an effective defence mechanism employed to

prevent psyche disintegration (1915/1963f; cited by Ewan, 2003). While Freud contributed immensely to the field of psychology, particular aspects of his theories are contradictory, or plainly incorrect, when applied to working with CSA. Initially his ‘seductive child’ theory placed the victim in the role of provocateur, essentially absolving the perpetrator of any blame or responsibility (Freud, 1898; cited by Masson, 1994). This view was later abandoned and replaced by the notion that CSA were imagined fantasies of the child, consequently denying the reality of abuse (Freud, 1933, cited by Esterson, 1998).

John Bowlby’s theory of attachment (1951) has also been useful in identifying that poor parent-child attachment, characterised by attachment trauma such as CSA, can lead to an increased vulnerability to a range of psychological and social difficulties (cited by Fergusson & Mullen, 1999). Whilst this theoretical framework may explain abuse perpetrated by parents or immediate family members, it does not account for the effects experienced by individuals who are more commonly victimised by other acquaintances (Fergusson & Mullen).

The traumatogenic model has been adopted due to four noted merits. Firstly, this framework views CSA as a process that affects one’s attachment and developmental beliefs, unlike the PTSD formulation that conceptualises CSA as an event. Secondly, it offers a broad, depathologising, explanation for the associated effects of CSA on adult survivors. Thirdly, it accounts for certain consequences, such as depression, to a combination, or the emphasis of certain traumagenic dynamics. Finally, the traumatogenic model explains how individuals experience the effects in very unique and varied ways.

Research consistently suggests the effects of CSA can be experienced long after the abuse has ended, often lasting into adulthood (e.g., Denov, 2004; Mullen & Fleming, 1998; Neumann et al., 1996). An increasing body of research has focused on the neurobiology of trauma in order to account for these pervasive and long lasting effects of trauma on the brain and its processes (e.g., Cahill & Alkire, 2003; Gilbertson, Williston, Paulus, Lasko, Curvits, & Shenton, 2007; Karl, Schaefer, Malta, Dorfel, Rohleder & Werner, 2006; Smith, Makino, Kvetnansky & Post, 1995).

2.4 The Neurobiology of Trauma

Experiencing trauma, including childhood sexual abuse, is thought to contribute to both short-term acute stress responses, as well as long-lasting neurobiological effects on the survivor. Scientific studies have highlighted how trauma affects particular areas of the brain and its neurochemicals (e.g., Cahill & Alkire, 2003; Gilbertson et al., 2007; Karl et al., 2006). These studies have demonstrated how the hippocampus, amygdala, adrenal stress hormones (norepinephrine and glucocorticoids) and brain derived neurotrophic factor (BDNF) are implicated in the pathology of brain anatomy and functioning in survivors of trauma.

2.4.1 Brain areas affected by trauma.

Both the hippocampus and amygdala are believed to be affected by experiencing chronic stress and trauma. Anatomically, the hippocampus is part of the cerebral cortex and comprises of two hippocampi, one in each hemisphere of the brain. Functionally, the hippocampus is part of the limbic system and is associated with emotional processing, as well as learning and forming new memories (Pinel, 2003). Survivors of trauma who experience PTSD demonstrate decreased hippocampal volume when compared to the non-traumatised control group (Bremner, Randall, Vermetten, Staib, Bronen & Mazure, 1997; Bremner, Scott, Delaney, Southwick, Mason & Johnson, 1997; Villarreal, Hamilton & Petropoulos, 2002; Smith, et al., 1995). To ascertain if predisposing factors may contribute to this finding, Gilbertson and colleagues (2007) studied monozygotic twins – one with a diagnosis of PTSD and the other without. Their finding supported previous research, indicating that a reduction in hippocampal volume is an acquired sign of PTSD.

Anatomically, the amygdala is located in the medial temporal lobes of the brain and comprises of nuclei that resemble an almond. Functionally, the amygdala is part of the limbic system and is associated with emotional learning, such as fear conditioning, memory and emotional reactions (Pinel, 2003). Equivocal evidence suggests that survivors experiencing PTSD demonstrate significantly smaller

amygdala, particularly in the left hemisphere, when compared to non-PTSD controls (Carrion, Weems, Eliez, Patwardhan, Brown, Ray & Reiss, 2001; Karl et al., 2006). However, other research has not substantiated these findings (DeBellis, Keshaven, Clark, Casey, Giedd & Boring, 1999).

2.4.2 Neurochemicals affected by trauma.

Adrenal stress hormones (norepinephrine and glucocorticoids) and the neurochemical BDNF (brain derived neurotrophic factor) have been implicated in the trauma response of human beings (e.g., Cahill & Alkire, 2003; Smith et al., 1995).

Norepinephrine (or noradrenaline) is a neurotransmitter released upon activation of the sympathetic nervous system during a stressful event and is partly responsible for the ‘fight or flight’ response. The release of norepinephrine into the amygdala upon experiencing an emotionally arousing (positive or negative) event is thought to improve consolidation of memory for that experience. However, it does not affect memory consolidation of neutral information (Buchanan & Lovallo, 2001; Cahill & Alkire, 2003).

Glucocorticoids are a class of steroid hormone that is implicated in the stress response (Pinel, 2003). Prolonged exposure to glucocorticoids is thought to reduce BDNF levels by significantly impeding BDNF mRNA expression, especially in the hippocampus (Smith et al., 1995), therefore resulting in the atrophy of this area (McEwan, 2000). Recent evidence suggests a reduced level of plasma BDNF in survivors of PTSD compared to their control counterparts, highlighting the possible role of this neurochemical in the psychopathology of survivors (Dell’osso, Carmassi, Del Debbio, Dell’osso, Bianchi, da Pozzo & Origlia, 2009).

The effects of stress hormones on the activity of amygdala and associated brain regions, such as the hippocampus, may alter the consolidation and recall of emotional memories, therefore accounting for one of the core features of chronic anxiety, including PTSD (De Quervain, Aerni, Schelling & Roozendaal, 2009).

As this research highlights, experiencing trauma may contribute to long-lasting neurobiological effects on the survivor, which in turn can affect their cognitive and emotional processing, thus leading to issues that interfere with their

quality of life. Consequently, adult survivors may seek therapy from mental health professionals in order to cope with these associated difficulties.

2.5 Common Presenting Difficulties

Frequently, survivors¹ of CSA will contact a mental health professional with a ‘disguised presentation’, rather than for therapy about their abuse experiences (Gelinas, 1983). Therefore, mental health professionals² will be likely to encounter survivors who seek help for symptoms and issues associated with experiencing CSA, rather than for the abuse experience itself (Herman, 1992a).

The effects of CSA on adult survivors are well documented in literature on both clinical and non-clinical samples. Such effects include relational and sexual difficulties, revictimisation in adulthood, pregnancy and parenting difficulties, and the intergenerational transmission of abuse. These difficulties are framed within the study’s theoretical model that is believed to best account for these various concerns. CSA survivors may experience differing degrees of distress due to moderating factors, with some encountering particular mental health issues. These mental health issues may vary according to gender. It is important to note the following literature should be viewed critically, as majority of the studies do not account for other confounding variables, such as childhood neglect or physical abuse, which may also occur in conjunction with CSA and have been found to have negative effects on individuals (Fergusson & Mullen, 1999).

¹ Throughout this dissertation, adults who have experienced CSA are referred to as ‘survivors’ rather than ‘victims’, due to the former term attributing a sense of reclaimed power and resilience to the individual (e.g., McCaffrey, 1998).

² The term ‘mental health professional’ is used to describe any professional with mental health training, including psychotherapists, counsellors and psychiatrists.

2.5.1 Relational difficulties.

Adult survivors of CSA may experience disruptions to interpersonal relationships and difficulties with intimacy (e.g., Abdulrehman & De Luca, 2001; Alexander, 1993; Davis & Petretic-Jackson, 2000). As a result of the abuse experience, the survivor could expect betrayal from others and consequently encounter difficulties with establishing trusting attachments (Finkelhor & Browne, 1985). It is thought that experiencing CSA may leave survivors ambivalent about being close to others, simultaneously desiring closeness, whilst also distrusting and fearing the possibility of being manipulated for their own interests (Finkelhor & Browne; Sanderson, 2006). Experiencing intimacy could also evoke a sense of fear due to the survivor equating this with being overpowered or powerless, which is reminiscent of the abuse experience (Finkelhor & Browne; Sanderson). This could be attributed to communication difficulties, with survivors sometimes automatically complying with others' wishes in fear of rejection or judgement (Dale et al., 1998).

Individuals who have experienced a history of CSA may display impaired social behaviour that includes being mistrustful of others, avoiding relationships or, paradoxically, constantly seeking relationships with others who do not evoke one's sense of fear or mistrust (Davis & Petretic-Jackson, 2000). Abdulrehman and De Luca (2001) found young women who experienced CSA scored significantly higher on measures of social dysfunction than their non-abused counterparts. Participants reported a lack of satisfying relationships (including fewer friends and social contacts) and a desire for more friends and social interaction. Qualitative research has yielded similar results, with women survivors of CSA reporting a perceived lack of interpersonal skills, poor boundaries, anxiety about close relationships, being isolated and feeling unable to trust anyone (O'Brien, Henderson, & Bateman, 2007).

Romantic relationship satisfaction may be detrimentally affected if an individual has experienced CSA. A community sample of female CSA survivors reported relationship dissatisfaction and a tendency to describe their current partners as 'uncaring' and 'extremely controlling' (Mullen & Fleming, 1998). Similarly, Finkelhor, Hotaling, Lewis and Smith (1989) found that individuals who experienced CSA reported less satisfaction in their current romantic relationships than their non-abused counterparts. Attitudes to marriage may serve as a self-

fulfilling prophecy, with research suggesting that women who have experienced CSA tend to believe that adjustment to marriage is difficult, that conflict within the relationship is problematic, and predict their marriages will be unhappy (Larson & LaMont, 2005).

Despite most research focusing on women survivors of CSA, interesting qualitative research has suggested that males who have a history of CSA also tend to experience relationship difficulties (Alaggia & Millington, 2008; Denov, 2004). In a study by Denov, both men and women who were sexually abused by female perpetrators reported experiencing difficult and uncomfortable relationships with women. In a study focusing exclusively on male survivors of CSA, Alaggia and Millington found that the participants' romantic relationships tended to be affected by their own rage and anger, with most relationships consequently ending. These men also reported concern about their inability to sustain a meaningful and long-term partnership.

It is evident that survivors of CSA experience relational difficulties that involve lack of trust, an expectation of betrayal and a fear of being powerless.

2.5.2 Sexual difficulties.

Survivors of CSA have been found to experience issues concerned with sex and sexuality (e.g., Alaggia & Millington, 2008; Becker, Skinner, Abel & Cichon, 1986; Najman et al., 2005). Due to the abuse, sexual development has been inappropriate and mystifying (Finkelhor & Browne, 1985). Traumatic sexualisation is thought to lead survivors to view sex and their bodies as a commodity, be inappropriate about the norms of sexual activity, and or, be fearful of sex due to being retraumatised (Finkelhor & Browne).

Research supports this theory, with a tendency for adult survivors of CSA to engage in multiple sexual relationships and risky sexual encounters, possess a fear about sex, experience sexual dysfunction, and be confused about one's sexual orientation (Alaggia & Millington, 2008; Fergusson & Mullen, 1999; O'Brien et al., 2007, Phillips & Daniluk, 2004).

Both men and women who are survivors of CSA have been found to have a higher number of sexual partners and sexual relationships, as well as report

difficulties with controlling sexual feelings, when compared to non-abused controls (Holmes & Slap, 1998; Najman et al., 2005). Some research has focused solely on women (e.g., Mullen & Fleming, 1998) or male survivors (e.g., Holmes & Slap), whilst other studies have compared both genders (e.g., Najman et al.).

It is suggested that both genders tend to engage in risky sexual behaviour, such as being intoxicated during intercourse or working in prostitution (Holmes & Slap, 1998; Mullen & Fleming, 1998; Schraufnagel, Cue Davis, George & Norris, 2010). Holmes and Slap conducted a review of 166 studies focusing on men who had been sexually abused as children and found that male survivors of CSA reported higher levels of risky sexual behaviour, including prostitution and unprotected anal intercourse, which commonly lead to sexually transmitted infections. Women who experienced a history of CSA have reported promiscuity and prostitution, possibly attributed to the devaluation of herself and her sexuality (Mullen & Fleming; O'Brien et al., 2007). Bittenheim and Levendosky (1994) hypothesized that survivors of CSA often perceive sexual activity as an opportunity for coercion, exploitation and shame, and not as a means of being with a cherished other (cited by Bloom & Lyle, 2001). A finding of Hall's (2008) study echoes this meaning of sexual contact, with survivors reporting concern about a perceived imbalance of power in their current sexual relationship.

Being fearful of sex is associated with experiencing a history of CSA, particularly amongst female survivors (Becker et al., 1986; Jehu, 1988; Mullen & Fleming, 1998; O'Brien et al., 2007). Women who have been sexually abused as children tend to be phobic or fearful of sex, when compared with non-abused women. Reported rates of fear or phobia about sex have been estimated as 54% (Becker et al.) and 58% (Jehu). Becker et al. found a significant difference in the degree of sexual dysfunction between women who had a history of CSA when compared to their non-abused counterparts. Similarly, Denov (2004) indicated that survivors of CSA found sexual intimacy particularly difficult.

Research has generally suggested that men who have experienced CSA do not experience sexual dysfunction (Holmes & Slap, 1998; Najman et al., 2005). However, in a qualitative study, both male and female survivors of CSA by female perpetrators described being uncomfortable with sex, well into adulthood and long

after the abuse ceased (Denov, 2004).

Although male survivors of CSA may not experience as many issues surrounding sex as their female counterparts, they are more likely to encounter confusion with their sexual identity (Alaggia & Millington, 2008; McAdam & Fitts, 1999; Richey-Suttles & Remer, 2003). The participants in these qualitative studies expressed confusion or fear of being, or the potential for them being, homosexual (Alaggia & Millington). Males tended to be confused about their sexual identity, possibly due to their belief they appeared homosexual to others (and the often male perpetrator who ‘picked’ them) and/or if there was a physiological response to the sexual abuse (Alaggia, 2005; Alaggia & Millington; McAdam & Fitts; Richey-Suttles & Remer).

It is apparent that CSA survivors experience sexual difficulties due to being traumatically sexualised in childhood, along with feeling stigmatised and powerless.

2.5.3 Revictimisation in adulthood.

Experiencing sexual abuse as a child is associated with sexual, physical and emotional revictimisation in adulthood (Barnes et al., 2009; Butler, Donovan, Fleming, Levy & Kaldor, 2001; Lievore, 2005; Mouzos & Makkai, 2004; Neumann et al., 1996). Finkelhor and Browne (1985) believe revictimisation occurs due to CSA survivors experiencing a pervasive sense of powerlessness that originates from their abuse experiences, which leads to further vulnerability. Judith Herman (1992a) explained that revictimisation occurs due to its dynamics that lead to adult relational and sexual difficulties. She stated that such vulnerability is borne out of a combination of difficulty in order to protect oneself in relationships, setting safe and appropriate boundaries, and devaluing oneself, along with idealising the other, being highly attuned to their wishes and being obedient.

Studies have supported these theories, with a significant association found between being sexually abused as a child, and being sexually revictimised in adulthood (Barnes et al., 2009; Casey & Nurius, 2005; Lievore, 2005; Neumann et al., 1996; Mouzos & Makkai, 2004). In Casey and Nurius’s study, experiencing sexual victimisation at an earlier age predicted future revictimisation by new perpetrators, and being victimised by a greater number of perpetrators was positively

correlated to significantly higher drug use. The cumulative effect of trauma was evident in this study, where women who had experienced multiple traumas reported significantly higher depressive and post-traumatic stress symptoms than those who experienced single event trauma. Post-traumatic stress symptoms, such as arousal and re-experiencing the trauma, are indirectly associated with experiencing revictimisation due to the survivor employing unhelpful coping strategies, such as ‘numbing’, forgetting, and alcohol use (Casey & Nurius; Filipas & Ullman, 2006; Ullman, 2009). It could be suggested that while forgetting serves an adaptive purpose to the survivor, it also contributes to future vulnerability to future threats of harm by preventing her from actively developing adaptive coping skills and challenging negative schemas (Casey & Nurius).

Similarly, revictimisation may occur due to survivors being unaware of personal boundaries, thus placing them in risky interpersonal situations and relationships. DePrince (2005) found that women who had been revictimised by age 18 were less likely to detect violations of conditional social values and register unsafe situations, possibly lowering ability to detect future perpetrators. This impaired ability could be found and exploited by potential new perpetrators (Casey & Nurius, 2005), resulting in survivors being more likely to be involved in abusive romantic relationships (Butler et al., 2001). In a recent Australian review by Tarczon and Quadara (2012), 19% of women who had experienced sexual abuse by the age of 15 years reported their most recent episode of sexual violence was perpetrated by their current partner, while 28% reported their most recent incident of sexual violence was perpetrated by a previous partner. Six percent of male survivors who experienced sexual abuse before the age of 15 reported their most recent episode of sexual violence was perpetrated by a previous partner.

Aside from experiencing further sexual victimisation, individuals who have been sexually abused as children are also likely to experience other abuse as adults (Casey & Nurius, 2005). It is estimated that the risk of violence almost doubles for women who have been sexually abused as children, when compared to their non-abused counterparts (Barnes et al.; Mouzos & Makkai). This violence is also more likely to result in more severe injury, when compared to non-victimised women (Barnes et al.).

2.5.4 Pregnancy and parenting issues.

Women who have experienced CSA may experience postnatal difficulties and engage in particular parenting practices, when compared to women who have not experienced CSA (Coles & Jones, 2009; Cross, 2001; Lev-Wiesel, Daphna-Tekoah & Hallak, 2009). Becoming pregnant could possibly arouse negative emotions, as women could feel vulnerable and dependent, which may be perceived as particularly threatening (Sanderson, 2006). Survivors of CSA may avoid important medical examinations during pregnancy to avoid retraumatisation (Coles & Jones). In Coles and Jones's study, participants reported their vaginal examinations lead to them feeling so violated and distressed that they either experienced intrusive flashbacks or dissociated from the physical experience. Leeners, Richter-Appelt, Imthurn & Rath (2006) conducted a comprehensive review of 43 studies that examined CSA survivors' pregnancies and the post-partum period. In particular, mental health issues, such as an increase in reported stress and anxiety during pregnancy (Christensen, 1992; Douglas, 2000, both cited by Leeners et al.) as well as depressive symptoms or suicidal ideation were reported (Benedict, Paine, Paine, Brandt & Stallings, 1999; Farber, Herbert & Reviere, 1996; Horrigan, Schroeder & Schaffer, 2000, all cited by Leeners et al.).

Mental health difficulties may continue into the postnatal period (Leeners et al., 2006; Lev-Wiesel et al., 2009). Survivors of CSA have also been found to score significantly higher on scales measuring posttraumatic stress symptoms of arousal and intrusion after childbirth, when compared to those who have no trauma or 'other' trauma in their history (Lev-Wiesel et al.).

Other issues, such as the sex of the baby, could raise unique concerns for women who have survived CSA. For example, giving birth to a girl could trigger a fear in the mother that she is unable to protect her from future abuse, whilst having a boy could possibly remind her of the perpetrator of her own abuse (Sanderson, 2006). Qualitative studies have suggested that breastfeeding tends to also be an issue for women who have a CSA history (Grant, 1992; Heritage, 1998). Instead of breastfeeding being a positive and bonding experience, memories of the abuse may be triggered (Grant; Heritage).

Experiencing a history of CSA may also affect one's parenting practices. In

Cross's (2001) study, she supported existing research that indicated women who have experienced CSA are more likely to view themselves as mothers and the role of motherhood more negatively than non-abused mothers (Cole, Woolger, Power & Smith, 1992; Cross; Herman & Hirschman, 1981). In addition, women with an abuse history tended to be involved with role reversal with their children (i.e., their children were expected to meet their needs more than the other way around), resulting in their children engaging in more parent-focused helping and protective behaviour when compared to the control group (Burkett, 1991; Cross). This may be partially associated with the mothers' tendency to hold unrealistic development expectations of their children (Cross).

It is evident that many female survivors of CSA encounter issues whilst pregnant, with childbirth, and in the post-partum period. These difficulties may occur due to a combination of traumatic sexualisation, where particular areas of one's body are being examined, combined with a pervasive feeling of powerlessness.

2.5.5 Intergenerational transmission of abuse.

This following section explores the 'transmission' of intergenerational abuse, which aims to explain how some parents who have experienced childhood abuse or maltreatment can go on to mistreat or abuse their own children. This phenomenon incorporates elements of both the survivor's likelihood for revictimisation and their subsequent parenting practices. As previously highlighted, survivors of trauma who are subsequently revictimised by age 18, tend to lack the ability to detect violations of conditional social values and register dangerous interpersonal situations, thus reducing their ability to detect future perpetrators (DePrince, 2005).

While this lack of awareness could be possibly related to due to the survivor employing unhelpful coping strategies, such as 'numbing', forgetting, and alcohol use (Casey & Nurius; Filipas & Ullman, 2006; Ullman, 2009), it has been found that mothers who have experienced high betrayal trauma and revictimisation in adulthood, also exhibit higher levels of dissociation than non-victimised mothers (Hulett, Kaehler & Freyd, 2011). Dissociation serves an adaptive purpose to survivors' psyche (DePrince, 2005; Freyd, 1996) but such defence mechanisms may

also lead to increased vulnerability due to persistent unawareness of threat to the survivor's self and her children (Chu & DePrince, 2006; Hulett et al.). In Hulett, Kaehler & Freyd's study, 72% of children who experienced interpersonal trauma had revictimised mothers compared to 28% of children who experienced interpersonal trauma and had non-revictimized mothers. Similarly, Chu and DePrince found that survivors of high betrayal trauma also had children who experienced betrayal trauma, compared to children with no such history.

A possible explanation for the relationship between revictimisation, dissociation and the transmission of intergenerational trauma could be that if a mother is too unaware of her child's safety and needs, she is unable to provide secure attachment and sensitive caregiving (Glaser, 2000). Survivors of emotional and physical traumas have been found to demonstrate sound parenting knowledge, but poorer parenting practices, including reduced responsivity and sensitivity to the child's needs, and increased use of punishment and likelihood of abuse and neglect (Bert, Guner & Lanzi, 2009). Therefore, if the mother is unable to assist in regulating her child's arousal, the child is then left to contend with her/his overwhelming arousal, alone (Glaser). Chronic stress in infants is thought to lead to hyperarousal that may persist throughout their lifetime (Heim & Nemeroff, 2001), potentially becoming 'trait' like (Perry, 2002).

This chronic hyperarousal combined with being unable to escape from a damaging home environment can result in children developing cognitive distortions to accommodate for, and survive, the 'abuse dichotomy' (Briere, 1992). The first way to make sense of their situation is to believe they are 'good' and blame their parent/s for the abusive treatment. However, this cognition is confrontational, as the child is dependent on their parent/s for survival. The alternative is to believe they are inherently 'bad' and therefore maltreatment is deserved (Goldsmith, Barlow & Freyd, 2004). The continued abuse serves to strengthen this cognition, and therefore, becomes a core belief that is internalised and hard to shift (Young, Klosko & Weishaar, 2003). Feelings of 'badness' and low self-esteem are significantly correlated with revictimisation in adulthood (e.g., Briere & Elliott, 1994; Van Bruggen, Runtz & Kadlec, 2006).

The transmission of intergenerational abuse is a concerning and pertinent

issue faced by survivors of trauma, as it not only affects their individual wellbeing, but can also continue to perpetuate the ‘cycle of violence’.

2.6 Mental Health Issues

While relational, sexual and pregnancy and parenting difficulties have been noted as common presenting issues amongst CSA survivors, underlying mental health issues may also coexist.

Literature consistently associates experiencing CSA with a range of mental health issues (e.g., Fergusson & Mullen, 1999; Maniglio, 2010; Neumann et al., 1996). Survivors of CSA may be affected to varying degrees by their experience of sexual abuse due to a range of moderating factors, with some encountering particular mental health issues. In addition, it is suggested that caution be exercised when placing a psychiatric diagnosis on a natural reaction to trauma of this nature.

2.6.1 Factors that moderate the effects of CSA on adult survivors.

Despite the noted associated effects of CSA on adult survivors, experiencing them is not inevitable due to possible moderating factors. In fact, Fergusson and Mullen (1999) suggest that up to 40% of those abused may not experience any negative effects at all. Factors such as the characteristics of abuse, the age of victimisation, relationship to the perpetrator, attribution of blame and social support may indicate the individual’s propensity for experiencing negative effects of abuse.

Filipas and Ullman (2006) found that the severity, frequency and duration of CSA were all significantly correlated with experiencing traumatic symptomology. In addition, the age of victimisation has been found to predict post-traumatic symptoms and psychological distress (Filipas & Ullman; Murthi & Espelage, 2005). Being younger (specified as being under the age of 12) when experiencing abuse has been associated with higher levels of distress, when compared to those who were abused after the age of 12 years (Murthi & Espelage).

The relationship one has with the perpetrator is also thought to moderate the associated effects of CSA on an individual (Filipas & Ullman, 2006; Leahy, Pretty & Tenenbaum, 2004; Ullman, 2007). Those who are abused by a known and trusted perpetrator, including relatives, are thought to experience greater post-traumatic

symptoms than those whose perpetrators are less familiar (Filipas & Ullman; Ullman). Leahy et al. posit that it is not the relationship as such, but the perpetrator's use of strategies, such as emotional manipulation, that is responsible for experiencing posttraumatic symptoms.

Attribution of blame, whether the survivor engages in self-blame or clearly blames the perpetrator, is associated with experiencing negative effects of CSA (Filipas & Ullman, 2006; Leahy, Pretty & Tenenbaum, 2003). Filipas and Ullman found that posttraumatic symptomology was positively correlated with high levels of current self-blame for the abuse. Conversely, Leahy et al. concluded that both clinically and non-clinically distressed individuals blamed themselves for the abuse and their inability to prevent it. However, the non-clinically distressed group were also able to clearly assign blame to the perpetrator, as well as view 'him' in disempowering terms, such as "a lonely male" and "slightly pathetic" (p. 662).

Social support of family, spouses and friends is an important moderating factor in the development of associated effects of CSA (Fassler, Amodeo, Griffin, Clay & Ellis, 2005; Murthi & Espelage, 2005; O'Dougherty Wright, Fopma-Loy & Fischer, 2005; O'Leary, 2009). In fact, some authors believe the support of family is so important, it supersedes factors such as the characteristics of abuse (Fassler et al.). In Murthi and Espelage's study, participants who reported feeling supported by their family reported less distress than their non-supported counterparts. Fassler et al. found that if a survivor's family environment was low in conflict and high in expressiveness and cohesion, the individual was significantly more likely to be better adjusted in areas such as social adjustment, life satisfaction and self-esteem. Spousal support has also been identified as being a protective factor amongst female survivors of CSA, with perceived support associated with less depressive symptoms and increased parenting competence (O'Dougherty Wright et al.). Friends and peers are also considered a valuable source of social support (Murthi & Espelage). Whilst studies have focused primarily on female survivors of CSA, the same has been found for male survivors, with participants who utilised social support reporting non-clinical outcomes (O'Leary).

Conversely, adverse family dynamics, characterised by high conflict and low expressiveness and cohesion, is associated with poorer outcomes such as depressed

mood and lower life satisfaction, self-esteem and social adjustment (Fassler et al., 2005). These family dynamics that consequently result in poor support, may be explained by the perpetrator being within, or trusted, by the family.

2.6.2 The psychiatric label.

While diagnosis may be helpful, Judith Herman (1992a) cautioned against psychiatrically labelling individuals who present with particular symptoms, as the diagnostic criteria for disorders is not designed for, nor fulfilled by, survivors of repeated trauma experienced in a child's developmental phase. She stated: "The persistent anxiety, phobias and panic of survivors are not the same as ordinary anxiety disorders... their depression is not the same as ordinary depression. And the degradation of their identity and their relational life is not the same as ordinary personality disorder" (Herman, 1992a, p. 118). Taking this into account, research conducted illustrates a link between CSA and experiencing a range of mental health issues, such as depression, anxiety, posttraumatic stress disorder (PTSD) and its associated symptoms, substance use and borderline personality disorder (BPD) (Alaggia & Millington, 2008; Fergusson & Mullen, 1999; Herman, Perry & van der Kolk, 1989; Neumann et al., 1996; O'Leary, 2009).

2.6.3 Depression.

Individuals who have experienced a history of CSA may be affected by depressive symptoms in adult life (Fergusson & Mullen, 1999; Maniglio, 2010; Neumann et al., 1996). The criteria for depression include feelings of sadness or emptiness, worthlessness, or excessive or inappropriate guilt, according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; APA, 2000; American Psychological Association, 2009). Fergusson and Mullen estimate that women who have experienced CSA are up to four times more likely to experience depression in adulthood than their non-abused counterparts. In a meta-analysis, Neumann et al. found a significant correlation between women experiencing CSA and being affected by depressive symptoms in their adult life. This correlation was strongest within clinical populations. More recently, Maniglio conducted reviews of 160 studies comprising of both women and men, and found that a history of CSA

was a statistically significant risk factor for the development of depression or depressive symptoms. Like Neumann et al., larger effect sizes were found in studies that recruited from a clinical sample, when compared to samples gained from other sources, such as from the community or college undergraduates.

2.6.4 Anxiety.

Historical sexual abuse is associated with experiencing anxiety in adulthood (Fergusson & Mullen, 1999; Neumann et al., 1996; Spataro, Mullen, Burgess, Wells & Moss, 2004). Anxiety symptomology, characterised in the DSM-IV (APA, 2000) as physiological changes (e.g., increased heart rate, sweating), pervasive feelings of tension or worry, and avoidance of anxiety provoking stimuli, have been associated with experiencing CSA (Fergusson & Mullen; Spataro et al.). Fergusson & Mullen estimate that women who have experienced sexual abuse during childhood are up to three times more likely than those without a history of sexual abuse to encounter anxiety. Neumann et al. analysed available literature exploring these two variables and found a statistically significant correlation between women being sexually victimised as children and reporting symptoms of anxiety in adulthood. In Spataro et al.'s study, both male and female survivors of CSA were significantly more likely to experience anxiety compared to the control groups.

2.6.5 Posttraumatic stress symptoms.

Posttraumatic stress symptoms have been associated with experiencing a history of CSA (e.g., Neumann et al., 1996). In Neumann et al.'s meta-analysis of female CSA survivors, they found a significant correlation between experiencing CSA and being affected by traumatic stress responses in their adult life. This correlation was stronger amongst those in the clinical samples, when compared to non-clinical populations. Other studies have measured posttraumatic stress symptoms amongst CSA survivors and compared factors that can either exacerbate or reduce its occurrence, such as revictimisation, social support and coping mechanisms (Filipas & Ullman, 2006; Ullman, Najdowski & Filipas, 2009).

The criteria of posttraumatic stress symptoms are divided into: intrusive recollections, avoiding the stimuli, and hyperarousal (DSM-IV; APA, 2000).

2.6.5.1 Intrusive recollections.

Intrusive recollections are frequently experienced by survivors of CSA and can occur when awake in the form of flashbacks, or asleep, as nightmares. As previously noted, particular events or situations can trigger flashbacks, such as being physically examined by a medical practitioner (Coles & Jones, 2009) or entering a sexual relationship (Alaggia & Millington, 2008; Denov, 2004).

2.6.5.2 Avoiding stimuli.

Avoidance of stimuli is common amongst those who have experienced CSA and may involve dissociation or substance use (Herman, 1992a; Neumann et al., 1996). Dissociation is considered an adaptive psychological phenomenon, protecting the child by altering their state of consciousness while they are helpless and enduring overwhelming trauma (Herman). However, dissociation can continue long after the abuse has ceased, with Neumann et al.'s meta-analysis finding a statistically significant correlation between female survivors of CSA and dissociation.

For those who are unable to spontaneously dissociate, using substances such as alcohol and narcotics are thought to produce similar effects (Herman, 1992a). Adults who have experienced CSA may experience difficulties with substance use (Denov, 2004; Fergusson & Mullen, 1999; Neumann et al., 1996; O'Leary, 2009). Fergusson and Mullen estimate that female survivors are approximately three times more likely to have substance abuse issues, when compared to their non-abused counterparts. Other studies of female survivors have also established a statistically significant association between experiencing CSA and substance use (Neumann et al.; Ullman et al., 2009). Male survivors of CSA are thought to also use substances as a coping mechanism to control distress, or even erase the trauma from memory (Denov; O'Leary).

2.6.5.3 Hyperarousal.

Hyperarousal refers to a state of perpetual alertness, should the danger return, and includes symptoms such as explosive anger and sleeping difficulties (Herman, 1992a). Being in a state of hyperarousal results in individuals reacting

disproportionately to a provocation (Herman), with both quantitative and qualitative studies highlighting issues with anger for both sexes (Alaggia & Millington, 2008; Denov, 2004; Nelson, 2009; Neumann et al., 1996).

Sleeping difficulties are also a result of hyperarousal due to chronic activation of the sympathetic nervous system (Sanderson, 2006). Sleep may actively be avoided should the survivor experience a feared state of vulnerability or be retraumatised by nightmares (Sanderson).

Whilst the criteria of posttraumatic stress disorder has been helpful, with greater understanding of childhood trauma, it is increasingly recognised that this traditional model is not suitable for diagnosing those who have experienced childhood abuse (Herman, 1992a; 1992b). This is due to the trauma being conceptualized in terms of experiencing events such as combat, disaster and rape as adults, not complex, sustained and repeated trauma encountered as a child (Herman, 1992a). Therefore, an alternative diagnosis of Complex Posttraumatic Stress Disorder is considered more fitting in that its criteria addresses relational, affect regulation and self-perception aspects, in addition to alterations to consciousness, thus better reflecting common experiences of those presenting with issues around childhood abuse (Herman, 1992a).

2.6.6 Borderline Personality Disorder.

Borderline personality disorder (BPD) criteria include a pervasive pattern of instability in affect regulation (e.g., dysphoria, anxiety), impulse control (e.g., promiscuity, substance abuse), interpersonal relationships, self-image and difficulty controlling anger (DSM-IV; APA, 2000). These difficulties have been noted separately as common reactions to CSA. Studies of psychiatric inpatients suggest that survivors of CSA are more likely to be diagnosed with BPD than those who have experienced other trauma but not CSA (Herman et al., 1989; Ogata, Silk, Goodrich, Lohr, Westen & Hill, 1990). A disordered personality within an abusive context is considered borne out of being trapped in a traumatic situation where the child adapts in any way possible to ensure survival (Herman, 1992a). She stated, “[The child] must find a way to preserve a sense of trust in people who are

untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness” (Herman, p. 96).

It is important to note that the noted difficulties associated with experiencing CSA is not an exhaustive list due to the scope and limitations of this research.

2.6.7 Gender differences.

Despite many studies focusing entirely on the mental health effects of CSA on either female or male survivors, some research has compared both genders (Banyard, Williams & Siegel, 2004; Butler et al., 2001; Finkelhor, 1990). Some differences are thought to exist, where women’s self-reported symptoms of anxiety and depression have been found to be higher than their male counterparts (Banyard et al.; Finkelhor). Although small differences existed in Finkelhor’s study, it was noted that women survivors were more likely to report ‘internalising’ issues, such as depression, anxiety and affective disorders. Conversely, men tended to report ‘externalising’ issues such as substance abuse and aggression. Crowder (1995) contends this difference may exist due to anger being culturally and socially acceptable for males to express, as opposed to other emotions they could be feeling, such as sadness or fear.

Despite these noteworthy differences, there are more similarities than differences between associated issues of experiencing CSA between genders (Denov, 2004; Finkelhor, 1990; Romano & De Luca, 2001; Scott-Young, Harford, Kinder & Savell, 2007). For example, Scott-Young et al. concluded the detrimental effects of CSA on survivors’ mental health did not vary between genders in their study of college undergraduates. Regardless of gender, the detrimental effects of experiencing CSA are irrefutable (Romano & De Luca).

This chapter provided background information about CSA, including its definition, prevalence rates and other key information. A theoretical framework was proposed to best account for the difficulties survivors may experience. These difficulties include relational, sexual and parenting difficulties, as well as mental health issues. Common mental health issues include depression, anxiety,

posttraumatic stress symptoms and borderline personality disorder. However, CSA survivors are affected by the abuse experience to varying degrees, due to a range of moderating factors. Possible differences in associated difficulties may exist between genders.

Chapter 3

Literature Review Part Two:

Disclosure of Childhood Sexual Abuse and Mental Health Professional Practice

3.1 Introduction

This chapter begins by examining the process of disclosing CSA and how reactions can affect the wellbeing of the survivor. Next, common triggers that prompt survivors to seek therapy from mental health professionals are identified. Professionals asking, or conversely, not asking about a possible history of CSA is then explored. The benefits and risks of disclosing CSA in therapy is examined, along with the possible consequences it has on survivors.

3.2 Adult Survivors Disclosing Childhood Sexual Abuse

Disclosure of CSA is a complex process, which has warranted much research attention. Due to the nature and dynamics of CSA, the resultant shame, secrecy and silence makes disclosure particularly difficult for survivors of any age or gender. If and when the survivor is courageous enough to disclose, the reactions of the listener may either facilitate or inhibit further disclosure. Experiencing social support or conversely, a lack of social support, may result in survivors seeking assistance from formal helping agencies and mental health professionals.

As disclosure is a difficult process, even when seeking therapy, it is important for mental health professionals to ask about a possible history of trauma. However, particular barriers may prevent them from doing so. Disclosing CSA in therapy to a mental health professional is thought to be positive for the survivor, and factors that are thought to facilitate disclosure are examined. Helpful practice aimed at working with CSA survivors is also considered. Despite research suggesting that disclosing experiences of CSA can be beneficial, such disclosure is associated with particular risks. These risks may result in considerable detrimental consequences for the CSA survivor.

3.2.1 Childhood non-disclosure of sexual abuse.

Previous research indicates that children tend to not disclose their experience of CSA at the time of the assault, and often delay disclosure until adulthood (Alaggia, 2005; Hunter, 2011). During childhood, only a third of all sexual abuse experiences are reported (Tang, Freyd & Wang, 2008). The characteristics and dynamics of sexual abuse act as a deterrent for children to disclose abuse to an adult (Paine & Hansen, 2002). Factors influencing non-disclosure include fear, shame and self-blame (Alaggia; Hunter). For those who do have the courage to disclose in childhood, research has suggested that disclosers experience more physical and violent abuse, as well as more negative reactions from their social network (Jonzon & Linblad, 2004). Jennifer Freyd (1994) theorised how the significance of the relationship between the child and perpetrator may influence disclosure, with a closer relationship more likely to result in dissociation and consequent unawareness of the abuse. Based on this premise, sexual abuse perpetrated by a stranger or acquaintance is more likely to result in disclosure, compared to abuse by a close friend or immediate family member. This theory accounts for research suggesting the closer the relationship to the perpetrator, the longer period of non-disclosure, and the less likely to disclose sexual abuse at all (Foyne, Freyd & DePrince, 2009). Therefore, due to this range of factors, it is common for a child to endure sexual abuse for prolonged periods without either practical or therapeutic intervention (Alaggia).

3.2.2 Adults disclosing childhood sexual abuse.

Disclosure of childhood sexual abuse is more typical in adulthood, with research indicating that individuals tend to disclose to informal sources (friends or family members) before formal sources such as police or health professionals (Ullman, 1996; 2003). It is common for the discloser to assess the reaction they receive from the first listener, which then may influence the individual to either continue disclosing to others, or revert to non-disclosure (Ullman, 2003).

3.2.3 Positive social reactions to the disclosure of CSA.

Positive social reactions, which include feeling listened to, being believed and providing emotional support, are thought to encourage the individual to further disclose their experiences (Ahrens et al., 2010; Filipas & Ullman, 2001). Positive social reactions to disclosure, along with a sense of possessing social support, have been associated with psychological benefits (Murthi & Espelage, 2005; Ullman, 2007).

3.2.4 Negative social reactions to the disclosure of CSA.

On the other hand, negative social reactions, such as ‘victim blame’, denial, minimisation, responding in an egocentric manner and withdrawing social support, are thought to result in harm to the discloser’s wellbeing and secondary victimisation (Ahrens et al., 2010; Campbell & Raja, 1999; Filipas & Ullman, 2001; Ullman, 2003). Negative social reactions, such as disbelief or scepticism, is more likely when the listener does not have a history of trauma, holds sexist views, subscribes to CSA myths or is male (DeMarni Cromer & Freyd, 2009). Disclosing non-continuous memories of CSA is also correlated with negative social reactions (Cromer & Freyd, 2007). In Lorentzen, Nilsen & Traeen’s (2008) qualitative study, a common narrative from participants was that negative social reactions from family, friends and healthcare professionals resulted in them continuing to feel victimised, long after the abuse had ceased. This feeling of continued victimisation is called ‘secondary victimisation’, where victims of crime, particularly regarding sexual offences, are subject to processes and responses that cause further victimisation or compound feelings of victimisation (Condry, 2010). Secondary victimisation can occur when disclosing to both informal and formal sources, and has been found to exacerbate mental health symptoms, delay recovery from trauma and prevent further disclosure (Campbell & Raja; Ullman, 1996). Experiencing secondary victimisation is also associated with dissuading the survivor to attempt disclosure again, in effect silencing them (Ahrens, 2006).

It is important to note, positive reactions are not interpreted as so by all survivors, and vice versa (e.g., Campbell, Wasco, Ahrens, Sefl & Barnes, 2001). In

Campbell and colleagues' study, reactions noted as 'positive' to the researchers were not entirely endorsed as healing and helpful by participants, with some reporting these reactions as hurtful or unhelpful. Similarly, not all 'negative' reactions were deemed hurtful or unhelpful by participants. Therefore, social reactions can be perceived quite differently by survivors. Whether a social reaction is perceived positively or negatively (or mixed) may also be influenced by the identity of the support provider (Ahrens Cabral & Abeling, 2009).

3.2.5 Gender patterns of disclosure.

Research has indicated that particular gender differences exist regarding adults disclosing their CSA experiences (Alaggia, 2005; McAdam & Fitts, 1999). These may exist due to socio-cultural myths, expectations and norms (Alaggia, 2010; Sorsoli, Kia-Keating & Grossman, 2008).

A qualitative study by Alaggia (2005) suggested that women tend to experience feelings of responsibility over the sexual assault and reported anxiety about how the listener would react to their disclosure. Despite both men and women expressing a universal fear of not being believed or being blamed, the latter cited this as the prevailing reason as to why they decided to withhold disclosure.

Men are faced with unique barriers, resulting in them being less likely to disclose their experiences of CSA (Alaggia & Millington, 2008; Holmes, Offen & Waller, 1997; McAdam & Fitts, 1999). Whilst shame is pervasive and common factor in any survivor's experience of CSA, socio-cultural norms and expectations can exacerbate shame for men wanting to disclose their experiences of CSA (Kia-Keating, Sorsoli & Grossman, 2009; Sorsoli et al., 2008). Society and culture are not accepting of male vulnerability or the propensity for male victimisation (Kia-Keating et al.; Sorsoli et al.). For example, boys are not often warned by parents about sexual assault and are taught to be self-reliant, therefore preventing disclosure (Gordon, 1990).

Alaggia (2005) found the common myth that being abused is a precursor to becoming an abuser was also a barrier for men to not disclose their CSA. Participants reported concern about being perceived as a potential sexual predator if

they disclosed their childhood sexual assault, which has been dispelled by research (Bartol & Bartol, 2006).

As perpetrators are commonly male, a fear of being viewed as homosexual by both the (usually male) perpetrator and the listener is a common barrier (Alaggia, 2005; McAdam & Fitts, 1999). This, in addition to the fact that males tend to biologically respond to sexual touch, adds to their sense of complicity in the abuse (Alaggia & Millington, 2008).

As illustrated by the research, disclosure of CSA is difficult and complex process for anyone, and is partially determined by social reactions from listeners. Eventually, many survivors seek assistance from formal service providers and specifically mental health professionals.

3.3 Adult Survivors Disclosing to Mental Health Professionals

Due to the noted associated relational issues and mental health difficulties associated with experiencing CSA, adult survivors may consider seeking assistance from a mental health professional in order to decrease their distress.

3.3.1 Triggers for seeking help.

A range of reasons are thought to exist as to why survivors of CSA finally decide to seek help. Generally, individuals only seek treatment when their own techniques of managing the issue is no longer effective (Manthei, 2005). Many triggers that are common to the general counselling population are also relevant to those who have experienced CSA (Herman & Harvey, 1997; Manthei). Literature indicates that significant life events, relationship changes and withdrawal from substances may induce flashbacks or intrusive memories of the abuse experience, which in turn may encourage survivors to seek therapy (Alaggia & Millington, 2008; Herman & Harvey).

Significant life events, such as births, deaths (including that of the perpetrator) and anniversaries may induce flashbacks or intrusive memories that prompt individuals to seek therapy for their CSA experiences (Alaggia & Millington, 2008; Herman & Harvey, 1997; Lievore, 2005). Pregnancy and

childbirth can be particularly salient and stressful for survivors of CSA (Coles & Jones, 2009; Sanderson, 2006). Routine, but invasive, prenatal medical checks are thought to be retraumatising for the survivor due to reports of experiencing intrusive flashbacks or dissociating from the physical experience (Coles & Jones). Survivors of CSA have been found to have clinically higher scores on arousal and intrusion measures of PTSD after childbirth, when compared to those who have no trauma or ‘other’ trauma in their history (Lev-Wiesel et al., 2009).

Memories of CSA may also be triggered when the survivor’s child reaches the same age they were when the abuse began (Sanderson, 2006). In Denise Lievore’s (2005) qualitative study of women’s help seeking decisions, she noted that survivors of CSA often approached sexual assault services for therapy as their children were around the age they were when first abused.

The breakdown of an existing relationship, or conversely, the formation of a new relationship, may be a precipitant to seeking help (Herman & Harvey, 1997). The survivor could attribute problematic aspects of the relationship that lead to its demise, to their CSA experience, thus prompting them to consider therapy (Alaggia & Millington, 2008). Entering a sexual relationship could be anxiety provoking and trigger flashbacks of prior abuse (Alaggia & Millington; Denov, 2004).

Withdrawing or abstaining from drugs and alcohol has been cited as a precipitant for experiencing intrusive memories and flashbacks (Alaggia & Millington, 2008; Herman & Harvey, 1997). When the survivor has been using substances as a coping mechanism, withdrawal or abstinence is likely to induce more negative emotional states and intrusive thoughts the substances were essentially blocking (Alaggia & Millington; Maes, 2011).

3.3.2 Asking about CSA in therapy.

Despite the reported rates of CSA and its associated effects, which may trigger survivors to seeking assistance from mental health professionals, mental health professionals tend not to ask about CSA (Lab et al., 2000; Lothian & Read, 2002; Read et al., 2007). In a study by Lothian and Read that examined the views of survivors utilising mental health services, 64% reported experiencing abuse in childhood, but only 22% had been asked about it during the initial assessment.

Asking about a possible history of CSA results in a higher level of disclosure when compared to not asking. In Zaidi and Foy's (1994) study of clients being admitted into emergency psychiatric care, asking about CSA yielded a disclosure rate of 70% as opposed to the 7% of spontaneous disclosure when not asked.

3.3.3 Barriers for mental health professionals asking about CSA.

Literature indicates that mental health professionals may not ask clients about a possible history of CSA due to either a lack of knowledge about the phenomena, or fear of inducing 'previously unreported traumatic memories' (e.g., Lab et al., 2000; Read et al., 2007; Young, Read, Barker-Collo & Harrison, 2001).

3.3.3.1 Lack of knowledge or training.

Mental health professionals cite many reasons to why they do not ask about a possible history of CSA. For example, Read et al. (2007) noted that clinicians tend to only ask about a history of CSA if the client is presenting with particular trauma symptoms, such as PTSD, despite literature illustrating the diverse associated effects of experiencing CSA. Many mental health professionals are thought to be unaware of the link between various presenting problems and the history of trauma (Gelinas, 1983).

Clinicians are also less likely to ask male clients about a history of sexual abuse due to a perception that males do not experience abuse (Lab et al., 2000; Read et al., 2007). Finally, another possible barrier for some mental health professionals is their belief that they lack the training to ask about or handle the disclosure or engage effectively with the client (Lab et al.; Read et al.; Yarrow & Churchill, 2009).

3.3.3.2 Fear of inducing previously unreported traumatic memories.

Young et al.'s (2001) study of psychiatrists and psychologists explored reasons for not asking clients about previous abuse experiences. A few, but statistically significant number of both professionals responded that they were mindful of their asking being construed as suggestive and, therefore, inducing false memories.

Literature commonly refers to Previously Unreported Traumatic Memories as ‘false’, ‘repressed’, or ‘recovered’ memories (e.g., Colangelo, 2007; Gleaves & Smith, 2004). However, the Australian Psychological Society’s (2010) guidelines have defined such memories as ‘Previously Unreported Traumatic Memories’. Amongst the many recommendations, it outlines psychologists’ professional responsibilities, such as operating within the scope of competence, and to either refer or consult with an experienced colleague or agency if needed. In addition, the guidelines note that psychologists should aim to assist their clients to tolerate and eventually accept the doubt and vagueness of such memories, instead of trying to recover them (p. 5).

3.3.4 Survivor opinions about being asked by mental health professionals.

Survivor perspectives regarding mental health professionals asking about a possible history of CSA varies, from the belief everyone should be asked directly, to the idea that limited inquiry or providing an opportunity for disclosure is best, to the notion that asking is a violation (Schachter, Radomsky, Stalker & Teram, 2004). Despite these varied responses from survivors, Lothian and Read (2002) concluded that asking does not result in any dire or long-lasting negative effects. In addition, studies suggest survivors prefer to be asked (Robohm & Bутtenheim, 1996), and not asking may result in feelings of distress or anger (Lothian & Read). If a survivor is not asked about a history of CSA, there may be a tendency for survivors to ‘drop hints’ or ‘test the waters’ if they want to disclose (Draucker et al., 2011; McGregor et al., 2006; Sanderson, 2006).

Studies exploring survivors’ opinions of being asked about CSA have suggested that whilst most participants report they would reply honestly if asked (Friedman, Samet, Roberts, Hudlin & Hans, 1992), they would only answer if they felt comfortable (Read et al., 2007). Therefore, whilst asking about CSA is considered helpful in facilitating disclosure, survivors will not disclose if they do not feel comfortable. Other factors, such as the quality of the therapeutic relationship, the use of normalisation and a psychosocial assessment may promote disclosure of CSA in therapy (McGregor et al., 2006; Read; Schachter et al., 2004).

3.3.5 Is disclosure of CSA useful for survivors in therapy?

Disclosure of CSA may be helpful to client mental health and wellbeing (Campbell et al., 2001; Ullman, 2007). However, this is dependent on whether the experience of disclosure has been satisfactory (Campbell et al.). For example, Campbell and colleagues found participants reported better physical and emotional health when they were able to disclose their experience of CSA and encounter positive reactions by the listener, such as being believed. Bradley and Follingstad (2001) reviewed the effect that disclosure had on psychological distress and found significant improvements on several measures including depression, self-image and interpersonal functioning.

On the other hand, delaying or suppressing disclosure of CSA tends to be associated with psychological distress (Herbert, Tourigny, Cyr, McDuff & Joly, 2009; Sinclair & Gold, 1997; Ullman, 2007). Specifically, symptoms of depression, post-traumatic stress and PTSD are significantly related to delayed or non-disclosure (Ahrens, 2010; Herbert et al.; Ullman & Filipas, 2005; Ullman). In addition, the amount of effort required to withhold disclosure is positively correlated to the amount of trauma related symptoms experienced (Sinclair & Gold).

Despite disclosure being viewed as useful, Munro and Randall (2007), whilst concluding that disclosure of CSA was an essential part of treatment, also reported that some mental health professionals interviewed believed that exploring trauma could only exacerbate, rather than relieve symptoms. Participants stated that working with presenting symptoms, being future orientated and talking about 'ordinary things' were possibly more effective than disclosure of CSA. Based on this literature, it should not be presumed that disclosure is always helpful. The helpfulness of disclosure is determined by certain factors, such as the perceived reaction of the listener.

3.3.6 Factors facilitating disclosure of CSA.

Three factors are thought to facilitate disclosure of CSA in therapy. They are the quality of the therapeutic relationship, using normalisation, and conducting a psychosocial assessment.

3.3.6.1 Quality of therapeutic relationship.

Paramount to asking about and facilitating disclosure of CSA in therapy appears to be the quality of the therapeutic alliance, and in particular, the degree of trust and safety the client feels within that relationship (Sanderson, 2006; Schachter et al., 2004). Whilst trust and safety are undeniably important for any effective therapeutic relationship, it applies more so for those who have been abused as children (Dale et al., 1998; Sanderson). Due to the very nature of childhood abuse, survivors are used to, and expect betrayal and danger (Sanderson). Therefore, establishing a good therapeutic relationship, characterised by trust and safety, may facilitate disclosure if the mental health professional asks about a history of CSA (Dale et al.; Schachter et al.). Ullman (2011) believes it is critical for service providers to provide a safe space for survivors to disclose. However, it is interesting to note that establishing a positive therapeutic relationship may also deter survivors from disclosing their experience of CSA to the mental health professional, due to possibly only wanting to be viewed in favourable terms (Dale et al.).

3.3.6.2 Normalising.

Normalisation is particularly useful for survivors of CSA (Dale et al., 1998; McGregor et al., 2006; Read et al., 2007). Due to the dynamics of abuse and the self-blame and shame it evokes, it can leave survivors feeling ‘abnormal’, ‘special’ and different to others (Herman, 1992a; Sanderson, 2006). Therefore, the use of normalisation is the antithesis of what the survivor has experienced. Research has suggested that mental health professionals preface asking about CSA by using a statement that indicates that everyone is asked about historical trauma (Read et al.). This indicates to the survivor that they are not being asked due to appearing ‘abnormal’ or ‘different’. In addition, normalising the disclosure with a statement such as, “In my experience, people often find that although it’s difficult, it can often be really helpful to talk about” (Read et al., p. 106). Using normalisation is useful in both facilitating disclosure of CSA, as well as working with CSA in therapy (Dale et al.; McGregor et al.; Read et al.).

3.3.6.3 Psychosocial assessment.

A thorough psychosocial assessment is thought to provide an opportunity for survivors to disclose their experiences of CSA, as this includes childhood and historical events (McGregor et al., 2006; Read et al., 2007). However, completing such an assessment is a process and can take time (Briere, 1996). It is also suggested that both positive and negative events be explored, so the survivor recognises that their history is not entirely difficult or unpleasant (Read et al.). If CSA is disclosed, then general details including the type, severity and duration of victimisation, as well as the survivor's current psychological symptoms and needs should be explored (Astbury, 2006). However, it is essential the mental health professional refrain from wanting to ask about specific details immediately, as this is not necessary and potentially detrimental (Read et al.).

Whilst research indicates a thorough psychosocial assessment is helpful in providing a context for asking about CSA, it is not without its dilemmas. Firstly, treatment is often time-limited, thus making lengthy assessments unrealistic (e.g., O'Brien et al., 2007). Secondly, disclosing CSA experiences after investing time and developing rapport with the mental health professional may result in the professional communicating their inability to work with such issues, thus referring on or terminating therapy (e.g., McGregor et al., 2006). Such a response is considered unhelpful by many CSA survivors, and is a salient issue for mental health professionals' practice.

3.4 Working with Disclosures of CSA in Therapy

Helpful mental health professional practices have been identified when working with disclosures of CSA histories, as well as the benefits and risks of disclosing such trauma in therapy. Possible reasons for unhelpful practice are explored, along with the consequences of such practice on survivors.

3.4.1 Helpful practice when working with CSA survivors.

Research exploring the perspectives of what survivors of CSA find helpful in therapy has been limited, but invaluable, in providing insight to what their needs are. Whilst many perceived helpful practices are considered universal for all clients

seeking treatment from mental health professionals, certain practices are considered especially important for survivors of CSA. Particularly useful practices employed by mental health professionals, include: basic counselling skills, listening, not replicating the dynamic of abuse (i.e., transparency, empowerment, the use of ‘meta-dialogue’, and providing education), and longer treatment.

3.4.1.1. Basic counselling skills.

Although basic counselling skills are considered efficacious when working with the general population (e.g., see Manthei, 2005 for review), particular skills, such as being empathetic and non-judgemental, whilst acknowledging and validating the survivor’s experience, have been evaluated as very helpful by survivors of sexual trauma (Astbury, 2006; Denov, 2003; Lievore, 2005; Palmer, Brown, Rae-Grant & Loughlin, 2001). Assuming a non-judgemental stance is thought to be very valuable when working with survivors of CSA, who have most likely been judged and further shamed when discussing, or attempting to discuss, their abuse experiences before (Sanderson, 2006). Adults who have experienced CSA may be highly attuned to both verbal and non-verbal messages that might belie the mental health professional’s understanding demeanour, thus causing the survivor to be distrustful and negatively affecting the therapeutic relationship (Sanderson).

Being validated is considered particularly beneficial (Denov, 2003; Palmer et al., 2001). Survivors in Denov’s study reported that acknowledgment and validation of their experiences reduced the negative effects of the abuse. Having one’s experience validated by the mental health professional was also considered especially beneficial by participants in Palmer et al.’s study. Validating a survivor’s experience is important to maintain engagement in the therapeutic process. If the survivor does not perceive the mental health professional doing this, then they are likely to have their feelings of betrayal reinforced (Sanderson, 2006).

3.4.1.2 Listening.

A mental health professional’s capacity to listen to the survivor’s story is considered particularly helpful (Dale et al., 1998; Lievore, 2005; McGregor et al., 2006; O’Brien et al., 2007; Palmer et al., 2001). It also conveys to the survivor that

the mental health professional is able to cope with such information (Dale, 1999), and that the survivor is important and ‘matters’ (McGregor et al.; O’Brien et al.). Dale noted that survivors are attuned to both verbal and non-verbal gestures indicating an inability to cope with such information. Thus, the ability to calmly accept the account is considered helpful for mental health professional practice (Schachter et al., 2004). McGregor et al. recommend that training of all mental health professionals should include skills needed to listen to difficult accounts of CSA, be able to assess and address the effects of the CSA on the survivor or refer to an appropriate professional or agency if necessary.

3.4.1.3 Not replicating the abuse dynamic.

When working with survivors of CSA, it is imperative to foster dynamics that is the exact opposite of the abuse experience. It is suggested the mental health professional should attempt to be, and act, exactly the opposite of the perpetrator (Astbury, 2006). As the abuse experience has essentially robbed the survivor of power, safety and the ability to voice their experience, needs and wants, the therapeutic process should endeavour to restore this (Herman, 1992a).

3.4.1.3.1 Transparency.

Transparency is considered essential when working with survivors of CSA (McGregor et al., 2006; O’Brien et al., 2007; Schachter et al., 2004). The dynamics of abuse is that of secrecy, whilst being transparent is its antithesis. In practical terms, this requires the mental health professional to explain the process of therapy, set clear therapeutic boundaries and explore the survivor’s expectations of therapy (McGregor et al.; O’Brien et al.; Schachter et al.). Providing information about the therapeutic process at the outset is considered beneficial to survivors and thought to decrease anxiety about engaging in therapy (McGregor et al.; Schachter et al.). Similarly, the setting of clear boundaries is important to survivors of CSA, as the survivor experienced fundamental violations of their mind, body and spirit (O’Brien et al.; Sanderson, 2006; Schachter et al.). Providing clear boundaries may assist the survivor to feel safe and secure in the therapeutic relationship (Sanderson). In

practice, this can include what the mental health professional can and cannot do, and the client's rights and responsibilities (Sanderson).

3.4.1.3.2 Empowerment.

Empowerment, in terms of an equal, collaborative and client driven therapeutic process is considered helpful and for survivors of CSA (McGregor et al., 2006; Palmer et al., 2001; Schachter et al., 2004). Qualitative research suggests that experiencing equality in the client-professional relationship is greatly appreciated by participants (McGregor et al.; Palmer et al.; Schachter et al.). Loss of power and control are fundamental dynamics of CSA, therefore placing the mental health professional in a position of responsibility not to replicate it (Herman, 1992a; Sanderson, 2006). In practical terms, client-driven therapy includes the client setting their own pace and focus of treatment, and ultimately, being considered the 'expert' of their own experience and needs (Sanderson). The mental health professional is the survivor's ally, contributing unique set of skills, knowledge and experience to form a collaborative therapeutic relationship (Herman). Astbury (2006) notes that whilst client compliance is expected in other sectors of health care, this is not only unnecessary, but also counterproductive, in the mental health field.

3.4.1.3.3 Meta-dialogue.

The term 'meta-dialogue' has not been used in available literature, but refers to the process of discussing what is being discussed in therapy, as well as the therapeutic relationship. Talking about how the process and the experience of therapy, in terms of its pace, intensity etc., as well as what is helpful, unhelpful and what could be improved, are all regarded as beneficial (Briere, 1996; Farber, Khurgin-Bott & Feldman, 2009; McGregor et al., 2006). Conversations about therapy may add to the survivor's sense of empowerment over the therapeutic process.

Mental health professionals providing opportunities to raise and discuss the therapeutic relationship in terms of possible miscommunication or therapy errors is also considered helpful, if not daunting, for the survivor (Courtois, 1999; Dale et al., 1998). Whilst this may foster an effective working relationship, it could be

particularly disconcerting for the survivor, who, due to the dynamics of abuse, might be used to automatically complying with others' wishes in fear of rejection or judgement (Dale et al.). As one participant in Dale et al.'s study noted, "The hard thing about therapy is they want you talk. And the problem with being abused as a child is that you are told not to..." (p. 148). However, if the mental health professional normalises the survivor's anxiety about this, as well as appears receptive to the survivor's verbal and non-verbal cues, this may foster communication and address problematic aspects of therapy (Farber et al., 2009; Schachter et al., 2004). Successfully negotiating this could provide the survivor a unique opportunity to learn that disagreeing with another does not lead to the sudden end of the relationship.

3.4.1.3.4 Education.

Educating survivors about the dynamics and effects of CSA is noted as being beneficial due to the normalising effect it has (Dale et al., 1998; Herman, 1992a; Lievore, 2005; McGregor et al., 2006). As the dynamics of historical sexual abuse often leaves survivors feeling 'abnormal', isolated, shamed and therefore silenced, learning about how common this phenomenon is, as well as how people often experience it, can be a very normalising and connecting experience (Herman, Sanderson, 2006). Research reinforces this notion where qualitative studies found that survivors particularly appreciated reassures by mental health professionals they were indeed not 'crazy', but experiencing common effects of CSA (Lievore; McGregor et al.; Schachter et al., 2004).

Mental health professionals may not necessarily possess information and knowledge specific to the sequelae of such trauma. If this is the case, it is suggested that the mental health professional could seek information about CSA and share this with the survivor, thus promoting a mutual learning process (Schachter et al., 2004). Otherwise, providing information and contacts to other services is also helpful (Astbury, 2006).

3.4.1.4 Longer treatment.

It has been suggested that being able to engage in longer treatment is appreciated by survivors of CSA (O'Brien et al., 2007; Palmer et al., 2001). Qualitative studies reviewing what was helpful for survivors noted the importance of long-term treatment (O'Brien et al.; Palmer et al.). In addition, continuity, in terms of working with the same mental health professional, was also considered important. The effects of losing the mental health professional were “devastating” (p. 142) possibly due to the survivor experiencing multiple losses over their lifetime (Palmer et al.). While longer-term treatment has been considered beneficial in these studies, Sanderson (2006) cautioned that treatment length is highly individual. She outlined that while short-term therapy is generally more focused and may foster independence from the mental health professional, at the same time it could place undue pressure the survivor to achieve their goals and mimic the highly controlling dynamic of abuse. Conversely, long-term therapy provides an opportunity to explore complex issues in-depth, but may foster dependence on the mental health professional and be financially unviable for many (Sanderson).

While some factors being cited as helpful to survivors require specific training and knowledge, other research indicates that fundamental and basic counselling skills, the therapeutic relationship and simply listening can be effective in itself (McGregor et al., 2006). In addition, Schachter et al. (2004) believe that because not all survivors disclose, professionals may not be aware that they are working with a survivor, sensitive practice should, therefore, be practised as a ‘universal precaution’ for all clients.

3.4.2 Benefits of disclosing CSA in therapy.

There are many benefits of disclosing CSA in therapy (Farber et al., 2009; Phillips & Daniluk, 2004). These benefits include experiencing the opportunity to be heard, understanding and developing one's identity, and making meaning, or a different meaning, about the abuse experience (Farber et al.; O'Brien et al., 2007; Phillips & Daniluk).

3.4.2.1 Being heard.

Childhood sexual assault is characterised by secrecy, shame and silence (Sanderson, 2006). This secrecy, shame and silence is often reiterated to the survivor by the perpetrator, the survivor's family and friends, as well as society at large (Alaggia, 2005; Sanderson). Therefore, being provided with an opportunity to disclose one's experience of CSA is powerfully cathartic in that it is the antithesis of abuse itself (Farber et al., 2009). Other research echoes this primal need, where being heard and understood were considered to be a major benefit of disclosing one's experience of CSA (O'Brien et al., 2007)

3.4.2.2 Understanding and developing one's identity.

Survivors of CSA may possess an unstable sense of identity (Neumann et al., 1996; O'Brien et al., 2007). Disclosing CSA experiences in therapy is considered beneficial for the survivor in that over time their sense of self developed, strengthened and was better understood (Bradley & Follingstad, 2001; Farber et al., 2009; O'Brien et al.; Phillips & Daniluk, 2004). Phillips and Daniluk's qualitative study found that disclosure allowed participants to understand their identity was interwoven with their experience of CSA. By recognising this, they were then able to separate their identity from their experiences of abuse and find aspects of themselves that were not related to experiencing CSA.

3.4.2.3 Making meaning or a different meaning.

The benefits of disclosure in therapy highlight the importance of making meaning, or a different meaning, from one's experience of CSA (Bradley & Follingstad, 2001; Draucker et al., 2011; Phillips & Daniluk, 2004). Due to the secretive, shameful and silencing nature of CSA, children often make self-blame saturated meaning of their experiences and are isolated from others who may help to re-frame the abuse (Draucker et al.; Sanderson, 2006). These unhelpful beliefs and understandings tend to continue, unquestioned, into adulthood (Draucker et al.).

Disclosure is thought to facilitate one's ability to alter unhelpful thought patterns associated with mental health issues such as depression and anxiety, as well as negative self-beliefs, like trust and safety (Bradley & Follingstad, 2001).

Participants in Spitzer and Myers Avis's (2006) study cited that learning about the meaning of their flashbacks was particularly useful for them. Placing one's individualising understanding of CSA in a broader socio-political context allows the survivor develop a new perspective and feel more connected, thus counteracting the sense of being 'abnormal' and reducing shame-based beliefs that are caused by the dynamics of CSA (Phillips & Daniluk, 2004).

3.4.3 Risks of disclosure of CSA in therapy.

Whilst beneficial aspects to disclosure of CSA in therapy have been identified, there are also particular risks associated with such disclosure, such as the survivor becoming distressed when disclosing their abuse experiences (e.g., Farber et al., 2009). In addition, the mental health professional may appear uncomfortable, assume a 'blank' therapeutic stance, or terminate therapy upon hearing the disclosure. Experiencing such negative reactions from the mental health professional has considerable detrimental effects on the survivor, including secondary victimisation.

3.4.3.1 CSA survivor being distressed by disclosure.

While the benefit of catharsis has been identified as useful to survivors of CSA, this may also prove to be a risk in that the survivor may feel overwhelmed by the experience (Dale et al., 1998; Farber et al., 2009). Upon disclosing, the survivor may become experience more negative affect, cognitions and imagery before an improvement is discernable to them (Dale et al.; Farber et al.). Survivors may have an expectation that disclosure alone will immediately resolve their difficulties and, therefore, feel let down and hopeless if this does not occur (Farber et al.). Spitzer and Myers Avis (2006) also found that participants who spent more time recalling graphic sexual abuse memories in therapy reported lower scores of functioning during therapy when compared to the group that spent less time doing so. Therefore, it is recommended that mental health professionals educate the survivor about the eventual benefits, but the potential risks of disclosing and exploring CSA (Farber et al.). In addition, Spitzer and Myers Avis warned against asking the survivor to recall or relate graphic details of the abuse experience, as well as suggest

the mental health professional be certain of what they hope to achieve by asking of this.

3.4.3.2 Mental health professional appearing uncomfortable.

Client perspectives on unhelpful therapy practice cite the mental health professional appearing uncomfortable discussing trauma as detrimental (Dale et al., 1998; Jeffreys, Leibowitz, Finley & Arar, 2010; Josephson & Fong-Beyette, 1987; McGregor et al., 2006). This was illustrated by accounts of mental health professionals who did not listen, or avoided discussing their experience of CSA (Josephson & Fong-Beyette; McGregor et al.; O'Brien et al., 2007). The effect of such avoidance was verbalised by a participant of McGregor et al.'s study: "It's still not OK to talk about it... it's been thirty years and I still can't talk about it!" (p. 50). Avoiding the topic is interpreted by the survivor as silencing and reinforces their previous experiences of being ignored, disrespected and unimportant (McGregor et al.; Sanderson, 2006). As survivors of CSA are often highly attuned to verbal and non-verbal cues of the listener's vulnerability, the mental health professional may not be aware of the signals that belie their feelings of discomfort (Dale et al.).

Avoiding discussing what the survivor wants to discuss results in the mental health professional assuming control of the therapeutic process in order to defend against their own anxiety, thus disempowering the client (Sanderson, 2006). With the mental health professional in control of the therapy, they might focus on employing interventions they feel comfortable with, such as focusing on therapeutic structure, diagnosis or symptom reduction without being able to hear about the context for their symptoms (Nelson, 2009; Sanderson). These reactions have been reported by survivors working with psychiatrists, in particular (Nelson; O'Brien et al., 2007).

3.4.3.3 Mental health professional assuming a 'blank' therapeutic stance.

Mental health professionals who assume a 'blank' or neutral therapeutic stance, are considered less helpful by survivors of CSA, especially by those naïve to the therapeutic process (Dale et al., 1998; McGregor et al., 2006). Such behaviours include exaggerating objectivity, being excessively guarded and the use of long and

unexpected silences (Dale et al.; McGregor et al.). This could be due to the survivor interpreting this stance as rejecting and reinforces their belief of being unworthy and undeserving of understanding (Dale et al.; Herman, 1992a; McGregor et al.). The silences in therapy may also evoke strong uncomfortable feelings in the survivor, where past experience of silence is associated with abuse, fear and punishment (Dale et al.; Sanderson, 2006). Assuming a 'blank' therapeutic stance and employing silences may be useful with particular individuals, but for those seeking therapy for CSA, mimics the abuse dynamic and is considered counterproductive (Herman; Sanderson).

3.4.3.4 Mental health professional terminating therapy.

As previously noted, survivors who seek therapy may not initially disclose their experiences of CSA due to factors such as not being asked, or not feeling comfortable within the therapeutic relationship (McGregor et al., 2006; Read et al., 2007). However, as time elapses and rapport is established, disclosure may occur (Dale et al., 1998; Sanderson, 2006). Some mental health professionals terminate therapy upon learning about a client's experience of CSA, with instances of not providing a referral to an appropriate service (McGregor et al.). Others are referred to an appropriate service, but face the frustration of having to establish rapport and tell their story again (O'Brien et al., 2007). While it may be impossible to prevent the survivor from feeling abandoned, the negative perception may be ameliorated by sensitively referring to appropriate therapists or services (Courtois, 1999).

3.4.3.5 Negative reaction of the mental health professional and secondary victimisation.

As previously noted, disclosures of CSA that are met with negative reactions from the listener can result in secondary victimisation, leaving the survivor to continue feeling victimised, long after the abuse has ended (e.g., Ahrens et al., 2010; Lorentzen et al., 2008). Disclosing a history of CSA in therapy is no different in that the reaction from the mental health professional may differ from what the discloser needs, expects or hopes for (Farber et al., 2009).

As highlighted earlier, 'secondary victimisation' occurs when victims of

crime, particularly regarding sexual offences, are subject to processes and responses that cause further victimisation or compound feelings of victimisation (Condry, 2010). Secondary victimisation from the listener can occur when disclosing to both informal and formal sources, with mental health professionals' reactions to disclosures of CSA is somewhat common (Denov, 2003; McGregor et al., 2006; O'Brien et al., 2007), and is cited as a "major preventable form of harm to the survivor" (Astbury, 2006, p. 6). Experiencing secondary victimisation from mental health professionals can lead to the survivor doubting the importance of their experience and feeling that future disclosures will be futile (Ahrens, 2006).

3.4.4 Possible reasons for unhelpful practice.

Disclosure of CSA can prompt negative reactions from the listener (e.g., Leahy et al., 2004; Lorentzen et al., 2008). These reactions are based on the listener's personal characteristics and beliefs, which are influenced by socio-cultural myths, expectations and norms (Alaggia, 2010; Sorsoli et al., 2008). Mental health professionals are also people who live in the same world and are, therefore, likely to react to accounts about, as well as hold particular beliefs about CSA.

No matter how experienced a mental health professional is, hearing traumatic accounts of CSA is likely to evoke strong feelings and reactions (Herman, 1992a; Schachter et al., 2004). However, a mental health professional's capacity to engage with the survivor is based on personal and professional factors (Wilson, 2004). Personal factors include temperament, containment, resistance to stress and sensitivity, whilst professional factors include one's level of experience, knowledge of trauma, access to support and resources, as well as psychological wellbeing (Wilson). In addition, many mental health professionals, including those who have a history of childhood sexual abuse, may experience countertransference issues, such as those involving boundaries (Herman, 1992a; Little & Hamby, 1996). Herman stated that listening to traumatic accounts may trigger memories and feelings associated with the mental health professional's own trauma. She therefore recommends that support is needed for individuals working with trauma – "Just as no survivor can recover alone, no therapist can work with trauma alone" (p. 141).

As previously noted, some mental health professionals do not believe they are knowledgeable or experienced enough to work with survivors of CSA (Lab et al., 2000; Read et al., 2007; Yarrow & Churchill, 2009). Literature indicates this is especially so for professionals who work with male survivors of CSA (Lab et al.; Yarrow & Churchill).

3.4.5 Consequences of unhelpful practice on survivors.

Unhelpful practice by mental health professionals is somewhat common (Dale et al., 1998; McGregor et al., 2006; O'Brien et al., 2007). Unhelpful, negative reactions, as outlined previously, may lead to secondary victimisation, which is harmful to the survivor (Campbell & Raja, 1999; Ullman, 1996). Secondary victimisation by mental health professionals' practice is both common and harmful (e.g., Dale et al.; Denov, 2003), with Astbury (2006) citing that this as a "major preventable form of harm to the survivor" (p. 6). In Dale et al.'s qualitative study, over a quarter of participants evaluated their experiences of counselling as negative or being harmful. Survivors who have experienced CSA by female perpetrators appear to be even more susceptible to negative reactions from mental health professionals, such as disbelief and minimisation (Denov).

Survivors who experience unhelpful therapy experiences may drop out of therapy (Dale et al., 1998; McGregor et al., 2006). Participants in these qualitative studies reported a strategy they employed to withdraw from therapy was to tell the mental health professional that they were 'better'. Whilst this approach serves a purpose to the survivor, who does not wish to remain in an uncomfortable relationship, it may only serve to reinforce the mental health professional's incorrect beliefs that guide their ineffective practice (Dale et al.).

In a best-case scenario, survivors will be motivated and persist and seek help from other professionals until they encounter somebody helpful (Palmer et al. 2001). However, future non-disclosure is common, based on the survivor's perception that future disclosures will be ineffective, thus dissuading them from attempting to disclose again (Ahrens, 2006). The implications of being silenced is associated with no longer seeking further treatment, and essentially, 'giving up', as illustrated by

McGregor et al.'s (2006). This is clearly a damaging, yet avoidable consequence of unhelpful mental health professional practice.

3.5 Summary

Chapters two and three provided a comprehensive review of the available published literature regarding disclosure of CSA in therapy as well as what is considered helpful and unhelpful professional practice when working with survivors. As demonstrated, being sexually abused in childhood can be particularly damaging in that it affects the developing child's view of themselves and the world. The associated effects of CSA may continue into adulthood, though the likelihood is thought to decrease according to moderating factors. While these effects can include a variety of attachment and relational difficulties, it may manifest as mental health issues. Survivors may disclose their experiences to informal supports but may also eventually seek assistance from a mental health professional.

Particular situations and events are thought to trigger a survivor to consider seeking therapy. However, it is unlikely the survivor will disclose their experience of CSA initially to a mental health professional. Therefore, it is important to ask all clients about a possible history of childhood trauma, though certain barriers prevent mental health professionals from doing so. Disclosure of CSA is considered to be helpful to the survivor and particular factors can facilitate this disclosure. Research illustrates there are many practices that are considered helpful when working with survivors of CSA. Conversely, disclosing CSA may be unhelpful in that it largely depends on the mental health professional's handling of the communication. Although valid reasons exist for unhelpful professional practice, the results can be especially distressing for survivors who are courageous to disclose their abuse experiences in therapy.

As research highlights, mental health professional practice can assist survivors' wellbeing for either better or worse. Quantitative data has been particularly useful when exploring a range of phenomena, such as the characteristics and prevalence of mental health issues experienced by CSA survivors, as well as the patterns and consequences of disclosure. However, qualitative data in the area of

CSA has been especially useful, if not limited, in available literature. Even more limited is research about what is considered helpful and unhelpful therapeutically from a CSA survivor's perspective. This study aims to address this identified limitation by exploring the experiences of adult survivors of CSA who have consulted with a mental health professional. In particular, the researcher will discuss with adult survivors what they found helpful or useful about the experiences, how satisfied they were, and what, from their invaluable perspective, could have been improved. In order to gain an alternative viewpoint, this study also aims to explore mental health professionals' knowledge and experiences of working with adult survivors who have disclosed their CSA in therapy. Specifically, mental health professionals will be asked about what they believe is helpful and unhelpful when working with survivors of CSA, as well as the adequacy of the training and education they received.

Chapter 4

Research Methods and Procedures

4.1 Introduction

This chapter describes the methods and procedures employed by this study to explore helpful and unhelpful therapeutic practice when working with CSA, based on mental health professionals, along with input from survivors. Firstly, the qualitative methods used in this study will be described, such as semi-structured interviewing and using thematic analysis guided by a social constructionist epistemology to evaluate the data. Demographic details of the participants will then be outlined. Next, the procedures associated with conducting the study are described and include developing the interview schedule, the recruitment process, and organising and conducting interviews. The process of analysis of the data will be explained, followed by the measures employed to maximise the quality of the study's findings. Finally, ethical considerations and other issues will be discussed.

4.2 Qualitative Methods

Qualitative research has been limited when exploring the therapeutic experiences and therefore suggesting particular practices for survivors of CSA. Due to the identified limitation of available published research in this area, the current study aimed to build upon and expand on current literature by identifying helpful and unhelpful practice when working with CSA survivors. As the reviewed qualitative research was perceived to provide rich and comprehensive information about survivors' experiences and therapeutic practice, it was thus adopted for the current study. A qualitative approach was considered most appropriate due to this study being exploratory in nature and concerned with developing a deep understanding of the experiences, opinions and knowledge of participants.

Qualitative research methods are frequently used in the social sciences as its design allows for in-depth, rich and sensitive information about phenomena to be discovered (Denzin & Lincoln, 2005). Not only does it assist researchers to identify what people believe, but also the underlying reasons why they do so, based on their

interpretation of complex, psychosocial subjective phenomena, such as CSA (e.g., Alaggia & Millington, 2008; Denov, 2004). Qualitative research allows participants to explain how they make meaning, and attach values to their experiences, thus enabling researchers to gain a deeper understanding of the phenomena. Aside from this type of inquiry enabling a comprehensive exploration of complex phenomena, it also allows for previously unanticipated or unidentified information to be discovered and elaborated on (Charmaz, 2006). Due to these strengths of qualitative research, it was considered best suited to exploring the needs and experiences of survivors of CSA, based on perceived helpful and unhelpful practices employed by mental health professionals.

4.2.1 Semi-structured interviewing.

Qualitative research frequently employs the use of a semi-structured interviewing style and is considered effective when investigating range of areas of social inquiry (Charmaz, 2006). The application of semi-structured interviews is an intensive and comprehensive method that allows for the capturing of the experiences of the participant. Semi-structured interviews comprise of non-directive, open-ended questions, formulated to elicit quality data. It allows the researcher to gain in-depth insight into beliefs, attitudes, perceptions and experiences relevant to the area of interest, without predetermining the nature of the information (Patton, 2002). The use of semi-structured interviews also allows the researcher to interact with the participant and ask for further clarification or explanation, thus deviating from the interview schedule. Using semi-structured interviewing has been used in previous research investigating what CSA survivors found helpful or unhelpful in therapy (McGregor et al., 2006).

Semi-structured interviewing is frequently used due to three main benefits. Firstly, it is complementary with many methods of qualitative research and data analysis (Willig, 2006). Secondly, semi-structured interviewing provides opportunities for new and unanticipated themes to emerge. While the researcher has their own guide, the participant is able to deviate from the question and explore topical trajectories (Cohen & Crabtree, 2006). This is particularly useful when exploring areas that have not been extensively researched. Finally, this interviewing

style is collaborative in that it places the participant in the role of being the ‘expert’ of their own experiences, and not the researcher. They are able provide context and elaborate on their interpretations and opinions. Due to these noted strengths, semi-structured interviewing was regarded as the most appropriate method of inquiring about the experiences and needs of CSA survivors.

4.2.2 Thematic analysis.

Thematic analysis was used for the current study as its fundamental principles are shared by all qualitative methodologies, which are essentially thematic in nature (Braun & Clark, 2006). This flexible type of analysis also accommodates and is suitable for a large range of theoretical frameworks and perspectives (Braun & Clark). Therefore, thematic analysis can be adopted and applied to any area of qualitative research.

Thematic analysis is a process for identifying, analysing and reporting themes within qualitative data (Boyatzis, 1998). Employing this approach allows the researcher to organise and describe data in rich detail, as well as interpret and account for complex data (Boyatzis).

The thematic analysis used in the current research was guided by a constructionist epistemological standpoint. Meaning and knowledge are produced and sustained by social interactions, and within social contexts, rather being innate and entirely subjective within individuals (Burr, 1995; 2003). The social constructionist approach has been increasingly used over recent years, highlighting that analysis and theory generation is affected by the researcher’s interaction with the world and socio-cultural influences, which in turn influence their own interpretations of yielded data (Burr, 2003). Therefore, thematic analysis conducted within this framework focuses on theorising socio-cultural contexts that provided the basis of an individual’s account, rather than exploring individual psychologies (Braun & Clark, 2006). Due to CSA being primarily a socio-cultural issue and influenced by socially constructed norms, especially for survivors of CSA, a social constructionist framework was considered to be the most appropriate epistemological standpoint. Whilst this also holds true for mental health professionals, their beliefs are also guided and informed by professional norms.

The usefulness of thematic analysis lies in its ability to construct theories in an inductive, or ‘bottom up’ manner, similar to grounded theory (Braun & Clark, 2006; Frith & Gleeson, 2004). Analysis rigorously conducted in an inductive way means that the resultant themes are closely related to the raw data (Patton, 1990). Theoretically, an inductive approach to thematic analysis means the analysis is data driven, with resultant identified themes bearing little, or a different relationship to the question asked to the participant (Braun & Clark). Employing thematic analysis has been used previously by researchers investigating CSA, including its subjective effects on survivors (Breckenridge, 2006), disclosure of CSA experiences (Alaggia, 2010), and therapeutic issues faced by survivors (MacIntosh & Johnson, 2008). Due to the exploratory nature of the current study, thematic analysis conducted in this manner was considered the most appropriate approach. Employing this approach was thought to provide an opportunity to build upon existing knowledge about the needs and experiences of CSA survivors, as well as potentially discover unanticipated and under-researched concepts.

4.3 Participants

Participants comprised of adult CSA survivors and mental health professionals who had consulted with CSA survivors in their practice. No inclusion criteria were established for mental health professionals. However, the following inclusion criteria was established when recruiting adult CSA survivors:

- a) They needed to have experienced CSA,
- b) The survivor had sought therapy from at least one mental health professional about their CSA experience/s,
- c) They needed to be over the age of 18 years, and,
- d) They needed to not be experiencing any current, acute or significant distress or crises.

A snowball sampling method was attempted in order to obtain CSA survivors for the study, which involved liaising with agencies and professionals. However, this was unsuccessful in obtaining further CSA survivors to participate, with all participants responding to the flyer (and outlined in Section 4.4.2, ‘Recruitment Process’). The snowball sampling method resulted in some limited

success with mental health professionals, who notified other colleagues about the study. This process is similarly outlined in Section 4.4.2 ‘Recruitment Process’. The following provides background information about the three adult survivors of CSA who sought treatment from a mental health professional, as well as the thirteen mental health professionals who participated in this study. Tables 1 and 2 provide demographic information about the participants.

4.3.1 Adult CSA survivors.

Three adult survivors of CSA participated in this study. All were female and aged between 25 and 35 years.

All three survivors sought assistance from between two to four different mental health professionals. Between the three survivors, a total of nine mental health professionals were consulted.

The length of treatment varied, with all three reporting they only attended 1-2 sessions with at least one mental health professional, or between 3 to 6 sessions with others. One survivor estimated she had consulted with two mental health professionals for at least eight sessions.

4.3.2 Mental health professionals.

In all, 13 mental health professionals participated in the study. Twelve were female and one was male. Some mental health professionals cited being qualified in more than one profession. Eight were qualified psychologists from various disciplines, with half of these being clinical psychologists. Three were qualified social workers. Finally, two participants held qualifications categorised as ‘other’ that included diploma qualifications.

Of the 11 mental health professionals asked about what they considered to be their area or areas of expertise, seven cited ‘trauma’. Majority of participants had worked in various settings, ranging from private practice to community mental health. Six worked at a Centre Against Sexual Assault (CASA) in the position of Counsellor/Advocate. Two participants worked at a sexual assault crisis line.

All mental health professionals had been practicing for a number of years. All participants had at least five years of professional experience. Five participants

worked between five and 9 years, six participants had between ten and nineteen years of experience, and two mental health professionals possessed between 20 and 35 years of practice.

Table 1: Demographic Information for CSA Survivors

Gender	(n=3)
Female	3
Male	0
Age	
25-30 years	1
30-35 years	2
Education level achieved	
Secondary school or equivalent	2
Tertiary qualification	1
Number of mental health professionals consulted	
2-3	2
4-6	1
Number of sessions	
1-2	3
3-6	3
8+	2

Table 2: Demographic Information for Mental Health Professionals

Gender	n = 13
Female	12
Male	1
Profession *	
Clinical Psychologist	4
Social Worker	3
Counselling Psychologist	2
Provisional Psychologist	2
Psychotherapist/Counsellor	2
General Psychologist	1
Forensic Psychologist	1
Other	2
Years of Experience	
5-9 years	5
10-19 years	6
20-35 years	2
Workplace *	
Private Practice	8
CASA	6
Community mental health	5
University counselling service	3
Sexual Assault Crisis Line	2

* More than one option could be selected.

4.4 Gathering Data

4.4.1 Developing the interview schedule.

The researcher, in collaboration with a psychologist who possessed expert knowledge in the area, developed a semi-structured interview schedule that addressed the research questions and the domains of inquiry. These questions were based on reviewing existing published literature, noting perceived gaps in such research, and developing questions of an exploratory nature. As previously noted, qualitative research has been scant regarding the importance of disclosure of CSA, factors that either facilitate or inhibit disclosure, and what survivors consider helpful and unhelpful practice when working with CSA survivors. Therefore, open-ended questions were designed to explore these areas in order to gain a greater understanding of CSA survivors' experiences of consulting with mental health professionals. Demographic questions for CSA participants were minimal to reduce the level of intrusiveness, by only focusing on information regarding the therapy sessions with mental health professionals (see Appendix A).

Complementary questions exploring mental health professionals' experiences of working with CSA survivors, including their opinions regarding disclosure of CSA and what they consider most important when working with survivors were developed. In addition, demographic questions were included for mental health professionals, such as their occupation, years practicing and qualifications (see Appendix B).

4.4.2 Recruitment process.

4.4.2.1 Adult survivors of CSA.

Adult survivors of CSA were recruited via notices being displayed at medical and community centres around metropolitan Melbourne, Victoria (see Appendix C). The researcher was then contacted via the telephone or email details on the advertisement. If survivors emailed the researcher, they were telephoned in order for a verbal conversation to occur, reiterating the nature and aims of the study. This conversation was of particular importance, as the researcher emphasised the

disclaimer printed on the recruitment notice, stating that the study only focused on the survivor's experience with consulting with mental health professionals, and not the CSA experience itself. The researcher ensured the potential participant was fully informed about the study and ensured no other major issues or crises were occurring for them at the time. Any questions or queries the survivor asked were answered. If they continued to be interested in participating, a date, time and location was agreed upon, along with the researcher posting the 'Information to Participants' to them for their perusal and consideration before the interview (see Appendix E). The researcher advised the potential participant they would withdraw from the study at any time, without consequence.

4.4.2.2 Mental health professionals.

Mental health professionals were recruited via an advertisement being placed in medical and community health centres in metropolitan Melbourne, Victoria (see Appendix D). In addition, the study's details were sent to the manager at Gatehouse, which communicates to all CASAs and their staff. Some professionals were invited to participate in the study by other mental health professionals, or the researcher, due to their identified expertise. Professionals contacted the researcher via the telephone or email details provided. If they had any questions or queries, they were answered. After the professional was fully informed of the study and if they consented in participating, then an interview was organised. The 'Information to Participants' was generally emailed to participants before the interview for their perusal and further consideration (see Appendix F). In other situations, the forms were provided on the day of the interview.

4.4.3 Organising and conducting interviews.

During the telephone conversation, a date, time and location for the interview were agreed upon by the participant and researcher. Due to the sensitive nature of the study, as well as the potential for distress to occur, it was of utmost importance that interviews with survivors were to be conducted in a private environment. In addition, it was ensured the location was convenient for the participant to travel to. Therefore, all interviews with survivors were conducted in private and convenient

locations. One interview was conducted at Victoria University in a privately booked room, whilst the other two were conducted in a privately booked room at their local library. Most professionals opted to be interviewed at their workplace, in their private office space. All participants were assured the interview was informal and they were free to deviate from the questions asked and add their own insights wherever they felt appropriate. Prior to the commencement of the interview, an informal chat helped put the participant at ease as well as establish rapport, which is important to facilitate disclosure and establish trust (Patton, 2002). It was also offered that a break could be taken at any time. Participants were asked questions using the semi-structured interview schedule developed, with interviews ranging from approximately thirty to ninety minutes in duration.

Throughout the recruitment and interview process, the researcher remained attuned to the participant's level of comfort about taking part in the study. It was reiterated to all that if they were uncomfortable or distressed, the topic could be changed or the interview be paused or suspended. Participants were also advised of their right to withdraw from the study at any time.

Interviews were recorded with the permission of each participant on an audio digital recorder. Whilst some participants expressed reluctance to be audio-recorded, it was explained that the recording would be kept confidential and was a tool allowing the researcher to capture the interview in its entirety. Once these issues were clarified, participants appeared comfortable with being audio recorded. Audio recording ensures full attention on the participant and allows the researcher to be in tune with any noticeable changes in the participant's demeanour or body language. This is preferred as it allows the researcher to replay the interview and gain further information such as pauses, emphases and stutters, which are all aspects of the interview that would otherwise be forgotten if not recorded (Silverman, 2010).

Interviews concluded after the researcher had asked all questions, offered the participant an opportunity to contribute any further insights or comments, and when no further information could be added. Some participants expressed disappointment about not being able to remember particular situations or experiences clearly in order to relay the information as accurately as possible. Survivors were debriefed about how the interview was for them, and if it brought up any issues they thought

required further assistance or support. The use of italicised quotes throughout this dissertation denotes a direct quote from the research participant. While no survivors reported any distress, they reflected on the interview process as “*cathartic*” and “*really helpful*”. The general consensus was that participating was valuable in that it brought clarity to their previous therapy experiences and helped them realise what they wanted from future therapy, should they seek it. Mental health professionals also reflected on participating in the study, stating they felt the project was “*really important*” and “*crucial for survivors*”.

At the conclusion of the interviews, the researcher thanked participants for volunteering their time and offering their experiences and opinions to the project. Participants were offered a summary of the study’s findings once it was concluded.

4.5 Analysing the Data

In all, 16 interviews were recorded and transcribed *verbatim*, yielding over 350 pages of transcripts. The interviews for both the CSA survivors and mental health professionals were conducted in the same timeframe, with the data gathered treated as one set. Transcribed interviews were notated as soon as possible after being conducted, in order to capture as much detail as possible before the researcher’s memory of the interview diminished over time. Unanticipated themes identified in early interviews were ‘followed up’ on and incorporated in future interviews, thus refining the interview schedule. Similarly, themes initially thought important by the researcher, but not identified or elaborated upon by participants were gradually eliminated from the interview schedule. Therefore, shaping of the interview schedule occurred thus avoiding unnecessarily lengthy interviews or irrelevant data collection.

Data was rigorously and systematically analysed in accordance with thematic analysis. This occurred from the initial transcribing process, when particular themes began to emerge. These emergent themes were identified via coding, and *in vivo* quotes by participants were transformed into thematic interpretations (Boyatzis, 1998; Charmaz, 2006). Coding was a process from which concrete and detailed data was analysed and converted into more abstract concepts. Four main phases of coding occurred: ‘open coding’, where the researcher coded each line; ‘selective

coding', where simpler categories were analysed and more sophisticatedly conceptualised; 'focused coding', which used the previously determined codes and applied them to other large amounts of data; and 'axial coding', where relationships between the categories and subcategories were explored and developed (Charmaz).

These emergent categories and subcategories informed the researcher, who referred back to literature and incorporated questions around these themes, back into the interview schedule for mental health professionals, some of whom were considered experts in the field. Referring to different sources of information enables the researcher to build a robust understanding and theory of the phenomenon (Bryant & Charmaz, 2007).

As the researcher read, re-read and coded participant information, constant comparative analysis systematically and rigorously identified similarities and differences that enhanced the researcher's understanding, knowledge and theory (Boyatzis, 1998; Bryant & Charmaz, 2007). One such example includes participants from both populations reporting how a collective silencing of survivors occurred, therefore suggesting that it was an uncomfortable topic for society, and the survivor's informal and formal supports, including mental health professionals. It became clear near the conclusion of the interviewing process that both survivors and professionals identified shared themes and concerns. Whilst these patterns were increasingly repeated, new codes were becoming less frequent. Theoretical 'saturation' was achieved when analysis and coding of the data resulted in no new identified, emerging categories (Charmaz, 2006; Willig, 2006). Therefore, at the end of analysis, most data was accounted for by broad categories and smaller sub-categories (Willig). After this intensive process, the resultant knowledge and understanding was documented, and is outlined and discussed in Chapters 5 and 6.

4.6 Quality of the Findings

Measures commonly adopted by qualitative researchers were taken to strengthen the quality and trustworthiness of the current findings. Firstly, the quality of findings is improved during the coding and analysis stages, provided they are conducted systematically and rigorously (Elliott & Lazenbatt, 2005). In the current study, the researcher used theoretical coding, using the participants' words as much

as possible in order to ensure their voices were dominant, and the categories and codes were as accurate as possible to what was expressed during interviews. The researcher also compared findings with as many other sources of information as possible, with sources including literature and documentation, as well as consultation with experts when possible. This included information being sought specifically from expert participants regarding particular concepts that emerged from the data, which is used many qualitative methodologies, such as grounded theory (Bryant & Charmaz, 2007; Lincoln, 1995). These measures were employed in order to validate and support the findings, as well as increase transferability (Willig, 2006).

Rigor of the findings was also improved by the researcher extensively reviewing the literature in the area of CSA and childhood trauma, and liaising with CASA and experts in the field who did not take part in the study. During interviews with both CSA survivors and mental health professionals, the researcher frequently clarified with participants if she correctly and accurately interpreted their expressed opinion or perception, as demonstrated in the transcripts (Lincoln, 1995). This quality enhancing process has been highlighted previously (e.g., Elliott & Lazenbatt, 2005; Henwood & Pidgeon, 1994).

Finally, it is important to recognise that whilst qualitative research and employing thematic analysis aims to gain ‘true’ subjective knowledge, this is a goal rather than a reality. During this process, the researcher was aware her own biases and expectations based on her own life experiences, and reflected on how this could possibly influence the findings. This reflexivity is important as it allows the researcher to consider possible alternative interpretations (Elliott & Lazenbatt, 2005; Henwood & Pidgeon, 1994).

The measures, as outlined above, highlight the efforts taken to maximise rigor and the quality of the current study’s findings.

4.7 Ethical and Other Considerations

This study obtained Ethics approval by the Victoria University Human Research Ethics Committee and the Melbourne Health Research and Ethics Committee (see Appendix G).

Participants were advised the project was part of the researcher's Doctor of Clinical Psychology (Clinical) degree. Stringent ethical research standards were adhered to in accordance with the 'Code of Ethics' produced by the Australian Psychological Society (2007). This included advising participants of their right to confidentiality and privacy, the benefits and risks of participating in the study, as well as the participant's right to withdraw from the study at any time. CSA participants were informed about the limits of confidentiality, where the researcher would be obliged to seek assistance, should they disclose any threat of harm to either themselves or a third party (e.g., having suicidal thoughts). All participants were informed that confidentiality would be ensured by the use of pseudonyms on transcripts and other documentation, as well as published documentation. CSA survivors were given the pseudonyms of 'Bella', 'Dora' and 'Gina', whilst mental health professionals are noted as MHP1 through to MHP 13. Consent forms bearing the names of the participants were stored in a locked cabinet, with only the researcher having access. Therefore, only the researcher would be aware of the participants' identity. In order to minimise distress for CSA survivors, it was planned that if a CSA survivor were to become distressed at any time during the interview, the researcher would either sensitively move on to another topic or offer to suspend the interview. The researcher would also provide the participant the opportunity to withdraw from the study entirely if the interview were too distressing. In addition, contact numbers of mental health services were provided to all CSA survivors, as noted on the participant information and consent forms (see Appendix E).

Chapter 5

Results and Discussion Part One: Survivors of Childhood Sexual Assault

5.1 Introduction

Mental health professional practice is thought to influence CSA survivors' wellbeing, for better or worse. The current study aimed to explore survivors' experiences of disclosure and working with mental health professionals, as well as what they found helpful, not helpful and what could have been improved. This study also aimed to obtain mental health professionals' perspectives on their experiences of working with CSA survivors, along with what they considered helpful and unhelpful practice.

Combined Results and Discussion chapters are presented in two parts. Chapter 5 is divided into three main sections. The first will address CSA survivors' commonly presenting and associated issues, including relational and mental health difficulties. The next section will address mental health professionals' perceived differences between genders. Finally, the third section will describe the experiences of CSA survivors who disclose their abuse experiences to informal support sources such as family and friends. Chapter 6 explores mental health professionals working with CSA survivors. In particular, common reasons that prompt survivors to seek therapy, professionals asking, or conversely, not asking about a possible history of CSA, as well as helpful and unhelpful practice, will all be examined.

5.2 Survivors' Presenting and Associated Issues

Survivors were found to present with a wide range of issues when consulting with a mental health professional, such as relationship issues, sexual intimacy and parenting difficulties, depression and anxiety. While these difficulties are associated with experiencing CSA, it is important to note they are also common issues experienced by individuals who have experienced other types of abuse, or alternatively, have never been victimised.

Two of the three survivors, Bella and Gina, referred themselves to therapy to address these common mental health and relational issues. Professionals employed

in settings not specifically related to sexual abuse stated that survivors generally did not present with issue of CSA, but rather for other, common, issues. This is consistent with literature suggesting that survivors tend to seek therapy with a ‘disguised presentation’, rather than for therapy about their abuse experience *per se* (Gelinas, 1983; Herman, 1992a). In contrast, Dora reported that she consulted with two mental health professionals, both in general settings, with CSA as the presenting issue.

Both survivors and professionals noted common issues, such as relationship and sexual intimacy difficulties, depression, anxiety, substance use and insomnia. Professionals across all settings cited parenting difficulties, posttraumatic stress symptoms, and borderline personality traits as issues encountered with CSA survivors.

5.2.1 Attachment, relationships and revictimisation.

Disordered attachment, relationship issues, and subsequent revictimisation were commonly noted by mental health professionals, as well as encountered by CSA survivors. Gina elaborated on this further:

[I experienced] anxiety that was in regards to a relationship, and to have been abused by males, or allowing males to treat me without respect...There is a pattern of me being disrespected in relationships and having very unstable interpersonal relations with males...

and,

... Because he was also a source of love and comfort as well as abuse... it is difficult to disentangle what is abuse and what is not as adults... and what is acceptable in adult relationships....

Gina’s account reflects similar issues that participants in other studies have experienced, regarding anxiety about close relationships and poor boundaries (e.g., O’Brien et al., 2007). Gina also indicates her ambivalence about interpersonal closeness and attributes this to the contradictory nature of the relationship with her perpetrator. This is consistent with literature suggesting that survivors of CSA

simultaneously desire closeness, whilst also being distrustful (Finkelhor & Browne, 1985; Sanderson, 2006). The inability to set safe and appropriate boundaries and being obedient (i.e., “disrespected”) are aspects that may result in revictimisation in future relationships (Herman, 1992a). Experiencing both physical and sexual revictimisation has been consistently associated with historical sexual assault (e.g., Mouzos & Makkai, 2004; Neumann et al., 1996).

This common theme of relational difficulties, characterised by lack of trust, an expectation of betrayal and a fear of being powerless was also observed within the therapeutic relationship by mental health professionals. The implications of this were a longer time required to establish rapport, trust and safety, the importance of boundaries, and empowering the survivor. It was also noted that CSA survivors tended to be overly compliant, which may also have implications for mental health professionals working with survivors of sexual abuse.

5.2.2 Sexual intimacy.

Sexual intimacy was commonly noted as problematic by both mental health professionals and survivors. Fear and avoidance of sexual interaction, disinterest, or conversely, hypersexuality, were described by participants. For Gina, being preoccupied with sex was something she experienced:

I find I tend to be very focused on sex and on the physical side of things, and you can understand the implications that may have...

Mental health professionals tended to note more extreme examples, with female CSA survivors experiencing heightened sexual behaviour that included engaging in ‘forbidden’ affairs/sex, as they explained:

A lot of women had heightened sexuality, so presented with sexually deviant behaviours in adolescence particularly, or had multiple sexual partners, classified ‘self’ on sex... so identity was forged on sexual identity... - MHP 5.
and:

I've seen women who have repetitively engaged in either risky sexual behaviour or who have engaged in repeated affairs because of the sense of the forbidden around it... - MHP 11.

This is consistent with literature that suggests that CSA survivors report a higher number of sexual partners and sexual relationships, as well as difficulties controlling sexual feelings (e.g., Najman et al., 2005). Promiscuity is thought to be associated with the CSA survivor devaluing herself and her sexuality (Mullen & Fleming, 1998; O'Brien et al., 2007).

Conversely, Bella noted she was almost “asexual” and found intimacy with her husband difficult due to traumatic memories being triggered. This has been supported by available literature, with the issues of sexual intimacy and sexual dysfunction being highlighted in studies (e.g., Becker et al., 1986; Denov, 2004.).

These findings indicate that CSA survivors may experience sexual difficulties, and possibly highlight how the dynamics of feeling powerless, stigmatised and encountering traumatic sexualisation, may play out in adult sexual relationships (Finkelhor & Browne, 1985).

5.2.3 Parenting difficulties.

Parenting issues were noted by one mental health professional (MHP 13) who had worked extensively with parents and children. She described facilitating groups consisting of new mothers who were experiencing attachment issues with their babies. MHP 13 reported mothers with sons tended to display reluctance to hold them in their “genital triangle” (i.e., on their laps) or breastfeed. Mothers with daughters were afraid of their babies being abused, therefore, banning their partners from being present when they were changing their daughters’ nappies (diapers). MHP 13 recounted one mother being so apprehensive about harming her children, she avoided towel drying their genital areas and used a radiator heater to do so instead.

These experiences have been supported by literature, with CSA survivors possibly encountering unique issues, when compared to other, non-abused counterparts. Sanderson (2006) noted similarities to MHP 13, such as giving birth to

a boy possibly reminding her of the perpetrator of her own abuse, whilst having a girl triggering a fear that she is unable to protect her daughter from future abuse. Issues with breastfeeding have also been noted amongst women who have a CSA history (Grant, 1992; Heritage, 1998).

These findings suggest that certain issues may arise in the post-partum period for survivors of CSA. Whilst only one mental health professional noted these difficulties, it is thought this is due to her being the only participant who possessed extensive experience in this field.

5.2.4 Mental health presentations.

Both CSA survivors and mental health professionals cited depression, anxiety, substance abuse and insomnia as common mental health issues experienced. However, only mental health professionals noted other mental health issues, such as posttraumatic stress symptoms, borderline personality disorder traits, and eating disorders. Many mental health professionals interviewed emphasised the need to view the survivors' symptoms in context of their trauma experience, and deemphasised psychiatric labels, such as Posttraumatic Stress Disorder and Borderline Personality Disorder, reiterating Herman's (1992a; 1992b) position on such labelling.

5.2.4.1 Depression and anxiety.

The majority of mental health professionals described depression as common amongst CSA survivors who presented to therapy. CSA survivors also discussed the depressive symptoms they experienced, such as feelings of worthlessness or excessive or inappropriate guilt. While these symptoms are included in the DSM-IV (APA, 2000) criteria, it was also cited amongst mental health professionals as common reactions to experiencing such trauma. This is consistent with literature, which suggests that depression, or its associated symptoms are common amongst individuals who have experienced a history of CSA (e.g., Fergusson & Mullen, 1999; Maniglio, 2010).

Most mental health professionals, and CSA survivors, cited anxiety as either a presenting, or an associated, issue in therapy. Common anxiety related symptoms

noted included a heightened level of alertness to the possibility of danger and an inability to experience relaxation. To mental health professionals, this made sense in terms of such vigilance being a primal survival strategy, and therefore invaluable to the survivor. This is consistent with literature linking anxiety to experiencing sexual abuse as a child (e.g., Fergusson & Mullen, 1999; Spataro et al., 2004).

5.2.4.2 Substance Abuse.

Both mental health professionals and CSA survivors reported abusing drugs and alcohol. Alcohol was cited as predominantly problematic, presumably due to its wide availability. However, abuse of cannabis, heroin and prescription drugs, such as benzodiazapines, was also common. One mental health professional thought these substances in particular dulled the survivor's startle response or helped "block out" memories or negative emotional states such as helplessness or worthlessness. This rationale is consistent with research suggesting that survivors of CSA use substances as a coping mechanism to control distress or even erase the trauma from memory (Denov, 2004; O'Leary, 2009). Herman (1992a) believes substance abuse helps those dissociate if they are unable to do so spontaneously. MHP 6, who possessed extensive experience in the drug and alcohol field, stated that CSA was particularly prevalent in her research population, which consisted of women:

[For my clinical masters dissertation] the correlation I found was approximately 90% of people with drug and alcohol problems had prior sexual abuse and trauma history.

Men were reported to abuse substances, as highlighted by MHP 11:

The men I've seen who have had histories of CSA have had significant drinking problems... [with one] being into narcotics as well...

These observations are consistent with literature that suggests adults who have experienced CSA are likely to have difficulties with substance use and abuse (e.g., Fergusson & Mullen, 1999; O'Leary, 2009), possibly employed as a coping

mechanism to avoid the trauma or the effects it evokes.

5.2.4.3 Insomnia.

Sleeping issues, particularly insomnia, were reported as common amongst both mental health professionals and CSA survivors. It was thought that sleep could provoke overwhelming feelings of vulnerability, as highlighted by Bella, who noted that falling off to sleep had “always” been a fear inducing for her. She believed being in the dark was particularly unnerving, as she was unable to anticipate any danger.

Sleep, or aspects surrounding sleep, could also induce flashbacks. For example, MHP 7 highlighted that, as the CSA experiences often occurred in bed, a bed was no longer a place of safety, but a location that could trigger distressing and intrusive memories. MHP 13 recalled a client who experienced flashbacks of the abuse when she was woken in the night by her baby, as it was reminded her of being woken by the perpetrator before being raped.

Literature supports these accounts of sleeping difficulties, and in particular, insomnia (e.g., Sanderson, 2006). The inability to sleep originates from a chronic activation of the sympathetic nervous system, where the survivor avoids feared states of vulnerability that can lead to retraumatisation (Sanderson).

While depression, anxiety, substance abuse and insomnia were mental health issues reported by both mental health professionals and CSA survivors, some differences were noted. Mental health professionals commonly observed less prevalent, but more ‘severe’ mental health issues, such as posttraumatic stress symptoms, borderline personality traits, and eating disorders. The researcher suggests this could be due to the CSA survivors in the current study being highly functional and not experiencing significant distress at the time of the interview.

5.2.4.4 Posttraumatic stress symptoms.

Posttraumatic stress disorder symptoms commonly cited by mental health professionals who worked with CSA survivors included dissociation and flashbacks when awake, or nightmares when asleep. Intrusive memories, or flashbacks were either of conscious, continuous abuse memories or unconscious, previously

undisclosed traumatic memories. Intrusive, continuous abuse memories were demonstrated by one professional recalling how a survivor experienced flashbacks of abuse when suddenly woken by her infant in the middle of the night. Unconscious, previously undisclosed traumatic memories (or repressed memories) was illustrated by MHP 13, who described how a male client recalled his CSA experiences only after he had woken from being anaesthetised from surgery. She believed this was due to the memories of abuse being so painful, that psychological defences were employed to keep it out of his consciousness. However, these defences were artificially lowered when he was anaesthetised. Literature supports the mental health professionals' accounts of CSA survivors experiencing flashbacks and dissociation, with particular events or situations such as being physically examined by a medical practitioner or entering a sexual relationship associated with triggering flashbacks (e.g., Alaggia & Millington, 2008; Coles & Jones, 2009).

5.2.4.5 Borderline personality disorder traits.

Mental health professionals cited that survivors of CSA were likely to display traits of borderline personality disorder. This is consistent with studies suggesting that survivors of CSA are more likely to be diagnosed with BPD than those who have experienced other trauma, but not CSA (Herman et al., 1989; Ogata et al., 1990).

However, interviewed professionals tended to view these traits as a combination of previously noted difficulties regarding attachment, affect regulation and risky behaviour, such as substance abuse and promiscuity. MHP 2 illustrated the general consensus of how borderline personality disorder was conceptualised:

I think people walk around life experiencing a cluster of symptoms, and I know when I work with people who are Borderline, it's a lifetime of abuse that culminates in BPD.

This non-pathologising view of borderline personality disorder echoes Herman's (1992a) view, where a disordered personality within an abusive context

should be considered a product of being trapped in a traumatic situation where the child adapts in any way possible to ensure survival.

5.3 Gender Differences

Some mental health professionals highlighted little difference between how male and female survivors presented, or the difficulties they experienced. MHP 9 noted:

Between men and women, there are more similarities than there are differences in terms of reactions and symptoms... because the survival mechanism is the same...

This is consistent with literature suggesting more similarities than differences exist between genders, as a reaction to experiencing CSA (e.g., Romano & De Luca, 2001; Scott-Young et al., 2007).

However, some notable gender differences were observed with male survivors. They were perceived to experience more shame, issues with sexual identity, and externalising behaviour such as anger and violence. Communication style also emerged as a difference between male and female survivors of CSA.

5.3.1 Male survivors and shame.

A theme identified by mental health professionals was that male survivors of CSA experienced more shame than females. Whilst it was strongly emphasised that shame was acute amongst both genders, mental health professionals believed that the male biological response to the abuse, along with societal attitudes that deny male victimisation, contributed to survivors' shame. These observations are supported by literature where males may perceive biologically responding to touch as implying they were complicit in the abuse (Alaggia & Millington, 2008). Shame perpetuated by society, such as existing socio-cultural myths surrounding male vulnerability and victimisation was cited by mental health professionals as a probable factor for delayed or non-disclosure of CSA amongst male survivors. This

was thought to result in males generally taking longer than female survivors to disclose their experiences in therapy:

Men don't seek help and perhaps that is a gender issue in terms of how they deal... and how we as a society kind of promote it as well... - MHP 9.

This view is consistent with literature suggesting that males face unique barriers preventing disclosure based on socio-cultural norms and expectations (e.g., Kia-Keating et al., 2009; McAdam & Fitts, 1999; Sorsoli et al., 2008).

5.3.2 Male survivors and sexual identity.

Many professionals noted that male survivors tended to experience sexual identity issues, characterised by rejecting stereotypical 'macho' behaviour or being uncertain their sexual orientation. MHP 6 explains:

Among the men I've worked with... there has been a lot of issues with the men who have had an early sexual trauma [perpetrated] by a male, that have really reflected on their concept around are they gay, are they not gay?

These themes are reflected in the literature, with males victimised by men often confused about their sexual identity (e.g., Alaggia & Millington, 2008; McAdam & Fitts, 1999). Male survivors believe they might be homosexual, due to being targeted by the perpetrator, along with encountering a biological response to the abuse (e.g., Alaggia & Millington; McAdam & Fitts).

5.3.3 Male survivors, anger and violence.

Anger and violence were noted by mental health professionals as issues more apparent amongst male survivors of CSA. While anger was common for CSA survivors of both genders, males were perceived to 'externalise' their anger, in the form of aggression and violence. MHP 5 recalled two male clients who had been sexually abused by their brothers as children, and later sexually revictimised as adults by women:

Both presented with significant anger management issues... and a desire to get retribution over females... so a lot of female hate, a lot of exposure to utilising things like brothels and strip clubs, because that was perceived as very demeaning for women, so that was a place they felt most powerful... both had had exposure to the criminal system, both had had histories of assaulting women...

Two reasons may explain this perceived gender difference. Firstly, aggression and violence could be symptomatic of hyperarousal, with individuals tending to react disproportionately to a provocation (Herman, 1992a). Secondly, aggression and violence is considered to be more culturally and socially acceptable for males to express, rather than other salient emotions, such as sadness or fear (Crowder, 1995). These findings are consistent with literature that suggests experiencing anger is common amongst CSA survivors (e.g., Denov, 2004; Nelson, 2009; Neumann et al., 1996). Existing research suggests males engage in the externalisation of anger, whilst female survivors tend to internalise their feelings of anger, with self-harming, anxiety and depression (Finkelhor, 1990).

5.3.4 Communication style.

Mental health professionals noted a difference in communication style between male and female survivors. Professionals observed that male survivors preferred to recall the abuse experiences rather methodically and graphically, whilst female survivors tended to be more oblique when describing their sexual trauma. Adult survivors corroborated this, by stating that while they had disclosed their experience of CSA, they had never “gone into details” of the abuse with anybody.

This observation was especially apparent to mental health professionals who worked on the sexual assault crisis line. For example, MHP 8 explained:

We find a lot of men want to, need to, get out what actually happened physically, and it always sounds like a porn sort of thing...

However, MHP 6, who consulted with CSA survivors face-to-face, also noted this difference:

[For her male client] ... it was really important for him to share every single detail of that abuse, what it felt like, what happened, where it happened, how it happened...

Professionals also noticed that male survivors tended to be less interactive with the listener, with MHP 3 noting:

... A lot of men just want an ear, they don't want you to interact with them at all, it's just about them letting off and telling you what they need and what they know!

On the other hand, female survivors tended to not speak about the assault experience itself, but referred to it rather vaguely. It was also perceived they used emotional language rather than graphic language to relate their experiences. The researcher also observed this when CSA survivors were relating their experiences of consulting with a mental health professional. They did not discuss details of the consultation (e.g., where it was, what was said), but rather their interpretation of what was said and how they felt about it. However, observation is difficult to substantiate as no male survivors of CSA participated in this study in order to allow for comparison.

Communication style was an unexpected theme that emerged from the data, and not an aim of this study. Differences in verbal communication style between genders have been the subject of research for many years (Haas, 1979). Such disparities may have implications for mental health professional practice, as highlighted by professionals who worked on a sexual assault crisis line. They raised the issue of having to discern quite quickly between what was a genuine and what was a 'sexual harassment' call. When incidents of male survivors being graphic in description occurred, these mental health professionals steered the conversation to

how the CSA resulted in the survivor feeling. This tactic was thought to separate the genuine survivors from the sexual harassment callers.

It appears that regardless of gender, it is irrefutable that experiencing CSA can have long-lasting, detrimental effects on survivors, even into adulthood (Romano & De Luca, 2001). However, these findings also draw attention to possible differences that may exist, due to socio-cultural myths, norms and expectations that are commonly attached to gender.

5.4 CSA Survivors Disclosing to Informal Supports

Both CSA survivors and mental health professionals provided many accounts of disclosing one's experiences of CSA over the course of the interviews. Overall, these findings highlighted how many survivors attempt to, or disclose their abuse experiences to family or friends first, and the many difficulties survivors face when doing so.

All CSA survivors had disclosed their abuse experience to informal sources, such as family and friends. Most mental health professionals stated their clients had either disclosed, or attempted to disclose, their CSA experiences to others. However, it was also noted that it was not uncommon for adult survivors of CSA to have not disclosed to any informal supports, and only be disclosing for the first time to a mental health professional.

5.4.1 Disclosing to family.

While two CSA survivors noted positive reactions from their families, such as being believed and listening, both survivors and mental health professionals cited overwhelmingly more accounts of negative reactions. In particular, mothers were noted as reacting negatively for reasons ranging from feeling responsible for being unable to protect their child, to blaming their daughter for "stealing" their husband. Gina discussed disclosing her CSA experience to her mother and family:

My mother is [open to discussing some things], but no one else in my family, and my mother... becomes defensive because she feels she has to take responsibility for what happened, and in some instances, she probably does...

Bella said that while her mother believed her at the time of the incident, her latter response was “insensitive” and still resonated with her years later. She recalls:

I remember mum saying to me, “Yeah, he [the perpetrator] can be like that” ... when I asked her what she meant, she told me about when he cracked onto her when she was an adult, and it didn’t involve any physical contact. I was so bloody outraged... she had no idea how different it was for me to be in that situation at 13...

Mental health professionals cited more severe negative, problematic reactions when CSA survivors disclosed to family, especially if the perpetrator was in the family circle. Common reactions included being disbelieved and the experience being denied or minimised as MHP 8 noted:

People [have] finally told their mother and the mother goes into absolute denial, because she’s denying her own role and turned a blind eye... they don’t want to talk about it... people have a lot of investment in playing happy families and pretending and maintaining a pretence. So the person who’s going to speak up will again get shot down – another form of victimisation.

Mothers blaming their daughter for the abuse, viewing their daughter as “stealing” their partner the abuse or covering for the perpetrator were common reactions related to mental health professionals by their adult clients.

You’ll often find an immature mother who’s actually jealous of the child because the father’s raping her, but they’ll call it ‘having sex’, then they’ll actually be nasty to that kid and then the kid will naturally have mental health problems, and they’ll say, “She’s always been like that, she’s always been a bit delusional,

she's always been crazy, she's always been slightly schizophrenic" ... you hear that all the time. - MHP 8.

Some mental health professionals also noted CSA survivors being threatened, rejected and becoming subsequent homelessness as a result of disclosing their abuse experiences:

You hear about people's lives actually being threatened for bringing things up by their family members... and look, in my experience, it seems that when the sibling is the perpetrator, like the brother, then things can become more vicious.
- MHP 8.

These findings seem logical in that the closer the perpetrator is to the family, the more negative the reaction from others will be when disclosing. However, literature tends to focus on 'informal supports', which combine both family and friends (e.g., Filipas & Ullman, 2001) and not delineate between the two groups. Negative reactions, such as responding in an egocentric manner, 'blaming the victim' and withdrawing social support was demonstrated in mental health professionals' accounts and thought to contribute to poorer mental health and secondary victimisation, which is consistent with literature (e.g., Ahrens et al., 2010; Filipas & Ullman; Ullman, 2003). These findings illustrate the inherent difficulties CSA survivors experience when disclosing to family members.

5.4.2 Disclosing to friends.

Survivors of CSA and mental health professionals tended to note that friends are viewed as more supportive than family members when disclosing CSA. Whilst reactions in literature note that being listened to, being believed and providing emotional support were positive social reactions (Ahrens et al., 2010), these findings demonstrate the powerful effect that normalisation often has on survivors. Mental health professionals noted that survivors spoke with friends more so than family, and tended to choose those who could share and relate to the 'abnormal' experience:

People... tend to talk to their best friends, or their best troubled friends... people who had obviously had a 'Yeah, me too' sort of experience... - MHP 6

Bella also highlighted this stating she felt too embarrassed to disclose her CSA experience at the time to her friends. However, with age, she also became increasingly aware that many others had also experienced similar incidents. Therefore, she became more open with the 'me too' friends, who responded in a supportive way. Bella found it was particularly helpful when friends talked about how “*pathetic*” the perpetrator was, and how he could not “*get anyone consensually*” his own age. Bella’s lack of psychological distress (as the inclusion criteria for participation for this study required) could be partly attributed to viewing the perpetrator in disempowering terms, which is consistent with Leahy et al.’s (2003) study.

However, positive support was not always received by friends and resulted in secondary victimisation. Dora explained how the reaction of her friends regarding her CSA experience left her feeling alone, unsupported and was in some ways, more traumatic than the CSA itself:

I never... I just never felt like anyone really cared – like [to] make sure I was OK, to talk to me about it... everyone just sort of dodged it, and I understand now it's because it's uncomfortable for people, but at the time I was like, “nobody cares”... [I] didn't feel like my friends cared and so [that] probably... caused me to be all silly and that, [more] than the actual [CSA] event.

The reactions from Dora’s friends perhaps still have an effect on her, with a common and natural reaction of isolating herself and abusing being minimised as “*silly*”. Dora continues to discuss how these reactions caused further traumatisation:

I think that was even worse than what actually happened... that I never felt like anyone cared... because even they didn't go into it with me and sort of left it... even to this day, I probably still hold a little bit of resentment to them for that...

Dora's account of how negative social reactions made her feel worse than experiencing the CSA event itself, clearly illustrates secondary victimisation. This is corroborated by research suggesting that lack of social support is associated with the survivor continuing to feel victimised, long after the abuse has ceased (Lorentzen et al., 2008). Experiencing secondary victimisation is also associated with dissuading the survivor to attempt disclosure again, in effect silencing them (Ahrens, 2006).

Mental health professionals discussed possible reasons for society's negative reactions to disclosures of CSA by survivors:

People minimise... that's a human survival strategy... as a society, sexual abuse is abhorrent... we don't even want to acknowledge that a parent has the capacity to do that... we don't want to believe that, so we try to deny... - MHP 9.

As previously noted, society's perceptions can result in male disclosure of CSA being challenging. However, mental health professionals raised the issue of disclosure of CSA being even more problematic by survivors who were victimised by a woman, due to society's stereotypes of sexual offenders:

I think the group that it is hardest for are people who have been sexually abused by their mothers, because no one's going to believe that of a mother, and for a long time, even in the feminist sexual assault field, there was absolute denial around that. - MHP 8.

Literature substantiates this particular issue, where survivors of abuse perpetrated by females thought to be more susceptible to negative reactions from mental health professionals, such as disbelief and minimisation (Denov, 2004).

5.5 Summary

This chapter analysed data from both survivors of CSA and mental health professionals and described the common presenting and associated difficulties when survivors seek therapy. These included attachment, relationship and revictimisation issues, as well as sexual intimacy and parenting issues. Mental health issues were also noted and included depression, anxiety, substance abuse, insomnia, posttraumatic stress symptoms, borderline personality traits and eating disorders.

Some gender differences were observed by mental health professionals, with males tending to experience issues with shame, their sexual identity and anger and violence. Mental health professionals noted differences in communication style between male and female survivors of CSA. However, it was also stated that gender differences were minimal, due to more similarities than differences existing in response to trauma.

Finally, both CSA survivors and mental health professionals described survivors' experiences of disclosing to informal supports, characterised as family and friends. While few participants noted positive and supportive reactions, it seemed that more negative reactions were prevalent, which was damaging to the survivor.

Chapter 6

Results and Discussion Part Two:

Mental Health Professionals Working with Survivors of Childhood Sexual Abuse

6.1 Introduction

As Chapter 5 outlined, CSA survivors may present with a range of relational or mental health difficulties, and have often disclosed their abuse experiences to family or friends, with degrees of varying success. Chapter 6 will explore the experiences of both survivors and professionals when working with historical sexual abuse. This chapter explores common triggers that prompt survivors to seek therapy, opinions regarding asking about therapy and barriers preventing professionals from asking clients about possible history of CSA. The implications of not asking are also discussed. Factors that both facilitate and impede disclosure of CSA are explored. The benefits, along with associated risks of disclosing a history of CSA in therapy are examined, along with the dilemma of referral and its constraints. Finally, the consequences of unhelpful practice on CSA survivors are noted.

6.2 Triggers for Seeking Therapy

Mental health professionals were asked about what tends to bring CSA survivors to therapy. Most antecedents for considering therapy appeared to be events that triggered the survivor to experience flashbacks or memories of the abuse. These included the survivor's child reaching the same age they were at the onset of abuse, significant life events, old coping strategies becoming ineffective, age and family occasions. Other situations were noted as inducing flashbacks, such as being reminded of their CSA experience via the media (e.g., if the perpetrator or others' experiences of CSA was publicised), or in everyday life (e.g., person having same mannerisms as perpetrator).

6.2.1 Child reaching the age of survivor's abuse.

A consistent theme found was of survivors seeking therapy for their CSA experiences when their own child became the age they were when their abuse occurred. MHP 8 highlighted what was overwhelming cited by fellow mental health professionals:

[Survivors] can be just toddling off in their life, they have buried that stuff in their past, they are coping really well, they have a child who gets to 3 [years] and their whole world collapses...

This theme was consistent with literature suggesting that survivors of CSA often seek sexual assault services for therapy when their own children were around the age they were when first abused (Lievore, 2005), possibly due to abuse memories being triggered at this stage of life (Sanderson, 2006).

6.2.2 Significant life events.

Mental health professionals reflected how significant life events, such as births, relationship beginnings and their endings, anniversaries and deaths (including that of the perpetrator) were also other common precipitators to seek therapy. For some survivors, these events resulted in experiencing distressing flashbacks, such as when pregnant or in the post-partum period, as previously outlined. In a similar vein, MHP2 noted gynecological examinations often prompted survivors to contact their sexual assault service for therapy. This finding is corroborated by research suggesting that medical procedures associated with childbirth are thought to trigger flashbacks that re-traumatise the survivor (Coles & Jones, 2009).

Entering a new relationship was cited by mental health professionals as particularly stressful and, therefore, considered a time to seek therapy for some CSA survivors. Experiencing intimacy and engaging in a sexual relationship were noted to trigger flashbacks of the abuse experience, causing the survivor considerable distress. Conversely, the ending of a significant relationship was also a precipitant for CSA survivors to consider therapy. One mental health professional thought this may be due to the effects of abuse exerting its influence on the relationship, leading

to its subsequent disintegration. Literature supports these findings, where the breakdown of an existing relationship, or conversely, the formation of a new relationship, being precipitants to seeking help (Herman & Harvey, 1997).

For other survivors, significant events provided an encouraging opportunity to seek help. MHP 4 discussed how death could be a powerful precipitator for CSA survivors to consider therapy:

Parents dying who have been perpetrators – it's safe to go and talk about it now... or before the parents die, but it's getting closer and they want some sort of resolution before the parents die...

These findings are consistent with literature suggesting significant life events such as births, relationship formations or endings, anniversaries and deaths prompt survivors to seek therapy for their CSA experiences (e.g., Herman & Harvey, 1997; Lievore, 2005).

6.2.3 Existing coping strategies becoming ineffective.

A factor commonly affecting all individuals' decision to seek therapy, regardless of whether they have experienced CSA, coincides with seeking treatment when their own techniques of managing the issue is no longer effective (Manthei, 2005). While the majority of mental health professionals also cited this, it seemed a common coping mechanism for CSA survivors was substance abuse, with withdrawal or abstinence a precipitator for seeking therapy. MHP 5, who was experienced in the drug and alcohol field, highlighted this issue:

It may be withdrawal from substances, because in the process, they tend to experience more difficult symptoms as the self-medication process is no longer supported.

Withdrawing or abstaining from drugs and alcohol has been substantiated in literature as precipitants to seek therapy as it can trigger survivors to experience intrusive memories and flashbacks (Alaggia & Millington, 2008; Herman & Harvey,

1997) as well as induce negative emotional states the substances were initially used for blocking (Alaggia & Millington; Maes, 2011).

6.2.4 Stage of life.

Mental health professionals noted that survivors of CSA tended to present to therapy later in life, rather than early adulthood. For example, MHP 3, who worked at a sexual assault crisis line, estimated that most callers were aged between their mid-twenties and mid-forties. MHP 2 stated that majority of survivors seeking help were over the age of 30 and the survivors' stage of life may also influence their decision to seek help:

I think [it's a time] people sit back and reflect on their life... "All my life I've sat with this and it's now time to deal with it" ...

It is thought the stage of life could coincide with old coping strategies no longer being effective, as well as experiencing a range of significant life events. Mental health professionals theorised that particular issues associated with CSA culminate and coincide with a survivor's stage of life, finally precipitating them to seek help. MHP 4 illustrated the toll anger had taken on male survivors:

It's like they get to a certain age and it's almost like a mid-life crisis of 'why am I so angry?' ... Suddenly they realise they're behaving badly because of their anger and aggression... their relationships haven't worked and they're wondering why...

This coincides with Herman's (1992a) observation that "often in the third or fourth decade of life, the defensive structure may begin to break down" (p. 114). Changes in relationships, experiencing the culmination of significant life events and existing coping strategies no longer working, may all contribute to the 'stage of life' phenomena (e.g., Alaggia & Millington, 2008; Denov, 2004; Herman; Herman & Harvey, 1997).

6.2.5 Family occasions.

CSA survivors were noted as attending therapy due to upcoming family occasions and celebrations. Events such as weddings, birthday parties and Christmas often triggered overwhelming memories and emotions for survivors, particularly if the perpetrator was still in the family circle. MHP 8 explains how such occasions can be an isolating and distressing:

Christmas can be an ugly time... they're the child that dad or the brother sexually assaulted, and everyone else is playing happy families and the media, and Woolworths and Myers are all telling you how wonderful it is to be with the family and everyone's white, blonde, with great table settings and your family's fucked. And you're thinking, "I'm [going to have] to look at the perpetrator, and if I bring it up, I'll destroy the family"... that's a common, common, common one. They think, "I can't do this [attend the function] because I'll destroy the family".

These occasions could be even more distressing if there was a new child or grandchild in the family, and the perpetrator remained in the family circle as MHP 4 observed. CSA survivors either being in a situation with the perpetrator, or witnessing the potential victimisation of another child could trigger distressing feelings and flashbacks, resulting in re-traumatisation.

6.3 Asking About CSA in Therapy

As it may be unlikely the CSA survivor will spontaneously disclose their abuse experiences to the mental health professional, it is suggested that they ask about a potential history of childhood trauma. However, barriers exist preventing professionals from asking. The survivor may perceive not being asked about the possibility of childhood sexual trauma rather negatively.

A finding of this study was that both survivors and professionals considered it important to ask about any potential childhood sexual victimisation. Survivors felt it was important to assist the professional in establishing an accurate picture of both

them and their problems. However, all survivors mentioned what was more important was the way it was asked, which is noted and explored later.

Professionals widely believed it was important to ask and cited a similar reason to CSA survivors for this, in that it assisted in building an accurate assessment of the survivor. MHP 12 elaborated upon this rationale for asking clients about childhood trauma:

If you go to a medical doctor specialising in physical health, they will ask for your medical history... have you had any major surgery, have you had any major illnesses... so that's exactly what we are doing, what we need to get, our client's psychological history and part of that includes asking about emotional, physical and sexual abuse... and bullying in school, domestic violence, things like that...

6.4 Barriers Preventing Mental Health Professionals from Asking about CSA

Despite a consensus regarding asking all clients about a potential history of childhood trauma, it was apparent that such questions are not commonly asked. Survivors reported that amongst nine mental health professionals consulted between them, not one asked them about a potential history of sexual abuse, nor any other childhood trauma. Professionals reflected on their own clients' experiences and noted it was also quite common for their previous mental health professionals to have not asked, even when they were engaged in therapy for some time. Themes that emerged from the data indicates that not asking could be associated with mental health professionals; tending to lack training about childhood trauma and CSA, fearing legal repercussions, and/or, are not being comfortable with the topic of CSA, for a variety of reasons.

6.4.1 Lack of training and knowledge of CSA.

An overwhelming majority of mental health professionals highlighted a lack of training, and reflected on their own education when acquiring their qualifications. As they believed training was essential, they sought other ways to gain knowledge, which is discussed later.

6.4.1.1 Mental health professionals' own training experiences.

Mental health professionals were asked about their view regarding the adequacy of training in the area of childhood trauma during their period of education to obtain their qualification. Of the 12 who responded, 10 stated they felt their training was “very inadequate”. MHP 6, a clinical psychologist, explains how assessment, rather than therapeutic skill was emphasised during her training, and that skills particular to working with a trauma background was omitted entirely.

Clinical psychologists noted that whilst they learned about traditional posttraumatic stress disorder, they felt it was particularly important to be taught about attachment trauma experienced during development, as MHP 12 stated:

What's the point of learning about the treatment approach for anxiety or PTSD if the issue that's underpinning... those issues is CSA, but you haven't actually been taught anything about that or told about its prevalence?

These opinions are consistent with literature suggesting that mental health professionals lack training about the various, long-term effects of CSA and other childhood trauma on survivors (e.g., Herman, 1992a; Read et al., 2007). While clinical psychologists, in particular, learned about traditional posttraumatic stress disorder and other DSM-IV (APA, 2000) disorders, this may be inadequate or inaccurate for working with CSA survivors (Herman).

An identified lack of training amongst interviewed professionals suggests that other mental health professionals who potentially work with survivors may also not know about the long-term effects of childhood trauma on adults. This could explain why it was common amongst survivors in this study to report that mental health professionals did not ask about CSA. When it was disclosed, survivors noted the professional appeared uncomfortable and did not engage effectively with them. This perceived lack of knowledge is consistent with literature suggesting that mental health professionals feel they are not equipped to ask about, or handle, a disclosure about CSA in therapy (e.g., Lab et al., 2000; Yarrow & Churchill, 2009).

Despite the overwhelming majority of mental health professionals citing an inadequacy in their training, two stated they felt training was “adequate”. MHP 2, a

qualified social worker, undertook electives in Women's Studies during her training, which she thought was a good foundation to learn about issues such as sexual assault and family violence. MHP 5 felt her Diploma in Psychotherapy that focused on all types of childhood trauma its manifestations in adult survivors, was particularly useful.

6.4.1.2 Increasing skills for working with CSA.

As the overwhelming majority of professionals felt their formal study left them unequipped to work with such complex trauma, they actively sought training from other sources. As MHP 13 noted, learning about issues such as CSA was not "going to be handed on a plate for you". Of the 12 mental health professionals who responded, an overwhelming majority noted that workshops and professional development, especially those provided by specialised services such as CASA (Centre Against Sexual Assault), were especially helpful. MHP 12, elaborated on her further learning:

[I handpicked] my professional development from then on [after formal qualifications] because I found my psychology studies inadequate to prepare me for the sorts of issues that clients generally came with...

Many professionals continued to keep up with current research and practice by subscribing to, and reading, journal articles and new publications.

Professionals also emphasised the importance of consultation, with either CASA, peers and/or supervisors. Both supervision and personal therapy were cited as useful with process and countertransference issues that often arose when working with traumatic material. MHP 11 noted the importance of supervision:

I'm kind of always training to think about it in terms of supervision, because it's such a complex issue and it has such ramifications for people's relationships and how they experience therapy, and what they elicit for the therapist... so supervision is pretty critical...

Engaging in one's own personal therapy was cited as important by professionals, with MHP 4 speaking about her own therapy, and how this allowed her to develop greater insight:

I had about six years of my own psychoanalysis that I did with a really good therapist, so going inside to all the dark and light places in myself, gives you a good idea of what other people have inside them, working with the conscious and unconscious... it was very challenging, but very supportive at the same time... I personally think all therapists ought to have their own therapy at some point in their life...

The importance of mental health professionals' own therapy to work with traumatic material being shared by CSA was an unexpected finding. Research highlights common supervision and therapeutic issues, such as that of 'vicarious traumatisation' (i.e., the impact of working with trauma on the mental health professional's level of empathy and engagement), and common countertransference issues (e.g., Neumann & Gamble, 1995). Judith Herman (1992a) recommends that support is needed for individuals working with trauma – "Just as no survivor can recover alone, no therapist can work with trauma alone" (p. 141).

6.4.2 Fear of legal repercussions.

One mental health professional acknowledged that whilst colleagues may have previously been reluctant to ask clients about a possible history of childhood trauma or CSA, relatively new guidelines established by the Australian Psychological Society (APS) in 2010 could further reinforce that reluctance. Titled, 'Guidelines for psychological practice with clients with previously unreported traumatic memories', this document recommends the same caution be exercised when working with both clearly remembered, but never disclosed memories of childhood trauma, as well as with 'repressed' or 'recovered' memories. MHP 12 elaborated on this further:

Psychologists are fearful to ask – even more fearful- perhaps to ask about historical CSA in case they then feel they might get into legal trouble... [the APS Guidelines] makes it sound like you treat any unreported memory with the same amount of... caution and doubt that you would a recovered memory... which is a different phenomena...

The mental health professional stated that particularly new psychologists, or psychologists who do not read the guidelines in depth, may feel so overwhelmed or fearful by the recommendation to audio or videotape future sessions for future possible legal proceedings, that they avoid the topic of addressing CSA altogether. This professional reported the APS guidelines state the psychologist should not ask ‘leading questions’, which in her opinion could limit the efficacy of the assessment process. The professional stated these guidelines were “*alarmist*” and could potentially be at the detriment of 99% of survivors in therapy, given that less than 1% of historical CSA cases proceed to court.

The APS’s *Guidelines for psychological practice with clients with previously unreported traumatic memories*’ advises psychologists to be aware that their practice and skills may be scrutinised when working with previously unreported memories of trauma, and therefore, they should maintain accurate records of sessions. This includes the use of audio and videotaping, which may be used in court if the psychologist is subject of a subpoena. If a complaint is lodged with the APS or the Australian Health Practitioner Regulation Agency (AHPRA) regarding the psychologist’s practice, then an investigation is potentially warranted, which could possibly jeopardise their registration and ability to remain in the profession, should the complaint be substantiated.

Given that speaking about CSA is already avoided, and these added potential legal issues may act as a further deterrent to mental health professionals, as well as survivors who find the courage to disclose their CSA experience/s. This caution and fear is consistent with literature suggesting that mental health professionals tend to be reluctant about asking a client about a possible history of CSA in case their inquiry was construed as suggestive and, therefore, likely to induce ‘false memories’ (Young et al., 2001).

6.4.3 Mental health professionals' level of comfort.

As previously noted, CSA survivors often encounter negative reactions from listeners, which is indicative of society's discomfort and denial of the issue. Professionals echoed this observation, having themselves encountered societal denial and silencing regarding CSA, in both their personal and professional lives. They reflected upon how these societal reactions to talking about CSA mirrored the abuse experience and provided a valuable insight into what survivors endure. MHP 2 described how her occupation was often difficult to talk about to others in her personal and social life:

People go, "Oh, so where do you work?", "I work for CASA", "Oh, yeah, what sort of counselling do you do?", I go "Trauma", and they go, "Road trauma?" and I'll go, "No, sexual assault and family violence", and they go, "Oh". And I get what clients feel... because it's like, oh, that... It just makes them feel awkward... perhaps they have their own trauma, perhaps they don't know what to say, perhaps it wrecks their world view that the world is a nice place... I don't know, but it's not a popular subject.

This taboo surrounding CSA extended to professionals working in the mental health field, which is logical as professionals are also people existing in the world, with their own opinions, judgements and prejudice. MHP 12 recounted an incident when she noted a high prevalence of CSA in her community work, and related this to her fellow students when completing further post-graduate studies:

[A male student] turned to me and said, "Well it could be said that if the majority of your caseload are presenting with a particular issue, then it's your issues", which was incredibly insulting on so many levels... and I [said], "I work in the public system, I don't hand pick who I see...". So I see those attitudes incredible. I had another student in that group – all mature aged students who were working professionals [saying] "You need to be careful, you need to stop bringing this up because... they might fail you in the course... you

need to stop making a fuss about this". So it was a real parallel of what the victim or child experiences in the community.

This example is particularly powerful in illustrating how mental health professionals are subject to the same potential for denial and minimisation of issues such as CSA, as the general population. Possessing such beliefs may contribute to their reluctance to ask clients about a possible history of CSA.

6.4.4 Mental health professionals' own trauma experiences.

The theme of mental health professionals' own trauma experiences, and the effect it could have on working with fellow survivors, emerged from the data. Opinions varied, ranging from it being viewed as potentially problematic for a professional to have not experienced childhood trauma, to it being possibly difficult for professionals who had experienced trauma to work with survivors. MHP 10 elaborated on how one's own experiences could potentially be a barrier for asking about CSA, due to their level of comfort. She explained:

I think the tendency is to worry about the clinicians that have potentially experienced abuse themselves, you worry about making them more vulnerable, but in actual fact, I think that people who have never had an experience may be so horrified by it that it can be really unnerving, particularly if they are new...

Conversely, other mental health professionals felt that there could be therapeutic implications for colleagues who also had a history of CSA, but had not sought therapy for their trauma. MHP 2 paraphrased noted childhood abuse expert, John Briere:

He said that a person who has experienced trauma and has not dealt with their trauma, their professional life will be fraught with danger... that a person who has processed their own trauma, they can be a really insightful and empathetic worker...

This point is particularly salient in that it distinguishes between those who have sought therapy for their personal experiences of abuse, and those who have not. Research regarding this issue suggests mental health professionals, regardless of whether they have experienced an abuse history, tend to experience countertransferential issues, such as those involving boundaries (Herman, 1992a; Little & Hamby, 1996). New mental health professionals working in trauma may experience more rescue fantasies, preoccupation with survivors of CSA and voyeuristic countertransference issues (Neumann & Gamble, 1995). Herman purported that listening to traumatic accounts may trigger a professional's own trauma memories and feelings, no matter how experienced they were, as issues such as CSA are highly evokative (Herman; Schachter et al., 2004).

These barriers may have implications for mental health professional practice, resulting in them being less likely to ask clients about a potential history of CSA, or any other childhood trauma, for that matter.

6.5 The Implications of not Asking

Findings of this study suggest that not asking may send particular messages to the survivor about the importance of their CSA experiences, as well as assumptions about the professional. In addition, it was noted that if the professional did not ask, but the survivor wanted them to know, they commonly hinted about their trauma.

Not asking about a history of CSA was thought to imply to the survivor that their experience was not important, therefore, leading them to feel revictimised. MHP 12 noted that not asking could lead the survivor to make assumptions:

I think a therapist not asking... tells a lot in itself. And the client will make assumptions about them not asking, like... "Well it mustn't be important then... it's just something individual and particularly abnormal and aberrant about me that I have that history and not talking about it"...

Other professionals, as well as survivors felt that not asking is akin to working alongside the perpetrator, with MHP 3 elaborating further:

...If you don't ask, you don't know, and really, not asking is working side-by-side with the perpetrator, I think. Because the perpetrator wants to silence everybody, silence the victim, and silence all the people around the victim, so this nasty little secret never gets out... I think by saying nothing and remaining neutral is siding with the perpetrator...

As illustrated, not asking about a possible history of CSA can be viewed negatively. This is consistent with literature suggesting that survivors prefer to be asked (Robohm & Bутtenheim, 1996), with not asking possibly resulting in the survivor feeling distressed or angry (Lothian & Read, 2002).

Both mental health professionals and survivors discussed how hints tend to be dropped if they are not asked about CSA, to gauge if the professional is able to “handle” such an issue. Bella stated:

I was never asked about anything ‘messy’, so I told the psychologist about my alcohol problem and she immediately went into how dangerous it was and stuff like that... which of course, I already knew... I figured if she couldn't deal with that well, then what hope would I have with telling her about other, worse stuff? So I didn't tell her at all...

Mental health professionals noted a similar phenomenon:

A lot of people have not spoken for a long time [and] what they do is hint at people... they'll start talking and gauge people's reactions or start saying to their doctor, “I've had a really bad childhood”... - MHP 2.

These observations are consistent with literature suggesting that survivors tend to drop hints, or ‘test the waters’ if they are not asked and want to disclose a history of CSA (e.g., Draucker et al., 2011; McGregor et al., 2006).

The implications of not asking clients about a potential history of CSA can be detrimental to the survivor and to engagement in therapy, as these findings

suggest. Therefore, it appears important to ask about a history of CSA, but whether the survivor decides to disclose is yet another issue, confounded by many factors, as the next section explores.

6.6 Is Disclosure Important in Therapy?

Disclosure refers to the survivor stating they have experienced CSA, either in response to being asked, or doing so spontaneously. Both survivors and professionals believed disclosure was important in therapy, but particular caveats were noted. Survivors strongly stated they would only disclose if they felt comfortable. While professionals generally believed it was important for survivors to disclose their CSA experiences in therapy, its benefits were dependent on the response of the mental health professional, as MHP 3 noted:

Disclosure's a good thing, provided they are talking to someone who is professional and trustworthy... it's not always a good thing though, it depends on who you're telling, and that's what I should qualify my answer with...

The stage the survivor was at was also considered important by many professionals, with MHP 5 elaborating on this:

I guess that depends on what stage the client is at. Sometimes it can be important and helpful, and sometimes it can be not so important and not so helpful... clients often don't know how to regulate themselves... so it might be up to us to support them in non-disclosure if appropriate...

These findings are consistent with literature that indicates disclosure of CSA may be helpful to client mental health and wellbeing, depending on the experience of disclosure being satisfactory (e.g., Campbell et al., 2001). Satisfactory reactions include being believed and feeling listened to (e.g., Campbell et al.).

Despite the general consensus of disclosure being beneficial to the survivor, a minority of mental health professionals did not agree. One professional cited the survivor's symptoms of distress could be reduced without disclosure of CSA. This

view is consistent with Munro and Randall's (2007) study of professionals working with CSA survivors, who believed that working with presenting symptoms, being future orientated and talking about 'ordinary things' were possibly more effective than disclosure of CSA.

MHP 6 believed investing in the value of disclosure could be interpreted as being on the therapist's own agenda, as she illustrated:

I think a therapist having an opinion of disclosure or non-disclosure is quite unhealthy and a little bit arrogant... [this field] ... can be enormously clinical... I don't think it's anyone's business aside from the client's, whatever helps the client...

This is an important point for professionals to keep in mind, and ensure the process of working with CSA survivors is not directed by their own agenda or beliefs. While it may seem intuitive that disclosure is beneficial, this serves as a reminder that survivors may not feel ready to disclose. Mental health professionals reported some survivors' trauma was so unspeakable they couldn't "*even write it down on a piece of paper*" (MHP 10). Therefore, to encourage disclosure and explore trauma may only exacerbate, rather than relieve symptoms, which is consistent with literature (Munro & Randall, 2007).

Despite a general consensus about disclosure of CSA being beneficial, these findings strongly emphasise the importance of the survivor's level of comfort and the reaction of the mental health professional, as well as the need for mental health professionals to support and work with survivors' non-disclosure.

6.7 Factors Facilitating Disclosure

Mental health professionals and survivors were asked about what they believed would encourage survivors to disclose their abuse history, if they wanted to. Four themes emerged, that being of the quality of the therapeutic relationship, being transparent, obtaining information by conducting a thorough and broad psychosocial assessment, and the mental health professional framing it in the form of a hypothesis.

6.7.1 Quality of the therapeutic relationship.

As noted by both survivors and professionals, the survivor's level of comfort is paramount to facilitating disclosure. Therefore, the quality of the therapeutic relationship is important for establishing such comfort. Both participant groups noted that a high quality therapeutic relationship was characterised by trust, safety and warmth, but this took time. These observations are consistent with literature suggesting that the degree of trust and safety felt by the client in the relationship with the mental health professional is beneficial, and may possibly facilitate disclosure of CSA (e.g., Sanderson, 2006; Ullman, 2011). These aspects are thought to be important due to the nature of CSA, where the survivor may be used to, or expecting betrayal and danger from others (Sanderson). CSA survivors also emphasised that not feeling judged was important in establishing a strong therapeutic alliance, which again, is supported by literature (Sanderson). Assuming a non-judgmental stance is thought to be valuable when working with survivors of CSA, who have most likely been judged and further shamed when discussing, or attempting to discuss, their abuse experiences before (Sanderson).

However, a minority of professionals noted that it was not unheard of for a CSA survivor to have established a working relationship with the mental health professional, but to have not disclosed their abuse history, possibly due to not wanting to be viewed in a different light. A pervasive sense of shame was also cited as a possible barrier for a survivor to not disclose to their trusted professional, as MHP 3 illustrated:

A lot of people are already seeing a psychologist or generalised staff [and] haven't disclosed yet. Some of them haven't disclosed, so they've seen a profession for anxiety or depression or whatever, and they've built up a relationship and don't feel like they can tell them about this other shameful stuff in their life...

Such non-disclosure has been identified in the literature, where a positive therapeutic relationship is thought to also deter survivors to disclose their experience

of CSA, due to possibly only wanting to be viewed in favourable terms (Dale et al., 1998).

A survivor's sense of comfort with the mental health professional has been noted as potentially facilitating factor regarding the disclosure of CSA. Conversely, these findings indicated that if survivors do not feel comfortable with the professional, they are not likely to disclose their experiences of CSA, even if asked, as Dora noted:

I know if I wasn't ready, I would've just gone, "No". So, I guess you can ask it [but] it's going to up to someone when they feel comfortable to disclose it [as] it's something you have to be ready to talk about.

CSA survivors noting they would deny a trauma history of unless comfortable, is consistent with Read et al.'s (2007) study. However, it is contradictory to other research suggesting that most survivors will answer honestly about CSA if asked (Friedman et al., 1992).

These findings indicate that the quality of the therapeutic relationship is an important factor for disclosure, but such a relationship could take time to establish. As survivors of CSA tend to expect betrayal, abandonment or danger from others, the formation of a trusting, safe and therapeutic relationship may take more time than for non-abused clients.

6.7.2 Transparency.

Both mental health professionals and survivors noted that being transparent about the process of therapy was helpful in promoting disclosure of CSA. It was thought such transparency reduced anxiety and by increasing the survivors' knowledge about what to expect, allowed them to feel more in control of the process of disclosure. Mental health professionals described informing survivors of what was going to be asked, making it clear they did not have to answer if they wished, and advising them that no detail was necessary, was considered useful. MHP 12 described how she was transparent with survivors she worked with:

I'll say, 'I'm going to ask you a lot of questions and if I ask you about something or someone and you don't feel comfortable to talk about that right now, then that's OK if you say to me, I don't want to go there right now... that's all right we will move onto something else. I might revisit it in later sessions, but we will move on so you are in control of what you talk about...

Highlighting the expectations of, as well as limits of privacy and confidentiality was thought to also assist survivors to feel a sense of safety in the therapeutic relationship. Clarifying expectations a survivor may have of therapy and the therapeutic power of disclosure was considered beneficial, with MHP 13 noting that she explained the cost and benefits, and the likely possibility at the outset that “you may feel worse before you feel better”.

Survivors also appreciated transparency, as Gina highlighted:

I think being transparent and open ... that's really helpful... because the whole problem about being sexually abused is that you feel disrespected and disgusting... so if someone is respecting you enough to work with you collaboratively, that's really helpful...

These findings are consistent with literature indicating that transparency is important when working with CSA survivors (e.g., McGregor et al., 2006; Schachter et al., 2004). Being clear at the outset reduces anxiety by increasing survivors' knowledge of the process and assists them to feel in control of what they share (e.g., McGregor et al.; O'Brien, 2007). Transparency is also the antithesis of the secrecy and boundary violations surrounding the abuse experience (e.g., McGregor et al.; O'Brien et al.; Sanderson, 2006).

6.7.3 Conducting a thorough psychosocial assessment.

Professionals and CSA survivors alike, considered a thorough and in-depth psychosocial assessment an effective way to facilitate disclosure of CSA. Dora elaborated on this:

I think that if you're getting to know them [the client] and hearing what their life's about, asking about their childhood and that, you may get that anyway through that sort of thing...

Engaging in a thorough assessment was thought to also allow the mental health professional to ask broadly about all trauma in childhood, which survivors believed was important. MHP 12 described how she approached a psychosocial assessment with new clients:

I learned that it was important in the assessment phase to do a genogram, to do a good historical timeline, to actually ask people about their life experiences and if there had been any experiences of trauma or anything significant they felt impacted on them that they wanted to tell me about...

Conducting a thorough, in-depth psychosocial assessment may identify common triggers, such as births, deaths, and stage of life that often prompts survivors to seek therapy for their previous CSA experiences. A genogram could also prompt the survivor to talk about, or conversely state they did not wish to talk about, particular members of the family, which again could inform the professional about the possibility of childhood victimisation. Asking about previous therapy experiences, including what was helpful and unhelpful, could possibly provide further insight to the survivor's current difficulties.

This finding is consistent with literature highlighting how a thorough psychosocial assessment provides opportunities for disclosure of CSA experiences, as it allows the professional to understand the survivor and their experience of childhood and development (McGregor et al., 2006; Read et al., 2007). Survivors interviewed for this study reported only three of the nine mental health professionals consulted attempted to conduct a psychosocial assessment. A lack of time could be amongst the many reasons for this, as highlighted by Briere (1996).

6.7.4 Offering a hypothesis.

Both survivors and mental health professionals believed it was useful to phrase the question regarding CSA in the form of offering a hypothesis. The assessment process and listening to the survivor's issues may alert professionals to a possible history of childhood trauma. Therefore, professionals could reflect their thoughts about the underlying reasons for their current distress by framing it as a hypothesis. A noted advantage of offering a tentative hypothesis was that provided the survivor an opportunity to either agree, or disagree, rather than fully disclose.

For example, MHP 4 stated that she found clients were more open to disclose CSA after she had offered a hypothesis and made cautious links between their current presenting symptoms, and the story they had told, often involving other types of abuse, poor safety in the home or dislocation from caregivers that often places people in situations where the risk of being exposed to CSA is increased. This professional believed offering a hypothesis "puts the idea (of CSA) out there", so the survivor can gauge if the professional can "sit with it". She also felt it sent a message to the survivor that they were being really heard and consequently, understood.

It was also considered especially important for both survivors and professionals for the hypothesis to be worded in normalising manner. MHP 5 illustrated how she sensitively asked about the possibility of CSA by incorporating normalisation into her hypothesis when working with survivors:

By normalising their experience... through utilising other examples of, 'This is quite common for people who experience anxiety', or whatever the symptoms they are presenting... often that style provides information, normalises their experience, doesn't isolate them and actually identifies it as a ... common experience, which... reduces that feeling of shame, that it's just me, and that I'm different....

A CSA survivor described the effect of having the professional offer a hypothesis in her therapy:

(Having a hypothesis offered) has been very valuable, because I don't make the connection between things, but to have that external input, it helps you make sense of things... and realise that maybe talking about sexual abuse is actually important to talk about... because if the counsellor is willing to ask in that way, it's not so... threatening I guess...

The survivor was also very clear about the importance of the hypothesis being normalised:

(It shouldn't be) but not being like, 'Mmmm... I'm looking at the evidence here and it sounds like you have been sexually abused... is that the case?'...

If disclosure does occur, telling survivors their 'crazy' behaviour, thoughts or feelings are not abnormal, but indeed a reaction to experiencing CSA can often result in survivors feeling overwhelming relief, as MHP 7 illustrated:

[Explaining] this happens to a lot of people, you are not alone, you're not an alien who was chosen for this and it was not your fault. This happens to a lot of people... and often for people, it's a relief to hear that, because they think they are the only person it's happened to.

Survivors agreed that normalisation was particularly powerful for them. Dora explained that if she had experienced normalisation and been educated about the myths of CSA, and the thoughts around, 'I didn't protest enough, I didn't scream, so therefore it is my fault', it would have reduced her self-blame and guilt, as she "struggled for years" with this. She explains:

... I think that's what would have really helped because you hold a lot of it in your mind... it's all those little things that make you [think], should I be complaining when I could have made more of a ruckus?

Incorporating normalisation, including when offering a hypothesis to a survivor, is considered particularly powerful, as it reduces shame they may be feeling, as well as being ‘abnormal’ and different to others (e.g., Herman, 1992a; Sanderson, 2006). There is a sense of relief of feeling they are not alone and not ‘crazy’, which can be powerfully therapeutic (e.g., Lievore, 2005; McGregor et al., 2006). While this finding indicates that offering a hypothesis could be useful in facilitating disclosure of CSA, the survivor may only agree if they feel ready to do so.

6.8 Factors Impeding Disclosure

Not being comfortable or ready to disclose were major themes to emerge from the survivors when asked what inhibited disclosure of their CSA experiences. In particular, being asked specifically and directly about CSA, as well as the gender of the mental health professional were cited by survivors to inhibit disclosure due to discomfort.

6.8.1 Asking specifically and directly.

Although disclosure of CSA was considered important by survivors, asking directly and specifically about it, especially before a strong therapeutic relationship had been established, was considered counterproductive to facilitating disclosure.

Bella voiced what other CSA survivors noted:

It's too big a question to ask specifically ... you'd be thinking, 'What's wrong with me for them to ask me that? Do I have a sign on my head or something?' ...

As Bella illustrated, asking this way may reinforce the already existing belief that the survivor is ‘abnormal’ or different to others and it is perceptible by others. This feeling of being different may be reminiscent of what they felt regarding the abuse experience, therefore, precipitating a sense of shame and discomfort. This view contrasts with other literature where some participants reported being comfortable with being asked specifically and directly about CSA (Schachter et al., 2004). However, Schachter et al.’s study focused on patients of practitioners of

physical health, where expectations may be different from those who engage in therapy with a mental health professional.

Survivors, as well as many professionals, suggested that it was best to ask about CSA in the context of broadly asking about all trauma, and stating they were questions every client was asked. It was recommended by professionals in the study that this should occur as part of a comprehensive psychosocial assessment that asks about all abuse and trauma, including road accidents, bullying etc. Asking about all trauma was thought to convey to the survivor that having such experiences were both common and normal. This is consistent with research suggesting that mental health professionals preface asking about CSA by using a statement that indicates everyone is asked about historical trauma, indicating to the survivor they are not 'abnormal' or different (Read et al., 2007).

6.8.2 Gender of the mental health professional.

A theme that emerged from the data of both interview groups concerned the gender of the mental health professional. Survivors who consulted male professionals reported they were dissatisfied with the experience.

Survivors who disclosed to male mental health professionals, discussed how they felt uncomfortable about doing so. Gina stated she was uncertain if this was due to his gender, although she did acknowledge a natural ease with females:

I didn't feel overly comfortable with him... I don't know if it was because he wasn't open in the sessions, or if he was male... because the perpetrators during my childhood were all male, I feel instinctively more comfortable with a female...

Dora also explained:

I really struggled with [the mental health professional being male]. I didn't think I would care, but... I just felt really uncomfortable with him.... With the male I felt so uncomfortable...

While both Gina and Dora disclosed to males, both expressed regret for doing so as they felt extremely uncomfortable. This discomfort may have originated from the resulting response, rather than the professional's gender. However, as men were the perpetrators of their abuse experiences, this could account for why they felt uneasy with male professionals. This explanation is not accounted for by research that suggests a professional's gender does not affect therapy effectiveness (Moon, Wagner & Kazelskis, 2000). The quality of the therapeutic relationship is considered to determine treatment outcome more than the gender of the professional (Simpson & Fothergill, 2004). In fact, assuming survivors will be uncomfortable with professionals who are the same gender of the perpetrator may potentially deny them the opportunity for a positive role model or unique experiences to be forged (Morgan, 1992).

The issue of the professionals' gender being problematic was a theme also echoed by interviewed professionals. A female professional, who facilitated mothers' groups, observed that disclosure of CSA amongst participants was considerably lower if it was co-facilitated by a male therapist. However, this discomfort was perhaps reciprocal. MHP 11, who was male, noted that his gender could prove challenging for female survivors who disclosed CSA to him in therapy and would raise issues, including whether he would be able to continue with therapy.

I would say... that it's very tricky as a male therapist to work with a female who's had a history of CSA... if I had a woman come along who disclosed a history of CSA, it would raise lots of questions about whether we would continue... that's not to necessarily say that you'd never continue, but it would raise lots of questions... because you always get to a point where the woman might feel like she wants to talk more about that experience and I think... [it's] pretty tricky... it raises all sorts of problems for client and therapist... it's very tricky territory...

This was an unexpected, but very relevant, theme to emerge from the study, and has implications for all mental health professionals, given that females also perpetrate sexual violence.

6.9 Benefits of Disclosing CSA in Therapy

Consistent with literature, both mental health professionals and survivors noted particular benefits of disclosing CSA in therapy. These benefits included being acknowledged, to make meaning or a different meaning, and, developing one's identity.

6.9.1 Being acknowledged.

Mental health professionals and all survivors believed that disclosure of abuse experiences was important in that it provided them an opportunity to be heard and acknowledged. Dora spoke of about how disclosure would have allowed her to tell her story and understand why she was experiencing what she was experiencing:

I think if you can tell it, well, I would have felt ten times better if I had known... because that's what went around in my head for years... like it's all those other little things, not the actual event, it's all the shame you carry about why [did I do this, why didn't I do that?]. It was all that crap that I struggled with, not the actual [CSA itself].

As CSA is characterised by shame and silence, perpetuated by family, friends, society and the perpetrator, it was considered particularly powerful for the survivor to have a voice and have their experiences heard and acknowledged. This is consistent with literature indicating that disclosure can be cathartic and the antithesis of the abuse experience (Farber, 2009).

6.9.2 To make meaning or a different meaning.

Both mental health professionals and survivors noted that disclosing CSA in therapy provided an opportunity for the survivor to make meaning, or a different meaning from their trauma. Gina spoke of how disclosure resulted in an objective perspective, which in turn, enabled a different meaning to be made:

Some of the formulations have been very valuable... it helps you make sense of things... because I'm the sort of person that if I understand something, I can

move forward... I'm re-owning it, because I'm no longer a child experiencing it, I'm an adult understanding it...

Gina's account highlights how making meaning can assist survivors to begin the process of healing. This finding is consistent with literature suggesting that a benefit of disclosure in therapy regards making meaning, or a different meaning, from one's experiences of CSA (Bradley & Follingstad, 2001; Draucker et al., 2011; Phillips & Daniluk, 2004). This different meaning could highlight the survivor's strengths rather than focusing on the problematic, negative ways they have perceived themselves and their situation, as MHP 10 explained:

What I find incredibly important is pointing out their resilience, because for the most part, they're... resilient people and they're coming to treatment voluntarily, so they're wanting to address whatever issue... they are here for the most part because they want to use the resilient part of them and build on that... it doesn't have to be all doom and gloom about the abuse...

Emerging literature emphasises the inherent strengths survivors of family violence possess, and emphasises highlighting resilience (Anderson, 2009). By taking this alternative perspective, new understandings can shift unhelpful beliefs and may reduce feelings of self-blame, guilt and shame that were previously unquestioned by the survivor.

6.9.3 Developing one's identity.

Mental health professionals consistently identified that disclosure of CSA in therapy provides survivors an opportunity to develop their identity and self-concept. For example, instead of viewing themselves as sexual objects, over time, survivors began to see this self-concept was inaccurate and were then able explore other elements of themselves. This is consistent with literature suggesting that survivors of CSA may possess an unstable sense of identity (e.g., Neumann et al., 1996), or an identity tied with the abuse experience (Phillips & Daniluk, 2004). Therefore, disclosing CSA experiences in therapy allowed an alternative sense of self to be

developed, strengthened and better understood (e.g., Farber, 2009; Phillips & Daniluk). Despite mental health professionals noting this benefit, no CSA survivors cited this. This may be due to the inclusion criteria for this study emphasising that participants not be currently in distress, resulting in the included participants exhibiting a high level of functioning. Their high level of functioning may be due to moderating factors, such as experiencing CSA at a later age, which could account for their identity not being severely affected.

6.10 Risks of Disclosure in Therapy

Despite the noted benefits of disclosure of CSA in therapy, there are considerable risks associated with such disclosure, too. Both survivors and mental health professionals commonly identified the risk of the professional driving therapy. However, CSA survivors tended to experience other, different, risks such as the mental health professional either appearing uncomfortable, or assuming a blank therapeutic stance. These negative reactions resulted in secondary traumatisation.

6.10.1 Mental health professional driving therapy.

All survivors had experienced the mental health professional driving therapy, which was considered by interviewed professionals as detrimental to survivors' wellbeing. Specifically, professionals being overly treatment focused, having inflexible and restrictive time limitations placed on therapy, and recommending inappropriate strategies were cited as problematic.

6.10.1.1 Being treatment focused.

All survivors experienced professionals taking charge of treatment and found this rather confronting. Gina perceived the professional's words and actions as "*arrogant*" and "*forward*":

He was very treatment focused in that he started our relationship with, "Right, what are your presenting issues, and what are we working on? We have a time-frame on this and let's get started"...

Bella recalled how the mental health professional she consulted immediately set goals for treatment and described what strategies should be used, as it was considered efficient for treating insomnia. However, she stated she was never once asked about her history, or why she thought she was having trouble sleeping.

It was like she was a doctor prescribing me the best type of medicine... not actually listening or considering who I was as a person...

Bella initially agreed with the mental health professional and attempted the strategies suggested, but “*felt like a failure*” when she was unable to complete the tasks. When she reported her lack of success to the mental health professional, she was advised to keep trying, which added to her feelings of inadequacy. Dora noted that both mental health professionals she disclosed her CSA experiences to immediately went into what she described as “*fix mode*”, which she found very unhelpful.

6.10.1.2 Time limits and inflexibility.

Mental health professionals placing limits on the number of sessions or being inflexible about scheduling were examples of professionals driving therapy. Professionals are often constrained to a limited amount of sessions that are subsidised by Medicare, the Australian Government’s health system. Under the ‘Better Access to Mental Health Care Initiative’, individuals are able to access psychological assistance for up to 10 sessions per calendar year, for many of the mental health issues CSA survivors commonly experience. Depending on the mental health professional, sessions can be ‘bulk-billed’ (i.e., free of cost to the individual), or partially subsidised, resulting in more affordable access to quality mental health care (Australian Psychological Society Limited, 2013). Private health insurance may cover a portion of the fee to consult a mental health professional, but for individuals who are low-income earners, such cover is unaffordable. In addition, the Medicare rebate cannot be used if an individual is covered by private health insurance. Therefore, survivors who cannot afford mental health care are reliant on a system

that determines the number of sessions. It was noted that more sessions than standard was especially important for survivors of CSA, due to the nature of the issue. Gina discussed how time limited therapy was something she was “*struggling with*” as she felt she was “*compromising a part of [herself]*”.

Mental health professionals also recognised the need for CSA survivors to engage in longer treatment compared to those who experienced adult, single event trauma, with MHP 7 stating it was a “*tortoise, not a hare job*”. MHP 12 further elaborated:

There can never be an eight-session model, not for someone who has experienced CSA... those guidelines have been endorsed for instance by Victims of Crime Tribunal... eight sessions may work really well for a man whose never had any abuse in his life, and then he's at a petrol station when it's held up... but with someone with CSA, it's affected their whole development of self, so it's difficult to return to a functioning level of self, because self is what was affected.

Flexibility with scheduling was considered by both survivors and professionals as useful. Extension of time in session was considered helpful on the odd occasion when the survivor was in the midst of an important point, or distressed. Gina noted that “not being cut off” was particularly useful for her:

[A couple of occasions] when were in the middle of something, or I was in the middle of a story or a self-revelation, she would allow the session to go over, rather than cut me off... it was only 10 minutes or so, but I felt really understood and cared for and important.

While it is important to establish boundaries, it was also perceived as important to use common sense and not adhere unwaveringly to them if the client appeared upset or in visible distress.

Mental health professionals noted that survivors needed flexibility as they noticed survivors sometimes ‘go to ground’ for varying periods before returning to therapy, as MHP 10 explained:

I see treating sexual abuse, and the issues around sexual abuse, as long-term therapy... I don't think it's something that can be rushed, I think people need to work on things in their own time and people need to be able to have a space to reflect and back away, then re-engage...

This finding supports research that long-term treatment may be beneficial for working with disclosures of CSA. The nature of the abuse, along with the potential for survivors to experience difficulties with establishing a trusting therapeutic relationship, means that short-term treatment may not be as effective. This is consistent with literature examining other survivors’ opinions about the benefit of longer treatment for CSA (e.g., O’Brien et al., 2007; Palmer et al., 2001).

6.10.1.3 Recommending inappropriate strategies.

Mental health professional driven therapy included the professionals providing inappropriate strategies or referrals when the topic of CSA was mentioned. Dora cited this occurring with both mental health professionals she consulted with:

That's why I got sick of it, because he was just trying to keep giving me all this information for activities and clubs and to make friends, which I understand... but that's not where I was at, at the time... and,

The [female] counsellor actually gave me details of a support group... and I was really annoyed that she was... really pushing it on me because I didn't want to talk about it to a whole group of people at that stage. And I hadn't even told one person!

Gina described her experience:

He made some suggestions initially about approaching my family and discussing some things with [them], but unfortunately, they aren't open to discussing these things...

Whilst mental health professionals believed teaching clients to regulate their emotions and adopt relaxation skills were beneficial for managing distressing emotional states associated with the disclosure, this was not the case for the survivors interviewed. Survivors believed suggesting strategies was unhelpful, to the extent that Gina believed it was “*almost insulting*”. However, this could be due to the relaxation strategies possibly being recommended formulaically, rather than it being tailored to their individual needs or situation. It appears that while suggesting strategies may be helpful, they need to be thought through and offered in accordance to what the survivor feels is most comfortable with.

6.10.1.4 Violating survivor boundaries.

Mental health professionals noted more severe examples of fellow therapists directing treatment and fulfilling their own agenda. For example, one professional noted how her client's previous psychologist blamed her for any other future sexual assaults because she did not feel comfortable reporting the crime to police. MHP 3 noted how one psychologist took one step further:

[The caller] was seeing a psychologist already.... She told the psychologist that this had happened, and she [the psychologist] reported it to the police, without her consent...

These examples highlight how hearing about damaging experiences can affect the mental health professional and their own belief system, therefore affecting their actions and the therapeutic relationship.

Other mental health professionals noted how clients had disclosed their CSA experiences to their physician or therapist, and experienced subsequent sexual revictimisation. For example, MHP 11 recalled:

Another woman client, who had seen at least one therapist that I know of, she had a sexual relationship with him...

Experiences of the mental health professional either driving the therapeutic process, or violating the survivor's boundaries are considered unhelpful and damaging. Taking control of the process disempowers survivors and mimics the abuse experience.

CSA survivors discussed how professional driven therapy resulted in them feeling extremely uncomfortable and pressured to comply with their wishes. They also reported feeling unable to communicate their dissatisfaction, often resulting in them 'dropping out' of therapy, which is later explored. Professionals driving therapy is in direct opposition to literature recommending that mental health professionals should attempt to be, and act, exactly the opposite of the perpetrator (Astbury, 2006) in order to restore what the abuse experience essentially robbed from them (Herman, 1992a).

6.10.2 Mental health professional appearing uncomfortable.

All CSA survivors noted the theme of the mental health professional appearing uncomfortable. This message was conveyed by the professional's inability to listen and/or attend to, the survivor crying in the session.

Bella and Dora noted they were cut off abruptly when crying, with Bella recounting how this experience affected her:

... I was clearly upset and crying, when I saw her [the professional] reaching for her receipt book... and it was well before the hour was up... well, I just thought that I was just a number, another person to make money off... so I pulled myself together and got out of there, and didn't go back!

Dora also experienced a similar event with a male mental health professional:

... I remember I was just crying the whole session and at the end he... wrapped it up quite abruptly and didn't really address what was wrong... at the end he was like, "OK, well now I would like you to do these homework tasks" about some other shit... It takes a lot for me to cry in front of someone and when [he] sort of [ignored it]... I felt awkward... I kept saying sorry and he would just try to move it on, like he would go, "That's OK" and then shove the tissues to me and then go on with something...

Both these experiences illustrate that the mental health professional was uncomfortable with hearing, and listening to, such issues. Survivors discussed how these reactions made them feel unimportant, ignored and silenced.

These findings are consistent with literature from survivors' perspectives where mental health professionals appeared uncomfortable when discussing trauma, by either not listening or avoiding the topic of CSA (e.g., Josephson & Fong-Beyette, 1987; McGregor et al., 2006). The message this conveys to the survivor is that their experiences and distress is not important, essentially replicating the silencing the survivor may have experienced by family, friends, society and even the perpetrator.

Conversely, the importance of professionals appearing comfortable with the disclosure of CSA, was noted by MHP 1:

I think it's about how comfortable a person is with dealing with [CSA] more than anything... I think just being able to sit with it [the disclosure] and deal with it when they bring it up and not kind of back away from it or react in a bizarre way [is important]...

What was emphasised by the survivors, but is not indicated in literature, is the power of the mental health professional just listening. The survivor interprets listening, presumably defined as active listening rather than silent, passive listening, as the professional being comfortable with disclosures of CSA. As this was highlighted as incredibly valuable to CSA survivors, it is recommended that

professionals are able listen to, and tolerate, disclosures of CSA, as this can be powerful in itself.

The ability to of the professional to listen, along with maintaining a non-judgemental stance and being respectful, were all considered immensely helpful amongst all survivors. Dora explained:

... because there was so much going on in my head that I was so ashamed about that I didn't want to tell anyone because I didn't want them to judge me or think it was my fault...

The majority of mental health professionals agreed with the survivors' position, believing these fundamental counselling skills were helpful when survivors disclosed traumatic material. This is consistent with literature by other authors who investigated survivor perspectives (e.g., Denov, 2004; Lievore, 2005).

Mental health professionals appearing uncomfortable highlighted the need for professionals to be self-aware of their own actions, reactions and body language. Interviewed professionals noted that survivors of childhood abuse were finely attuned to their environment and people's cues, due to it being an adaptive mechanism needed for survival. MHP 2 explains:

You've got to be really conscious of what you're throwing back... People who have experienced long-term abuse are wonderful at reading facial cues, because they've spent their whole life watching... they're very good at watching your body... if you look at your watch or out the window, they're onto it... they take it as disinterest, they take it as abandonment...

This finding is consistent with literature suggesting that survivors are often highly attuned to verbal and non-verbal cues of the mental health professional, who may not be aware of their feelings of discomfort (e.g., Dale et al., 1998). The implications of not being self-aware can result in the survivor feeling ignored,

disrespected and unimportant, which may be a replication of previous disclosure experiences (e.g., McGregor et al., 2006; Sanderson, 2006).

Therefore, this finding highlights the need for mental health professionals to engage in consultation, supervision, or their own therapy, as their reactions may belie what they unconsciously feel toward the survivor.

6.10.3 Mental health professional assuming a blank therapeutic stance.

Two survivors noted experiences of the mental health professional assuming a blank therapeutic stance, and the resulting effect on them after they disclosed their experiences of CSA. A common interpretation by the survivor was that of feeling judged. Gina described how a ‘blank’ psychodynamic therapeutic stance was especially off putting:

I think he was judging, but it seemed as if he were uncomfortable... I guess when you say something like that [disclosing CSA] you would expect a response... it was [like] talking to a blank slate...

Bella noted that the mental health professional she consulted with appeared ‘unemotional’ and therefore prevented her from disclosing her CSA experience.

It was like having therapy with a textbook. She was young, so I thought she may have been hiding behind appearing overly professional... I thought if I told her, she wouldn't be able to handle it...

These observations are consistent with literature indicating that assuming a ‘blank’ or neutral therapeutic stance can be intimidating to survivors, especially those who are naïve to the process of therapy (e.g., Dale et al., 1998). Survivors stated they felt judged and, therefore, rejected, which is also reflected in literature (e.g., Herman, 1992a; Sanderson, 2006). Therefore, it is recommended that mental health professionals express some emotion that indicates to the survivor they are not being judged or rejected.

6.11 Referrals and Constraints

The issue of referring survivors on insensitively upon disclosure of CSA was raised spontaneously by nearly half of the mental health professionals interviewed. Their previous clients had related how this had occurred, and the resultant negative reinforcing message it had sent to them.

Referring survivors on to CASA or another mental health professional was considered common practice once the survivor disclosed CSA to their current provider. However, this was viewed as both negative and positive for client welfare. On the negative side, referring was viewed as detrimental, as a positive therapeutic relationship had been established to promote disclosure. MHP 3 stated:

... And then have to build up trust with somebody else! I mean, people who have been sexually assaulted as children have a very hard time trusting people... I think they have a hard time trusting [professionals], and then to be shunted off to somebody else is not appropriate...

Gina described the difficulties she faced when she was no longer consulting with a mental health professional she built a strong rapport and therapeutic relationship with. Gina described this loss as “*really painful*” and that nobody could “*fill [her] shoes*”. This experience left her feeling disappointed and demoralised with the prospect of having to establish rapport with somebody new, as well as having to retell her story.

While it could be difficult for any client to lose a valued mental health professional, this may be especially so for survivors of childhood abuse. CSA survivors may already expect betrayal and abandonment, as well as difficulties establishing trust. Having that connection discontinued at the mental health professional’s behest could reinforce the survivor’s core belief that others are not to be trusted and will eventually abandon them.

Many mental health professionals believed that insensitively referring the survivor to another professional or service conveyed the message that the issue of CSA was too great a problem, leading to clients feeling like a “*hot potato*”.

Now what message does that send? That you're so stuffed and what you're telling me is so terrible that I can't deal with it? ... You've got to be careful about a really quick handball. – MHP 2, and,

Some of the men I had seen who had disclosed [to a professional] almost had a shaming, or felt like the person couldn't handle it, or they were too quickly referred on, or they felt like a 'hot potato', and they felt [the professional] couldn't deal with it... - MHP 6.

Usual practice dictates that only one mental health professional is seen at a time so 'splitting' does not occur, as MHP 9 explains:

When you start seeing two people, there's a dynamic, a split... so I don't think that's therapeutically helpful... I think you're recreating a split... I've tried to explain to clients before why they should go back to the initial person, or that they actually consider to find somebody who can do both, rather than separate out the depression and relationship issues, but actually somebody who can hold the lot...

Another mental health professional agreed, stating it was “*unethical*” for a mental health professional to continue receiving payment for CBT treatment for particular mental health symptoms, while also referring the client to a service to work with the underlying issues for such symptoms.

Published literature has not highlighted the issue of appropriate referral. McGregor et al.'s (2006) study indicted that some mental health professionals terminate therapy upon learning about the CSA experience, but it was identified they were not referred on to anybody else. This theme of insensitively referring on was an unexpected and important finding that could have implications for practice.

Despite the opinion that referring on can be detrimental, mental health professionals are guided by the principle to 'do no harm' and work within their realm of expertise. Specifically, the Australian Psychological Society's Code of Ethics (2007) states that psychologists 'only provide psychological services, within

the boundaries of their professional competence', including, 'working within the limits of their education, training, supervised experience and appropriate professional experience' (Section B.1.2). An "ideal" solution to circumvent these issues and work ethically was cited, where the current mental health professional could work alongside a service such as CASA for secondary consultation. As survivors' issues cannot usually be clearly and neatly delineated between 'sexual assault' issues and 'mental health' issues, the survivor is then able to address both simultaneously. MHP 2, who works at a CASA explains:

There are many situations where we will provide secondary consultations and utilise that really good therapeutic relationship. If you've worked with somebody for years and you've got great rapport with them, why not use that?

This sentiment was demonstrated by an example provided by MHP 9:

We thought she [the mental health professional] had a good relationship with her client and they had been working together for a while, so it would be almost crazy to interrupt that to tackle this issue... [the professional] was great... she really welcomed the idea of receiving that service and support and consultation... I don't know how experienced she was, but for me that [situation] was ideal, the way to go...

According to mental health professionals, one did not have to be an expert in the field of sexual violence in order to work with CSA. In fact, Gina noted that despite her current mental health professional not being an expert in CSA, she was learning about complex trauma and relaying newfound knowledge to her. Gina viewed this approach as highly collaborative and respectful in that the professional did not assume the role of 'expert', and shared the mutual learning process.

As suggested by interviewed professionals, seeking consultation or supervision with knowledgeable individuals or agencies is considered an ideal approach to maintaining a therapeutic alliance and assisting the client. However, if

the mental health professional does not desire to learn about, or work with trauma, or believes their own personal beliefs or trauma experiences could be detrimental to working with the survivor, then it is recommended that referral be done sensitively. This could include being as collaborative as possible, being transparent about their level of expertise, and working with the survivor to find the best possible professional. These practices may reduce the survivor's feelings of betrayal, abandonment and shame.

An additional referral issue was raised by two professionals, where offenders of violence, who were also CSA survivors, were unable to find a professional or relevant agency to work with them on issues associated with the abuse. MHP 1, a forensic psychologist, noted:

[Some of my clients] were sexual offenders and quite often when they had a history of CSA, they found it really hard to find someone that would provide a service, because they were a perpetrator as well... I don't think it was only CASA [but] a lot of psychologists and probably other professionals in lots of areas kind of freak out about it.

MHP 5, whose two male clients had both experienced histories of CSA and committed crimes against women, stated she “*didn't even bother*” to contact CASA about referral as she was aware they did not work with perpetrators of violence, even if they were victims themselves. This issue was an unexpected theme found by the current study. There is a general lack of available published literature that highlights this dilemma, due to much research being framed within a feminist framework.

6.12 Consequences of Unhelpful Practice on CSA Survivors

All survivors of CSA had experienced unhelpful therapy and consequently, dropped out of treatment. Dora spoke about her experience of avoiding her therapist's calls to return to therapy:

After that I just stopped going and didn't let him know, and I remember he kept trying to call me... I just avoided him and left. I never actually said, "I don't want to come", I just avoided him... I remember he called me and I just said, "Oh yeah, everything's fine" and I think he was trying to get me to come back, saying, "There are still things we can work on, blah, blah", and I said, "No, I'm fine. Thank you" and said 'bye'...

Survivors who experience unhelpful therapy experiences may drop out of therapy (Dale et al., 1998; McGregor et al., 2006). Participants in these qualitative studies reported a strategy they employed to withdraw from therapy was to tell the mental health professional that they were 'better'. Whilst this approach serves a purpose to the survivor, who does not wish to remain in an uncomfortable relationship, it may only serve to reinforce the mental health professional's incorrect beliefs that guide their ineffective practice (Dale et al.).

Bella was more direct with her approach when she terminated therapy:

Well, I thought it was only fair to let her [mental health professional] know how I felt. She called... I told her about how she cut me off, and how this affected me, as I was obviously upset at the time. After going quiet for a bit, she then told me she would give me an extra ten minutes in the next session! Can you believe it?! She didn't get it that the time wasn't really the issue... it was more that she didn't understand that you just don't cut someone off when they are so distressed. So even her reaction made me realise that it was pointless to try and go back... in the end I told her that it wasn't working.

Due to the poor management of disclosure of CSA in therapy, two of the three survivors were extremely reluctant to further disclose and did not disclose to future mental health professionals until a very high level of trust and rapport was established. Bella explains how she saw two more mental health professionals after this, but did not disclose her CSA experience:

After being let down, I thought, 'what's the point of putting all my cards on the table if this could happen again'?

This finding is consistent with literature suggesting that future non-disclosure often results from receiving negative reactions to CSA disclosure, based on the survivor's perception that future disclosures will be ineffective (Ahrens, 2006).

After experiencing unhelpful practice from two consecutive male professionals, Gina decided to abandon the idea of seeking further therapy. However, legal issues forced her to seek treatment again. Happily, she reported her current mental health professional was very supportive and helpful. This is a best-case scenario, where survivors are motivated to persist and seek help until they encounter a helpful professional (Palmer et al., 2001).

Unfortunately, after encountering negative experiences from two mental health professionals, Dora gave up seeking assistance altogether. She explains:

... Well I never saw anyone else... I was like, well, 'just give up' ... I think it added to the list, [because] when you go through that, you feel really alone... it just adds another person to that... another person that doesn't care.

What Dora describes is secondary victimisation, where the survivor continues to feel victimised, long after the sexual abuse has ceased (e.g., Ahrens et al., 2010; Lorentzen et al., 2008). This is consistent with literature indicating that not receiving appropriate reactions or support leads to future non-disclosure (Ahrens, 2006). Dora's story highlights how mental health professionals can effectively silence the survivor and reinforce their belief that nobody can help. Abandoning the prospect of ever seeking support is common and also noted in literature (McGregor et al., 2006).

As illustrated, the consequences of experiencing negative reactions or unhelpful professional practice can have long-lasting, damaging effects on the

survivor. Ideally, the survivor will continue to seek therapy. However, as these findings indicate, it is common for survivors to not disclose to future mental health professionals, or worse still, ‘give up’ on the hope of being understood by anyone and abandon therapy altogether.

6.13 Summary

This chapter analysed data from both survivors of CSA and mental health professionals, who noted common triggers that prompted survivors to seek therapy. These included the child reaching the age the survivor was at the age of abuse, significant life events, existing coping strategies becoming ineffective, stage of life and family occasions.

The issue about mental health professionals asking all clients about a possible history of CSA, particular barriers preventing mental health professionals asking and the implications of not asking were examined. Mental health professionals noted barriers such as a lack of training and knowledge, reflecting on their own training experiences and how they increased their knowledge. Mental health professionals also cited additional barriers such as fear of legal repercussions, lack of comfort with discussing CSA, as well as the influence of the mental health professionals’ own trauma experiences.

The topic of disclosure was examined, with its importance in therapy being evaluated by both CSA survivors and mental health professionals. Factors facilitating disclosure were thought to include the quality of the therapeutic relationship, the mental health professional being transparent, conducting a thorough psychosocial assessment and offering a hypothesis. Factors impeding disclosure were cited to be asking the CSA survivor specifically and directly, as well as the gender of the mental health professional.

The benefits of disclosure were being acknowledged and heard, making meaning or a different meaning, and developing one’s identity and self-concept. Conversely, the risks of disclosure in therapy were noted as the mental health professional driving therapy, appearing uncomfortable, and assuming a blank therapeutic stance. The issue of referral and its constraints were also examined.

Experiencing negative therapeutic practice by mental health professionals was found to often have detrimental and long-lasting consequences on the survivor.

Chapter 7

Conclusions and Recommendations

7.1 Aims of the Study

The current study satisfied the aims of exploring the experiences and needs of adult survivors of CSA when consulting a mental health professional. Specifically, the experiences surrounding disclosure, or non-disclosure, of CSA in therapy, what the adult survivor found helpful or useful about the consultation/s, how satisfied they were with it, and what, from their invaluable perspective, could have been improved were all investigated.

The study also satisfied the aim of exploring mental health professionals' knowledge and experiences of working with adult clients of CSA who had disclosed historical sexual abuse in therapy. In particular, opinions about disclosure of CSA in therapy, what they believed is helpful and unhelpful practice for working with survivors of CSA, as well as adequacy of the training and education they received were all explored.

7.2 Findings of the Study

This study found that survivors who seek therapy from general or community counselling services tend to present with a 'disguised presentation' in the form of relationship difficulties, being revictimised in adulthood, sexual intimacy and identity issues. Mental health issues that commonly affect the wider population were also common, such as depression and anxiety. Substance abuse, hypervigilance, and insomnia were also common. Mental health professionals noted more severe mental health presentations such as posttraumatic stress symptoms, borderline personality disorder traits and eating disorders in their practice.

Findings of this study suggest that males may experience the effects of CSA slightly differently to females in that they could carry more shame, experience issues with sexual identity, and externalise their anger as violence. These differences were attributed to societal and cultural norms, expectations and myths. In addition, some differences in communication style were noted, with males being more graphic and

less interactive than females when describing CSA experiences. This was somewhat problematic for professionals who worked on telephone crisis lines, as it was difficult to discern genuine survivors from sexual harassment callers.

CSA survivors had often disclosed to informal supports such as family or friends, before seeking therapy from a mental health professional. Families tended to respond more negatively than friends, especially if the perpetrator, and/or other victims were within the family circle. Negative reactions included minimisation and denial, mothers blaming their daughters for the abuse, and survivors being threatened or rejected from the family unit. Friends were generally considered to demonstrate more positive reactions, such as empathy, normalisation and a shared, “me too” response. The negative reactions often lead to secondary victimisation, where lack of social support, coupled with emotional distress, was perceived as worse than the abuse experience itself. Negative reactions such as denial, were accounted for by society’s investment in ‘playing happy families’ and an aversion to speak of sexual victimisation.

Many triggers were thought to prompt survivors of CSA to seek therapy, either for their CSA experiences or for the issues associated often associated with experiencing sexual abuse. These included one’s own child reaching the age of when the survivor was when s/he experienced the abuse, significant life events such as births, deaths and relationship beginnings and endings. Existing coping strategies no longer being effective and the survivor’s stage of life were also considered triggers to seek therapy. Finally, family occasions and gatherings could prompt a survivor to seek help, especially if the perpetrator was in the family circle. All these events were thought to trigger intrusive memories or flashbacks and induce distressing emotional states.

When survivors attend therapy, it is unlikely they will spontaneously disclose their experiences of CSA. Despite this study finding that it is generally important to ask all new clients about a possible history of CSA, particular barriers prevent professionals from doing so. These barriers included an identified lack of training and knowledge of CSA, a fear of legal repercussions, and professionals’ discomfort about the topic of CSA, dictated by society or their own trauma experiences. However, consulting experienced professionals or agencies, attending

training and workshops, reading, and seeking supervision for arising countertransferential issues, were strategies to overcome these barriers. Regardless of if the professional had experienced her or his own trauma, seeking personal therapy was considered beneficial, as this could increase empathy and understanding. Support, in the form of consultations, supervision and personal therapy, was also thought to be helpful for preventing vicarious traumatisation.

If the mental health professional did not ask about CSA in therapy, it sent a silencing message to the survivor that their abuse experiences were not important, and was likened to working alongside the perpetrator. Survivors also dropped hints if the professional did not ask in order to gauge their response and determine if they were able to 'handle' traumatic disclosures.

While it was generally considered that disclosure of CSA was beneficial in therapy, there were two caveats to this. The first was only if the survivor felt comfortable, in terms of the therapeutic relationship with the mental health professional, as well as the stage they were at in terms of other life events or stages. The second caveat was if the mental health professional responded in a positive, supportive and professional manner.

Aside from the therapeutic relationship being of fundamental importance, other ways to facilitate disclosure of CSA was to conduct a thorough psychosocial assessment, or to provide a hypothesis, if after some time the survivor did not disclose. A thorough psychosocial assessment included aspects such as a genogram and developmental history, as well as asking broadly about all forms of trauma, from road accidents and bullying, to physical and sexual trauma. Mental health professionals being transparent about the assessment process, by placing the survivor in control of what information s/he wanted to share and emphasising that all new clients are asked the assessment questions were thought to reduce the survivor's anxiety by increasing their sense of safety and control. If the mental health professional believed the survivor was hesitant to disclose, then offering a hypothesis was considered helpful. This was normalising and provided the survivor an opportunity to either agree or disagree, rather than fully disclose.

Factors that impeded disclosure of CSA was asking directly and specifically, as this was perceived by the survivor that something about them was obvious and

different, reinforcing their existing belief of being 'abnormal'. Also, the gender of the mental health professional was a factor that either impeded disclosure, or made the disclosure process very uncomfortable for both the survivor and the mental health professional.

The benefits of disclosing and working with CSA experiences in therapy included being acknowledged, to make meaning, or a different meaning and to develop one's identity. These benefits reduced the effects of being silenced and shamed, and to reframe and understand their reactions and experiences as an adult. One's identity could be developed as disclosure and therapy allowed the survivor to establish a more accurate and alternate self-concept.

However, three risks associated with disclosure of CSA in therapy were identified. They were, the mental health professional driving therapy, appearing uncomfortable, and assuming a blank therapeutic stance. The mental health professional driving therapy included being treatment focused, being limited in time and flexibility, recommending inappropriate strategies and violating the survivor's boundaries. Mental health professionals also appeared uncomfortable when disclosure of CSA occurred, which was conveyed by the professional's changing the topic or not attending to the survivor's visible distress. The professional's ability to listen was powerful and therapeutic, in that it demonstrated their level of comfort with hearing such material. It was highlighted that being self-aware was particularly important when working with survivors of CSA, and that professionals may convey discomfort unconsciously. Assuming a blank therapeutic stance resulted in the survivor feeling judged.

A contentious and ethical dilemma was raised regarding referring survivors on after disclosure of CSA. This was due to the mental health professional needing to work within their realm of expertise, yet breaking the established therapeutic relationship. Referring survivors on resulted in negative messages being conveyed, which reinforced their existing beliefs. An ideal solution was suggested where the existing mental health professional seeks consultation and works alongside expert professionals or agencies. Learning 'on the go' was not considered negative as it fostered mutual learning and collaborative therapy process. Another referral issue

was identified, where perpetrators of violence were unable to seek appropriate treatment for their own CSA experiences.

The consequences of unhelpful practice on CSA survivors included dropping out of, or terminating therapy. The survivor either avoided contact with the mental health professional or advised the professional that they no longer needed therapy due to feeling better. Unhelpful practice generally resulted in future non-disclosure to future mental health professionals, or ‘giving up’ on therapy altogether. As the survivor believed there was no use in disclosing, they were effectively silenced even further.

7.3 Implications and Recommendations to Improve Professional Practice

Based on the current study’s findings, improving mental health professional practice when working with survivors of CSA may be achieved by the following:

- Mental health professionals, including clinical psychologists, should learn about all types of childhood trauma, including CSA. Due to the prevalence of CSA, as well as its association with common presenting relational difficulties and mental health issues, it is likely most professionals will work with survivors, knowingly or unknowingly, at some stage in their careers. Learning about complex trauma, including CSA, will better equip mental health professionals, who traditionally only learn about diagnosable disorders and their treatment. As previously noted by Herman (1992a; 1992b), diagnostic criteria for these disorders is neither designed for, nor fulfilled by, survivors of repeated trauma experienced in a child’s developmental phase.
- Learning about all types of childhood trauma, including CSA, could increase mental health professionals’ knowledge, as well as their level of comfort when working with survivors, resulting in an improved therapeutic alliance and effectiveness of disclosure and therapy.
- A comprehensive psychosocial assessment should be conducted with all clients, as this allows time for the therapeutic relationship to develop, as well as provides the survivor several opportunities to reflect on their childhood and history, and disclose any instances of trauma, including CSA.

- If disclosure of CSA occurs in therapy, mental health professionals should endeavour to continue working with the survivor in order to maintain the established therapeutic relationship, whilst seeking consultation from expert professionals or agencies, such as CASA. Should referral be deemed necessary, it is recommended it be done in a transparent and collaborative manner with the survivor, in order to reduce feelings of betrayal or abandonment.

7.4 Limitations of the Study

Several limitations of this study are acknowledged. Firstly, the sample size of CSA survivors was extremely small. In future, research of this nature could greatly benefit if it involved payment to participants and/or agency affiliation. As this study was self-funded, the initial proposal was for all participants to participate on an entirely voluntary basis, with no payment offered. However, with the lack of response from CSA survivors to participate, payment was then considered in order to compensate potential participants. After consultation with an expert in the field, it was highlighted that providing payment to survivors could potentially recreate the dynamic of CSA. It is common for perpetrators to bestow gifts or money to the children they abuse in order to maintain power and control over them for their personal gain. As this study has illustrated how mental health professionals should endeavour to be as unlike the perpetrator as possible in everything they do, it was assessed as inappropriate and unethical to provide payment to potential CSA survivors.

In addition, the study was not affiliated with any agency, despite attempts to access CSA survivors utilising agencies where participating mental health professionals practiced. Not being affiliated with agencies precluded the researcher's ability to employ venue-based methods of recruitment, possibly affecting participation numbers of CSA survivors. Although CASA assisted the researcher by notifying mental health professionals of the study, no direct referral to their clients was made, nor recruitment flyers placed in the agencies. This lack of affiliation occurred after consultation with experts in the field and interviewed mental health professionals, who believed that survivors seeking assistance could feel indebted, coerced or pressured to participate in order to appease their mental

health professional or the agency. Due to the dynamics of abuse, survivors may try to please others by automatically complying with what they perceive to be others' wishes for fear or rejection or judgement (Dale et al., 1998). Again, as mental health professionals should practice the exact opposite of the abuse experience, placing recruitment flyers at CASAs was deemed to be inappropriate.

These recruitment issues resulted in a very small sample of CSA survivors, which then caused the methodological issue of lack of categorical saturation. While it was initially proposed that between 10 and 12 CSA survivors participate, only three took part in the study, resulting in insufficient data being gathered to achieve theoretical saturation. Theoretical saturation is one of many measures that ensure the rigor of qualitative studies. Whilst "saturation is the key to excellent qualitative work... there are no published guidelines or tests of adequacy for estimating the sample size required to reach saturation" (p. 147, Morse & Field, 1995). However, it is generally agreed upon that saturation is reached when no new information is identified from further gathering of data, therefore indicating that no new categories are emerging, or that existing themes require expansion (Charmaz, 2006; Morse & Field). However, qualitative research is recognised as being limiting, where findings derived from a small sample size is not considered representative, and therefore, generalisable, to the wider population. This is even more applicable to findings obtained from survivors, despite all three participants reporting similar experiences, opinions and concerns. While CSA participants provided important and exploratory insights, a larger sample would have been invaluable, as the voice of authority in regards to what is unhelpful or unhelpful practice lies with the survivors.

Finally, limitations regarding the mental health professionals who took part in the study were recognised. Those who participated may have done so due to their knowledge and confidence in working with CSA survivors, whilst it is thought that professionals who were not knowledgeable or comfortable in this area, did not volunteer. Therefore, findings about mental health professionals' experiences of working with CSA survivors may not be applicable to the wider professional community. The overrepresentation of professionals in comparison to survivors is also problematic. As this study demonstrated, CSA survivors may not express their concern or disagreement with the mental health professional if their practice is

unhelpful, or could drop out of therapy on the pretence of having improved. Therefore, participating professionals may not be aware of their own unhelpful practice.

7.5 Future Directions for Research

The findings from the current study highlighted areas that could be further explored to increase mental health professionals' knowledge and understanding when working with survivors of CSA. Firstly, it is suggested that future research incorporate qualitative methods in order to gain a greater depth of information and capture the complexity of CSA survivors' therapeutic experiences and needs. Given the rich, in-depth data obtained in previous research and the current study, using qualitative methodology and semi-structured interviewing is thought to provide optimum quality data. Secondly, future research could also incorporate a larger sample size of CSA survivors in order to gain a broader perspective of what is perceived to be helpful and unhelpful practice in therapy. As this was a major limitation of the current study, a larger sample size could improve the generalisability of the qualitative findings, as well a potentially discover further, unexplored areas of importance. Thirdly, in addition to a larger sample size, research investigating male survivors' therapeutic experiences and needs would also add invaluable knowledge to this field. Similarly, obtaining the perspectives of male mental health professionals would also balance the findings obtained in the current study. Exploring male professionals' knowledge and opinions would be important due to the professional's gender being an issue identified in this study. Fourthly, it is also suggested that future qualitative research could further investigate what affects a survivor's decision to disclose, or not disclose, CSA experiences in therapy, as this is an underexplored area. Finally, research exploring the dilemma of referring CSA survivors who have disclosed to mental health professionals could further contribute to knowledge and understanding of working effectively with CSA survivors.

7.6 Conclusions

The current study highlights how CSA survivors' therapeutic needs are not always met, and that mental health professional knowledge and practice can influence a survivor's wellbeing for better or worse. It is apparent that mental health professionals do not have to be experts in the area of CSA in order to be judged as effective by survivors, as basic counselling skills and the ability to listen are highly valued. Despite this finding, it is also clear that mental health professionals are not always comfortable with disclosures of CSA, possibly due to perceiving they are not knowledgeable or experienced enough to work with survivors. Unhelpful reactions or practice on behalf of the mental health professional can negatively affect a survivor who has disclosed, resulting in secondary victimisation and further silencing the survivor.

Therefore, it is considered important that mental health professional training deviate from conceptualising and treating textbook disorders, and also incorporate childhood trauma and the effects it has on adult survivors. This could increase mental health professionals' feelings of competence in the area and subsequently foster their level of comfort, which could have a positive effect on the therapeutic relationship and efficacy of therapy. Being understood, supported and listened to is powerful for survivors' wellbeing. Mental health professionals are in a privileged position to provide this and assist survivors in the process of healing.

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Appendix A- Semi-structured Interview Schedule (CSA Survivors)

<h4>Semi-structured Interview Schedule (CSA Survivors)</h4>

- Did you visit the mental health professional for the purpose of discussing or disclosing your experience of childhood or adolescent sexual assault? If so, what prompted you to do so? If not, what was the reason why you were referred?
- Who initiated the discussion of CSA?
- If it was you, what lead you to do so?
- If it was the mental health professional, how did they approach it?
- What was the experience of the initial disclosure like?
- How satisfied were you with this initial disclosure?
- How useful did you find it?
- Were there aspects of the first disclosure that you felt was particularly valuable or problematic?
- How did you decide whether the mental health professional would be a good person to discuss the CSA with?
- If you did not disclose or discuss your experience of CSA having previously planned to, what reason/s was/were behind this?
- What were the mental health professional's reactions and responses to your disclosure/discussion of CSA?
- What did you find helpful or useful about the discussion/s with the mental health professional?
- What other aspects helped, besides talking or discussing the CSA?
- What impact did the discussion have on you?
- How satisfied were you with the discussion/s?
- What could have made the discussion about your experience of CSA more helpful or useful?
- Do you think mental health professionals should ask their clients whether they have experienced CSA? Why or why not?
- How would it be best for mental health professionals to ask about CSA?
- Are there any other comments or insights you would like to add?

Appendix B – Semi-structured Interview Schedule (Mental Health Professionals)

Semi-structured Interview Schedule (Mental Health Professionals)

- What occupation and position do you hold?
- How long have you worked in this position?
- What are your areas of expertise?
- Where and what did you study to qualify for your current job?
- What have been your experiences of working with adults who were sexually assaulted as children or adolescents?
- What tends to be the presenting condition or issue?
- What is the trigger for the client seeking help?
- What tends to be the associated mental health difficulties or personal problems?
- Have you observed any differences between male and female presentations (e.g., approximate rates of seeking help, presenting problems, ways of coping)?
- Do you think disclosure of CSA is important?
- What do you think is the best way of gaining that information?
- What do you regard as most important when working with adult clients who have experienced CSA?
- Have clients told you they have disclosed a history of CSA with informal sources (e.g., friends) or formal sources (e.g., doctors)? What happened?
- What are your ideas around repressed memories of CSA?
- Was your training about CSA adequate?
- What other ways are there to gain knowledge about CSA and its sequelae?
- Is there anything else you would like to mention regarding this issue?

Appendix C – Expression of Interest Flyer (CSA Survivors)

Have you ever consulted with a mental health professional about sexual assault experienced as a child or adolescent?

Are you over 18 years of age?

If 'yes', then please read on...



If you have experienced childhood sexual assault (CSA) and spoken (or attempted to speak) to a mental health professional about it, then we would like to hear from you.

We are interested in your experience/s of speaking with, or attempting to speak with a mental health professional about the issue of CSA. If you would like to share this with us, it would be conducted as an informal interview, lasting between 60-90 minutes.


This is an opportunity for you to contribute to furthering the education and practices of mental health professionals, which may lead to an improvement in supports and services.

If you would like to participate in this study or would like further information, then please contact the Student Researcher Alison Barber on 0400 107 235 (mobile), or via email at alison.barber@live.vu.edu.au and leave a contact number and convenient time to be contacted.

Please note: Participation is subject to the number of expressions of interest, availability and suitability. This study is solely about your experience with mental health professionals and not about your actual experience of CSA. Privacy and confidentiality is strictly adhered to in accordance with ethical guidelines.

- Thankyou

Appendix D – Expression of Interest Flyer (MHP)



**Mental Health Professionals...
WE NEED YOU!**

Have you ever consulted an adult client who has experienced sexual assault as a child or adolescent?

We are aiming to develop a greater understanding about the experiences and knowledge of mental health professionals who have consulted with adult survivors of childhood sexual assault (CSA).

At the moment, we believe the needs and experiences of CSA survivors are sometimes not well understood or managed by all mental health professionals. We hope to address these issues and potentially improve support and services.

If you would like to participate, it would involve an informal interview lasting approximately 30-45 minutes. This interview is in no way evaluative. We are solely interested in your opinions, views and experiences.

If you would like to participate in this study or would like further information, please contact the Student Researcher Alison Barber on 0400 107 235 (mob.) or via email at alison.barber@live.vu.edu.au

*Please note: Privacy and confidentiality are guaranteed due to strict adherence to ethical guidelines.
-Thankyou*

Appendix E – Participant Information and Consent Forms (CSA Survivors)



**VICTORIA
UNIVERSITY**

**A NEW
SCHOOL OF
THOUGHT**

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH: ADULTS WHO HAVE EXPERIENCED CSA.

You are invited to participate

You are invited to participate in a research project entitled **'Discussing Childhood and Adolescent Sexual Assault: Experiences of Adult Survivors and Mental Health Professionals'**.

This project is being conducted by Student Researcher Alison Barber as part of a postgraduate Clinical Psychology Study at Victoria University under the supervision of Associate Professor Adrian Fisher from the School of Social Sciences and Psychology, St. Albans.

Project explanation

This research project aims to explore the experiences of adult survivors of childhood or adolescent sexual assault (CSA) when talking about (or attempting to talk about) it with a mental health professional. We are interested in your opinion/s about what part of your disclosure or discussion/s was helpful or valuable to you. Questions will also ask you about the mental health professional's reactions and responses, and your satisfaction with the experience/s. Please note that this study is solely about your experience with talking to mental health professional/s and will not ask you any questions about the sexual assault itself. The researchers will also be exploring mental health professionals' knowledge, training and opinions about consulting with adult survivors of CSA.

What will I be asked to do?

Your participation is entirely voluntary. If you choose to participate in an informal interview with the student researcher, you will be asked about your experiences of discussing or attempting to discuss your experience of CSA with a mental health professional. This interview will only start once you have fully understood all relevant details of the study, signed the consent form, and given permission for the

interview to be audio-tape recorded. You are able to skip questions if you do not feel comfortable answering them and add information that you think is important. You are also able to suspend the interview, or withdraw from the study at any time, without any explanation needed.

What will I gain from participating?

This project will give you an opportunity to express your personal experiences and opinions regarding this issue in a forum where your views and recommendations may be used to further the education, practice and guidelines of mental health professionals, and in particular Clinical Psychologists. We hope this project will increase our knowledge and understanding so we can then try to improve future support for adults who talk about their experience of CSA with a mental health professional.

How will the information I give be used?

The information you provide during the interview will be tape recorded, transcribed and analysed in order to find out about your experience of talking (or attempting to talk) with a mental health professional about the issue of CSA. We are especially interested in what you found helpful or useful about the experience/s, your satisfaction and what could be improved, in your opinion. What you say to the interviewer will be kept private and confidential in accordance with the 'Code of Ethics' (Australian Psychological Society, 2007). Please note however, confidentiality is limited if it seems there is a risk of harm to you or others, where then the researcher is ethically bound and obliged to report this risk to the relevant agencies. Any information you give will be de-identified to maintain your anonymity in relation to all aspects of this research.

What are the potential risks of participating in this project?

You may experience some minimal distress during the interview. If you were to become upset during the interview, we could suspend or postpone the interview until another time. Otherwise, you could choose to withdraw from the study without any explanation needed. The interview is designed to be conducted in a manner that is supportive and flexible. If you require support at the end of the interview, please notify the student researcher.

In addition, you need further assistance at the conclusion of the interview, the following referrals are recommended:

CASA House	(03) 9635 3610 (Counselling & Support) (03) 9635 3600 (General inquiries and contact details for nearest CASA)
Mensline Australia	1300 78 99 78 talkitover@menslineaus.org.au
Lifeline	13 11 14 (24 hour service for counselling, information or referrals)
Dr. Gerard Kennedy School of Social Sciences and Psychology Victoria University	(03) 9919 2481

How will this project be conducted?

Information will be gathered via participants taking part in a semi-structured, informal interview, lasting between 60 and 90 minutes. With your consent, the interview will be tape recorded, transcribed and analysed in order to find out about your experience of talking with a mental health professional about the issue of CSA.

If you would like to take part in this study, please contact the Student Researcher Alison Barber via the telephone or email details below. The Student Researcher will also inform you of your rights to privacy and confidentiality, along with your right to withdraw from the study at any time without explanation needed.

Who is conducting the study?

Ass. Prof. Adrian Fisher (Principal Researcher)	Alison Barber (Student Researcher)
School of Social Sciences and Psychology	School of Social Sciences and Psychology
St. Albans Campus	St. Albans Campus
(03) 9919 5221	0400 107 235
adrian.fisher@vu.edu.au	alison.barber@live.vu.edu.au

Any queries about your participation in this project may be directed to the Principal Researcher listed above.

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.



**CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH: ADULTS WHO HAVE
EXPERIENCED CSA**

We would like to invite you to be a part of a study that is exploring the experiences of adult survivors of childhood sexual assault (CSA), when discussing, or attempting to discuss the issue of CSA with a mental health professional. We are interested in your opinion/s about what parts of your disclosure or discussion/s were helpful or valuable to you. Questions will also ask you about the mental health professional's reactions and responses, and your satisfaction with the experience/s. Some questions could potentially touch upon sensitive areas that may cause discomfort. However, this study is solely about your experience with mental health professionals and not the sexual assault itself. Your participation is entirely voluntary, and will give you an opportunity to express your experiences and opinions regarding this issue in a forum where your views and recommendations may be used to further the education, practice and guidelines of mental health professionals, and in particular, Clinical Psychologists.

I, _____ (name) of _____ (suburb)

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study:

'Discussing Childhood and Adolescent Sexual Assault: Experiences of Adult Survivors and of Mental Health Professionals', being conducted at Victoria University by Alison Barber, under the supervision of Associate Professor, Adrian Fisher.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by Alison Barber (Student Researcher), and that I freely consent to participation involving the below mentioned procedures:

- Semi-structured interview lasting between 30-90 minutes, tape-recorded on audio cassette

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential, with the exception of if I disclose that there is a serious risk of harm to myself or others. I understand that in the reporting of the research findings, for example in publications, I will not be personally identifiable.

Signed: _____

Date: _____

Any queries about your participation in this project may be directed to: Alison Barber (Student Researcher) on 0400 107 235, or Principal Researcher, Associate Professor Adrian Fisher (03) 9919 5221. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

Appendix F – Participant Information and Consent Forms (MHP)



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INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH: MENTAL HEALTH PROFESSIONALS

You are invited to participate

You are invited to participate in a research project entitled '**Discussing Childhood and Adolescent Sexual Assault: Experiences of Adult Survivors and of Mental Health Professionals**'.

This project is being conducted by Student Researcher Alison Barber as part of a Doctor of Clinical Psychology course at Victoria University under the supervision of Associate Professor Adrian Fisher from the School of Social Sciences and Psychology, St. Albans.

Project explanation

This research project aims to explore mental health professionals' experiences, formal and informal education, and knowledge of working with adult clients who have discussed their childhood or adolescent sexual assault (CSA) in therapy. In particular, we are interested in your opinion/s regarding adequacy of the available training you received, as well as the perceived effectiveness of your specific profession in regards to discussing CSA. This study is not a personal evaluation of your knowledge and experiences. The researchers will also be interviewing adult survivors of CSA about their experiences of disclosing/discussing their CSA with a mental health professional.

What will I be asked to do?

Your participation is entirely voluntary. If you choose to participate in an interview with the Student Researcher, you will be asked about your knowledge and experience of working with adult clients who have discussed their CSA in therapy. You will also be asked about your formal and informal education about CSA, your views on if training is adequate and if there are any improvements you

would recommend. Again, this informal interview is not a personal evaluation of your knowledge and experiences.

What will I gain from participating?

This project provides an opportunity for you and other mental health professionals to express your personal views and recommendations in a forum whereby these opinions will further the education, practice and guidelines for your peers, and in particular Clinical Psychologists.

How will the information I give be used?

The interview will only proceed once the consent form has been signed, and will be audio-tape recorded, with your permission. You are able to skip questions if you do not feel comfortable answering them and add any information that you find important. You are also able to suspend the interview, or withdraw from the study at any time, without any explanation needed.

What you say to the interviewer will be kept private and confidential in accordance with the 'Code of Ethics' (Australian Psychological Society, 2007). Please note however, confidentiality is limited if it seems there is a risk of harm to you or others, whereby the researcher is ethically bound and obliged to report this risk to the relevant agencies. Information you give will be de-identified, and in future presentations and possible publications of the research your anonymity will be maintained.

What are the potential risks of participating in this project?

You may find parts of the interview distressing. If you were to become upset during the interview, we could suspend or postpone the interview until another time. Otherwise, you could choose to withdraw from the study without any explanation needed. The interview is designed to be conducted in a manner that is supportive and flexible.

If you need further support at the conclusion of the interview, please speak to the Student Researcher. Otherwise, Dr. Gerard Kennedy at Victoria University on (03) 9919 2481 is available for telephone consultation.

How will this project be conducted?

Information will be gathered via participants taking part in a semi-structured, informal interview, lasting between 30 and 90 minutes. With your consent, the interview will be tape-recorded, transcribed and analysed in order to find out about your opinions and knowledge about formal and informal education or training, and any recommendations you may have.

If you would like to take part in this study, please contact the Student Researcher Alison Barber via the telephone or email details below. The Student Researcher will also inform you of your rights to privacy and confidentiality, along with your right to withdraw from the study at any time without explanation needed.

Who is conducting the study?

Ass. Prof. Adrian Fisher (Principal Researcher)	Alison Barber (Student Researcher)
School of Social Sciences and Psychology	School of Social Sciences and Psychology
St. Albans Campus	St. Albans Campus
(03) 9919 5221	0400 107 235
adrian.fisher@vu.edu.au	alison.barber@live.vu.edu.au

Any queries about your participation in this project may be directed to the Principal Researcher listed above.

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.



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CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH: MENTAL HEALTH PROFESSIONALS

We would like to invite you to be a part of a study exploring mental health professionals' knowledge and experiences of working with adult clients who have disclosed or discussed their childhood or adolescent sexual assault (CSA). We are interested in your knowledge, formal and informal education, and experiences of working with adult clients who have discussed their childhood or adolescent sexual assault (CSA) in therapy. In particular, we are interested in your opinion/s regarding adequacy of the available training you received, as well as the perceived effectiveness of your specific profession in regards to discussing CSA. You will also be asked if there are any improvements you would recommend. Participation in this study is entirely voluntary and provides you an opportunity to express your views and recommendations in a forum and will be used to further the education, practice and guidelines of mental health professionals, and in particular, Clinical Psychologists.

I, _____ (name) of _____ (suburb),

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study:

'Discussing Childhood and Adolescent Sexual Assault: Experiences of Adult Survivors and of Mental Health Professionals' being conducted at Victoria University by Alison Barber, under the supervision of Associate Professor Adrian Fisher.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by Alison Barber (Student Researcher), and that I freely consent to participation involving the below mentioned procedures:

- Semi-structured interview lasting between 30-90 minutes, tape-recorded on audio cassette

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential, with the exception of if I disclose that there is a serious risk of harm to myself or others. I understand that in the reporting of the research findings, for example in publications, I will not be personally identifiable.

Signed: _____

Date: _____

Any queries about your participation in this project may be directed to: Alison Barber (Student Researcher) on 0400 107 235 or Principal Researcher Associate Professor Adrian Fisher (03) 9919 5221. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

Appendix G – Ethics Approval & Amendment

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TO	Dr Elizabeth Short School of Social Sciences and Psychology Footscray Park Campus	I 24/06/2009 DATE
<hr/>		
FROM	Dr Harriet Speed Chair Victoria University Human Research Ethics Committee	
<hr/>		
SUBJECT	Ethics Application – HRETH 08/267	

Dear Dr Short,

Thank you for submitting this application for ethical approval of the project:

HRETH 08/267 Discussing Childhood and Adolescent Sexual Assault: Experiences of Adult Survivors and of Mental Health Professionals

The proposed research project has been accepted and deemed to meet the requirements of the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007)' by the Victoria University Human Research Ethics Committee. Approval has been granted from 11 June 2009 to 10 June 2011.

Continued approval of this research project by the Victoria University Human Research Ethics Committee (VUHREC) is conditional upon the provision of a report within 12 months of the above approval date (by **11 June 2010**) or upon the completion of the project (if earlier). A report proforma may be downloaded from the VUHREC web site at: <http://research.vu.edu.au/hrec.php>.

Please note that the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious events or adverse and/or unforeseen events that may affect continued ethical acceptability of the project. In these unlikely events, researchers

must immediately cease all data collection until the Committee has approved the changes. Researchers are also reminded of the need to notify the approving HREC of changes to personnel in research projects via a request for a minor amendment. If you have any queries, please do not hesitate to contact me on 9919 5412.

On behalf of the Committee, I wish you all the best for the conduct of the project.

Dr Harriet Speed

Chair

Victoria University Human Research Ethics Committee

MEMO



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TO A/Prof Adrian Fisher
School of Social Sciences and Psychology
Footscray Park Campus

DATE 14/04/2010

FROM Dr Harriet Speed
Chair
Victoria University Human Research Ethics Committee

SUBJECT Ethics Application – HRETH 08/267

Dear Dr Short,

Thank you for submitting this application for ethical approval of the project:

HRETH 08/267 Discussing Childhood and Adolescent Sexual Assault: Experiences of Adult Survivors and of Mental Health Professionals

The amendment to the proposed research project has been accepted and deemed to meet the requirements of the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007)' by the Victoria University Human Research Ethics Committee. Approval has been granted from 14 April 2010 to 10 June 2010.

Continued approval of this research project by the Victoria University Human Research Ethics Committee (VUHREC) is conditional upon the provision of a report within 12 months of the above approval date (by **14 April 2011**) or upon the completion of the project (if earlier). A report proforma may be downloaded from the VUHREC web site at: <http://research.vu.edu.au/hrec.php>.

Please note that the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious events or adverse and/or unforeseen

events that may affect continued ethical acceptability of the project. In these unlikely events, researchers must immediately cease all data collection until the Committee has approved the changes. Researchers are also reminded of the need to notify the approving HREC of changes to personnel in research projects via a request for a minor amendment.

If you have any queries, please do not hesitate to contact me on 9919 5412.

On behalf of the Committee, I wish you all the best for the conduct of the project.

Dr Harriet Speed

Chair

Victoria University Human Research Ethics Committee