PS<##>/24

# The impact of non-recent child sexual abuse on the mental health of adults

Consultation draft: February 2024

POSITION STATEMENT

# Contents

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# Acknowledgements

*<To be completed>*

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# The importance of language

## Non-recent child sexual abuse

The terminology used to describe non-recent child sexual abuse (NRCSA) varies and there is no single agreed or preferred term for it, nor for the person who has been subjected to it. Terms such as ‘historical child(hood) sexual abuse’ (often abbreviated to ‘HCSA’ or ‘CSA’) may be used.

The use of non-recent is to indicate that the acts of child sexual abuse occurred in the person’s past and under the age of 18. However, this does not mean that the impact is historical. As this statement demonstrates, the impact is typically current, ongoing and long-lasting.

In this position statement, the term ‘non-recent child sexual abuse’, abbreviated to ‘non-recent abuse’ or ‘NRCSA’, is used. It refers to sexual abuse that occurred in an adult’s childhood (when they were under 18).

### Definition of child sexual abuse

Child sexual abuse “Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.”

Source: Working Well to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (HM Government, 2018)

*See the Glossary for definitions of other terms used in this position statement.*

## Adult survivors of child sexual abuse

The terms adults use to describe themselves when they have been affected can change or be interchangeable. For example, survivor, victim and patient can be used, depending on the context and how a person wishes to identify themselves. As set out elsewhere in this statement, the terminology used by professionals when supporting someone with experience of NRCSA is vitally important.

In this position statement, the term ‘survivor’ is used.

## The language and tone used by professionals

For professionals, we advise that the language and tone used in communication with the people they are supporting is compassionate and reflects the person's preferences. The language and tone should demonstrate an understanding of the impact of NRCSA and how difficult it is to seek help. It is crucial that the terminology used avoids the potential for re-traumatisation[a] and prevention of survivors from seeking help.

> *"Please don't use 'them and us' language. We are all touched by abuse in one way or another and if you use language to distance us, it just creates more isolation."*

> *"The words used to talk about us – be that to us in consultations, in reports, in research papers (which we read you know!) and books – will either solidify the silencing, the self-blame, minimisation and shame, or will help create openness for us to speak about what happened, to feel and to heal. So please be careful how you talk about abuse and about those of us who experienced it."*

DRAFT

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[a] See the Glossary for a definition of re-traumatisation.

# Executive summary

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# 1. Aims and introduction

## 1.a. Scope and aims of this position statement

This position statement sets out the College view on the impact of non-recent child sexual abuse (NRCSA) on mental health. This follows the College's recognition of a need to present a clear position on historical childhood sexual abuse in the context of mental health disorders and their management across mental health services. That is the first aim of this position statement. The second is to make recommendations for clinical care and commissioning guidance, teaching and training of psychiatrists, research and public policy in relation to NRCSA.

The principles of good practice contained in this document are applicable to all forms of child abuse, whether they occur alone or with child sexual abuse.

| **Aims** | |
|---|---|
| **1** | To raise awareness of the substantial impact of non-recent child sexual abuse (NRCSA) on adult mental health. |
| **2** | To demonstrate that understanding the impact and providing support to people with a history of NRCSA is a core business for all psychiatrists and other mental health professionals. |
| **3** | To support psychiatrists and other mental health professionals to recognise the complexity of providing appropriate trauma-informed care. |
| **4** | To improve the overall response of psychiatrists and mental health professionals to people with a history of NRCSA, and improve the confidence of people seeking support in mental health services. |
| **5** | To influence organisations involved in the design and delivery of mental health services to provide comprehensive trauma-informed services that meet the needs of patients with a history of NRCSA. |
| **6** | To influence organisations that provide and set standards in medical training and further education, to ensure high-quality care for people with a history of NRCSA across all healthcare settings. |
| **7** | To encourage and support research into NRCSA, to develop an evidence base that will inform the delivery of services. |

> *"Recognise that this is my healing journey and it's your role to be alongside me and resource me to navigate it for myself, with your support."*

## 1.b. Introduction

Child sexual abuse is a widespread global problem with profound repercussions for those who experience it, their families, communities and for society as a whole. It often occurs with other experiences of abuse, such as physical, spiritual and emotional abuse, including coercive control and neglect.

The consequences and repercussions of child sexual abuse can be profound and wide-reaching. Without the right help and support, the devastating impacts on a person's physical and mental health and wellbeing can be lifelong.

While this position statement focuses on the impact of NRCSA on mental health, it is vital that professionals are aware of the extent of its impact on physical health and provide support that addresses the needs of the whole person.

### The impact of child sexual abuse on adults

There is strong evidence linking a history of child sexual abuse (and other forms of childhood abuse and adversity) to short- and long-term adverse effects in adulthood, including severe and enduring mental illness.

NRCSA is associated with higher rates of depression, anxiety, post-traumatic stress disorder (PTSD) and complex PTSD (CPTSD), psychotic illness, alcohol and substance misuse, dissociative disorders and eating disorders. These effects may lead to poorer social, educational and economic outcomes and the risk of further sexual abuse in adulthood.

On the other hand, for some, an abuse history may be masked by pro-social coping styles, 'appeasement' survival responses, and by hyperfunctioning and perfectionism.

> *"Alcohol makes everything better and more manageable. It seems to make it go away so you can do things."*

> *"I experienced severe childhood domestic violence, psychological abuse and sexual abuse and it is the psychological abuse that has scarred me the most. It really distresses me when professionals talk only about the sexual abuse. I did not experience my abuse in categories, like I can separate out the impact and only be treated for one type. I sometimes feel that the rest of what happened to me would not matter at all if I hadn't been sexually abused as well."*

### Disclosure[b]

Research has consistently shown that many people do not disclose child sexual abuse at the time the abuse is occurring. A large number of survivors report only disclosing abuse experiences in adulthood[1]. One study found that almost 60% of adult survivors delayed disclosing for 5 years or more, with one in five reporting never having disclosed to anyone[2].

If they are then met by professionals who are poorly equipped to respond in a helpful way, it is due to significant gaps in the training of mental health professionals, a shortfall in the provision of trauma-informed services and inadequacies in the evidence base for developing interventions that survivors find helpful and effective.

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[b] See the Glossary for a definition of disclosure.

## Gaps in treatment and services

Many survivors are left trying to manage the devastating impact of abuse with inadequate, short-term or unhelpful interventions, or with no help at all. Some actively avoid mental health services due to the fear of being re-traumatised or misdiagnosed.

Equally, professionals can end up treating people without adequate training and support and without fully understanding what might be behind their presentations, therefore not offering what is needed or helpful.

> *"If I could go back in time, I wish I'd never come into contact with the mental health system."*

> *"I have tried to think back in my training as a psychiatrist but I cannot recall ever being taught anything about NRCSA. I had no training on how to facilitate disclosure or what to do if someone did disclose, and certainly no training on how to work with survivors."*

DRAFT

## Economic costs

A Home Office report has estimated that the cost of all contact child abuse in 1 year is at least £10.1 billion[3].

A recent study analysed the costs of disclosures being delayed, denied or disbelieved, and of survivors not receiving effective treatment and support. It was estimated that the delays cost nearly £3 billion, with an average lifetime health cost per survivor of nearly £5 million.

Services that enable early disclosure and provide the right support are therefore vital to reduce the economic burden, as well as the impacts on safety, health and wellbeing.

## 1.c. About the development of the position statement

The College's Policy and Public Affairs Committee agreed at its meeting in December 2019, that an expert reference group with wide representation across the College should be convened, to focus on (a) the development of this position statement, (b) the identification of what other work the College could do beyond a policy statement and (c) recommendations for research to fill existing gaps in knowledge and for future work to contribute to service improvement.

This position statement was developed alongside a literature review that explored the prevalence of childhood sexual abuse in adults diagnosed with mental health conditions. Development started in 2020, and the literature searches spanned 1 January 2019 to June 2021, to capture studies published after Hailes and colleagues' 2019 umbrella review[4]. A summary of the literature review findings is provided in Appendix A.

This statement has been co-produced[c] as a collaboration between survivors, some of them also professionals, psychiatrists, mental health policy professionals and researchers. In the process of producing this document, it became clear that the direct and comprehensive involvement of people with lived experience is vital to minimise re-traumatisation and improve services, care and treatment for adult survivors of NRCSA.

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[c] See the Glossary for a definition of co-production.

Testimonial quotes are placed throughout the position statement from experts by experience and psychiatrists; see also Appendix B for more quotes.

*"I sought help for my abuse but was told I am 'too functional' to get any help. So I am left alone to manage the debilitating impacts of what was done to me."*

*"It is unethical to shame a patient for their presenting symptoms, to refer them for inappropriate treatment, or sedate them to manage their symptoms whilst ignoring the cause of those symptoms."*

*"If I could sum up good support in just three words, they would be…*

- *Heard – above all, I need you to listen.*
- *Held – I cannot fully describe how excruciatingly painful this can be for me. I need to be emotionally held safely while I process that.*
- *Helped – healing is my job, but I need a trusty companion. You can help me find the resources I need to recover in the long term."*

DRAFT

# 2. Overarching considerations

## 2.a. Survivor-centred charter

We support the recommendation of The Charter for Engaging Survivors[5]: that all work with people who have experienced abuse and trauma[d] needs to be the opposite of abuse, so that it does not (inadvertently) replicate the dynamics of abuse and cause harm. Services for survivors should follow the principles of the Survivors' Charter by ensuring they are:

| | |
|---|---|
| **Safe** | Abuse is inherently unsafe. It leaves a long legacy of fear. Many survivors remain frequently triggered into 'flight, fight, freeze or appease' responses. Some survivors will still be in situations of ongoing abuse and risk of harm. Thus, the first priority for engagement is a safe environment: this begins with providing attentive listening and connections that are warm, collaborative and relational, which recognise and minimises triggers and may include safety protocols. Dedicated time is given to building trust and safety at the start. |
| **Empowering** | People who are abusive dominate and take away personal power. Good engagement should be collaborative and must empower survivors to have control of decisions about their own involvement. This includes the decision about their capacity to participate in services or projects, within agreed boundaries of being able to keep themselves safe and support the maintenance of safety for other participants. Services and projects may be survivor-led or co-produced with survivors and survivor organisations. Shared decision-making should be used in clinical/treatment settings. |
| **Amplifying the voices of survivors** | Abuse is silencing. Engagement should help release and amplify survivors' voices, experiences and expertise. Good engagement is survivor-centred, meaning it sees things from the survivor's perspective and is led by their views, wishes and feelings. Services and projects are evaluated with survivors' voices as a key input, allowing them to be the 'experts by experience'. 'Participation' in projects should not be reduced to 'recruiting' participants or representatives 'round the table' with no attention to power dynamics that diminish true participation. Practitioners need awareness of these same dynamics in clinical/service settings, to ensure survivors are heard and have real choice in treatment decisions. |
| **Promoting self-care** | Abuse is self-negating, destroys self-worth and damages well-being. Many who have been abused experience times of fragile mental and physical health and may find it hard to practice self-care. Engagement in co-production, shared decision-making and trauma treatments can impact coping mechanisms – thus radical self-care should be promoted and normalised. This includes recognising that many survivors are both 'OK' and 'not OK' at the same time (often masking distress). Resilience and 'pathology' are intertwined (for example self-harm, dissociation, overwork) and are often coping strategies to participate in life despite the pain. Practitioners and organisations should support and not pathologise service users and workers and who are survivors, enabling them to be real about their struggles and 'not OK' days, and ensuring sufficient support, which may mean a holistic, 'circle of support' approach. |

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[d] See the Glossary for a definition of trauma.

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| **Accountable and transparent** | Abuse is hidden, and abusers often act with impunity. Engagement with survivors must have clear lines of communication and accountability, including to survivor-participants and survivor communities. Processes and decision-making should be relational, honest, real, transparent and open to feedback and dialogue. Clinical/service settings should adopt a shared decisions-making approach. There should be effective and clear complaint processes, and adequate support and information to access them. |
| **Liberating** | Abuse restricts and arrests healthy growth, imprisoning people in physical, mental and emotional shackles. Engagement should be a voluntary, unconditional process and easy to withdraw from at any point (without fear of permanent exclusion). Good engagement is liberating, dynamic, life-giving and helps survivors experience a sense of possibility and life beyond the aftermath of abuse. Services should include a focus on strengths and support, not just struggles and needs. |
| **Creative and joyful** | Abuse is corrosive, restrictive and soul-destroying. Engagement should be a creative process. Good engagement focuses on positive experiences and strengths as well as negative ones and can increase capacity for joy, creativity and imagination. Where appropriate, services should include elements of fun and celebration of achievements and landmarks. |

DRAFT

## 2.b. Intersectionality and non-recent abuse

In addition to the negative mental health impact of sexual abuse in childhood, survivors with protected characteristics (people from racialised and minoritised ethnic communities, LGBTQ+[e] people, women and people with disability) are at greater risk of mental health problems because of discrimination[6]. A person may have more than one protected characteristic, and these multiple political and social identities combine, intersect and overlap. This may lead to greater or lesser advantage or disadvantage (intersectionality[f]).

> *"Don't make me the disorder. Recognise the structural inequalities, oppression, violence and other social exclusion that cause mental distress."*

The abuse in NRCSA is a form of oppression and marginalisation. Intersectionality is significant in the context of NRCSA, because the oppressive nature of the abuse can combine with and add to the oppression and marginalisation experienced by those with intersecting identities. In addition, those with protected characteristics may experience shame and stigmatisation because of negative appraisals of the group to which they belong. These oppressions and marginalisations can accumulate, making it much more difficult to access appropriate and culturally/identity competent mental health services.

It is therefore important for mental health professionals to be aware of intersecting identities. When initially meeting people with mental health problems, assumptions should not be made about race, ethnic background or gender, because they could influence the person's engagement, treatment and outcome.

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[e] LGBTQ+ = lesbian, gay, bisexual, transgender, queer plus.
[f] See the Glossary for a definition of intersectionality.

A brief look at the evidence related to protected characteristics and CSA is included below. However, the evidence is sparse, and more research in this area is recommended.

In their 2020 report on childhood sexual abuse in minoritised ethnic communities, the Independent Inquiry into Child Sexual Abuse (IICSA)[7] found that literature for England and Wales focused more on the experiences of Asian and South Asian communities than Black communities, and only a few studies mentioned other minoritised ethnic groups. From their research into the literature and in the form of focus groups, IICSA concluded that:

- Cultural stereotypes and racism can lead to a failure to identify and respond to NRCSA, and can make disclosure more difficult.
- Seeing only the ethnic group, not the whole person, was a common experience.
- Shame and stigma can lead to a code of silence in some communities.
- Child sexual abuse can impact the survivor's sense of identity and belonging, and can lead to the belief that to disclose will lead to being ostracised.
- The response to childhood sexual abuse is linked to expectations about gender in some minoritised ethnic communities.
- Institutions were often perceived and experienced negatively, particularly the police and social services, but also healthcare. They are often experienced as predominantly White and oriented to more privileged communities. Sometimes they are seen as coercive.
- Much more could be done to raise awareness, remove barriers to disclosure and improve responses to child sexual abuse in minoritised ethnic communities.

*"Black and ethnic minorities often have an already strained relationship with statutory services, for example, police or health services, creating additional barriers for us to receive care for our mental health."*

In relation to cultural stereotypes and racism, processes of cultural stereotyping and profiling, such as the 'adultification' of Black children (seeing them as older than they are and making assumptions about their sexual experiences) and not seeing Black children as victims, can lead to NRCSA in Black women and men being ignored.

*"In my experience as a Black woman, a big thing is that Black children are often not seen as victims. So even though they are disproportionately impacted by sexual violence, we are underrepresented in receiving care for this abuse. There's a concept known as the adultification of Black girls that is very key to this."*

On shame and stigma, the Inquiry found that some men from minoritised ethnic communities who are survivors of sexual abuse perpetrated by men fear being labelled as gay; this was particularly the case for those from cultures in which same-sex sexual activity is taboo and from countries where it is illegal[8]. The Inquiry also learned that trauma and other mental health problems are "not widely accepted and understood in many ethnic minority communities"[8].

The Inquiry[9] found that while social and political attitudes to LGBTQ+ identities have improved, there are still views in society that were "built on harmful myths and stereotypes". Some LGBTQ+ survivors reported to the Inquiry that they were blamed for the abuse because of their sexual orientation or gender identity ('you brought it on yourself') or had been told that their sexual orientation or gender identity resulted from the abuse, or that people who had been abused as children would go on to abuse others. These myths severely affected LGBTQ+ survivors' self-identity and mental health.

The Inquiry also learned that because LGBTQ+ people are seen as 'different', it could be more difficult to disclose NRCSA. Internalised homophobic shame and stigma and overt

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homophobia, particularly affecting gay and bisexual men, also constituted significant barriers to disclosure and seeking help.

Another myth that prevails is that child sexual abuse is perpetrated by heterosexual cisgender men and that the survivors are heterosexual cisgender women and girls. This myth can be damaging for men and boys, who could feel reluctant to disclose, and is exacerbated by male rape not being recognised by law until 1994: until then, a male victim of rape could be subject to the same gross indecency laws as his rapist. The Inquiry was told that, as a result, many male survivors of NRCSA have never disclosed[9].

*"In my culture, loyalty to the family and preserving family honour is everything and you must not bring any shame to the family name by speaking about 'family business' to anyone. On top of this, as a girl, I was taught that I had to submit to anything my brothers or father did to me. Speaking up made me a shame-bringer and shame-bearer. Mental health services need to educate themselves about the profound shaming and silencing dynamics of honour-based cultures (which also exist in White communities like mine) so that you can sensitively ask the right questions and help us dare break the loyalty bonds that stop us from healing."*

Men of all sexual orientations and ethnicities are less likely to access or engage in psychological therapy than women, which limits the opportunities for them to disclose childhood sexual abuse.

## 2.c. Iatrogenic harm in relation to NRCSA

While the potential for harm exists throughout healthcare, iatrogenic harm[g] should be thought of in terms of avoidable unintentional harm and considered separately from known complications or side-effects of a medical intervention.

In relation to NRCSA, iatrogenic harm can be understood in the following ways:

1) **Harm caused by lack of awareness of abuse and trauma**, leading to triggering and subsequent re-traumatisation, as well as misinterpretation, misdiagnosis and lack of appropriate treatment.
2) **Harm caused by treatment** (including medication and all psychosocial interventions, including psychotherapy):
    - harm can be caused as a result of the intervention itself or as a result of interactions with professionals and others involved in disclosure and treatment
    - harm may result from a lack of appropriate treatment, or from appropriate treatment that is delivered incorrectly.
3) **Restrictive and what could be experienced as punitive practices** occurring for people with NRCSA (and be associated with particular contentious diagnoses such as emotionally unstable personality disorder [EUPD]). The harm could be understood as arising from working with people who have experienced serious trauma and professionals' responses to this (including inappropriate behaviour and sexual assault by professionals).
4) **Harm caused by systemic failures** (when the structures and systems fail to provide the necessary education, training, support and appropriate intervention, including sufficient funding and resources).
5) **Harm caused by poor or inappropriate response** from other professionals or services such as social care and police services.

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[g] See the Glossary for a definition of iatrogenic harm.

DRAFT

It is common for individuals affected by NRCSA to experience re-traumatisation when disclosing abuse, misdiagnosis, inappropriate treatment and care planning, and insufficient healthcare provision. It is the view of the working group that there is a significantly increased risk of iatrogenic harm. To experience re-traumatisation at multiple points in their contact with service. The potential for iatrogenic harm can occur at the time of the disclosure, process of diagnosis, care planning and treatment and is significantly increased in this group of patients.

Currently, there is an insufficient body of knowledge on the iatrogenic harm that some psychosocial treatments have the potential to inflict[10]. Problems associated with adverse effects of certain aspects and types of psychotherapy are well-recognised, yet there remains work to be done to prevent it from occuring[11]. There needs to be better standardised definitions of harms, and a way of monitoring and documenting its effects. Adequately powered trials to identify benefits and harm would help move the field forward, in particular, research to seek views directly from survivors about what helps and harms[12].

The systematic research review for this position statement identified a lack of guidance for best practice after a person's disclosure of NRCSA to a mental health professional (see Appendix A). Existing guidance from the National Institute for Health and Care Excellence (NICE) for treating people with mental health conditions and experience of NRCSA were limited to PTSD and emotionally unstable personality disorder (EUPD)[13,14], but were not considered comprehensive.

## Re-traumatisation

In the context of iatrogenic harm, re-traumatisation can be an unintentional result of contact with health care services[15]. The risk of services re-traumatising survivors is lower when collaboration and trust are established as an integral part of the therapeutic relationship[16]. This leads to better outcomes and increased patient satisfaction. A trauma-informed approach to treatment seeks to prevent occurrences of re-traumatisation when delivering psychiatric care by working to understand the complex and pervasive impact of trauma on a person, including their relationships, worldview and ways of engaging with support services[16,17]. Services that take a trauma-informed approach are organised and delivered to prevent re-traumatisation.

*"At my first psychiatric consultation I was told I needed therapy for my poor adult coping mechanisms – I was totally shamed. Those were the same strategies that helped me survive my years of childhood abuse. Don't invalidate my experience and shame me for my survival strategies"*

*"I have worked in the NHS all my life, and the one time I needed help, I was shamed and later abandoned. If you can't trust those who are meant to care, who can you trust?"*

*"What I went through needs long term, relational therapy. There is none through NHS and I can't afford it privately."*

*"What I have learnt [in psychiatric practice] has been most informed by my patients, who continue to teach me what being 'trauma-informed' really means."*

*"I'm not sure I can even explain the damage that services have done to me over the years."*

DRAFT

## 2.d. Cultural competence and trauma-informed practice[h]

Cultural competence relates to understanding how beliefs and values may differ between people and/or groups of people, and how those beliefs and values may at times be in conflict with one another. This directly influences the ability to communicate with people of other cultures effectively and appropriately. In relation to NRCSA, a lack of awareness among healthcare professionals and health systems of prejudices, stereotypes, cultural norms and beliefs may be a barrier to providing support and/or treatment. For example, not understanding how some cultures may interpret abuse as punishment or a rite of passage (for example, female genital mutilation) can significantly impact the likelihood of individuals disclosing their experiences.

A health professional's cultural beliefs, such as strong patriarchal views and behaviours, may also impact on the extent to which they can understand or provide support in a non-judgemental and compassionate way. Where services aim to be culturally competent in relation to a particular aspect of someone's identity (for example, race and ethnicity), it can lead to a lack of recognition of the intersectionality with the person's faith/religion, sexual orientation, socioeconomic status and literacy level (see 2.b. Intersectionality and non-recent abuse).

Cultural competence is also critical to understanding and avoiding the emotional and mental health impact of being marginalised, including the potential for professionals to 'other' people seeking support (the act of viewing or treating someone differently or not part of a group).

### Training for healthcare professionals

It is essential that healthcare professionals are comprehensively trained in cultural competence, which should take into account trauma-informed principles[18]. For example, this training should help professionals understand that individuals from some cultural groups might not want to have their experience of abuse written in their notes or for this information to be passed on to other care professionals. Understanding this reduces anxiety about unwanted disclosure (see also Appendix C, Resource 1 and Resource 2 on trauma-informed talking therapies assessments and addressing inequalities in the health service).

*"Understand that I am wounded not sick. Always use a trauma-informed approach."*

*"I received no training on NRCSA as a medical student or a junior trainee. I remember an Irish man I saw as an SHO [senior house officer] who was admitted with a suicidal crisis. He spoke about being sexually abused as a child in care of the religious institution and a court case relating to this. He was treated with suspicion and the nursing staff spoke openly about him not to be believed as he was 'making things up'."*

*"Be relational.*
*Don't medicalise me.*
*Offer choices."*

*"Don't imagine you can 'fix' me, or that you know better than me what I need. Help me to make sense of my experiences and work out what I need, to have voice and agency."*

DRAFT

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[h] See the Glossary for a definition of trauma-informed practice.

# 3. Aspects of NRCSA

## 3.a. Dimensions of NRCSA

Child sexual abuse has been defined as "developmentally inappropriate sexual activity between a child and another individual who is in a relationship of power, trust or responsibility to the child"[19]. Determining when childhood sexual abuse becomes non-recent, especially given that how recently the experience took place, does not determine the size of the impact on survivors.

There are significant attempts to define child sexual abuse and exploitation[i] that are worth reading, including in the government guidance, Working Together to Safeguard Children[20,21]. Recognising the complexities of a definition of child sexual abuse, a conceptual approach can be helpful – see Matthews and Colin-Vezina (2019)[22].

The literature review accompanying this position statement (see Appendix A) highlights the inconsistencies in definitions of NRCSA. Also, preferences around terms used differ between individual survivors and between stakeholder groups.
In the literature and in clinical practice, a consensus has not been reached on the definition of NRCSA[22].

Child sexual abuse often takes place in the broader context of abuse:

> "All abuse involves a misuse of power within interpersonal relationships. The power may be due to age, relationship, strength, personality, profession, role or position. These experiences can occur in a variety of social settings including families, schools and communities. We understand that different forms of abuse can all have a deep and long-lasting effect on us as children and adults and this can be even more profound if it occurs in early years and within significant relationships."[5]

*"It is not just about 'what happened'. The anticipation and expectation of the abuse happening were so debilitating that they are as damaging as the abuse itself. In one sense, as long as the threat of re-abuse remained, it only needed to happen once. The hypervigilance and constant fear I have been left with are utterly exhausting."*

One also has to consider other factors, such as the relationship of the abuser to the survivor, the age at which abuse occurred and the age of the abuser, to mention just a few. Peer-to-peer sexual abuse (often missing from definitions) should also be recognised.

Often child sexual abuse occurs alongside or as a part of other forms of abuse (such as physical, emotional and institutional abuse), all of which are underpinned by an abuse of power on the part of the abuser, and of powerlessness on the part of the victim. There is a significant complexity when abuse occurs within a relational caregiver situation, for example. In defining child sexual abuse, clarification of the distinction between 'consent' and 'compliance' in line with the imbalance of power is vital; a child has no agency, is not able to consent and is not responsible even if their behaviour may be sexualised.

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[i] See the Glossary for a definition of child sexual exploitation.

DRAFT

Sexual abuse can take many forms. It can include grooming, covert sexual abuse, verbal or written sexual abuse and non-contact abuse perpetrated before any form of physical contact. Grooming and other forms of non-contact abuse still constitute sexual abuse even if contact abuse does not follow. Non-contact sexual abuse can be as mentally and emotionally damaging and debilitating as contact (physical) sexual abuse. Definitions of childhood sexual abuse used in research, and across health and social care systems, should include all forms of sexual abuse regardless of whether the abuse was contact or non-contact and survivors should receive whatever help and support they need, regardless of the type of sexual abuse experienced. The impact of childhood sexual abuse can be exacerbated or mitigated by the response (or lack of) received by the child at the time, so impact should be assessed person-to-person rather than based on any assumptions or ideas of 'hierarchy of abuse'.

*"Please do not compartmentalise my experience and only focus on sexual abuse. It is more than sexual abuse and the impact of the psychological abuse and coercive control I experienced reaches its tendrils into every area of my life. The impact is profound and decades later, I am still trying to heal from it."*

It is important to consider cultural and regional differences. For example, honour-based abuse (abuse conducted to protect or defend the 'honour' of a family or community) can include sexual abuse such as violence, harassment, sexual assault, coercive control, 'policing' of sexuality and sexual expression, and female genital mutilation. Abuse may be understood and interpreted differently across cultures, but it remains the duty of clinicians and health and social care professionals to support people to recognise abuse, disclose it safely and get the right care and support, while practising individual and cultural sensitivity.

## 3.b. Different journeys

There are considerable differences in how each individual is affected by child sexual abuse, in the immediate aftermath and during their lifetime. As part of defining and understanding child sexual abuse, it is important to acknowledge the substantive effect that abuse can have on a person's life. A definition of child sexual abuse should also acknowledge the impact across a person's lifespan, particularly how those experiences the resulting trauma can contribute to different forms of physical, emotional and mental ill health. Intersectionality is of particular importance when it comes to understanding different journeys (see 2.b. Intersectionality and NRCSA).

*"My experience of childhood rape has left me feeling like a half -formed person. I'm more often than not observing myself in the world but never fully a part of it. As a result of what happened to me, I've spent over half of my life in psychiatric services."*

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# 4. Awareness and prevalence of abuse

## 4.a. Awareness

While there are several high-profile criminal cases, police operations and social campaigns (including the '#metoo' movement, which focuses on sexual violence to women but also includes NRCSA), there is insufficient informative and coordinated public and media education and awareness of non-recent abuse. A national public awareness campaign to address this is a key recommendation in the final report of the Independent Inquiry into Child Sexual Abuse (IICSA).

There is also not enough awareness in the health and care sector, where the scale of the impact of non-recent abuse and associated mental health problems continues to be inadequately addressed. This lack of awareness can lead to:

- a failure to facilitate disclosure of non-recent abuse at initial contact with services
- a failure to identify and diagnose trauma, leading to a large disparity (80% of mental health service users have experienced trauma, 5–20% with a diagnosis of C/PTSD[23])
- inadequate provision of resources and training in services, for the recognition and treatment of non-recent abuse, resulting in long histories of service use without the underlying cause (trauma) being addressed[24,25]
- not being familiar with the latest research into effective treatments for complex trauma, and little research into trauma-informed care pathways and their impact.

## 4.b. Prevalence

The high heterogeneity between studies of child sexual abuse makes it difficult to appraise the of prevalence of abuse[26]; however, our understanding is improving in this area.

Recent Government research and analysis brought together a number of data sources to gain a more accurate picture: these indicated a prevalence of 3.1 million adults aged 18–74 who had experienced sexual abuse before the age of 16[27].

*"This is not just a national crisis but a global one."*
*– IICSA*

IICSA also reported the prevalence of child sexual abuse as one in six girls and one in 20 boys[21]. We know that abuse is vastly under-reported[28]; in the UK, one in seven adults who called the National Association for People Abused in Childhood (NAPAC) helpline were disclosing for the first time[27], and research suggests that child sexual abuse is 30 times higher than official reports[29].

Global estimates range from one in 10 girls (less for boys) having been subjected to sexual violence[28], to even higher[30], reaching endemic levels[31].

The review of the literature undertaken to support this position statement (see Appendix A) explored the broad topic of prevalence of childhood sexual abuse in adults with mental health problems. Estimates vary considerably, but there is consistent evidence for a link between experiences of non-recent abuse and the development of mental health problems later in life[32,33].

Variation in the definition of sexual abuse and the lack of routine data collection has led to problems in understanding its prevalence in and between mental health conditions[4]. The variation seen in research also depends on whether an age difference between the people involved was taken as a defining factor (and what the upper age limit was), whether encounters involving no physical contact were included, and whether one or more episodes were considered[4]. Although the review undertaken for this position statement did not explore how experiences of abuse affect people by gender, many studies of NRCSA focused on female survivors. Potential differences in the impact of abuse on people from different ethnic groups was also not explored in the review; however, we do know that Black, Asian and minority ethnic groups are more likely to experience trauma[34]. The complexities and variation in national, regional and local data on the prevalence of NRCSA as a contributing factor to the development of mental ill health may cause a barrier to the provision of services that meet people's needs.

While it is challenging to give an exact prevalence of NRCSA in mental health disorders, the evidence strongly supports an association between experiences of sexual abuse in childhood and the development of diagnosed mental health problems in adulthood[35,36].

> *"Childhood sexual abuse is so frequent in the psychiatric population that it should be the bread-and-butter, everyday work for psychiatrists and allied health professionals."*

Moreover, research suggests that most people who use mental health services have trauma histories which are ignored[37,38], suggesting that awareness, disclosure and diagnosis are the key issues in ensuring childhood sexual abuse survivors are recognised and get the service that they need.

> *"No one working with humans can say, 'I don't work with people who've been abused, this is not my area'. Read the stats!"*

> *"Child sexual abuse is not a problem consigned to the past and the explosion on online facilitated CSA underlines the extent to which the problem is endemic."* – IICSA

> *"My childhood experience of rape has fundamentally changed the course of my life. The chronic sense of shame has prevented me from doing so many things that other people take for granted. I find it so hard to make friends because I am carrying around this shameful secret. On top of this I now have the shame of ending up in the psychiatric system and all of the terrible things I experienced there."*

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# 5. NRCSA and memory

Survivors of NRCSA may commonly present with histories that are fragmented, inconsistent or confused. They may be unable to verbally recall the event(s) or only experience somatic sensations connected to the abuse. They may recover the memories of abuse as an adult in what is often a disturbing, discontinuous and fragmented experience, and this may occur while in treatment for physical and mental health conditions. The reasons for this are many and may include:

- Grooming techniques that create confusion and uncertainty in the child's mind.
- Silence, shame and secrecy, which all perpetuate a sense of uncertainty and potential unreality in relation to the events.
- Early (preverbal) abuse may mean the trauma is held as somatic experience within the body (procedural memory).
- Memory processing during and after traumatic experiences, which is unlike memory processing of non-traumatic experiences[j].
- Linked to memory processing, dissociation during the event or events may lead to partial or complete amnesia for the traumatic experience.

> *"The trauma has trapped me in guilt and shame and no amount of tablets will make that underlying belief leave me."*

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## 5.a. Dissociation

Dissociation[k] may be understood as the separation of realms of experience that would normally be connected. It can be thought of as the ultimate survival defence, the escape when there is no escape. Dissociation is a psychic process that everyone experiences to some degree at some time, which may be transient or enduring. It can be used defensively, adaptively or as a form of protection. Examples of dissociation may include trance and mystical states, hypnosis and meditation; sleep-related dissociative disorders such as sleep walking, night terrors, hypnogogic and hypnopompic phenomena, dreams; daydreams; and altered states due to drugs. Dissociation as a defence against overwhelming, unbearable terror and helplessness is part of the hypoarousal freeze response.

Dissociation is likely to occur in response to trauma, especially if a person has endured traumatic experience during childhood when the brain is developing.

Dissociative identity disorder (previously referred to as 'multiple personality disorder') has been widely disputed and seen as controversial in the past. This has led to a failure to diagnose the condition and it is often misdiagnosed[39]. Neurobiological research has confirmed the existence of dissociative identity disorder[40] and it is important that clinicians are aware of this, especially in relation to a history of severe relational trauma.

> *"I feel totally disconnected to my own trauma and to my own body."*

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[j] An explanation of traumatic memory can be found on the National Institute for the Clinical Application of Behavioural Medicine website.

[k] See the Glossary for the DSM-5 definition of dissociation, and its symptoms.

## 5.b. False memory syndrome

There is no significant evidence base for false memory syndrome and it has never been ratified by any accredited psychological diagnostic systems as a formal medical diagnosis.

*"The memories are so unbearable that I may never be able to recall all that happened or tell it all."*

Despite the lack of evidence, the concept of false memory as a psychiatric syndrome has been used in legal proceedings to discredit survivors of abuse, and in areas of social work underpinning decisions about a person's care.

While there is no doubt that memory can be unreliable, and that there have been false accusations or retractions made following initial reporting, the evidence suggests that traumatic amnesia occurs in 19–38% of documented child sexual abuse cases with subsequent recovery of memories[41].

The harm that the concept of false memory syndrome can inflict is perpetuated (and likely also underpinned) by the unfortunate culture of disbelief around sexual abuse of children. In other words, people who have experienced sexual abuse as children are not always believed – a mindset that has likely contributed to the idea that false memory syndrome is a true phenomenon, despite the lack of evidence. Society's struggle to acknowledge the occurrence of such terrible abuse of children may be due to societal or cultural denial that something so nefarious is actually more commonplace than people can bear to consciously acknowledge.

The focus for a professional is to provide care and support to the survivor. It is not their responsibility to ascertain what is true or false.

## 5.c. Clinical implications

It's important that psychiatrists working with survivors of NRCSA are aware of the complexity of memory in NRCSA and of the concept of false memory, and of how a person seeking support can be impacted by this concept, either in their past interactions with services or its portrayal in the media. It's also vital that clinicians understand that it's important to listen openly and respectfully to any disclosure of abuse.

*"Don't blame me for developing coping mechanisms for dealing with the childhood abuse. I suffer enough shame as it is."*

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# 6. Disclosure

The conceptual understanding around disclosure of NRCSA has evolved from a singular or one-time event to a dialogical process that occurs over time, through reciprocated interactions with family members, spouses, other NRCSA survivors and mental health professionals.

Disclosure to a professional of CSA experiences is much more likely to happen in adulthood than before. The average time to disclosure for those with a history of NRCSA is 16 years after the abuse[21], and two-thirds of people who have been sexually abused in childhood don’t disclose during childhood[42,43].

It’s also much more likely that people in the adult mental health system will be survivors of sexual abuse compared with the general population[21], although only 20–25% of people accessing mental health services report being asked if they have been abused[44].

> *“In the physical health world, you don’t offer inappropriate treatment or restrict the number of outpatient appointments without first looking for the underlying cause. Leaving someone to suffer years of life changing debilitating symptoms without appropriate treatment is simply unethical.”*

Non-disclosure or delayed disclosure are the result of multiple factors (described below), but the consequences can be far-reaching and detrimental for survivors and for mental health services. If disclosure is not facilitated to occur, this may lead to misdiagnosis, inadequate care planning and insufficient healthcare provision[45], inappropriate psychological interventions and likely iatrogenic harm. Disclosure can be a turning point for survivors, and it’s critical that mental health professionals are appropriately trained and supported to facilitate disclosure in a trauma-informed and culturally competent manner.

> *“As a child you are powerless in the face of abuse. That terror remains within every cell of your body. Disclosure means revisiting that unbearable place which you have spent your whole life trying to forget or dissociate from.”*

## 6.a. Barriers that may prevent a person from disclosing NRCSA

### Survivors’ perspective

- Gender, in that males are significantly less likely to disclose than females.
- Culture and intersectionality, as there are specific barriers for marginalised communities[46].
- Guilt and shame, as disclosure usually triggers the emotions that were experienced when being abused. These, together with the core after-effects of shame and stigma, and the fear of being judged negatively, are major barriers to disclosure[47,48].
- Feelings of blame, responsibility and culpability.
- Concerns about the consequences of reporting abuse.
- Lack of education about sex or sexual relationships (including education for children as to what is or is not appropriate, and the ability to recognise acts as abusive).
- Actual or perceived lack of available support for survivors.
- Lack of trust in institutions.

> *“If you disclose a history of child sexual abuse and you are a woman, you are more than likely to end up with a diagnosis of personality disorder.”*

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- Presence of dissociation[I], which may mean that memories are fragmented and unclear.
- Grooming methods, which may create a culture of shame and secrecy.
- If the abuser is a close family member, feelings of guilt for the survivor about exposing them, sometimes out of a sense of loyalty to the perpetrator, or over how it may affect other family members[47,48].
- Fear of losing the support of family members or not being believed.
- Compounded feelings of fear, guilt and shame, arising from interactions with mental health professionals when there is an unequal power dynamic. Survivors might feel that they are not worthy of respect and therefore avoid discussing the abuse.
- Fear of disclosing again, if a survivor has previously felt they had a poor response to disclosure (for example, one that is negatively judgemental, disbelieving, trivialising or offhand[49]) from a care professional or someone in a position of authority.
- Worries about the processes of safeguarding and reporting.

> *"I was told, 'Don't tell anyone it's our little secret', and was threatened if I told. I wanted to scream, 'Help, I don't want to be left alone with him', but I was like a rabbit in the headlights."*

> *"It takes enormous courage to disclose abuse to go back to that unbearable place. If you are cold or dismissive when we have divulged the most vulnerable parts of ourselves then who can we trust? Don't destroy our faith in you. Or we may never disclose again."*

## Professionals' perspective

- Lack of training in facilitating disclosure.
- Fears of causing further harm or re-traumatising.
- Uncertainties about protocols and treatment pathways following disclosure.
- Lack of appropriate resources to support clients following disclosure.
- Concerns around survivors producing false memories or obstructing legal processes.
- Fear that the wrong timing may bring up strong reactions in the survivor.
- Lack of training and clarity around safeguarding and reporting.
- Beliefs that the topic of child sexual abuse should not be raised unless the client chooses to do so.
- Anxieties around impact on wellbeing, including the practitioner's own history of NRCSA or other traumas.

> *"Don't be afraid to ask about abuse. You need to understand. Just not 5 minutes before the end of the session."*

> *"Once I took on a role of clinical lead for a personality disorder service, I realised that almost every patient in the service had been sexually abused as a child. I became aware how for many of them, this experience became an organiser of their internal structure, like a nexus around which they functioned"*

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[I] See the Glossary for definition of dissociation.

## Eliciting and creating an appropriate environment for disclosure

The importance of mental health professionals creating a safe environment so that survivors feel able to disclose cannot be overemphasised. Disclosure should not be forced, but should move at the survivor's pace, giving them enough space and time[50,51]. A few simple prompts such as, 'Tell me your story', or, 'Would you tell me a bit about your childhood?', might be enough to elicit or prepare the ground for disclosure[50].

To address any power imbalance in the therapeutic relationship, mental health professionals need to demonstrate that they are empathetic, respectful, are listening and that they believe the survivor[5]. This is enormously important, as it enables trust. Exploring and understanding why earlier attempts to disclose have been handled badly by professionals could be helpful for both survivor and professional, so that mistakes are not repeated and re-traumatisation is avoided[m]. It might not always be possible to create the safest spaces or the strongest therapeutic relationship (for example, on a ward), but it is still necessary to create the opportunity for a survivor to disclose, in any setting.

It is important to understand that survivors might have a distinct and personalised way of articulating what happened to them, and to be attuned to this. The language used to elicit disclosure of NRCSA is important to get right and would need to be tailored to the individual. Some survivors might not apply the word 'abuse' to what happened to them as a child.

There might be certain events that will trigger disclosure, such as a national news story about child abuse, or a life event such as the death of the abuser or becoming a parent. Mental health professionals should be alert to such events and the possibility that they might present for disclosure.

*"When I first disclosed I was raped the psychiatrist didn't seem very interested. She just moved on to ask me about voice-hearing or if I could see anything unusual."*

## Disclosure as a journey not a single event

It's highly unlikely that everything will be disclosed by a survivor in one discussion; in fact, they might have hardly scratched the surface. Mental health professionals need to bear in mind that they might not have the 'whole story', and to work on establishing trust with survivors so that they feel safe to disclose further. A survivor might come into contact with a number of different professionals in mental health services, and therefore might disclose on several different occasions. This applies not only to mental health professionals but to other professionals that survivors may encounter, such as the police or social care professionals.

## Support and referral after disclosure

After disclosure, the survivor may feel distressed and fearful about the consequences, and the support that they are given at this time is crucial. It is important to elicit what immediate support systems the survivor might have in place, arranging a time to check in with them, and talking to them about what might happen next in their care.

*"My first contact with mental health services was at the age of 12 or 13. Although I didn't have the words to explain what had happened to me, after years of silence, and of feeling that I didn't have a voice, my story was pouring out. I was closed down with medication and changes of topic. I still do not have the words to tell my story."*

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[m] See the Glossary for definition of re-traumatisation.

Care professionals need to understand the referral and treatment pathways, and the safeguarding and reporting procedures appropriate for a person who has disclosed NRCSA. There must be clear protocols for communication, note-keeping and the sharing of information with other professionals.

> *"Now I've had some trauma therapy from a rape charity, from a psychologist, my life has been transformed. It seems to me that the medical model of labels and tablets is way out of date."*

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# 7. Psychiatric diagnosis

Mental health diagnosis is reached on the basis of meetings with an individual in which the presenting problems are discussed. This is done in the context of their history and completing a mental state examination. It also includes the assessment of risk, and tests and investigations to determine if there are physical problems underlying the presentation. Categories of mental health diagnosis are based on the current clinical teaching, underpinned by diagnostic tools and manuals such as DSM-5-TR[52] and the ICD-11[53].

It is important to acknowledge that for many survivors, their difficulties cannot be captured by diagnosis and are recognised by the survivor as arising out of the experience of NRCSA.

## 7.a. Diagnosis and access to support and treatment

Mental health services, particularly in the NHS, tend to be designed and commissioned around individual diagnostic categories based on which the services are funded. Being given a psychiatric diagnosis typically becomes the gateway to accessing support and therapeutic interventions for the patients and funding for the services. It also may enable access to psychosocial interventions such as welfare benefits, housing, or support for legal claims and compensation.

*"The psychological abuse can often be more damaging – it's difficult to completely dissociate from it."*

## 7.b. Problems with the diagnostic model

For survivors of non-recent NRCSA, the diagnostic model is potentially problematic for a number of reasons:

1. Categorisation of mental health diagnoses is socially and culturally informed. It is influenced by an understanding of social norms and practices to which people in society are expected to adhere, and deviance from such norms has formed part of our understanding of mental ill health. Psychiatry has long faced criticism for this approach of using categories and classes of disorder because it can be dehumanising; labelling people with mental health problems as 'deviant' without considering subjective experiences of culture, oppression and trauma can cause re-traumatisation, shame and further mental distress[54].
2. Growing evidence[21] shows that the potential harm caused by child sexual abuse may lead to a wide variety of possible presentations as an adult, which can lead to multiple diagnoses. Fragmentation of care often results in people being given multiple brief interventions that do not address the NRCSA but are instead symptom-focused. (See also 2.c. Iatrogenic harm in relation to NRCSA).
3. Undue focus on symptoms can be unhelpful and may impact on the quality of the consultation to offer a space which can facilitate disclosure of NRCSA. (See also 6. Disclosure).
4. For a survivor, a diagnostic label may be experienced as the medicalisation of distress, perpetuating the shame and stigma that is often already linked to the original trauma. This may be felt as a description of 'what is wrong with you' rather than an exploration and understanding of 'what has happened to you'.
5. For some people, referring to their experience/presentation with the term 'symptoms' might feel unacceptable or uncomfortable. The way in which the person presents is a reaction to what was done to them, not having arisen from them. Certain feelings, thoughts or behaviours that can be understood in terms of symptoms by mental health professionals might have been protective for the individuals, allowing them to survive in a hostile and abusive world around them in their early years.

*"I got diagnosed with personality disorder, anxiety and depression. It took me 7 years to get a diagnosis of PTSD."*

*"Don't attach the sticky label of borderline personality disorder. It has been proved that this leads to contempt, discrimination, more trauma and abuse. We deserve specific trauma therapy and real care and compassion. We matter!"*

## 7.c. A holistic approach to diagnosis

To better understand NRCSA, it is crucial to take a holistic view of the complexity of each person's life and to work with the individual according to their needs, including the biopsychosocial and environmental. Understanding the distress and suffering that may arise from NRCSA relies on taking into account the complexity of the presentations, to facilitate the experience of seeking therapeutic help. When using a biopsychosocial formulation, it is vitally important to recognise the centrality of the traumatic experiences and to use a trauma-informed approach.

## 7.d. Attitudes and knowledge that should be applied by the diagnosing clinician

At its core, taking such a holistic view means that for CSA survivors the clinical encounter needs to:

- Be collaborative and culturally sensitive, with an emphasis on working alongside the survivor. This may include a discussion of how helpful a diagnosis might be for the person and what it may mean for them in their circumstances. (See also 2.d. Cultural competence and trauma-informed practice).
- Recognise and explicitly acknowledge the inherent power imbalances that may interfere with the therapeutic relationship.
- Understand, acknowledge and address intersectionality issues that may be contributing to the person's presentation. (See also 2.b. Intersectionality and non-recent abuse).
- Recognise the potential for diagnosis to be stigmatising and re-traumatising. (See also 2.c. Iatrogenic harm in relation to NRCSA).
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*"If you have no trust in the person who's meant to help you, where do you go from there?"*

*"From previous experience, I would avoid a psychiatrist. I have no trust in their profession. They push pills, many of which do harm."*

*"I have had many consultant psychiatrists and each one just gave me yet another irrelevant label."*

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# 8. Care pathways and treatment

## 8.a. The current situation: support for survivors of non-recent childhood sexual abuse

People who have experienced child sexual abuse are at a higher risk of suffering from mental health issues than people who have not experienced abuse[55]. However, for many survivors of non-recent abuse, it is extremely challenging to access the appropriate trauma-informed treatment. In the report of the All-Party Parliamentary Group of Adult Survivors of Childhood Sexual Abuse[56], only 16% survivors of CSA said the mental health system met their needs. Accessing appropriate care for NRCSA survivors may take years and, for some, this can feel impossible and may lead them to stop searching. Geographical inequalities in the availability of services increases this difficulty.

The current organisation of statutory services around psychiatric diagnoses is often problematic for survivors of non-recent abuse, who may receive multiple diagnoses and treatment by several services. This can lead to a spiral of exclusion and a fragmentation of care, with repeated short-term interventions aimed at particular symptoms that do not address the underlying cause. Interventions based on diagnosis may also offer little in terms of flexibility and choice in modality or ways of working (see also 2.c. Iatrogenic harm in relation to NRCSA and 7. Psychiatric diagnosis).

*"Neither of the evidence-based treatments recommended as treatment for emotionally unstable personality disorder addresses NRCSA in their treatment manuals in any depth, while for many, not all, of those patients being heard, believed and understood was absolutely vital."*

To date, there has been a profound lack of a coherent interagency response between statutory and voluntary support services. This perpetuates the difficulties in accessing care and the fragmentation of the care received. While many voluntary services may work in a trauma-informed way, they may struggle with the more complex presentations that may be better treated within the NHS. The lack of coordination between voluntary and NHS services hinders shared learning between these organisational structures.

*"What we as survivors say helps us heal and what is offered by the NHS are poles apart."*

Not only is such care likely to be difficult to find, but the person may have feelings of shame, fear of the consequences of disclosure, and fear of the impact on their life and family or loved ones, as well as fear of the repercussions of reporting (to social services or police). There may also be cultural, religious, gender or sexuality-based issues that are not met with an appropriate, culturally competent framework to facilitate the access and engagement with a therapeutic service. All of these issues can contribute to the creation of barriers to accessing care, and these barriers reflect a lack of prioritisation of mental health care for survivors of non-recent abuse in key areas of relevant guidance.

Not identifying that NRCSA is part of the presentation (through a failure to facilitate disclosure) and a failure to understanding the role that non-recent abuse can play in mental health presentations, may mean the person either does not meet the criteria to access treatment or, if they do, they do not receive the most appropriate care, which leads to unmet mental health needs.

*"Even with a diagnosis of complex PTSD, I received no effective therapy in the NHS. This resulted in many years of being unable to function, due to the joint effect of debilitating symptoms and sedative side-effects of prescribed medication."*

The long-term lack of understanding and acknowledging the prevalence and impact of NRCSA has resulted in a failure of trauma-informed services and a coherent and accessible pathway of care. As the recognition of the impact of adverse childhood experiences and the growing movement for trauma-informed care increases, there is a rudimentary and nascent period of development in which NRCSA is beginning to be addressed in mainstream psychiatric care. This will be supported by the recent development of NHS England's Pathfinders for Adult Victims and Survivors of Sexual Assault and Abuse with Complex Trauma-related Mental Health Needs (forthcoming).

Alongside the literature review exploring prevalence, an exercise was undertaken to explore any reference made to providing or adapting treatment following disclosure of non-recent abuse in mental health clinical guidelines.
There is a lack of guidance for clinicians and health workers on supporting people to disclose abuse or on providing appropriately adapted treatment when non-recent abuse has been disclosed. A summary of the findings of review of guidelines is included with the literature review in Appendix A.

See also Appendix C, Resource 3 and Resource 4, for the interdependent model of apology in non-recent institutional abuse and the IICSA's report on their investigation into accountability and reparations.

> *"Once I became a consultant, I very quickly realised that I wasn't prepared for the deluge of presentations of patients with history of NRCSA. For most of them it wasn't a presenting problem, with the disclosure taking place during the assessment with me. Many of those patients had spent years in the mental health system and yet this was the first time they spoke*

> *"I bring at times unbearable pain and inconsolable loss, looking for someone with the strength to hold me in that suffering. I need to*

## 8.b. NRCSA treatment and care pathway principles

1. The survivor's voice should be at the heart of all treatment and care pathway design, production and implementation.
2. Pathways need to be designed within the principles of trauma-informed practice.
3. Following disclosure, pathways of care allow for choice and flexibility of care commensurate with need and complexity. This may include a general hierarchy of need from trauma-informed to trauma-specific to trauma-specialist.
4. Pathways recognise the impact of attachment trauma and the recognition that continuity of a therapeutic relationship is vital to engagement, the development of trust and a therapeutic alliance.
5. While a significant number of survivors may not require specialist trauma services, some will. These need to be separate from personality disorder services[57].
6. Collaboration and learning across the voluntary and statutory sectors to include easier access and transfer between sectors as needed.
7. Appropriate research to ensure growing evidence-based care and support appropriate training of staff. This could also lead to development of guidelines for care (for example, NICE guidelines).

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## 8.c. Treatment issues

> *"Listen to us and be a bit more curious. Learn from our experiences. If you don't know the answer, be honest and do not recommend inappropriate treatment. Instead, refer us to a specialist trauma centre that understands what we need to heal. That is an example of good medical practice."*

It is important to acknowledge that many survivors of NRCSA turn to voluntary sector and peer-led support, or pay for private psychiatric or psychotherapeutic services. This is often because of the lack of available services, long waiting lists or because of a lack of trust in statutory mental health services. It is important for clinicians to ask about and be aware of other services being accessed by a patient and to liaise as appropriate with private or third sector therapists to ensure coordination and safety. It is often a decision taken at a local service level as to whether patients are able to access statutory services at the same time as private or voluntary sector services. Whether it is facilitating a handover to statutory services or providing ongoing care, communication across these different settings is vital for good care and coordination.

There is a growing body of evidence in relation to complex trauma that highlights the need for a multimodal approach that needs to be both verbal and body-based. Coupled with this is the trauma-informed approach of co-produced treatment plans. It is also important to be survivor-led in regard to what a person finds helpful in their own healing. This may include a range of other approaches, such as peer-support groups, mindfulness and yoga, body/somatic work, neurofeedback, art, music and dance/movement approaches.

A Cochrane systematic review of studies into psychosocial interventions highlighted the importance of providing a *range* of treatment interventions for sexual abuse and assault survivors[58]. This may involve supporting a patient as they access such services and helping ensure a safe and coordinated approach.

There is promising emerging research evidence for the use of neurofeedback, psychedelic-assisted psychotherapy for PTSD, and trauma-informed yoga as an adjunct therapy (references). Improving access through clinical trials and addressing the need for research into what helps recovery is necessary to close the 'research gap' and allow appropriate treatments to become available on the NHS.

Although some survivors find such holistic approaches helpful, some approaches operate outside of robust accountability systems. This underlines the difficulties faced in accessing safe, appropriate treatment that is coordinated across statutory, voluntary, private and community sectors. Harms can occur within and outside the statutory system. This highlights the importance of trauma-informed principles of collaboration, power-sharing and processes for dealing with harms, as discussed in 2.c. Iatrogenic harm in relation to NRCSA.

> *"Despite several attempts to seek help from the mental health system, it almost always did me more harm than good. The only real help I have received has been from outside the system, through peer support, private therapists who really know and understand trauma, and from 'alternative' healing approaches. The mental health system feels a million miles away from anything that could help me heal."*

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# 9. Training

## 9.a. Types of training

Training is fundamental to this position statement, underpinning all of the discussion points. The right type and level of training is essential to ensure that survivors receive appropriate support and treatment.

It is clear that there is a substantial lack of formal training in the area of NRCSA for all psychiatrists, and across all grades. It is essential that NRCSA is included in the training curriculum for junior doctors, and as CPD for those who have finished their training or are in non-training posts. It is also important to ensure that this training is embedded in reflective practice and through every level of leadership.

A primary level of training should enable staff to:

- facilitate disclosure
- recognise common presenting symptoms/coping mechanisms
- be confident in the use of trauma-informed language
- know where to access necessary information to signpost or refer survivors for further help, support and, if required, trauma-informed psychological therapies.

More specialist training would enable the appropriately qualified staff to provide appropriate trauma-informed psychological therapies in a safe and trauma-informed environment.

In addition, as patients with a history of NRCSA are seen across the whole spectrum of health and social care (including by GPs, obstetricians and gynaecologists, midwives, nurses, paramedics, A&E staff, physicians, physiotherapists, dentists, social workers and blue light services), a basic level of training also needs to be provided for these specialties.

Provision of effective training packages is also likely to lead to cost savings. Reducing the time to disclosure, and providing prompt access to appropriate help, are likely to reduce the incidence and severity of mental health problems for survivors of child sexual abuse.

Survivors of NRCSA should be empowered and enabled to meaningfully co-produce any training provided. This includes co-design and delivery of training. To support this, the Royal College of Psychiatrists' is already committed to developing co-produced guidance for trainees and trainers, as well as an e-learning module to provide continuing professional development (CPD) for more established psychiatrists. Intersectionality should be incorporated into all training and education efforts.

*"Given how ubiquitous child abuse is and the profound impact it has on mental health, why is so little time and resource dedicated to this topic in core training and CPD?"*

*"There is a lack of real help on the NHS – just CBT which treats the symptoms not the causes. CBT isn't always helpful, if I could think my way out of my trauma, I would be doing so."*

*"Now I've had some trauma therapy from a rape charity, from a psychologist, my life has been transformed. It seems to me that the medical model of labels and tablets is way out of date."*

## 9.b. Conclusion

To ensure continuing professional development and ongoing optimal delivery of services in the area of NRCSA, staff will need to have reflective practice sessions with their supervisors and in their teams. Sessions need to be regular and structured, and should allow each team member to openly share their reflections on their own practice and how it might impact on other members of the team.

At an organisational level, there needs to be leadership that recognises the potential for vicarious traumatisation, secondary traumatisation and burnout linked to working with traumatised people, and that reflective practice sessions can be used to work through some of these issues.

> *"I believe that our lives would have unfolded very differently if … staff had been supported to understand and engage with our pain – if we were encouraged to tell our stories instead of being shut down with looks, words, drugs and ECT."*

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# 10. Research

Despite a plethora of research on prevalence of abuse, the evidence base is challenging to navigate because of the inconsistencies in definitions and methodology, and the availability of data (see Appendix A). Compared with quantitative studies, qualitative research into the impact of NRCSA on mental health and wellbeing in adulthood is minimal, including survivor-led and survivor-focused research, yet both are equally vital.

## 10.a. Priorities for research into non-recent child sexual abuse

Across medical research, the involvement of people with lived experience in research has been inadequate, but the situation is improving as co-production[n], co-development and co-design become more standardised and essential components of the research process. The importance of Public and Patient Involvement (PPI) and its value to healthcare research is generally recognised; PPI standards[59] are a priority for the National Institute for Health and Care Research[60], and an expected part of funded research projects.

The Violence and Mental Health Network has funded a number of research projects to improve research in this field, focusing on measurement, understanding and interventions. They found that key research priorities for survivors included helping survivors to understand what happened to them as abuse, and providing professionals with tools to recognise abuse[61].

Researchers, clinicians and people with lived experience are all vital to helping shape the health research agenda on non-recent childhood abuse. A joint research approach allows for the identification of unanswered questions, the prioritisation of important topic areas and the publicising of opportunities for researchers and funders[62]. See also Appendix C, Resource 5, for priorities in sexual violence and abuse research.

While 62.5% of the mental health primary care research reported having PPI, this was true in only 12.9% of studies about abuse survivors, with survivors tending to fill more advisory roles at isolated stages of research development[12]. Survivors have put forward ethical, epistemological and methodological for more inclusion in research[63]; yet there is a pragmatic argument, too. Abuse survivor-led research identifies solutions to tackle key issues of disclosure, diagnosis and treatment[57,64]. There remains considerable opportunity for improved research that is driven and led by survivors, with their voices truly at the forefront. This is crucial to a better understanding of the impact of abuse and for continuing to improve approaches to treatment.

*"There's clear evidence of how vital it is that the voices and experiences of abuse survivors are brought into knowledge generation, through more survivor involvement in training and research."*

## 10.b. Conducting research in partnership with survivors of abuse

When embarking on research with survivors, creating a sense of safety, trust and non-judgement is vital. Joint working can be carried out in different ways (workshops, online consultations, surveys, and so on), but safety and compassion are always of utmost importance. Fortunately, there is guidance on setting principles for consultations so that approaches used are safe and do not lead to re-traumatisation[65]. Survivors should be treated as research partners, respected, listened to and offered the opportunity to provide

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[n] See the Glossary for the NCCMH's definition of co-production.

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feedback on processes. Research led by survivors is an important step towards the development, commissioning and provision of appropriate services to meet needs.

## 10.c. The evidence base on non-recent childhood sexual abuse and mental health

As identified by the literature review (see Appendix A), there is a significant body of literature exploring the impact of NRCSA on mental health later in life. An association between experiences of sexual abuse in childhood and the development of mental health problems later in life is consistently supported by the evidence. However, prevalence rates vary substantially, making it difficult to estimate prevalence even within specific mental health conditions or diagnoses. The under-reporting of abuse also affects the reliability and accuracy of available data.

Problems with establishing prevalence are also the result of the ethical limitations of methods of study design in this area. As such, there is reliance on retrospective and often qualitative methods. Qualitative research in this area is incredibly valuable, but more quantitative research is also needed to give a fuller picture.

## 10.d. Conclusion

Recent research establishes the importance of a trauma-informed approach to mental health care[66,67], and there is a growing body of evidence on effective treatments for complex trauma[68–71]. However, there is little formal evaluation of trauma treatment pathways, and issues such as diagnostic overshadowing and lack of awareness prevent many survivors from accessing the services they need. Our search of the available guidance found that explicit treatment advice and guidance on disclosure, management or support related to traumatic experiences of sexual abuse was either minimal or absent from several mental health treatment guidelines. It is possible that challenges and inconsistencies in the evidence base have contributed to these gaps. The need for further research into effective treatment pathways and approaches is clear.

*"We are told there is insufficient evidence for things that are often found by us to help. But what is prioritised for research is what gets evidenced and eventually becomes treatment. So why are we not being listened to?"*

*"We know from evaluation of Public & Patient Involvement (PPI) that centring the experiential knowledge of survivors in research enables new and deeper knowledge, and a different kind of evidence to emerge. The proximity of knowledge and experience of survivor co-producers is essential, to better understand survivors' needs and how to meet them, and to ensure practitioners and services are trauma-informed and working with survivors on effective solutions."*

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# 11. Recommendations for action

The recommendations reflect the outcomes of the research for this position statement, and the guidance and advice from the expert reference group. Several areas in need of action were identified, including increasing awareness, trauma-informed care, professional training, clinical guidance, service provision and future research.

Only by implementing these recommendations in full will we develop a healthcare service in which people can feel confident in disclosing non-recent abuse, knowing that when they do they will receive appropriate support and treatment from professionals who've had comprehensive training in this area.

## 11.a. Awareness, training and support

1. **The Department of Health (Northern Ireland), Department of Health and Social Care (England), Scottish Government and Welsh Government should commission tailored awareness campaigns** aimed at the general public and at professionals about non-recent abuse. They should be aligned with the development of guidelines, clinical services and pathways of care, to make sure that anyone who goes on to disclose childhood sexual abuse receives appropriate care and support.

2. **The Medical Schools Council should ensure that teaching on non-recent abuse is integrated in the undergraduate medical curriculum**. The teaching should include the significance of non-recent abuse in the development of a wide range of mental health problems in adulthood. It should also include the importance of the biopsychosocial model in identifying possible non-recent abuse in people who use substances, symptoms of psychosis and other conditions.

3. **The Royal College of Psychiatrists will develop supplementary guidance for trainees and trainers, co-produced with patients and survivors**, that supports the gaining of relevant capabilities[o] as set out in the psychiatric curricula. It will include training on:
   - facilitating disclosure and providing appropriate practical and emotional support
   - assessment and treatment
   - management of reporting issues, such as safeguarding, reporting to the police and advocacy
   - appropriate language that will reduce stigma and avoid re-traumatisation
   - understanding of trauma-informed care and the principles of this way of working to facilitate collaboration, empowerment to provide appropriate care and recognition of cultural, gender and historical issues, and to prevent re-traumatisation
   - support for clinicians to facilitate therapy sessions that reflect on and allow for incorporation of patients' intersectional identities.

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[o] The curricula for psychiatry includes the following capabilities:

- "Demonstrate an appropriate understanding of a person-centred holistic approach, which includes biological, psychological and social, to mental disorders, including a knowledge of developmental, social, cultural, trauma, adversity, genetic and epigenetic risks (including resilience and vulnerability factors) and neuro-biological influences on mental disorder.
- Demonstrate that you have an in-depth understanding of human psychology, including the importance of early relationships, attachment styles, parenting, the impact of adverse childhood experiences, and traumatic events throughout life.
- Formulate the presentation of the patient using an appropriate framework mindful of the impact of historical complex trauma."

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4. **NHS training organisations should ensure trainees have appropriate clinical exposure to recognising and responding to patients who disclose NRCSA**, in line with the Royal College of Psychiatrists guidance on integrating patient and carer voices into educational programmes (Learning from Experience: Working In Collaboration With People With Lived Experience To Deliver Psychiatric Education, May 2021).

5. **NHS training organisations and local authorities should ensure that all clinical and non-clinical staff should have mandatory training on non-recent abuse**, co-produced with patients and survivors (including on disclosure, appropriate language and immediate actions to take).
   - Health and social care staff who are, or may be, in contact with survivors of NRCSA should receive some level of training about NRCSA. This includes GPs, social workers, obstetricians, gynaecologists, midwives, nurses, paramedics, A&E staff, physicians, physiotherapists and dentists as well as mental health care professionals.

6. **The Royal College of Psychiatrists will commission the development of an eLearning resource on its CPD Online platform to support psychiatrists' ongoing training and awareness on NRCSA**. This will be co-produced with patients and survivors and include training on:
   - facilitating disclosure and providing appropriate practical and emotional support
   - assessment and treatment
   - management of reporting issues, such as safeguarding, reporting to the police and advocacy
   - appropriate language that will reduce stigma and avoid re-traumatisation.

7. **Teaching on NRCSA, co-produced with patients and survivors of NRCSA, should be integrated in undergraduate and postgraduate curricula, and CPD training**, provided by other medical and healthcare professional bodies (including emergency services).

8. **NHS organisations and local authorities should ensure all clinical and non-clinical staff working with people who disclose non-recent abuse have effective team support, time for group discussions** about the emotional and social aspects and complexity of this work, **and timely access to psychological support** when needed.

## 11.b. Guidelines, clinical services and care pathways

9. **NICE and Scottish Intercollegiate Guidelines Network (SIGN) should develop clinical guidance on how to recognise and respond to NRCSA**. This should cover:
   - Principles for discussing non-recent abuse sensitively, using appropriate language that will reduce stigma and avoid re-traumatisation.
   - Factors and signs that may indicate a history of child sexual abuse, and how to recognise them.
   - How to facilitate disclosure (including considerations about the therapeutic setting and environmental safety), provide immediate practical and emotional support, and referral, when necessary.
   - Procedures for reporting issues, such as safeguarding, reporting to the police and advocacy.
   - Carrying out assessments and discussing available therapeutic interventions (including their potential advantages and disadvantages). This should take account of the different approaches that may be needed for different groups, for example:
     - whether the abuser was a family member or an attachment figure

  - different generational groups (for example, young adults, working-age adults or older adults)
  - different cultural and ethnic groups
  - people receiving support for specific issues (for example, perinatal mental health care or disability).
- Providing a multidisciplinary response in which care and support may be provided by a range of range of professionals in collaboration (for example, psychiatric nurse, surgical doctor and physician).
- Coordinating a multi-agency response to providing care and support between health, social care, probation, housing, voluntary sector and other services.

10. **The Health and Social Care Board, NHS England and NHS Improvement, Scottish Government and Welsh Government should map services, and develop, pilot and implement clinical care pathways** for the multidisciplinary and multi-agency management of non-recent abuse. These should:
    - be co-produced with patients and survivors
    - promote partnership working across health, social care, probation, housing, voluntary and other services
    - ensure continuity of care through integration of primary care and secondary/specialist care services
    - provide appropriate and timely access to health care that meets the physical, emotional and mental health needs of the individual
    - offer a holistic and trauma-informed approach to therapeutic interventions, supported by a trauma-informed multi-agency workforce.

11. **NHS England and NHS Improvement, Northern Ireland Executive, Scottish Government and Welsh Government should continue to increase funding for mental health services** to ensure timely access for all those who need general and specialised treatment and support for the mental health impact of non-recent abuse.

## 11.c. Research

12. **The UK Medical Research Council should prioritise funding to standardise and strategically improve research into NRCSA**. This should include the following areas:
    - prevalence of non-recent abuse, including consideration of gender, ethnicity, disability and age
    - impact of confounding factors (for example, socioeconomic status of the family and other forms of abuse) and protective factors to better understand the influence these may have on the development of mental health symptoms in adulthood
    - effects of non-recent abuse and its disclosure on physical health and general physical wellbeing
    - efficacy of available treatments
    - best practice in management of disclosure and trauma-informed pathways of care.

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# Glossary

Terms in the glossary were either written by the project group or the source is supplied.

**Child sexual exploitation** "is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology."

Source: Working Together to Safeguard Children (HM Government, 2023)

**Co-production** is "an ongoing partnership between people who design, deliver and commission services, people who use the services and people who need them. Co-production should flatten hierarchies and promote respect, while acknowledging and making the most of the experiences and skills of people with mental health problems, and of their families, friends and carers."

Source: Working Well Together (NCCMH, 2019)

**Disclosure** in the context of NRCSA, refers to when a survivor of abuse informs a professional of their experience of trauma, usually by way of verbal revelation of the experience. Disclosure is a journey, not one act or action and is generally conceptualised as a dynamic process evolving over time. Disclosure of abuse is a process that can take months or years to unfold and survivors may be in a state of denial or tentative disclosure for a long time before they reach a state of active disclosure.

**Iatrogenic harm** is "a pathological condition that is invertedly induced or aggravated in a patient by a health care provider."

Source: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), (American Psychiatric Association, 2013)

**Intersectionality** is the complex and cumulative ways in which our social and political identities (including protected characteristics such as our gender, race, sexuality and so on) combine to create different forms of discrimination and privilege depending on the context in which we find ourselves. These identities intersect to give us multiple disadvantages and advantages. This can be both oppressing and empowering.

**Re-traumatisation** refers to the conscious or unconscious reminder of a past traumatic experience that results in a person re-experiencing the original trauma event in some form. It can be triggered by an event, situation, attitude or experience, or by certain environments and conditions that replicate the dynamics of the original event. Re-traumatisation can result from interactions in healthcare settings that remind survivors of their previous traumatic experience. Trauma-informed approaches to care seek to avoid re-traumatisation when providing healthcare.

**Trauma** "results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being."

Source: Working definition of trauma-informed practice (HM Government online guidance, 2022)

**Trauma-informed practice** is "an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development. […] Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff."

Source: Working definition of trauma-informed practice (ibid.)

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# Appendix A. Summary of the literature review

## A.1. Sexual abuse in childhood: prevalence in common psychiatric conditions, and recommendations for adult mental health treatment

### Introduction

The review is an umbrella review of recently conducted systematic reviews, with the aim of contributing to (a) the literature on prevalence of NRCSA and (b) the association between NRCSA and adult mental health conditions. The review summarises the literature on NRCSA across different mental health diagnoses and symptoms, as reported in systematic reviews and meta-analyses conducted since the umbrella review by Hailes and colleagues in 2019. Their paper also discusses the inclusion of recommendations in NICE mental health treatment guidelines for treatment after disclosure of NRCSA.

For the review, the following research questions were posed:

1. Does the evidence support an association between experiences of sexual abuse in childhood and mental health problems in adulthood?
2. What is the prevalence of sexual abuse in childhood for different common psychiatric diagnoses and symptoms in adulthood?
3. What is recommended across UK NICE guidelines for treatment of adults with psychiatric conditions following disclosure of sexual abuse in childhood?

### Method

To answer the first two questions, we performed a search of several online databases for systematic reviews published between January 2019 and the dates of the searches (June 2021). The search strategy searched for: *(terms for non-recent or historical child sexual abuse)* and *(terms for psychiatric diagnostic* conditions) and *(terms for systematic reviews or meta-analyses).*

To answer the third question, an exploratory search of NICE guidelines was conducted to examine recommendations for the mental health treatment for adults with mental health conditions following a disclosure of NRCSA. To achieve this, we searched NICE guidelines for mental health disorders using the following terms: *sex*, abuse, childhood, adapt*, disclos*, trauma*.

### Findings

We identified 29 systematic reviews and meta-analyses that explored the association between experiences of child sexual abuse and mental health problems in adulthood, of which 18 reported prevalence estimates.

Table 1 shows the included studies, which cover a range of psychiatric conditions and symptoms.

Prevalence rates varied substantially, which made forming an estimate challenging. However, the evidence consistently supported an association between experiences of sexual abuse in childhood and the development of mental health problems later in life.

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*Table 1: Included systematic reviews and meta-analyses (k=29)*

| Study ID (first author/year) | Study design | Year range of review | Abuse types included | Mental health conditions/symptoms |
|---|---|---|---|---|
| Armoon 2020 | Systematic review and meta-analysis | 1995–2020 | CSA | Suicidal behaviours |
| Barbosa 2020 | Systematic review | 1995–2019 | Adverse childhood experiences/traumatic events in childhood (including sexual abuse, physical aggression/violence, negligence/neglect) | Psychopathy; ASPD; substance use |
| Cavallo 2021 | Systematic review | NR | Childhood abuse (including neglect, childhood loss events and sexual abuse) | Anxiety symptoms: worry, rumination and negative thinking |
| Chang 2021 | Systematic review and meta-analysis | 2011–2020 | Childhood trauma/ developmental trauma | Psychosis symptoms and experiences (hallucinations, delusions, paranoia) |
| Cividanes 2019 | Systematic review and qualitative analysis | Until 2016 | CSA and ASA (revictimisation of people who had experienced CSA and ASA) | PTSD symptoms or diagnosis |
| Cobb 2020 | Systematic review | 1976–2018 | Adverse childhood experiences (including sexual abuse, physical abuse, sexual assault, emotional abuse) | Eating disorders |
| Duarte 2020 | Systematic review and meta-analysis | Until February 2019 | Childhood maltreatment | Suicidal behaviours (in people with diagnosed bipolar disorder) |
| Favaro 2020 | Umbrella review of meta-analyses | Until December 2019 | Childhood abuse (including sexual abuse and other types of child victimisation) | Eating disorders |
| Fletcher 2021 | Systematic review | 2009–2019 | CSA | Substance use disorders |
| Gardner 2019 | Systematic review and meta-analysis | NR | Child maltreatment including physical abuse, sexual abuse, emotional abuse, neglect and exposure to IPV | Depression and anxiety disorders; PTSD |
| Goddard 2019 | Systematic review and narrative synthesis | 2006–2016 | Child abuse (including neglect, abuse, maltreatment and victimisation) | Substance use disorders; Depression, Psychopathic features, Anxiety |
| Grose 2019 | Review of reviews | 2000–2016 | Gender-based violence (including contact and non-contact CSA) | Mood disorders; Substance use disorders; Eating disorders; Anxiety Disorders (including stress) |
| Humphreys 2020 | Meta-analysis | NR | Childhood trauma | Depression diagnosis or symptoms |
| Karlsson 2020 | Systematic literature review | Until August 2017 | Sexual victimisation (including childhood and adulthood sexual abuse, rape and unwanted touching) | Mental illness (any diagnosed) |
| Kuzminskaite 2021 | Integrated review | 2009–2020 | Childhood trauma (including sexual abuse, neglect, emotional abuse, physical abuse) | Depression and anxiety disorders |
| Li 2020 | Systematic review and meta-analysis (2 meta-analyses conducted) | Up to December 2016 | CSA | Depression |
| Mainali 2020 | Review | NR | Child abuse (including sexual abuse, physical abuse and maltreatment) | Emotionally unstable (borderline) personality disorder |
| McKay 2021 | Systematic review and meta-analysis | Until August 2019 | Childhood trauma (including physical neglect, bullying, emotional abuse, physical abuse and sexual abuse) | Depression; Anxiety; Psychosis; Bipolar disorder |
| Ou 2020 | Meta-analysis | Until April 2020 | Childhood maltreatment (5 types included: sexual abuse, emotional abuse, emotional neglect, physical abuse, physical neglect) | Obsessive-compulsive disorder |
| Peh 2019 | Systematic review and meta-analysis | 1990–2019 | Childhood adversities (including trauma exposure, bullying, victimisation, parental separation, parental loss) | Psychosis (risk) |
| Porter 2020 | Systematic review and meta-analysis | 1980–2019 | Adverse childhood experiences (including child abuse, physical abuse, sexual abuse, psychological abuse, emotional abuse, | Emotionally unstable (borderline) personality disorder |

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|---|---|---|---|---|
| | | | neglect, trauma, maltreatment, bullying, loss of parent) | |
| Prangnell 2020 | Systematic review | 2020 | Childhood abuse (including CSA. physical or emotional abuse, neglect, early life stress, adverse childhood experience) | Substance use disorders (injection drug use) |
| Santo 2021 | Systematic review and meta-analysis | 1990–2020 | Childhood maltreatment | Substance use disorders (opioid use disorder) |
| Schorr 2020 | Systematic review | No date filter applied | Childhood trauma (including physical abuse, neglect and sexual abuse and included parental bonding experiences) | ASPD |
| Shamblaw 2019 | Meta-analysis | 1980–2016 | CSA and ASA (also included physical violence and emotional abuse) | Prenatal depression |
| Tschoeke 2019 | Narrative review | 1945–2017 | Various abuse types (including CSA) | Dissociative disorders or dissociation symptoms |
| Thomas 2019 | Systematic review and meta-analysis | NR | Various abuse types (including CSA, neglect, emotional abuse, physical abuse, emotional neglect and physical neglect) | Psychosis |
| Zhang 2020a | Meta-analysis | Until April 2018 | Various abuse types (including CSA, neglect, emotional abuse, physical abuse, emotional neglect and physical neglect) | Substance use disorders |
| Zhang 2020b | Meta-analysis | Until August 2019 | Various abuse types (including CSA, neglect, emotional abuse, physical abuse, emotional neglect and physical neglect) | Depressive disorders (MDD; BD) |

**Research question 2: What is the prevalence of sexual abuse in childhood for different common psychiatric diagnoses and symptoms in adulthood?*
*ASA: adult sexual abuse; ASPD = antisocial personality disorder; BD = bipolar disorder; CSA = childhood sexual abuse; IPV = Intimate partner violence; MDD = major depressive disorder; NR = not reported*

The NICE mental health guidelines that refer to a history of childhood sexual abuse are those on PTSD and emotionally unstable personality disorder (National Institute for Health and Care Excellence, 2009b, 2018). In the guidance on EUPD, practitioners are advised that to build an effective practitioner–patient relationship they must be aware of the potential abuse patients may have faced. Treatment adaptations are not explicitly stated in the recommendations, and none are made for treating people diagnosed with depression, social anxiety disorder, antisocial personality disorder, generalised anxiety disorder and panic disorder, psychosis and schizophrenia, drug misuse, or coexisting severe mental illness and substance misuse (National Institute for Health and Care Excellence, 2007, 2009c, 2009a, 2011b, 2013, 2014, 2016).

There is no NICE guidance for the treatment of dissociative disorders. For common mental health problems and eating disorders, practitioners are again advised “to be aware of” non-recent abuse (National Institute for Health and Care Excellence, 2011a, 2017) with no further detail on adapting treatment.

## Discussion

The literature is fairly consistent in support of an association between experiences of childhood sexual abuse and the development of mental health problems in adulthood. People who experience sexual abuse at a young age are at increased risk of developing mental health difficulties later in life, but this relationship remains complex and poorly understood.

The prevalence of childhood sexual abuse in adults with mental health problems is unclear, with estimates varying considerably globally. For specific psychiatric symptoms and diagnoses, estimated prevalence rates vary even within conditions. It is likely that inconsistences can be at least partly accounted for by methodological limitations, such as variations in sampling and small study samples. The range of sample selection has introduced problems, being college samples, convenience samples, clinical samples and national probability samples. The potential for over- and under-representation in samples has limited research.

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Many studies used retrospective and cross-sectional designs, which could affect reliability of recall in either direction (that is, recall bias and failures of ascertainment). However, some prospective studies have used large-scale cohorts and addressed potential confounding variables.

A number of issues also arise from variations in definitions, such as the cut-off age of abuse occurring for it to be considered as ‘in childhood’. Some studies used 16 years as the cut-off, while others used 18 years.

Childhood sexual abuse may also be classified according to the duration, frequency, age of onset and relationship of the child to the perpetrator, and these differences were not always outlined in the literature.

Many studies fail to differentiate between the different levels of abuse, such as non-contact sexual abuse (for example, exhibitionism, indecent exposure, sexual harassment or voyeurism); contact sexual abuse without penetration (for example, non-genital fondling, kissing or genital touching); and contact sexual abuse with penetration (for example, oral, anal or vaginal intercourse).

Several studies from this review referred to ‘child maltreatment’ or ‘child abuse’ in general, amalgamating all abuse types into prevalence estimates and into explorations of association between abuse experiences and mental health outcomes. Some studies provided disaggregated estimates of prevalence by abuse type.

Finally, potentially confounding variables such as other forms of maltreatment, family dysfunction, maladaptive cognitive patterns and environment are difficult – if not impossible – to adequately control for. Many studies therefore failed to control for confounding variables, despite evidence that some of them may act independently to promote clinical symptoms in survivors of NRCSA or interact with childhood sexual abuse to increase the likelihood of symptoms. Few systematic reviews addressed possible confounding factors such as familial features, characteristics of abuse or overlap with other types of child abuse.

Although the association between childhood sexual abuse and mental health problems appears well-established, explicit treatment advice and guidance on disclosure, management or support was minimal or absent from several mental health treatment guidelines.

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# Appendix B. Testimonial quotes from survivors and psychiatrists

*“Current psychiatry practices traumatise those who have suffered child sexual abuse. We do not ‘imagine’ abuse. Survivors’ symptoms are not like those of other mental illnesses – they are not ‘disorder’.”*

*“The personality disorder construct is systemically harming childhood sexual abuse survivors. We have known about this harm for many years. It is time to abandon the ideas behind this diagnosis and try to listen to what survivors find helpful.”*

*“Over the years in our survivor groups, we have heard account after account of professionals using language that minimises, shames and blames. For example, writing on notes: “had sex and regretted it” when referring to rape; referring to emotional distress of a survivor in a consultation as her “behaving like a silly little girl”; or doubting a survivor who was describing the loyalty bond with her abusive father by asking “So, if he was as abusive as you say, why were you attached to him?”. If there is even a hint of denial, disbelief or blaming, we will not feel safe to open up. Language matters as does the attitude that is*

*“I need more than a label and medication. The trauma has trapped me in guilt and shame and no amount of tablets will make that underlying belief leave me. Your certainty that you know how to cure me with your tablets leaves me with no trust in you. Or the dozen that went before you that had equal certainty, but gave me different labels! Different tablets! And I don’t hallucinate by the way. I have flashbacks. And I’m not crazy because I have flashbacks. It’s part of the trauma. So learn more about trauma instead of giving me anti-psychotic medication which turns me into a zombie. That’s just you trying to control me because you don’t understand the chaos in my head.”*

*“If someone has just been punched in the face, we wouldn’t dream of running up to them with a coping skills worksheet. We wouldn’t dream of telling them to ‘take responsibility’ for the emotions that might follow the assault. But this is what we do with trauma.”*

*“I am not mentally ill. I was abused – and my ‘symptoms’ are simply coping mechanisms.”*

*“The psychiatrist dismissed the severe childhood sexual abuse my husband disclosed to him and the jealousy-driven violence my husband was now threatening to do to me as a result of his rage, which included threats to stab me. The psychiatrist said there was not really anything wrong, just the stress of my husband adjusting to living in a new country. As soon as we left the consulting room, my husband was emboldened. It wasn’t the psychiatrist who had to go back and sleep in a bed with him, wondering what’s going on in his head and what he’ll get me to do. A few days after that, I had to run from my house in my pyjamas with my three young children.”*

*"I got no real help with the reasons for my distress – I'm being offered only medication. I have had doctor after doctor who don't understand trauma and just says 'take the tablets'."*

*"Telling me to think differently without understanding where I am coming from is just another way of blaming me."*

*"If someone has just been punched in the face, we wouldn't dream of running up to them with a coping skills worksheet. We wouldn't dream of telling them to 'take responsibility' for the emotions that might follow the assault. But this is what we do with trauma."*

*"Ultimately, it was my patients that taught me the most. I learnt about difficulties they have with trust, sense of betrayal they grew up with, shame associated with the disclosure and the need for secrecy installed in them by their abuser. I frequently heard about their anxiety and sometimes fear of speaking out, and the belief that the professionals they spoke to before were not prepared to hear them, not interested or able to hear about their abuse. Many of them spoke about the abuse being something they cannot remember and cannot forget and how it affects them profoundly, despite the years that passed."*

*"Stop trying to make me put it all into words: my trauma is held in my body."*

*"The apprehension may be as traumatic as the deed happening- you're continually on edge wondering if/when…"*

*"Sexual trauma for me, was stored in my body. It was frozen. And every now and again, it would suddenly thaw and I would be right back there in the middle of all those men pinning me down."*

*"The memories are always there ready to surface instantly – it's awful."*

*"If I don't/can't say no it doesn't mean I consented."*

*"Survivors are often the go-to for other survivors when they fall through the broken cracks in the system. As one person recently said to me "I no longer try and talk about hunger to someone who has never missed a meal". We survivors carry our own trauma and each other's. We carry the burden when the system fails and get no funding or supervision to do*

*"In the physical health world, you don't offer inappropriate treatment or restrict the number of outpatient appointments without first looking for the underlying cause. Leaving someone to suffer years of life changing debilitating symptoms without appropriate treatment is simply unethical."*

*"Your certainty that you know what is wrong with me, what disorder I have and that you know how to cure me with your tablets leaves me with no trust in you. Or the dozen psychiatrists that went before you that had equal certainty, but gave me different labels! Different tablets! I don't hallucinate – I have flashbacks. And I'm not crazy because I have flashbacks. It's part of the trauma. So, learn more about trauma instead of giving me your labels and anti-psychotic medication which turns me into a zombie."*

*"Communicate your compassion and belief that I can heal."*

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# Appendix C. Resources

## Resource 1: Principles for trauma-informed talking therapy assessments

The principles on trauma-informed assessments were developed following research with survivors and provide detailed guidance on a trauma-informed approach to assessment. The research indicated that implementing the principles into services can enable vital healing encounters between survivors and therapists. The principles provide detailed guidance on the following areas:

1) Reflections on power
2) Focus on relationships
3) From systems to people
4) Supported trauma-competent therapists
5) Understanding trauma, intersectionalities and anti-oppression
6) Healing environments
7) Post-assessment support
8) Clarity and options when therapy is not offered

*Source*: Evidence-Based Guidelines for Conducting Trauma-Informed Talking Therapy Assessments (Sweeney et al, 2021)

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## Resource 2: Addressing inequalities in the health service

NHS England's strategic document sets out six core priorities for the health service to address inequalities, and ensure the right support and care is made available for survivors of sexual assault and abuse. These priorities are:

1) Strengthen the approach to prevention
2) Promote safeguarding and the safety and welfare of victims and survivors
3) Involve victims and survivors in development and improvement of services
4) Introduce consistent quality standards
5) Driving collaborative and reducing fragmentation
6) Ensure an appropriately trained workforce

The document addresses not only current incidences of sexual assault but also non-recent sexual abuse. Underpinning both of these issues is the need for commissioners and service providers that support survivors of sexual abuse and assault to work together, to create a seamless approach that recognises individual need and reduces fragmentation between services.

*Source*: Strategic Direction for Sexual Assault and Abuse Services (NHS England, 2018)

### Resource 3: The interdependent model of apology in the context of non-recent institutional abuse

The interdependent model proposes a way "to better understand the function and meaning of apology" in the context of historical institutional abuse.

It looks at "the multi-layered relational dimensions of shame" surrounding historical abuse and "presents apology as a potential means of invoking:
1) truth for victims
2) accountability of offenders
3) leadership of institutions
4) the re-imagination of national identity."

*Source*: Apologies as 'shame management': The politics of remorse in the aftermath of historical institutional abuse. (A McAlinden, Legal Studies, 2022).

### Resource 4: The Accountability and Reparations Investigation Report

The Accountability and Reparations Investigation Report from the IICSA defines key elements of what accountability and reparations mean to survivors, making a clear case for acknowledgement and apology. The report's focus is on the justice system, but there are valuable messages that are relevant across services. Its messages lay a foundation that services should build on to address the needs of people who have experienced childhood sexual abuse. Apologies from institutions must be genuine and sincere, never watered down or ambiguous.

### Resource 5: The Top 10 Priorities for Sexual Violence and Abuse Research

The James Lind Alliance established a Priority Setting Partnership focused on supporting survivors of sexual violence. The top 10 priorities were co-produced with a range of stakeholder representatives, especially survivors, and are as follows:
1) From the perspective of survivors, what does recovery involve and what outcomes do they value?
2) How can survivors from Black, Asian and Minority Ethnic (BAME) communicates be best supported?
3) How can access to high quality psychological therapies be improved?
4) What interventions could reduce the stigma and its consequences of survivors?
5) How can contact with the police avoid re-traumatisation, distress and victim-blaming attitudes?
6) What support is most helpful to and valued by survivors?
7) How can health services become more trauma-involved?
8) What support do survivors need during and in the aftermath of criminal justice proceedings?
9) How can support be more accessible, inclusive and effective for LGBTQ+ survivors?
10) How can survivors of historical abuse be best supported?

*Source*: *Webinar: The James Lind Alliance Supporting Survivors of Sexual Abuse Priority Setting Partnership (July 2022)*

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