

Support services for victims and survivors of child sexual abuse

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Support services for victims and survivors of child sexual abuse

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Commissioned and undertaken on behalf of the
Independent Inquiry into Child Sexual Abuse

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Disclaimer

This research report has been prepared at the request of the Inquiry's Chair and Panel. The views expressed are those of the authors alone. The research findings arising from the fieldwork do not constitute formal recommendations by the Inquiry's Chair and Panel and are separate from legal evidence obtained in investigations and hearings.

The report contains direct accounts and quotes from victims and survivors of child sexual abuse and exploitation. Reading the report can have an emotional impact. There are some support organisations that it may be helpful to contact if you have been affected by any of the content in the report: <https://www.iicsa.org.uk/help-and-support-0>.

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● Contents

Acknowledgements	viii
Executive summary	1
Chapter 1: Introduction	7
1.1 Background to the Inquiry	8
1.2 Background to the report	8
1.3 Aims and research questions	9
1.4 Policy context	9
1.5 Definitions	12
1.6 The nature, scope and prevalence of child sexual abuse	13
1.7 Impacts and effects of child sexual abuse	15
1.8 Existing research on support services for victims and survivors of child sexual abuse	15
1.9 The structure of the report	20
Chapter 2: Methods	21
2.1 Design	22
2.2 Sample	22
2.3 Survey	23
2.4 Interviews	24
2.5 Pen portraits	24
2.6 Network map	25
2.7 Ethics	25
2.8 Safeguarding	26
2.9 Limitations	26
Chapter 3: Respondents' characteristics, experiences of child sexual abuse and disclosure	27
3.1 Characteristics of victims and survivors	28
3.2 Experiences of child sexual abuse	29
3.3 Relationship of perpetrator(s) to victims and survivors	32
3.4 Disclosing child sexual abuse and experiences of doing so	33
3.5 Barriers to disclosing child sexual abuse	34
3.6 Pen portraits	37

Chapter 4: Experiences and views of support services	40
4.1 Accessing support services	41
4.2 Perceptions of the helpfulness of support services accessed in response to child sexual abuse	44
4.3 Forms of child sexual abuse-related support considered most helpful by respondents	45
4.4 Forms of child sexual abuse-related support considered least helpful by respondents	52
Chapter 5: Barriers to accessing support and unmet needs	57
5.1 Barriers to accessing support	58
5.2 Unmet needs	65
5.3 How services could be improved for victims and survivors	69
5.4 Comparative analyses	71
Chapter 6: Network mapping	73
Chapter 7: Key research findings	77
Appendices	83
Appendix A: Support service categories	84
Appendix B: Method of survey analysis	86
Appendix C: Method of qualitative analysis	88
Appendix D: Full qualitative analysis results	90
Appendix E: Crime Survey for England and Wales (CSEW) recontact sample and survey participants	93
Appendix F: Relationship between perpetrators and victims and survivors	94
Appendix G: Use of multiple forms of support	95
Appendix H: Ratings of helpfulness	96
Appendix I: Overall most helpful service	98
Appendix J: Overall least helpful service	99
Appendix K: Full results of comparative analyses	100
References	104

Figures

Figure number	Title
3.1	Settings in which child sexual abuse had been experienced
4.1	Respondents' experiences of support services across different sectors
4.2	Time (years) between first experience of child sexual abuse and first accessing support
4.3	Ratings of 'helpfulness' (ranging from 0 to 10) for support services accessed because of child sexual abuse
5.1	Views on the accessibility, availability and quality of information and support around child sexual abuse
5.2	Types of issues encountered by respondents which served as a barrier (either 'quite a lot' or 'a lot') to accessing or continuing with child sexual abuse-related forms of support
6.1	Network map of services accessed and required as a result of experiencing child sexual abuse
G.1	Number of forms of support accessed

Tables

Table number	Title
2.1	Contact methods
3.1	Survey respondents' ethnicity
3.2	A comparative assessment of the perceived appropriateness of responses to child sexual abuse disclosures over time
3.3	Barriers or concerns about disclosing child sexual abuse at the time or later in life
5.1	Type of support identified as being of potential use/benefit
A.1	Support service categories
B.1	Explanatory variables used in comparative analysis
C.1	Thematic analysis against research aims
D.1	Aim 1 – Barriers to accessing support services: master themes and sub-themes
D.2	Aim 2 – Victims and survivors' perceptions and experiences of support services
D.3	Aim 3 – What services victims and survivors think are available and how to access them
D.4	Aim 4 – The extent of unmet needs and ways services could be improved
D.5	Barriers to disclosure
E.1	A comparative assessment of key demographic characteristics of the CSEW recontact sample and the online survey respondents
F.1	Relationship of perpetrator to victims and survivors of child sexual abuse (N=181)
H.1	Ratings of 'helpfulness' for support and services accessed because of child sexual abuse (N=46)
I.1	Forms of child sexual abuse-related support considered most helpful (N=44)
J.1	Forms of child sexual abuse-related support considered least helpful (N=33)

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Executive summary

Introduction

The Independent Inquiry into Child Sexual Abuse ('the Inquiry') was established in 2015 to consider the extent to which state and non-state institutions have taken seriously their duty of care to protect children from child sexual abuse in England and Wales. At the heart of the Inquiry's work is understanding the experiences of victims and survivors themselves. This research, which was carried out by independent research consultants Broome|Gekoski in conjunction with the University of Hertfordshire, was commissioned by the Inquiry specifically to learn more about child sexual abuse victims and survivors' views and experiences of support services.

Child sexual abuse is prevalent, with 7.5% of adults aged 18–74 years having reported experiencing child sexual abuse in England and Wales before the age of 16 (Office for National Statistics, 2020). Experiencing child sexual abuse can have various short and long-term impacts, including physical and mental health problems, socio-economic issues, effects on relationships, religious/spiritual impacts, and vulnerability to re-victimisation (Fisher et al., 2017). To cope with these impacts, victims and survivors may need the help of statutory and voluntary support services. However, very little research has been carried out regarding their experiences of support systems (Chouliara et al., 2012). This research aims to address that knowledge gap.

Definition of support services

While support services may mean different things to different people at different times, for the purposes of this report support services are defined as:

Any service, organisation or intervention that provides support, advice or treatment to victims, survivors and their families to reduce the impact of having experienced child sexual abuse.¹

Specifically, three broad forms of services are explored: justice, recovery and health.²

1 It should be noted that this research looks at formal/official support services. Victims and survivors may also have access to informal support – for example, through family and friends – which is not considered here.

2 For the purposes of this report, 'justice'-based services include: the police, Crown Prosecution Service, criminal and civil courts, sexual assault referral centres and Independent Sexual Violence Advisors. 'Recovery'-based services include: counselling, psychotherapy, specialist child sexual abuse support services, faith groups, Samaritans and children's charities. 'Health'-based services include: hospital services, sexual health services, mental health services and general practitioners.

Aims

The four broad research aims were to:

- understand more about victims and survivors' reasons for not accessing support services and any barriers to access;
- learn about victims and survivors' perceptions and experiences of support services;
- understand what support services victims and survivors think are available to them and how to access them; and
- explore whether there are unmet needs for support services which impact on whether victims and survivors access support.

Methods

The sample was drawn from 634 adults who self-identified as victims and survivors of child sexual abuse as part of the 'Abuse during childhood' module in the Crime Survey for England and Wales (CSEW) year ending March 2019 (Office for National Statistics, 2020).³ A mixed-methods approach was used to explore the above research aims:

- A quantitative online survey⁴ of 181 victims and survivors from the CSEW recontact sample, including both those who had and had not accessed support. Descriptive and inferential analyses were conducted.
- Twenty-four qualitative in-depth interviews with three groups: (A) eight who had not accessed support services; (B) eight who self-identified as having had positive experiences of support services; and (C) eight who had negative experiences of support services. The interviews were analysed using thematic analysis.

These were supplemented with six pen portraits (two from each of the above groups), and a network map to aid understanding of the service landscape.

The research participants

The ages of the survey respondents ranged from 19 to 74 years, with an average of 47 years. Around four in five identified as female (82%), the majority identified as being of a White ethnic background (92%), and one in three reported having a disability (33%). All regions of England and Wales were represented, with one in four living in London or South East England (26%). Nearly nine in ten identified as heterosexual (89%).⁵

³ This recruitment method was considered particularly valuable, as most research in this area draws on samples recruited from support services themselves.

⁴ The survey was completed between 15 October and 24 November 2019.

⁵ There were no statistically significant differences between the Crime Survey for England and Wales recontact sample and the online survey respondents in relation to key demographic characteristics (eg age group, gender and ethnicity).

Respondents reported experiencing between one and eight types of child sexual abuse. The two most common forms were being kissed or groped on any part of the body in a sexual way (73%) and penetration (64%). The age at first victimisation spanned from infancy to 17 years old, with an average of 9 years old.

Child sexual abuse was more likely to have occurred in a familial setting (41%) than an institutional one (11%). Two in five (43%) respondents identified a friend, acquaintance or neighbour as the perpetrator. Around one in four (27%) identified an immediate – typically male – family member as the perpetrator. A stranger was identified by one in five (20%) respondents.

Just over one in five respondents had never previously disclosed their experiences of child sexual abuse (21%), while four in five had made a disclosure (79%). Respondents were more than twice as likely to report making a disclosure later in life (75%) than at the time of the abuse (28%). A quarter disclosed at both points (24%).

Research findings

The key research findings from both the quantitative and qualitative aspects of this work are presented below. Victims and survivors who took part in the quantitative survey are referred to as ‘respondents’, while those who took part in qualitative interviews are referred to as ‘participants’.

1. Most victims and survivors have not accessed support services.

Nearly three-quarters of survey respondents reported not having accessed any support services, with only just over a quarter having received some form of support, advice or treatment due to their experience of child sexual abuse.

2. Victims and survivors who access support services take a long time to do so and rate them as mediocre.

The average time between first child sexual abuse victimisation and contact with a support service was 19 years and there was a substantial variation in time between sexual abuse and access to support services (0–58 years). The average ‘helpfulness’ rating across all support services was 5.3 (on a scale of 0–10 with 0 being ‘Not helpful at all’ and 10 being ‘Extremely helpful’).

3. The most highly rated forms of support across all services were those provided by voluntary sector specialist services.

Across all support services, the most highly rated by survey respondents were counselling provided by a charity/voluntary organisation specialising in child sexual abuse and sexual abuse and/or rape support services provided by a specialist charity/voluntary organisation. One participant said of such a service: *“They were really, really good. I felt very, very comfortable talking to them. I just needed to try and get closure to the way I was feeling.”*

Interview participants also stressed the importance of such specialist support being from counsellors/therapists with training in, and particular knowledge of, trauma generally, and child sexual abuse specifically. One participant said that there should be more *“people that are trained in child sexual abuse. Not a generalised counsellor.”*

4. Counselling provided through health services was considered the least helpful service overall by some respondents, and the most helpful service overall by some other respondents.

Survey respondents were asked what one service was the most helpful overall. The service selected by the highest number of respondents was counselling provided through health services like a GP or hospital.

However, it is notable that when survey respondents were asked which one service was the least helpful overall, counselling provided through health services was again selected by the highest number of respondents.

While the finding that counselling provided through health services was named as both the most and least helpful form of support may seem counterintuitive or contradictory, there are a number of potential explanations. First, it is important to note that this form of support is the most commonly accessed. Therefore, more respondents had experience of the service on which to judge it. Second, there are many different factors that might impact on how different individuals perceive the helpfulness of services and these can vary between services of the same 'type'. These include the individual needs and preferences of the respondent, where and when they accessed the service, and the reason for accessing the support service. In addition, respondents' relationships with individual counsellors may have differed, as might the type of counselling (eg trauma-informed versus generic mental health), and the number of sessions offered and attended.

For example, one participant who had a positive experience of counselling through health services said: *"I felt the person [counsellor] that I was talking to really cared about what happened and was giving me the courage to open up about it."* While a participant who had a negative experience of counselling said: *"I had the feeling she just wanted to do the prescribed six sessions with me and just get me out of the surgery to move on."*

5. Victims and survivors stressed the importance of being heard, listened to, understood, believed, and not judged, by caring and empathetic professionals.

Interview participants appreciated professionals who were caring and empathetic; heard, listened to and believed them; did not judge or blame them; and gave them enough time to talk. One participant said: *"She [the counsellor] was empathetic. She'd studied it. She'd looked at it. She understood it."*

Participants also talked of the importance of welcoming, warm, private and comfortable physical environments, as opposed to clinical ones: *"It was a very friendly, very calm place. Each of the rooms was very private, very kind of neutral, like comfy chairs, quite dim lighting."*

6. The vast majority of victims and survivors reported at least one barrier to support.

More than four in five (84%) survey respondents identified at least one form of barrier to support, such as personal (67%), service-specific (53%), family or community (48%), practical (33%) or financial (29%) issues.

One personal barrier participants spoke of was feeling that you should 'just get on with it': *"These two things happened and you get over it. You don't make a big fuss or a dance about it. Get on with life."* Service-specific barriers included long waiting times: *"The NHS wait was too long ... I was desperate. I was in a really bad way."*

While family or community barriers included protecting the family: *"One abiding thought I've always had is: I was aware of protecting my parents ... so I didn't say everything ... I've always kept some of it back."*

7. A key personal issue or reason for not accessing support was victims and survivors not feeling they needed it.

One particularly interesting finding was that some participants reported not feeling that they needed support and had not been adversely affected by their experiences. It is notable that these participants tended to be older. One said: *"It didn't do me any lasting harm ... I suppose, deep down, I don't feel that I've got a problem."*

There are different ways to interpret this finding. It could be argued that victims may benefit from support even if they do not think that they need it. However, such arguments can be seen as paternalistic and it may be that some victims and survivors have higher levels of resilience than is commonly supposed.

8. A substantial minority of victims and survivors reported having unmet needs.

Two in five (43%) respondents reported currently having unmet needs linked to their experiences of child sexual abuse. The most commonly mentioned type of support desired (but not available or offered) was counselling provided by a specialist organisation. One participant said: *"I've looked in my area for services specific for child sexual abuse and it's very thin on the ground."*

Participants also talked of how support services could be improved by: help being available as soon as it is needed; better training; less reliance on medication; services for females only and services for males only; specialist support groups; multi-agency working; ongoing support; free services; and up-to-date treatments. One participant said: *"I think there should be almost immediate help."*

9. Significant relationships were found between the views and experiences of victims and survivors of child sexual abuse and their demographic characteristics and the type of child sexual abuse experienced.

Female respondents were significantly more likely than males to report having experienced child sexual abuse in a family setting, but were less likely to have done so in an institutional setting. Those respondents who tried to get support but were unable to, and those who had unmet needs, were significantly younger in age.

Those respondents experiencing child sexual abuse within family and/or institutional contexts were significantly more likely to report experiencing barriers to accessing support services than those who experienced child sexual abuse in other settings. Those who experienced child sexual abuse within the family were, however, significantly more likely than others to have accessed support.



CHAPTER 1: Introduction

1.1 Background to the Inquiry

The Independent Inquiry into Child Sexual Abuse ('the Inquiry') was established in 2015 to consider the extent to which state and non-state institutions have taken seriously their duty of care to protect children from child sexual abuse in England and Wales. The Inquiry will identify institutional failings where they are found to exist, demand accountability for past institutional failings, and support victims and survivors to share their experience of child sexual abuse. The Inquiry will also make practical recommendations to ensure that children are given the care and protection they need. The Inquiry has a dedicated research function, set up to generate new insight into child sexual abuse that will help inform the Inquiry's recommendations, as well as contributing to and advancing the evidence base more broadly. This is achieved through a combination of drawing learning together from existing research and undertaking primary research to fill key evidence gaps about child sexual abuse.

1.2 Background to the report

At the heart of the Inquiry's work is understanding the experiences of victims and survivors themselves. This piece of work, which was carried out by independent research consultants Broome|Gekoski in conjunction with the University of Hertfordshire, was commissioned by the Inquiry specifically to learn more about victims and survivors' views and experiences of support services for child sexual abuse, focusing on services to adult victims and survivors.⁶ The sample for this research consists of participants from the 'Abuse during childhood' module in the Crime Survey for England and Wales (CSEW) year ending March 2019 (Office for National Statistics, 2020) who agreed to participate in further research conducted by, or on behalf of, the Inquiry (referred to as the 'recontact sample'). The study consisted of the following elements:

- A briefing note on the current policies and guidance on support available to victims of child sexual abuse, to contextualise the research.
- A survey of those in the Crime Survey for England and Wales recontact sample.
- Semi-structured interviews with three groups: (A) those who have not accessed support services; (B) those who self-identified as having had positive experiences of support services; and (C) those who have had negative experiences of support services.
- Six qualitative anonymised pen portraits (two from each of the above groups).
- A network map to better understand the service landscape.

⁶ Although this report focuses on adult victims and survivors' experiences of support services, some respondents/participants also refer to services that they received as children.

1.3 Aims and research questions

The four broad research aims of this research were to:

- understand more about victims and survivors' reasons for not accessing support services and any barriers to access;
- learn about victims and survivors' perceptions and experiences of support services;
- understand what support services victims and survivors think are available to them and how to access them; and
- explore whether there are unmet needs for support services which impact on whether victims and survivors access support.

Taken together, these elements provide a better understanding of what support services are available to victims and survivors; how victims and survivors perceive and experience such services; how experiences of accessing these services differ; and issues relating to access and unmet need for services. They also foster a better understanding of victims and survivors' positive and negative experiences of support services. The research findings increase understanding of support service provision for victims and survivors, enhance knowledge of potential barriers to accessing support services and identify unmet needs for support services for victims and survivors of child sexual abuse.

It is important to note that access to support services will be driven by the funding and commissioning landscape, the pathways through which victims and survivors directly access or are referred to services, as well as victims and survivors' needs and wants. This research does not aim to systematically evaluate the appropriateness (availability and effectiveness) of support service provision in England and Wales. The research does aim to capture the experiences of victims and survivors of those services they have accessed, the barriers they experience in accessing support services and their views on unmet needs for support services.

1.4 Policy context

The infographics below summarise key, current, policy documents in relation to victims of crime and summarise key responsibilities in relation to support services.

The Victims' Code and Victims Strategy

Current policies and guidance on support services for victims of crime (including victims and survivors of child sexual abuse) in England and Wales

2015

Victims' Code

The Code of Practice for Victims of Crime is a statutory Government document which sets out the information, support and services that victims of crime are entitled to receive from criminal justice agencies in England and Wales

The **code** covers the support victims of crime are entitled to receive at every stage of the process from reporting a crime to post-trial support.

It states that victims should receive appropriate support to help them, as far as possible, to **cope** and **recover** and be protected from re-victimisation.

Although the Victims' Code is relevant to all victims of crime there are specific provisions which are aimed at victims and survivors of child sexual abuse. This includes 'special measures' available for vulnerable witnesses in court proceedings including those who are adult victims and survivors of sexual offences.

2018

Victims Strategy

A cross-government strategy setting out the Government's vision for victims of crime. Sets out new policy and brings together existing funding commitments made by various government departments

The **strategy** reiterates the requirement for the police to refer victims and survivors to appropriate support services and that victims and survivors are entitled to access these services whether or not they have reported a crime. This update to the code:

- Acknowledges that a lack of consistent information and an uncoordinated approach can make it difficult for victims and survivors to access services which can make the process frustrating and therefore reduce the impact of the services.
- Acknowledges that not everyone who is eligible for special measures in court cases is being identified by the authorities.
- States that spending will increase from £31 million in 2018 to £39 million in 2020/21 to improve services and pathways for survivors and victims of sexual violence and abuse who seek support from sexual assault referral centres (SARCs).
- Promises better service integration between statutory services and third sector services which provide support services to victims and survivors of child sexual abuse and assault.
- Commits to fund national rape services for a minimum of two years and explore further commissioning of local services by Police and Crime Commissioners to improve the support for victims and survivors of sexual violence.

Responsibilities across government

Current responsibilities in relation to support services (including victims and survivors of child sexual abuse) in England and Wales

Ministry of Justice

Directly commissions **79 Rape Support Centres** (including support for child sexual abuse) and allocates grants to Police and Crime Commissioners for other victims' services (piloting local commissioning of rape and sexual assault services)

Home Office

Funds a number of projects under the **Victims and Survivors of Child Sexual Abuse and National Sexual Violence Support Funds**

NHS England and GIG Cymru/ NHS Wales

Provide free at point of use health services, commission sexual assault referral centres (SARCs) and mental health services (including those that understand the specific needs of victims and survivors of sexual assault and abuse)

Local Councils

Councils have statutory duties to provide social care to support people experiencing mental health problems

Police and Crime Commissioners

Responsible for commissioning **victim services to meet local needs (including child sexual abuse)**

1.5 Definitions

1.5.1 Definition of child sexual abuse

For the purposes of this research child sexual abuse includes:

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.

(Department for Education, 2018)

Much research on child sexual abuse defines a 'child' to be 'any person under 18 years of age', in accordance with the United Nations Convention on the Rights of the Child 1989. The terms of reference of the Inquiry also consider a child to be under the age of 18. While the survey for this research asked about experience of child sexual abuse before the age of 18, the recontact sample was from the CSEW, which measures the prevalence of adults who experienced child sexual abuse (by adults or children) before the age of 16.

1.5.2 Definition of support services

There is no widely agreed upon definition of 'support services' in the literature (see section 1.8 for further discussion) and 'support' means different things to different people. For the purposes of this report, support services are defined as:

Any service, organisation or intervention that provides support, advice or treatment to victims, survivors and their families to reduce the impact of having experienced child sexual abuse.

This definition therefore encompasses a range of different types, sectors and providers. These services can be statutory, voluntary, or private;⁷ and may be specialist or generalist in relation to child sexual abuse. Support services are provided across different sectors such as criminal justice interventions, health service treatments, specialist counselling and mental health support. Some services will incorporate specialist provision for adult survivors of childhood sexual abuse; some will offer direct support for trauma; some may be trauma informed, some may do all three of these things. It is likely, however, that the majority of support accessed by participants in this research will have been aimed at general forms of distress and mental ill health, not specialist. A summary of support services is set out in Appendix A (based on Smith et al., 2015).

⁷ Informal support services are not included within this report, as explained in footnote 1.

1.5.3 Definition of disclosure

In this research we use the term 'disclosure' to refer to the victims and survivors telling anyone about the child sexual abuse. This includes family members, friends, strangers and people in authority. 'Disclosed' and 'told someone' are therefore used interchangeably. Disclosure is therefore much broader than 'reporting' child sexual abuse to the police.

1.5.4 Fit with the Inquiry's Terms of Reference

The Inquiry considers child sexual abuse experienced before the age of 18. The CSEW, from which the sample was drawn, uses before 16; nonetheless we asked respondents about child sexual abuse experienced before the age of 18, in line with the Inquiry definition. It should further be noted that most of the respondents were abused in familial settings (which is a finding in line with the research in this area). While the Inquiry is focused on institutional child sexual abuse, those abused in familial settings may still have been let down, or failed, by institutions. Thus, the research is relevant both to the Inquiry's work and to the broader child sexual abuse support service landscape.

1.6 The nature, scope and prevalence of child sexual abuse

Assessing prevalence rates of child sexual abuse with any precision can be problematic, as there is no universally accepted definition of child sexual abuse (as noted in section 1.5 above), nor any widely agreed upon and utilised measurement tools and approaches (Gekoski and Broome, 2019). The latest figures from the CSEW,⁸ from which the recontact sample was drawn, reports that around 7.5% of adults aged 18 to 74 years reported experiencing sexual abuse before the age of 16, which equates to 3.1 million people (ONS, 2020). More specifically, it was estimated that 3% of adults (aged 18 to 74 years) had experienced non-contact child sexual abuse and 6% experienced contact child sexual abuse. Over a third (36%) of adults who were sexually abused before the age of 16 years experienced more than one type of contact or non-contact child sexual abuse.

Furthermore, the same report – which brings together data from government and voluntary sectors⁹ – found that there were 73,260 sexual offences against children recorded by police forces in England and Wales in the year ending March 2019; just over one-quarter (27%) of these were rape offences. The report shows 2,230 children in England were the subject of a child protection plan (CPP) and 120 children in Wales were on the child protection register (CPR) for experience or risk of sexual abuse at that time. Furthermore, it was found that sexual abuse is now the most common type of abuse counselled by Childline and the most frequently reported type of abuse by adults calling the National Association for People Abused in Childhood (NAPAC) helpline.

⁸ For the year ending March 2019.

⁹ Including the Department for Education (DfE), Home Office, National Association for People Abused in Childhood (NAPAC), National Society for the Prevention of Cruelty to Children (NSPCC), National Crime Agency (NCA), Welsh Government and police forces in England and Wales

Other key findings from the CSEW, which are relevant to this study, include:

- Women were around three times as likely as men to report having experienced child sexual abuse (12% and 4%, respectively).
- Nearly half (48%) of those who reported experiencing child sexual abuse report that the abuse started or occurred by age 11.
- Over half (54%) reported that the abuse lasted for less than one year.
- A quarter (25%) reported that the abuse lasted one to four years.
- Around nine in ten (92%) experienced child sexual abuse committed by males; 4% by both males and females; and 4% by females.
- Perpetrators were most likely to be a friend or acquaintance (37%); just under one-third (30%) were abused by a stranger.
- Women were approximately five times as likely as men to have experienced sexual abuse by a step father (7.5% versus 1.4% respectively).
- Women were more likely than men to have experienced sexual abuse by a family member that was not a parent or step parent (24% versus 15%, respectively).
- Nearly a quarter (24%) who experienced (attempted) rape/assault by penetration told someone at the time.
- One in three (30%) disclosed other contact child sexual abuse and four in ten (40%) disclosed non-contact child sexual abuse at the time.
- Those who disclosed at the time were most likely to tell someone they knew well (eg a family member, friend, partner or neighbour).
- Common reasons for non-reporting were: embarrassment; fear of not being believed; fear of being humiliated; not thinking that anything would be done.
- Around half (46%) only told someone about the abuse later in life.

The CSEW prevalence estimate relies on adults' recollections of past experiences of child sexual abuse and does not ask about abuse experienced aged 16–17. Furthermore, it does not attempt to measure the current level of child sexual abuse in England and Wales.

Further issues relating to estimates of prevalence should be noted. For example, estimates that do not rely on crimes that are reported to official agencies – such as the police, child protection services, or social services – and which strive to uncover the 'hidden' or 'dark' figure of child sexual abuse, report higher rates of child sexual abuse. For example, a UK study found that 11% of young people aged 18–24 reported experiencing contact sexual abuse in their lifetime (Cawson et al., 2000). While another UK study found that 17% of 11–17-year-olds reported having experienced contact or non-contact sexual abuse (Radford et al., 2011). Even at the conservative end of the scale, such statistics suggest that several million children and adults in the UK have experienced child sexual abuse (Fisher et al., 2017).

1.7 Impacts and effects of child sexual abuse

As a result of child sexual abuse, victims and survivors may experience a range of adverse emotional, psychological, behavioural, physical, cognitive, sexual and financial impacts, which may manifest throughout the life course and may be both short-term and/or long-term (Gekoski et al., 2016). In naming potential impacts, it must be noted that victims and survivors are not a homogeneous group who all feel the same effects arising from victimisation (Allnock, 2016). According to Fisher et al. (2017), potential influences on the impacts experienced as a result of child sexual abuse may include:

- Victim and survivor characteristics: for example, levels of resilience, personality traits, demographic factors and other adverse life events.
- The circumstances and nature of the sexual abuse: for example, the age of onset, the identity of the abuser and the nature of the sexual abuse.
- Interpersonal relationships and immediate environment: for example, the attitude of victim and survivors' caregivers.

Thus, the severity of the consequences of child sexual abuse will vary between victims and survivors (McNeish and Scott, 2018). Moreover, some suggestion has been made of the potential for positive adaptation following child sexual abuse (Hartley et al., 2016). That is, there is evidence that victims and survivors may not only passively or maladaptively cope with their trauma but some may actively cope with it, potentially developing positive psychological change, or what may be termed 'post-traumatic growth' (Gekoski and Broome, 2019).

With those caveats in place, a recent All-Party Parliamentary Group for Adult Survivors of Childhood Sexual Abuse online survey of 365 victims and survivors of child sexual abuse (APPG ASCSA, 2020) found that the abuse had negatively affected their intimate relationships (90% of respondents), mental health (89%), family life (81%), career (72%) and education (65%). While a review by Sneddon et al. (2016) found common outcomes of being a victim of child sexual abuse to include: mental and physical health issues, maladaptive behaviours, relationship issues, sexual re-victimisation and challenges in being a parent. Similarly, the Inquiry's own rapid evidence assessment by Fisher et al. (2017), which analysed over 200 pieces of research on child sexual abuse, found impacts on every aspect of victims and survivors' lives, grouped into seven categories: (i) physical health problems; (ii) emotional/mental health problems; (iii) externalising behaviours; (iv) interpersonal relationship issues; (v) socio-economic issues; (vi) religious/spiritual beliefs; and (vii) vulnerability to re-victimisation.

1.8 Existing research on support services for victims and survivors of child sexual abuse

Unsurprisingly, victims and survivors frequently need contact with, and help from, various statutory and voluntary support services (Chouliara et al., 2011). Given the likely negative psychological impact on victims and survivors, it "*makes it all the more important that, when they need to access social, healthcare and other services, they can do so without fear or trepidation and in the knowledge that they will be given strong and appropriate support*" (Robinson, 2008, p. iii).

The types of services that victims and survivors may come into contact with include: social services and the child protection system; the legal system (if they choose to report the crime); the medical system for physical examinations or to treat any injuries sustained; the mental health system for

therapeutic treatment; and support groups, organisations and charities for advice and help (Gekoski et al., 2016). As noted above, provision of support may be specialist. However, some intervention may be more focused on the symptoms or diagnosis with which a service user or client presents, or has been referred, than with their experience of child sexual abuse. Thus, assessing the appropriateness of support provision may not be straightforward.

However, there has been very little research carried out on victims and survivors' experiences of support systems, particularly in the UK (Chouliara et al., 2012). As Smith et al. (2015, p. 5) observe:

There is a remarkable lack of research about survivors of child sexual abuse (CSA) in the UK. This is true generally and particularly in relation to evidence about the availability and quality of support to survivors.

Existing research with victims and survivors suggests that seeking and receiving help from support services is a long, complex and difficult process for many (Chouliara et al. 2011). A large online survey of nearly 400 victims and survivors of child sexual abuse – recruited through Survivors in Transition and The Survivors Trust – looked at adult victims and survivors' experiences of support systems, finding that victims and survivors used a range of support services over a long period of time (Smith et al., 2015). On average, they used between four and five services, over a 10-year span between the first service accessed and the most recent service use. Of all support services, counselling, mental health and GP services were most commonly used, followed by voluntary sector specialist sexual abuse and rape support services and psychotherapy services. The police, Samaritans, accident and emergency (A&E), secondary health services, and social services were less commonly used.

Some research has found that victims and survivors may have negative experiences of support systems. In the worst cases, such experiences may compound harms already done and serve as a form of secondary victimisation (Gekoski et al., 2013). For example, a rapid evidence assessment by Horvath et al. (2014), which analysed nearly 300 pieces of relevant research, concluded that although there are some elements of good practice, victims and survivors are being let down by the system, including the child protection system, police, Crown Prosecution Service (CPS) and courts.

The All-Party Parliamentary Group for Adult Survivors of Childhood Sexual Abuse survey of 365 victims and survivors also found that victims and survivors are not getting what they need from the criminal justice system, such as the police and the courts (APPG ASCSA, 2020). Although mental health services were identified as the second most important form of support by respondents, only 16% said that NHS mental health services met their needs. Furthermore, seven in ten victims and survivors said they were not given adequate support when going to court as a witness. Special measures were also often not offered or utilised, with two in five victims and survivors not having the opportunity to give evidence remotely or from behind a screen. When it came to sentencing, four in five victims and survivors did not feel heard.

Other negative experiences that victims and survivors of child sexual abuse may encounter include professionals: taking a sexual interest in survivors; dealing ineffectively with errors in talking therapy; being passive or unresponsive to survivors; and relying on prescription or heavy medications (eg Koehn, 2007; Nelson, 2009). Looking at talking therapies, Chouliara et al. (2011) found that victims and survivors, as well as therapists, spoke of:

- difficulties in conducting trauma-focused work;
- supportive contact;
- continuity and consistency of services;
- accessibility during acute episodes;
- problems surrounding hearing and managing disclosures;
- child protection issues;
- availability and accessibility of services.

However, victims and survivors may also derive numerous benefits from accessing support services. Most research in this area tends to concentrate on therapeutic services – chiefly, counselling and psychotherapy – as these are typically the services that victims and survivors access the most frequently and find the most helpful (eg Smith et al., 2015). For example a systematic review, which identified 23 qualitative research studies exploring how adult survivors of child sexual abuse experienced non-specific and trauma-focused talking therapies (Parry and Simpson, 2016), found that talking therapies could help victims and survivors to:

- develop choice, control and empowerment;
- foster relationships and connectivity with others and the self;
- aid them in developing a sense of self, self-awareness, self-esteem, self-kindness and self-empowerment;
- learn coping skills and strategies;
- aid with healing.

While a qualitative study, which explored the perceptions and experiences of talking therapy services for 13 child sexual abuse survivors and 31 professionals in statutory and voluntary services in Scotland (Chouliara et al., 2011), found numerous beneficial effects of talking therapies. These included:

- feeling less isolated;
- enhancing self-worth and sense of self;
- helping to contextualise the abuse;
- helping victims and survivors to move towards recovery.

Such benefits were most likely to be felt and achieved when the therapeutic relationship is confidential, transparent, non-judgmental, safe, trusting, honest and boundaried; the therapist is aware of, and knowledgeable about, trauma-related issues generally and child sexual abuse specifically; and victims and survivors feel listened to, heard and believed (eg APPG ASCSA, 2020; Parry and Simpson, 2016; Sneddon et al., 2016; Smith et al., 2015; Chouliara et al., 2012; Chouliara et al., 2011; Schachter et al., 2008).

For example, the All-Party Parliamentary Group for Adult Survivors of Childhood Sexual Abuse survey (APPG ASCSA, 2020) found that nearly half (47%) of victims and survivors thought that the most important form of support was specialist voluntary sector counselling or therapy that is trauma-informed. The report defines “*trauma-informed care*” as “*an approach that recognises the psychological trauma caused by abuse, its impact across all aspects of a person’s life, and which supports a person to recover from the trauma*” (p. 4). Relatedly, survivors felt that all frontline professionals – for example GPs, police, social workers and Jobcentre Plus work coaches – should be trained in a trauma-informed approach.

Smith et al. (2015) found that nearly all (90–100%) of those who used sexual assault referral centres (SARCs), Independent Sexual Violence Advisors (ISVAs), voluntary sector specialist psychotherapy and counselling services, and rape and sexual abuse support services felt that these services had listened to, believed and respected them. In comparison, less than half of those who used social services, A&E or hospital services, felt that they had been listened to, believed and respected. Furthermore, when asked what the most helpful support they had received overall was, some respondents referred not to *types* of service in themselves but more broadly to services that had listened to and believed them. The median average satisfaction score across services was 2.5, somewhere between ‘neither good nor poor’ and ‘good’,¹⁰ suggesting that victims and survivors “*were more satisfied than dissatisfied with the support they received*” (p. 3).

However, some victims and survivors never get as far as having *any* experiences of support services, because various factors act as barriers to access. Barriers may be internal or external. For example, victims and survivors may have various internal feelings, beliefs and reactions surrounding the sexual abuse which act as barriers to them disclosing their abuse and accessing services. These may include shame, guilt, self-blame, embarrassment, fear, low self-esteem, inability to trust, confusion, fear of not being believed, helplessness, numbness, grief, shock, stigma, feeling dirty, sadness, anger and disillusionment (Nelson and Hampson, 2008).

10 Support was measured on a 5-point scale (0–4), with 0 being very poor and 4 being very good.

Other potential barriers to access, identified by Schachter et al. (2008), include:

- a lack of trust in authority figures;
- trouble stating their needs;
- ambivalence about their body and reluctance to seek help for health problems;
- fear and anxiety about encounters with professionals;
- lack of previous disclosure;
- questioning their sexuality/sexual orientation;
- concern that they may be seen as potential abusers themselves;
- the transference/displacement of thoughts, feelings and beliefs about past situations onto present ones;
- survivors dissociating¹¹ during interactions.

It is clear that some of these internal barriers may be exacerbated or caused by the primary victimisation. However, barriers may also be external. For example, Smith et al. (2015) found that victims and survivors expressed problems with:

- availability and adequacy of provision;
- insufficient free-at-point-of-use provision;
- long waiting lists for too brief counselling programmes;
- limited options in terms of therapeutic techniques.

Furthermore, it is important to note, as observed by Smith et al. (2015, p. 4) that:

The impact of poor service experiences is more than the absence of effective help at one point-in-time. Instead, poor service experience is associated with a delay in survivors accessing future services and with survivors using more services over a longer duration. As such a poor service can have a long-term impact and represent a barrier to support for survivors. In contrast, a good service response can result in survivors coming to a point of recovery or resolution sooner in their lives while at the same time making more efficient use of service resources.

The current research aims to better understand whether, and how, adult victims and survivors of child sexual abuse perceive and have experienced support services, seeking to explore barriers to accessing support services, reasons for attrition and referral pathways across these services. This will be achieved through a mixed-methods design, using both quantitative and qualitative data to solicit the experiences of adult victims and survivors themselves.

11 Dissociation is a response to trauma in which people 'dissociate' or disconnect from their surroundings.

1.9 The structure of the report

Following this introductory chapter, Chapter 2 details the research methodology. It includes an overview of the sample of victims and survivors in this research, explains how the survey and interviews were carried out and analysed, and considers ethical and safeguarding issues.

Chapter 3 looks at the respondents' characteristics, experiences of child sexual abuse, and disclosure, including barriers to disclosure. It ends with six pen portraits developed from the qualitative interviews, to set the scene/context for the findings about victims and survivors' experiences and perceptions of support services in the subsequent two chapters.

Chapters 4 and 5 present the main research findings, integrating both the survey results and qualitative interview data to explore the four main research questions. Chapter 4 investigates respondents' experiences and views of support services, including accessing support, perceptions of helpfulness of support services, services considered the most helpful, and services considered the least helpful. Chapter 5 looks at barriers and unmet needs, including existing barriers to accessing support, unmet needs of respondents, what participants said about how services might be improved, and the (statistically significant) results of the comparative analyses.

Chapter 6 presents the results of the network mapping, using some of the survey data, that was undertaken in order to better understand the service landscape.

Finally, Chapter 7 summarises the key research findings.



CHAPTER 2: Methods

2.1 Design

This study employed a mixed-methods design, using both quantitative and qualitative approaches, to answer the four main research aims set out in section 1.3. In order to address these questions, the research employed two main methods:

- An online quantitative survey of those in the CSEW recontact sample who self-identified as victims and survivors of child sexual abuse and agreed to take part in this research.
- Semi-structured qualitative interviews with a sub-sample of respondents, divided into three groups: (A) those who had not accessed support services; (B) those who self-identified as having had positive experiences of support services; and (C) those who had negative experiences of support services.

These were supplemented with the following elements:

- A briefing note on the current policies and guidance on support available to victims of child sexual abuse to contextualise the research.
- Six qualitative pen portraits (two from each of the above interviewee groups).
- A network map, or visualisation, to better understand the service landscape.

2.2 Sample

The recontact sample comprised 634 adults who self-identified as victims and survivors of child sexual abuse as part of the 'Abuse during childhood' module in the CSEW year ending March 2019 and agreed to be recontacted to take part in further research, providing their contact details for this purpose.

This sampling method was a positive, unique, feature of this research, as previous research has tended to use samples recruited from support services themselves (eg Smith et al., 2015). As such, previous samples are, by design and definition, skewed in favour of those who have accessed support; they do not incorporate those who have not accessed help at all, nor do they consider the extent of unmet needs.

The recontact sample's details were held by the Office for National Statistics (ONS) and were securely transferred to the University of Hertfordshire's Data Management System, in line with the British Psychological Society Code of Ethics and Conduct and the General Data Protection Regulation (GDPR).

In total, 181 respondents completed the survey and 24 of these also took part in qualitative interviews. The characteristics of these respondents (eg their gender, age, ethnicity and sexuality) can be found in section 3.1.

2.3 Survey

The online survey was hosted via Qualtrics and was open to responses for a six-week period from 15 October to 24 November 2019. Respondents were contacted using the details they provided, through their preferred means of communication, as indicated during the CSEW consent process. As well as receiving a notification about the launch of the survey, any non-responders were also issued with reminders at the midway point of the fieldwork and again in the week before the survey closed to responses.

A total of 237 people from the recontact sample accessed the online survey over this six-week period. Details of the different contact methods used to alert the sample to the existence of the survey and response rates are provided in Table 2.1.

Table 2.1: Contact methods

Contact method	Number contacted	Percentage contacted by method	Number accessing survey via link (A)	Number engaging with survey (B)	Survey response rate (B as percentage of A)
Email	414	65	181	144	65
SMS	474	75	136	78	75
Letter	68	11	20	15	11
All	634	100	337	237	70

Having read a participant information sheet, most respondents (n=191; 81%) agreed to progress and 185 provided informed consent. Four respondents, having provided consent, submitted no further responses. These cases have been removed, leaving a sample of 181. This is equivalent to a response rate of 76% for those who accessed the survey, and 29% for the entire recontact sample (N=634). Consent was recorded electronically for all respondents prior to completion of the online survey, and a debriefing sheet provided at the end of the survey.

In addition to descriptive statistics, inferential tests were used to examine the distributions of categorical variables (eg relating to whether a support service had ever been accessed) and determine whether these were the same across different groups (eg based on respondents' gender or ethnicity). In addition, comparative analyses were undertaken to assess how respondents' views and experiences varied according to their demographic characteristics, the type of child sexual abuse experienced, the types of services accessed, and the types of support accessed. The main outcome variables which served as the focus of the comparative analyses were: (i) accessing support services; (ii) perceptions and experiences of these support services; (iii) having experienced barriers to accessing support services; and (iv) reporting any current unmet need for services (Appendix B).

2.4 Interviews

At the end of the survey, respondents were asked if they would be interested in taking part in a one-to-one interview in order to explore their experiences in more depth. Those who expressed an interest in being interviewed were contacted by one of the researchers, via their preferred means of communication.

Interviews were conducted using VSee – a secure means of making calls which can be freely downloaded onto a PC, laptop or smartphone – or via telephone. Participants gave their verbal consent to be interviewed and for the interview to be audio-recorded. Interviews took approximately 45–60 minutes to complete. At the end of the interviews participants were emailed a debriefing sheet.

The recordings were subsequently transcribed verbatim for the qualitative analysis. Each transcript was anonymised and participants chose their own pseudonym at the end of the interview. In addition, other identifying features such as other people's names, or those of towns, schools or other institutions were replaced with [X].

The interview transcripts were analysed thematically, exploring patterns and ideas to emerge under each research aim, from each group. The qualitative technique of thematic analysis was used to identify common themes, following the six phases articulated by Braun and Clarke (2006). These involve the researcher immersing themselves in the data and identifying broad overarching master themes and narrower sub-themes. (See Appendix C for information on the qualitative analysis approach.)

As the interview participants were a subset of the survey respondents, many of the themes that emerged inevitably corresponded to the survey questions/answers. However, some came across more strongly than others in the interviews, and some novel themes also arose. Thus, while quotes from interviewees are used to illustrate survey findings, they also offer contrasting findings/experiences where these exist. Not all themes were used in the analysis as some were not considered representative enough, being, for example, only expressed by one or two participants. The full qualitative analysis results can be found in Appendix D.

In writing up the analysis, the survey and interview findings (ie the quantitative and qualitative results) were merged to tell a coherent story/narrative, in accordance with the mixed-methods approach.

2.5 Pen portraits

From the qualitative interviews, six anonymised pen portraits were written, two from each group. Each portrait gave an overview of the participant's experience, in addition to some detail, illustrated with quotes. The portraits chosen were those that were felt to best reflect the research findings from the survey and the interviews.

2.6 Network map

In order to better understand the service landscape, network mapping was undertaken using some parts of the survey data. This included whether the survey respondent had received any form of support, advice or treatment from a service or organisation because of their experience of child sexual abuse; whether they had tried to get help or support but were unable to, or were prevented from doing so; types of services used by those accessing help or support; and services respondents thought they would benefit from now as a consequence of their experience of child sexual abuse.

Answers to the question of whether the respondent had received any form of support, advice or treatment from a service or organisation because of their experience of child sexual abuse that were given as 'Don't wish to answer', or that were missing, were excluded from the network mapping. Similarly, respondents who did not wish to answer the question of whether they would benefit from services now, or who left their answer blank, were excluded from the network mapping. This gave a total of 154 respondents who were included in the network map. The relevant survey data were reconfigured as a network dataset: every respondent was linked to the services they had some kind of relationship with (whether this relationship reflected actual use, or an attempt or desire to use that service). This network dataset was then imported into UCINET for analysis and was visualised using NetDraw.¹²

2.7 Ethics

The study received full ethical approval from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee.¹³ The study was also approved by the Inquiry's Research Ethics Committee and was developed in consultation with its Victims and Survivors Consultative Panel (VSCP). As the issue of confidentiality and anonymity is particularly important for victims and survivors, it was vital to assure respondents that, in writing up final reports, the names of victims and survivors, offenders, locations and dates would be changed to protect their identity.

The issue of consent also needed to be approached carefully. Although agreement had already been obtained from the recontact sample to participate in further research, the team ensured that participants were fully informed about the research and were participating of their own free will, without any coercion involved, throughout the whole process. Debriefing is also particularly important at the conclusion of trauma-focused research. Therefore, it was crucial to debrief participants about the purpose and design of the study. Participants in qualitative interviews were also offered a follow-up telephone call with Professor Steve Broome, a qualified integrative counsellor. However, no participants chose to take up this option.

12 There are many techniques and software packages for undertaking network analysis. For an overview of the approach, see the Home Office guide to social network analysis at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/491572/socnet_howto.pdf

13 Protocol number: LMS/SF/UH/03880.

2.8 Safeguarding

Safeguarding concerns were at the forefront of the research. All researchers completed Inquiry safeguarding training at the beginning of the project and a safeguarding flowchart was subsequently developed which detailed the steps that should be taken if any safeguarding concerns were identified during the research.

Although anonymity and confidentiality were key concerns, in exceptional circumstances safeguarding concerns could override these. For example, if a participant disclosed any serious harm or illegal activity or the risk of such activity, or was intending to harm themselves or others. In such cases, the researchers would need to make a report to the Inquiry and any relevant authority (eg the police) immediately. One potential safeguarding issue arose during a qualitative interview; the case was logged by the Inquiry's safeguarding lead and no further action was required.

2.9 Limitations

Limitations to this research included the sample size of the survey, which rendered its statistical power limited, both for the entire sample (N=181) and particularly for the group of victims and survivors who had accessed services (n=46). Where very few significant associations were found, it also rendered the hypothesis testing challenging.

Limitations related to the survey included having to restrict the number of questions asked, in order to be mindful of the time it would take respondents to complete and the potential distress it might engender. Thus, the researchers often had to merge multiple initial ideas into one item, which limited the amount of useful information that could be gathered.¹⁴

A limitation of the qualitative interviews was that they were self-selected, with the survey respondents choosing whether they wanted to take part in an interview. Thus, when considered either as a whole sample of interviewees (N=24), or as three specific groups, they are not representative of the survey respondents as a whole (N=181).

The sample was also lacking in diversity, being very homogeneous, predominantly made up of heterosexual females in their mid 40s from White ethnic backgrounds.¹⁵ We can therefore say little about how child sexual abuse affects those from other ethnic groups or LGBTQI+ individuals.

14 For instance, the type of service (eg specialist services for child sexual abuse) rather than specific services (eg Rape Crisis England & Wales) were asked about.

15 However, there were no significant differences between the Crime Survey for England and Wales recontact sample and the online survey respondents in relation to key demographic characteristics (eg age group, gender and ethnicity).



CHAPTER 3: Respondents' characteristics, experiences of child sexual abuse and disclosure

3.1 Characteristics of victims and survivors

The ages of the survey respondents ranged from 19 to 74 years, with an average age of 47 years (median=49 years; $SD^{16}=14.3$). Around four in five respondents identified as female ($n=148$; 82%); this is consistent with the gender split within the recontact sample from which these cases were drawn. One respondent indicated that their gender identity had changed since childhood (another preferred not to say). Most respondents identified as being of a White ethnic background (92%). A detailed breakdown of the respondents' ethnicity is provided in Table 3.1.

Table 3.1: Survey respondents' ethnicity

Ethnic group	Frequency	Percentage*
White: British	154	85
White: Irish	3	2
White: Any other White background	9	5
Mixed/multiple ethnic groups: White and Black Caribbean	4	2
Mixed/multiple ethnic groups: White and Black African	1	1
Mixed/multiple ethnic groups: White and Asian	1	1
Asian: Indian	1	1
Asian: Pakistani	2	1
Asian: Chinese	1	1
Asian: Any other Asian background	2	1
Other ethnic group: Arab	1	1
Prefer not to say	2	1
Total	181	

*Figures may exceed 100 due to rounding.

One in three respondents reported experiencing some form of disability, illness or condition at the time of the survey ($n=59$; 33%). The number of conditions reported ranged from one to eight, with an average of two (median=2; $SD=1.5$). The most common disabilities, illnesses or conditions identified were linked to:

- (unspecified) mental health issues ($n=35$)
- mobility (eg walking short distances or climbing stairs) ($n=18$)
- stamina or breathing or fatigue ($n=13$)
- learning or understanding or concentrating ($n=11$)
- memory ($n=11$).

16 Standard deviation (SD) is a value which describes how much the individual members of a group differ from the mean value for the group overall.

Respondents were asked to consider and identify from a list of descriptions which best reflected their current situation.¹⁷ The most common responses were being:

- in paid work (for at least 10 hours of the week) (n=99; 55%)
- wholly retired from work (n=24; 13%).

All the regions of England and Wales were represented within the sample, with one in four living in London or the South East England (n=46; 26%). There were fewer respondents from North East England (n=4; 2%).

One in ten identified as gay, lesbian (n=6; 3%), or bisexual (n=10; 6%). Two respondents defined their sexual orientation in an 'other' way (1%). The same number chose not to answer this question (n=2; 1%). Most respondents identified as heterosexual or 'straight' (n=159; 89%).

There were no significant differences between the CSEW recontact sample and the online survey respondents in relation to key demographic characteristics such as their age group, gender or ethnicity (see Appendix E).

The majority of qualitative interview participants (N=24) were also heterosexual White women, although the average age was slightly higher than for survey respondents. Three-quarters of the sample (n=18, 75%) were female and one quarter (n=6, 25%) were male, with an average age of 53. All but one identified as being from a White ethnic background, with one female participant being Mixed White and Black Caribbean. Over five in six (n=21) of the interview participants described themselves as being heterosexual or 'straight' and three described themselves as homosexual or 'gay' (two men and one woman).

Looking at the three interview groups in isolation (n=8 in each group), there were some differences between them. Perhaps most notably, Group A (who had no experiences of support services) had a higher average age of 63, compared to Group B (who had positive experiences) who had an average age of 55 and Group C (who had negative experiences) who had an average age of 48. Other differences included Group C comprising entirely of females and Group A comprising entirely of those who identified as heterosexual.

3.2 Experiences of child sexual abuse

Here we present data on respondents' self-reported experiences of child sexual abuse, including: the nature of the abuse; their age at first victimisation; the setting(s) in which it occurred; their relationship to the perpetrator(s); the extent to which child sexual abuse was disclosed and to whom (both at the time of the abuse and later in life); the perceived appropriateness of any response to disclosure; and any barriers and concerns which may have prevented disclosure.

¹⁷ Respondents could identify as many statements (adapted from the 2017 British Social Attitudes Survey) which they thought applied to them.

Child sexual abuse can take many forms. Respondents reported experiencing between one and eight different types¹⁸ of sexual abuse during childhood, with an average (median) of three distinct forms being reported (mean=3; SD=1.6). Seven respondents indicated that they could not recall the nature of the child sexual abuse they had experienced (n=5; 3%) or 'preferred not to say' (n=2; 1%).

The two most common forms of child sexual abuse reported were being kissed or groped on any part of the body in a sexual way (whether or not they were wearing clothes) (n=132; 73%) and child sexual abuse involving penetration (n=115; 64%). Around half the sample described someone deliberately exposing themselves ('flashing') (n=94; 52%), or being forced or manipulated into touching someone's body (their own or another's) for sexual purposes (n=86; 48%).

One in five recalled being made to watch or listen to sexual acts, or to look at sexual images (for example in person or in films, videos, internet images or telephone calls) (n=38; 21%). By contrast, far fewer respondents reported someone taking or sharing sexual images or videos of them (n=9; 5%), or being sent sexual images or videos of themselves or others (n=8; 4%) as a child. Given that the sexual abuse was non-recent for many, this result is not unexpected.

The age at first victimisation spanned from infancy to 17 years of age,¹⁹ with an average age of nine years (median=9; SD=3.8).²⁰ On average, this child sexual abuse was estimated to have been perpetrated over a four-year period²¹ (mean=4; SD=3.5).

Most reported having experienced child sexual abuse in one (n=92; 54%) or two specific settings (n=61; 36%) (range 1-5; median=1; SD=0.7).²² The most common settings for child sexual abuse reported by respondents were:

- someone else's home (n=83; 46%)
- their family home (n=81; 45%)
- the street or other public place (n=50; 28%).

By contrast, there were fewer reports of child sexual abuse having occurred within:

- schools (all settings) (n=16; 9%)
- sporting, community or cultural locations (n=6; 3%)
- health services (eg hospital, GP's surgery) (n=6; 3%)

18 The questions on forms of child sexual abuse in our online survey replicated those used by the Crime Survey for England and Wales module on 'Abuse during childhood'.

19 Four respondents (2%) reported experiencing child sexual abuse beyond the legal age of consent (ie at 16 years or above).

20 N=172. Two respondents were unable to recall the age of first victimisation and in 11 cases no response was provided.

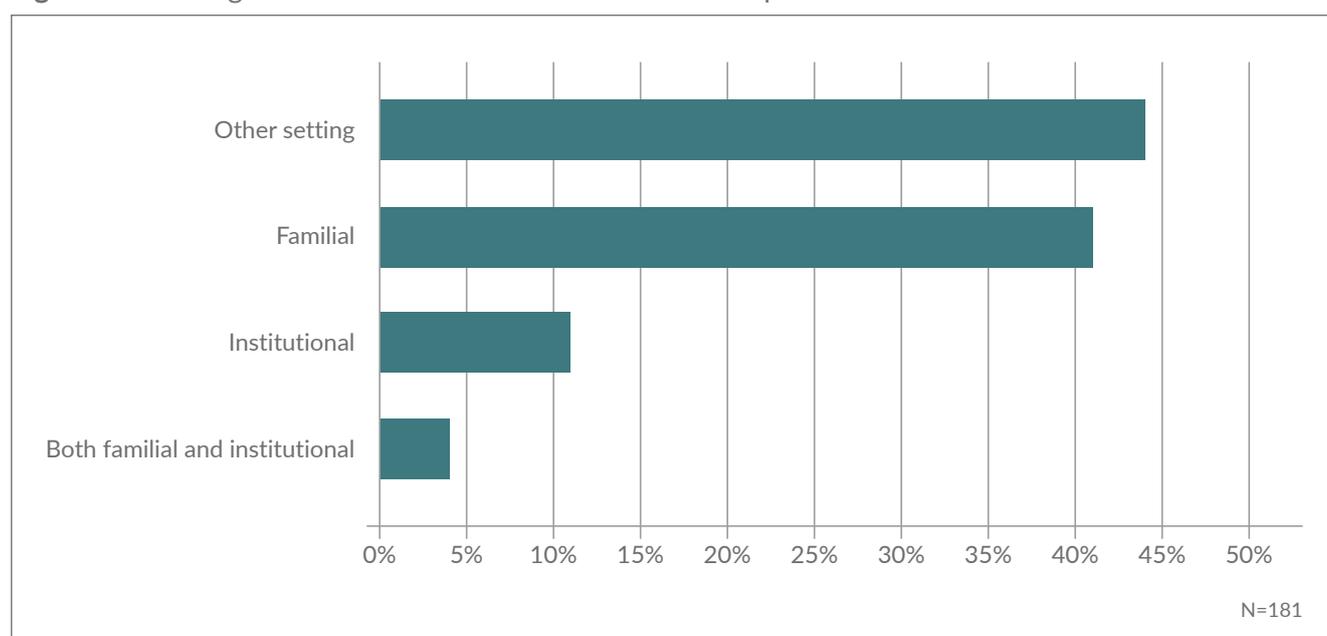
21 This was calculated using respondents' estimates for their ages the first and last time they experienced child sexual abuse before the age of 18 (N=162). Seven respondents (4%) were unable to recall how old they were the last time someone did any of these things to them before they turned 18. Nine respondents (5%) provided no data on this question. Data for one case, where the reported age at which the child sexual abuse ended pre-dated the starting age, were excluded from our analysis.

22 Ten respondents (6%) provided no details on the nature of the setting(s) in which they had experienced child sexual abuse.

- welfare services (eg care home, children’s home, foster home or other welfare institution) (n=2; 1%)
- faith-based settings (eg church/faith/religious organisation) (n=2; 1%)
- youth justice centres (eg remand detention, secure children’s home, young offender institution) (n=1; 1%)
- ‘other’ settings (n=24; 13%), such as a work-based environment (eg shop or office) (n=6; 4%), in a car/taxi (n=4; 2%) or while using public transport (n=3; 2%).

As illustrated in Figure 3.1, child sexual abuse was more likely to have been experienced by respondents in a familial setting²³ (n=75; 41%) than an institutional²⁴ one (n=20; 11%). Only a small proportion (n=7; 4%) had experience of child sexual abuse in both these contexts. Most experiences of child sexual abuse, however, occurred in ‘other’ settings (n=79; 44%).

Figure 3.1: Settings in which child sexual abuse had been experienced



23 Based on responses to the question ‘Where did any of these things happen to you before you were 18 years old?’

24 For the purposes of this report the institutional settings used in the survey were as follows: schools (eg pre-school, religious school, college); sporting, community or cultural locations (eg Cubs, Scouts, Guides, language schools); health services (eg hospital, GP’s surgery); welfare services (eg care home, foster home); faith-based settings (eg church/faith/religious organisations); and youth justice centres (eg remand centres, secure children’s homes, young offender institutions).

3.3 Relationship of perpetrator(s) to victims and survivors

Over half of the sample defined the perpetrator of their child sexual abuse with reference to just one type of relationship (median=1; mean=2; range=1–6; SD=0.9) (see Appendix F).

- Two in five (n=78, 43%) respondents identified a friend, acquaintance or neighbour as the perpetrator of child sexual abuse. This included a friend or acquaintance of theirs (either another child or adult) (n=25; 14%), or a friend or acquaintance of a member of the family (n=35; 19%). A neighbour was identified by one in ten respondents (n=18; 10%).
- More than one in four (n=49; 27%) identified an immediate – typically male – family member as the perpetrator. This included a step father (n=20; 11%), biological father (n=14; 8%), brother (n=11; 6%), or a male step sibling or half sibling (n=1; 1%). Three respondents (2%) identified their mother as the perpetrator.
- A stranger was identified as the perpetrator by one in five respondents (n=36; 20%).
- Around one in six respondents reported experiencing child sexual abuse at the hands of another relative (n=28; 16%), while one in seven described another child (n=25; 14%), including those of an older age (n=15; 8%) and a peer or child of the same age (n=10; 6%).
- Around one in eight respondents (n=23; 13%) had been sexually abused by someone they described as a boyfriend or girlfriend at the time they experienced child sexual abuse (n=15; 8%), or from a previous relationship (n=8; 4%).
- A similar proportion described some ‘other’ link or relationship with the perpetrator (n=22; 12%) (eg a taxi driver, a shopkeeper, or a foreign exchange student).

By contrast, fewer respondents described the perpetrator as being someone in a position of trust or authority:

- a member of teaching or educational staff (n=9; 5%)
- ‘another’ professional (n=6; 3%), including a doctor/medical practitioner (n=4; 2%)
- a guardian or carer (n=3; 2%)
- someone from a youth organisation (n=2; 1%), such as a coach or volunteer working in a sports organisation (n=1; 1%), or a Scout master/guide leader (n=1; 1%)
- clergy (n=1; 1%).

3.4 Disclosing child sexual abuse²⁵ and experiences of doing so

Four-fifths of the victims and survivors reported that they had previously told someone about their experience of child sexual abuse (n=135; 79%). More respondents reported telling someone later in life (n=127; 75%) than at the time of the abuse (n=48; 28%).²⁶ Around one in four survey respondents told us that they disclosed or reported their abuse both at the time and subsequently (n=40; 24%).

Those disclosing child sexual abuse at the time of the abuse typically told two people (mean=2; median=2; range=1–8; SD=1.3). The most common responses included disclosing to their mother (n=33; 69%), father (n=12; 25%) or step father (n=1; 2%), a friend or acquaintance (child or adult) (n=11; 23%), the police (n=7; 15%), or another relative (n=3; 6%).

Half (n=24; 50%) of the respondents who said they had first disclosed their experience of child sexual abuse to someone at the time thought, overall, that the person(s) they informed responded appropriately to their disclosure.

Respondents disclosed their experience of child sexual abuse to more people later in life, and to a wider range of them (mean=3; median=2; range=1–13; SD=2.5). Around one in three of those disclosing in later life did so to four or more people (n=39; 31%). These later disclosures were most commonly made to a boyfriend/girlfriend/partner/spouse (n=76; 60%), or an adult friend or acquaintance (n=55; 43%).

Around one in four of those first disclosing in later life did so to a person providing a mental health service (including a counsellor or psychologist) (n=34; 27%), a sibling (n=33; 26%), or their mother (n=32; 25%). Approximately one in five subsequently disclosed to the police (n=26; 21%), or a previous boyfriend/girlfriend/partner/spouse (n=23; 18%). Fewer, by contrast, reportedly told their own child(ren) (n=14; 11%) or their father (n=14; 11%) about these experiences of child sexual abuse.

The majority of those disclosing their experiences of child sexual abuse later in life felt that the person(s) they informed responded appropriately to this disclosure (n=71; 56%), though one in six (n=21; 17%) were unsure. A comparative assessment of the appropriateness of responses to disclosures of child sexual abuse over time is provided in Table 3.2.

Table 3.2: A comparative assessment of the perceived appropriateness of responses to child sexual abuse disclosures over time*

Overall, do you think that the person(s) you told responded appropriately to your disclosure?	At the time (N=48)	Later in life (N=127)
Yes	24 (50%)	71 (56%)
No	22 (46%)	34 (27%)
Don't know	2 (4%)	21 (17%)
Don't wish to answer	–	1 (1%)

*Some respondents who disclosed both at the time and later in life will be included in both columns.

25 This relates to first disclosure.

26 Data on disclosure were not provided by 11 (6%) respondents. Three respondents (2%) said they 'Don't know/ Can't remember' if they disclosed at the time they experienced child sexual abuse.

3.5 Barriers to disclosing child sexual abuse

Seventy per cent (n=127) of survey respondents identified at least one barrier or concern which prevented them from telling someone about their experience of child sexual abuse, either at the time or later in life. Two-thirds of the respondents (n=119; 66%) identified at least one barrier or concern which prevented them from telling someone about their experience of child sexual abuse at the time. These respondents identified five distinct barriers or concerns (mean=5; median=4; range=1–17; SD=3.5). The most common barrier to reporting or disclosing child sexual abuse was feeling ashamed or embarrassed (n=57; 48%). Other barriers and concerns at the time included:

- not knowing “*the behaviour was not OK*” (n=45; 38%)
- being scared of not being believed (n=44; 37%)
- believing nobody would do anything about it (n=42; 35%)
- not wanting anyone else to know (n=40; 34%).

Feelings of shame and embarrassment remained the most common barrier to first disclosure later in life (n=17; 42%), as was not wanting anyone else to know (n=17; 42%) and wanting to forget about the experience (n=17; 42%). The full range of barriers and concerns are set out in Table 3.3.

While around one in six (n=33; 18%) encountered these barriers or concerns at both points in time, they were less likely to have been experienced later in life (n=41; 23%) and there were fewer of them reported (mean=3; median=2; range=1-7; SD=1.6).

Those who took part in qualitative interviews shed more light on some of these barriers to disclosure. The main themes to emerge in the interviews were: not knowing the behaviour was not OK or not understanding what child sexual abuse was; feeling ashamed; fear of not being believed; and parental attitudes. The theme of ‘parental attitudes’ was not explicitly articulated in the survey but could fall under a number of the above factors, eg not thinking others would be ‘sympathetic’ or concern about getting ‘in trouble’.

Several older participants who had no experience of support services told how – as children – they did not know the behaviour was not OK, showing little understanding of what child sexual abuse was, or that it was wrong:

“I didn’t know there was such a thing [as child sexual abuse] ... I thought it was normal ... At the time, as far as I was concerned it was just part of growing up.”

Fred, No experience of support services

“It didn’t really occur to me that there was anything particularly odd except that I didn’t like it.”

George, No experience of support services

“I think, at the time, I probably didn’t think what had happened was that bad. I look back now and it absolutely was.”

Kerry, No experience of support services

“While he was doing it, because he was my older brother, he made me think it was a game and that it was normal and OK. It wasn’t even a thought.”

Holly, Negative experience of support services

Table 3.3: Barriers or concerns about disclosing child sexual abuse at the time or later in life

Barrier or concern	At the time (N=119)	Later in life (N=41)
I felt ashamed, embarrassed	57 (48%)	17 (42%)
I didn't know the behaviour was not OK	45 (38%)	2 (5%)
I was scared of not being believed	44 (37%)	6 (15%)
I didn't think anyone would do anything about it	42 (35%)	4 (10%)
I did not want anyone else to know	40 (34%)	17 (42%)
I didn't want to hurt my family	35 (29%)	6 (15%)
I felt guilty	34 (29%)	7 (17%)
I thought I would get in trouble	32 (27%)	2 (5%)
I just wanted to forget about it	27 (23%)	17 (42%)
I feared retribution - by the perpetrator(s)	25 (21%)	1 (2%)
I didn't have the language to explain what was happening	23 (19%)	-
I didn't think others would be sympathetic	20 (17%)	4 (10%)
I had no one to disclose to or tell	19 (16%)	2 (5%)
I thought it was too trivial to report	18 (15%)	6 (15%)
I believed the perpetrator loved me	15 (13%)	1 (2%)
Some other reason	14 (12%)	4 (10%)
I didn't want the police to become involved	14 (12%)	1 (2%)
I believed I was special (eg given special privileges)	14 (12%)	1 (2%)
The perpetrator threatened me/my family/other significant people	12 (10%)	1 (2%)
I didn't want the person/people who did it to be punished	12 (10%)	-
I regarded it as a private matter	9 (8%)	7 (17%)
I was scared of/didn't like the police	5 (4%)	-
I didn't want to go to court	5 (4%)	-
I feared retribution - by the institution(s)	3 (3%)	-
I feared retribution against the perpetrator	2 (2%)	1 (2%)
Unknown/can't remember	1 (1%)	-

Some participants also told how they did not disclose their experiences of child sexual abuse due to feelings of shame:

“Certainly when I was a youngster, you just didn’t talk about it. It was absolutely, totally brushed under the carpet and you felt so ashamed of it.”

John, Positive experience of support services

While another participant also told how, after the police approached his mother to ask if he had been abused by a local man, he felt unable to disclose his experience due to feelings of shame:

“I guess the, not aggressive but quite a stern manner that my mother spoke to me at the time, it was almost making me feel shameful of what happened. My reaction was to back away and deny everything.”

Aaron, No experience of support services

Non-disclosure due to fear of not being believed was also talked of by some participants:

“It never occurred to me to tell anybody, let alone my parents. They would’ve just, sort of, told me to get lost. They wouldn’t have believed it. I never thought about it. Never even occurred to me.”

George, No experience of support services

“I didn’t do anything about it at the time because it was my friend’s dad. I thought people wouldn’t believe me. I might get in trouble. My friend wouldn’t want to be friends with me anymore. All those kinds of things really.”

Kerry, No experience of support services

A related theme to come out of the qualitative interviews was parental attitudes, with some participants stating that sexual abuse was not something that their parents would have understood, been sympathetic to, or willing to talk about:

“My mum, definitely, was not someone that you would talk to. My mum was very much, ‘this is life, you get on with it.’”

Wendy, No experience of support services

“It certainly wasn’t the sort of thing that my parents would discuss with me back in the roaring 50s.”

Fred, No experience of support services

“You didn’t dare talk to your parents. My parents were lovely. They were terrific but they were a different world.”

George, No experience of support services

“I think she [mother] would’ve just told me to get over it. Well, the world’s full of perverts, if you happen to bump into one, it’s a bit of bad luck.”

Barbara, No experience of support services

3.6 Pen portraits²⁷

In order to set some context for the results reported in Chapters 4 and 5, here we present six pen portraits from interview participants: two who had no experience of support services, two who had a positive experience of support services and two who had a negative experience of support services. These portraits, or short case studies, give a brief overview of the individual's experience, illustrated by quotes from the victim and survivor. In doing so, they tell a story, putting quotes from participants which are used through the results section in context and providing additional background. In addition, reading victims and survivors' (abbreviated) stories in this way also helps to humanise and personalise them.

Barbara, who has **no experience of support services**, is a White British woman in her 60s. She experienced two separate incidents of child sexual abuse, one when she was 10 and one when she was 14. Both incidents were perpetrated by strangers in public spaces: *"The first time, I told my mother and she didn't believe me. So, what do you do when you're ten years of age and you're not believed?"* She continued: *"I think she would've just told me to get over it. Well, the world's full of perverts, if you happen to bump into one, it's a bit of bad luck."* She continued: *"You don't make a big fuss or a dance about it. Get on with life."* Furthermore, she described feeling unscathed by the incidents of child sexual abuse – *"I suppose I wasn't that affected by it"* – and thinks of herself as a resilient person. Comparing herself to other victims and survivors, she says: *"I mean, I suppose, in the grand schemes of things, when you look at continued abuse in some cases, it was nothing really."* At no point did Barbara consider accessing support services as *"I wouldn't have considered it necessary or an option really."* She added that she was largely unaware of any support services that exist for people who have experienced child sexual abuse, and thought that there would have been little on offer at the time at which she experienced the incidents. She says that if she were to consider accessing support services now – which she wouldn't – she would probably look online for information. However, her overriding message was: *"Get over it. Put it down to experience."*

Aaron, who has **no experience of support services**, is a White British man in his 50s. He suffered "a number of experiences" of child sexual abuse at the age of eight/nine. As a child, Aaron did not seek help, partly because he wasn't sure whether what had happened to him was wrong or sexually abusive: *"I was not absolutely sure whether it was right or wrong what he did ... As I've grown older, I can understand that what happened was completely wrong."* After burying his feelings for years, emotions arose about the abuse when he had children of his own and started to feel angry. Aaron said that at that point he *"thought maybe it may be good to speak to somebody"* but questions *"who would you talk to? ... There's no one I could think of. I can't imagine I'd go along to my GP."* Other barriers to him seeking help were an enduring *"feeling of shame"* – *"I shouldn't have even been in that situation with this guy"* – in addition to the perception that *"there was no real harm caused to me other than the mental scar of this gentleman. There were no injuries. He didn't actually ever touch me, it was always the other way round. He was forcing me to do things to him."* Aaron also repeatedly referred to the abuse as *"historical"*, saying: *"I just don't feel I need to do anything with it. I've managed for all these years."* He also observed that not seeking help

27 In these pen portraits all names, locations and other potentially identifying features of participants have been changed. Please see Chapter 2 for more information about how participant confidentiality and anonymity were addressed.

is probably a masculine trait: *“a man’s a man sort of thing.”* Asked where he might go for support, if he needed it, Aaron said: *“I can’t think of anywhere ... you would go for inappropriate sexual behaviour. Is there anywhere out there that would deal with that? I don’t know.”* However, he reiterated that: *“I don’t feel that I need any support. Get on with life. What’s happened, happened.”*

Lara, who had a **positive experience of support services**, is a White British female in her 30s. She was abused from the ages of 14 to 16 by a family member. When she was in her late 20s she referred herself to a local private psychotherapy practice, where she was seen within *“a week or 10 days. Not long at all.”* She saw a humanistic therapist who *“had quite a lot of experience in talking to people that had been abused as children,”* for the next two to three years. She remembers the centre itself as *“a very friendly, very calm place. Each of the rooms was very private, very kind of neutral, like comfy chairs, quite dim lighting. All of which, it was the right environment to talk. It wasn’t sterile or public feeling. It felt quite private but not too isolated.”* Lara said that she and her therapist *“clicked instantly”* and that her experience was *“uniformly positive”*. Specifically, she said: *“I think my therapist was unbelievably professional but also warm. She was extremely good at maintaining boundaries and she was very good at talking about what she was doing.”* In addition to helping her deal with feelings of guilt, responsibility and shame, the therapist gave her techniques to deal with panic attacks and taught her the importance of self-care. Lara said that although therapy can’t *“magically”* fix everything, *“it helped me to come to a point where I could accept emotionally, psychologically, mentally, physically, all the different ways of how it happened.”* One of the reasons her experience was so positive, in her opinion, was due to the lack of time constraints: *“One of the things I liked was you had no pressure in terms of, ‘you’ve got six weeks,’ because I was paying for it ... At first, I didn’t tell her the whole story. I didn’t blurt it all out in one go. It was a process of ‘I’ll tell you a bit and we’ll see, I’ll tell you a bit more and we’ll see’. I had to learn to trust her and learn to trust the process.”*

Nic, who had a **positive experience of support services**, is a White British man in his 60s. He was sexually abused between the ages of 8 to 12. Two years before this research, he was signposted towards a specialist sexual assault support service for men by his counsellor. It took in the *“low months, not weeks”* to access the service, which offered two programmes, for which there was a nominal payment. Both were therapeutic groups, which consisted of six men who had been sexually assaulted as children or adults, facilitated by two male counsellors. He described the environment as *“kind of a shabby building. It’s a bit run down ... it made it warm and welcoming. It never felt clinical in any way.”* Nic said that the counsellors’ experience, sensitivity, empathy, and focus on building trust, *“made it easy for me to talk.”* During the second programme each group member was given an hour to speak about their own experiences: *“To describe to a group of other men who had similar experiences, what had happened to me and see them hear that in a very accepting and non-judgemental way, was probably one of the most powerful experiences of my life. I’d put it alongside watching my daughter being born. It was that profound of an experience for me.”* By the end of the programme he says that *“it was very clear to me that I bore no responsibility and, therefore, need hold no shame for what happened to me.”* He felt, in the group, that he was accepted and not judged, and this was affirming and humbling. Since finishing the programmes, he has had a reduction in trauma symptoms. He is only *“sad and angry”* that there are not more similar specialist sexual assault services for men only, as he feels that men are often not believed or treated in the same way as female victims and survivors.

Edna, who had a **negative experience of support services**, is a White British woman in her 40s. She was abused by a family member from infancy to the age of 12. She had a negative experience with mental health support services. She first received counselling after having a breakdown in her late teens when the police investigation and court case against her abuser were ongoing. It was a condition, laid down by the courts, of her receiving counselling, that the sessions were recorded and that both the prosecution and defence had access to them. She said: *"I couldn't be truly myself because I was aware they were recording it. Any, kind of, vulnerabilities I showed were then used against me."* She subsequently saw a counsellor through her university's mental health service who, during their first session, *"fell asleep"*. She left and never went back to that service. She has since accessed counselling through her GP: *"I've seen a couple of them and I find that while I'm doing it it's helpful, but it's a short thing, isn't it?"* She said that the allocated 12 sessions *"isn't enough time for me to trust someone. We don't really scratch the surface."* She later had group counselling which *"wasn't good"*, as the group was mixed gender, for people with various mental health problems, which she found *"a bit scary"*. Edna is not currently receiving any support as *"I just got lost off the system and I just - I don't know. I didn't try again."* She is now suffering from agoraphobia, which has prevented her from accessing further help: *"Currently, leaving the house is quite tricky so I might get better and be able to go to the GP and start it again but at the minute it's not possible."* Edna thinks that *"getting in early"* is key and that *"immediate help"* should be available, rather than when victims and survivors are *"desperate"*. In her opinion, help and support should also be ongoing.

Susan, who had a **negative experience of support services**, is a White British woman in her 50s. She was abused between the ages of 10 to 12, by an older child.²⁸ In her 40s she went to her GP to ask to be referred for counselling. However, the NHS waiting list was too long: *"I didn't know how long the waiting list was going to be, but I was desperate. I was in a really bad way. Even a week was too long for me."* Her GP signposted her towards a private counsellor, who she saw *"within days."* However, she describes the counselling as an *"awful experience"*, as her counsellor minimised and dismissed her experiences of abuse as *"normal"*, seeing it as children just *"playing"* and *"experimenting"*. She says: *"Because it was another child, she didn't see it as abuse."* Susan says that at times it felt as if the counsellor was acting like her abuser's *"defence lawyer"*. After terminating therapy, she was referred to a mental health team by her GP, where she was diagnosed with anxiety and depression, and reviewed every six months, during which time she *"got so, so bad"*. She said: *"I was falling apart and they couldn't see it. In the end, I just couldn't do it anymore. I'd had enough."* It took a suicide attempt to get her immediate help: *"When I went back, they said, 'we'll get you some help straight away,' and they did."* She then saw a *"fantastic"* counsellor who *"believed"*, *"understood"* and *"got"* her. Susan identified several ways in which mental health services could be improved for victims and survivors, particularly: *"The waiting times. You wouldn't wait that long for a physical problem and, when you're mentally ill, every day is a nightmare."* She also stressed the importance of *"finding the right person"*, summing up by saying: *"We're humans. We're falling apart. We just need to be listened to and understood. It's just the understanding."*

28 Some researchers/clinicians refer to abuse between children as 'harmful sexual behaviour'. However, for the purposes of this research (and in line with the Truth Project) we see this behaviour as abuse and encourage others to do so.



CHAPTER 4: Experiences and views of support services

4.1 Accessing support services

Respondents were asked if they had ever received any form of support, advice or treatment from a service or organisation because of their experience of child sexual abuse. Nearly three-quarters (n=122; 73%) of survey respondents reported not having accessed any support services, while one in four (n=46; 27%) reported that they had accessed support.²⁹

One in six (n=29; 17%) respondents said they had previously tried to get help or support from a service or organisation because of their experience of child sexual abuse but were unable to or were prevented from doing so.³⁰

Eight respondents – 17% of those with prior experience of accessing support services, or 4% of the entire sample – told us they were in receipt of such support at the time of completing the survey. Those no longer in contact with support services estimated that it had been, on average, 8.5 years since their last engagement with these services (median=7, range=0–28; SD=8.3).

Those respondents with prior experience of support services had accessed between one and 21 different forms of support, with an average of 4.4 (median=3; SD=4.2).

Among the 46 respondents with prior experience of accessing support services:

- almost all had accessed recovery services (n=45; 98%)
- almost half had accessed child sexual abuse-related help provided by healthcare services (n=21; 46%)
- just over one in four reported accessing justice-based forms of support³¹ (n=13; 28%).

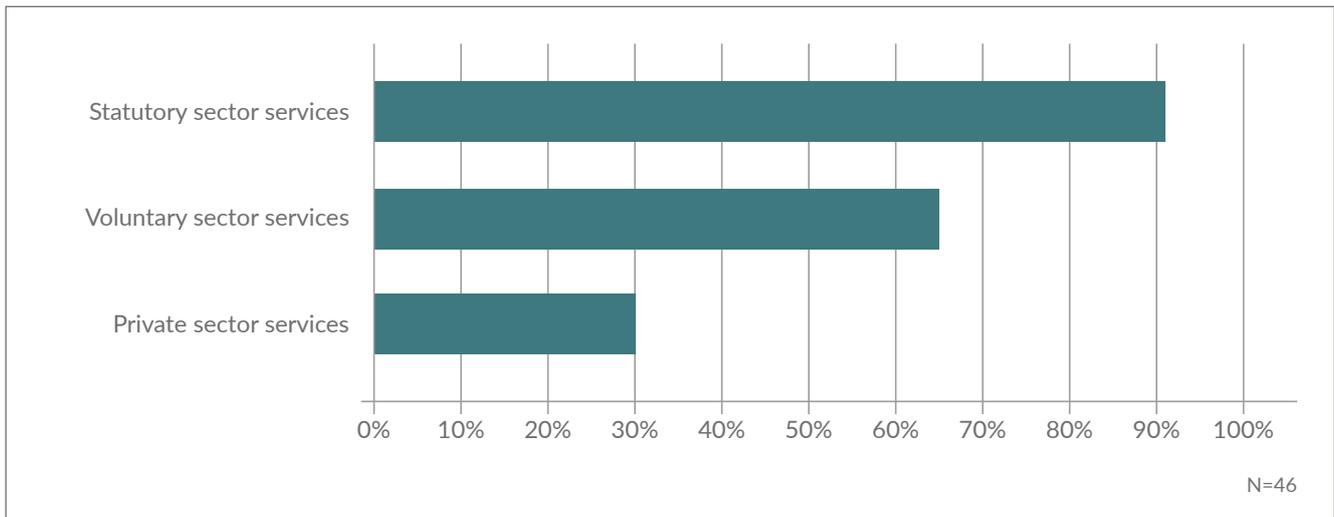
The most commonly reported forms of support, advice or treatment were accessed through:

- Counselling provided through health services like a GP or hospital (n=23; 50%).
- A general practitioner (GP) (n=21; 46%).
- Mental health services provided by the NHS (n=16; 37%).
- Counselling provided by a charity/voluntary organisation not specialising in child sexual abuse (n=13; 28%).
- Counselling provided by a charity/voluntary organisation specialising in child sexual abuse (n=12; 26%).
- The police (n=12; 26%).
- Psychotherapy provided through health services like a GP or hospital (n=10; 22%).
- Sexual abuse and/or rape support services provided by a specialist charity/voluntary organisation (n=10; 22%).

29 Thirteen respondents (7%) did not answer this question, N=168.

30 Responses to this question were missing for 13 participants. Ten (6%) respondents said they could not recall if they had ever felt unable to or were prevented from accessing support.

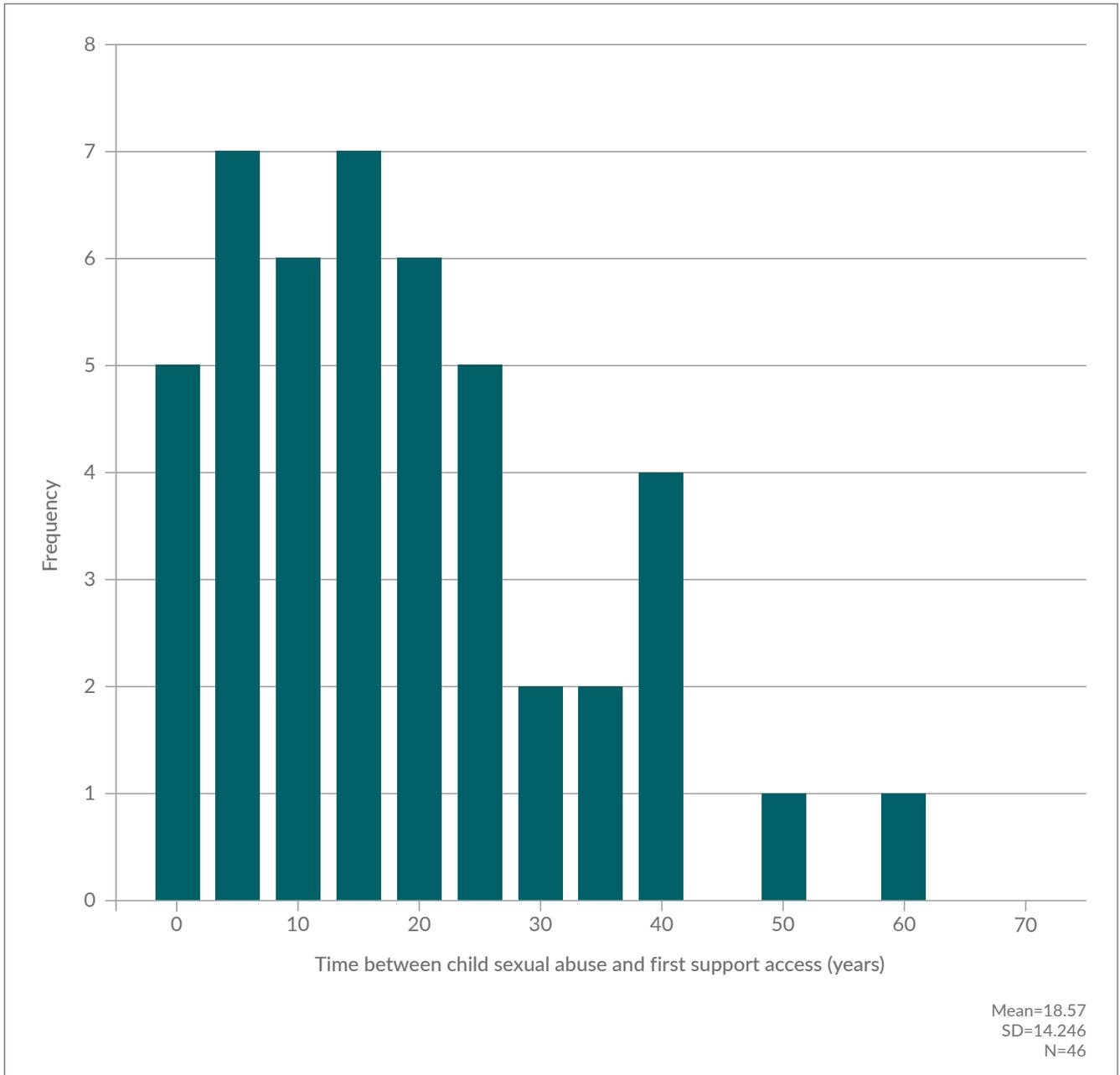
31 Specifically, police, CPS, criminal court, civil court, SARC and ISVA.

Figure 4.1: Respondents' experiences of support services across different sectors

Of the 46 survey respondents who reported having previously accessed child sexual abuse-related support, eight of them had done so using more than five different forms of support. Three respondents reported having accessed more than 15 different forms of support (16, 18 and 21 different forms of support, respectively) (see Appendix G).

Most of those accessing support services reported having done so via both statutory services (n=42; 91%) and voluntary sector services (n=30; 65%). Fewer experienced support provided by the private sector (n=14; 30%), as illustrated in Figure 4.1. Most of these respondents had accessed support in at least two different sectors (n=20; 44%). One in five (n=10; 22%) had experience across all three sectors.

The time between first child sexual abuse victimisation and contact with support services ranged from less than a year to 58 years (mean=19; median=15; SD=14.3). The distribution for the time taken to access support is illustrated in Figure 4.2. These support services were first accessed over a 37-year period (1983–2019), including the 1980s (n=7; 15%), 1990s (n=13; 28%), 2000s (n=16; 35%) and 2010s (n=10; 22%).

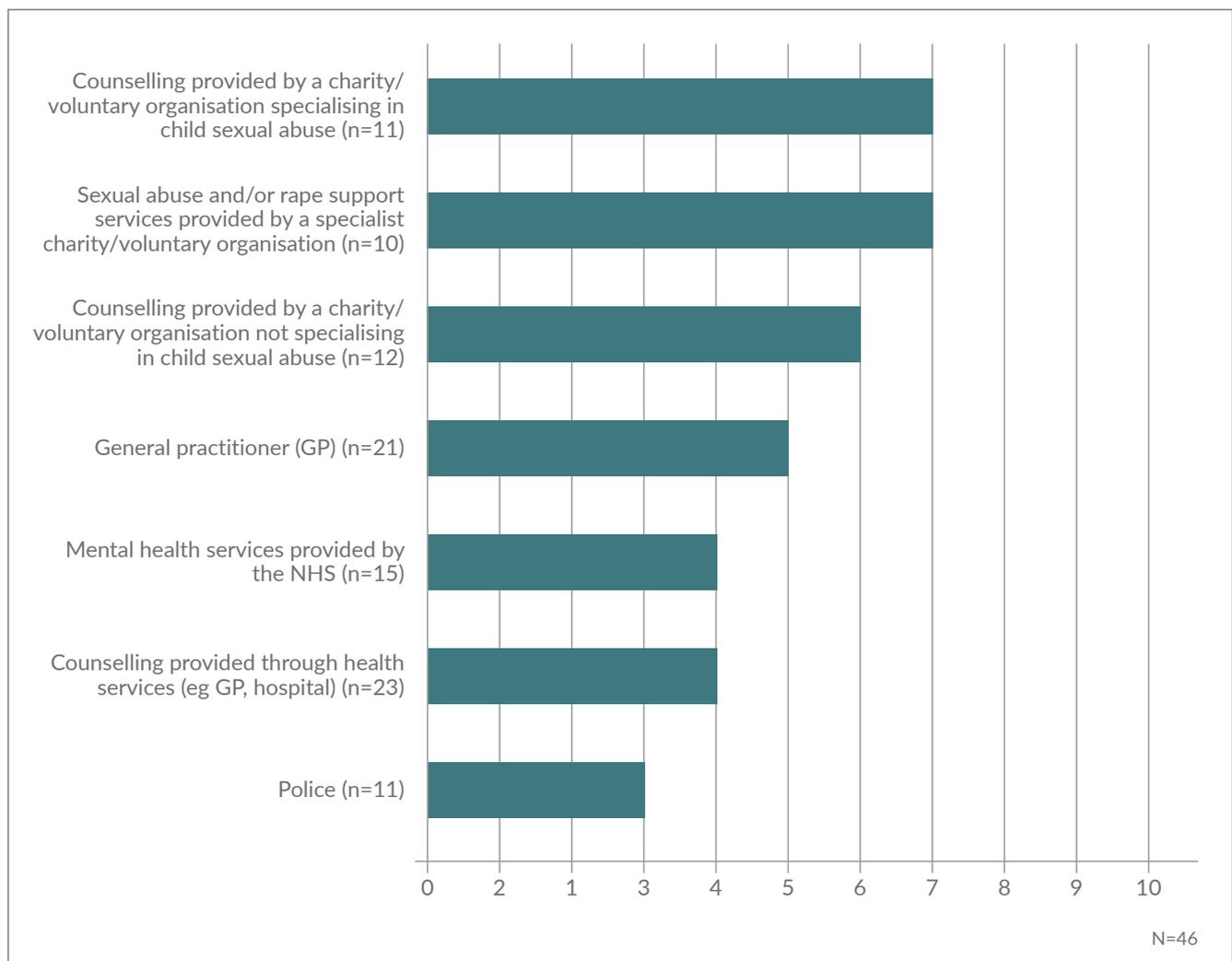
Figure 4.2: Time (years) between first experience of child sexual abuse and first accessing support

4.2 Perceptions of the helpfulness of support services accessed in response to child sexual abuse

Survey respondents were asked about their views on the helpfulness of the support services they had accessed because of the child sexual abuse they had experienced. Using the numbers 0–10, where 0 was ‘Not helpful at all’ and 10 was ‘Extremely helpful’, respondents were asked what number they would use to rate *each* of the support services they had accessed. The average overall rating across all forms of support services accessed was 5.3 (median=5; range=0–10; SD=3.0; N=46). The full ratings table is reported in Appendix H; only those most commonly accessed forms of support – rated by 10 respondents or above – are presented in Figure 4.3.

There was a negative correlation between the overall rating score for support and the number of types of support accessed: the more services received by respondents the lower these tended to be rated ($r = -0.286$, $p = 0.054$, $n = 46$). This might be due to service quality and/or differences in expectations of individuals over time.

Figure 4.3: Ratings of ‘helpfulness’ (ranging from 0 to 10) for support services accessed because of child sexual abuse



4.3 Forms of child sexual abuse-related support considered most helpful by respondents

Survey respondents were also asked which *one* service they had accessed was the most helpful overall.³² Seventeen different types of support were identified (full details can be found in Appendix I). The forms of support most frequently selected as most helpful by these respondents were:

- Counselling provided through health services like a GP or hospital (n=9).
- Counselling provided by a charity/voluntary organisation specialising in child sexual abuse (n=4).
- Psychotherapy provided through health services like a GP or hospital (n=4).
- Psychotherapy provided by a private practitioner not specialising in child sexual abuse (n=4).
- Sexual abuse and/or rape support services provided by a specialist charity/voluntary organisation (n=4).

Given the small number of survey respondents accessing support within the sample, it is not possible to draw any conclusions or inferences about the helpfulness of support services more widely. Interpretation of this finding is discussed further in Chapter 7.

Interview participants who had positive experiences of support services mostly identified counselling or psychotherapy provided through a private counsellor or therapist (with or without specialist knowledge of child sexual abuse or trauma) as being the most helpful form of support they had experienced:

“I accessed private therapy ... and it was the best thing I’ve ever done. The lady I ended up seeing actually had quite a lot of experience in talking to people that had been abused as children, but that wasn’t her specialism. Her specialism was humanist therapy, which I’d never really heard of, but I did a questionnaire when I first contacted the practice and they matched me with her and said, ‘I think you two will get along really well,’ and yeah we clicked instantly.”

Lara, Positive experience of support services

Some participants also talked of positive experiences with sexual abuse and/or rape support services provided by a specialist charity/voluntary organisations:

“They were really, really good. I felt very, very comfortable talking to them. I just needed to try and get closure to the way I was feeling, I suppose.”

John, Positive experience of support services

“I found them very easy to trust. They were very clear, very sensitive.”

Nic, Positive experience of support services

32 One respondent indicated that they could not “think of or identify a most helpful service”. Another did not provide a response to this question. N=44.

Self-referral and via a GP (both n=13; 30%) were the two most common referral routes to the most helpful services. Other referral sources included counselling provided through health services like a GP or hospital (n=6; 14%) and mental health services (n=4; 9%). Participants with positive experiences of support services elaborated on how they successfully referred themselves for support:

“I was going through another period of anxiety and depression, so I decided to get myself some counselling ... I searched it and made sure that she was properly backed up ... Made sure that she had interest, background and skills that I thought I might need.”

Caroline, Positive experience of support services

“They were a charity ... I approached them myself and went along for some meetings with them.”

John, Positive experience of support services

The time reportedly taken to access the most helpful service, from first seeking it, ranged from less than a day (1 hour) to 900 days (or two and a half years), with an average (median) of 43 days (mean=122; SD=176.2; N=40). Typically, the shortest times to access this support were following a referral for counselling provided by a private practitioner (median=18 days). One participant with positive experiences of support services, who self-referred to a private counsellor, reported shorter waiting times of *“a week or 10 days. Not long at all”* (Lara, Positive experience of support services). While the longest time was following a referral made by mental health services (median=242 days). A participant with negative experiences of support services said: *“I was on months and months of waiting lists for other counselling and things. It just took a long time”* (Annie, Negative experience of support services). Long waiting times to access support are explored further in section 5.1.

Most respondents (n=31; 71%) identifying a helpful form of intervention reported that they had declared or disclosed to staff about their experience(s) of child sexual abuse when they first accessed this advice, treatment or support. As a participant who had a positive experience of group counselling from a specialist support organisation for male survivors, elaborated:

“Because of their [the facilitators/counsellors] experience and their sensitivity and empathy, and their focus on building trust within the whole group ... that made it easy for me to talk.”

Nic, Positive experience of support services

A factor related to the helpfulness of services that was not covered in the survey was the physical environment of the services, which emerged as a strong theme in the interviews. Participants who had positive experiences partly attributed their ability to disclose, and discuss their experiences, to the extent to which they felt comfortable in the setting – with warm, comfortable, non-clinical, quiet and private environments being favoured:

“It was a very friendly, very calm place. Each of the rooms was very private, very kind of neutral, like comfy chairs, quite dim lighting. All of which, it was the right environment to talk.”

Lara, Positive experience of support services

"I felt comfortable going to their private offices; very comfortable to go in. It didn't feel as though you were walking into a hospital or something."

John, Positive experience of support services

"For me, the kind of slightly shabby nature of it made it warm and welcoming. It never felt clinical in any way."

Nic, Positive experience of support services

"It was set up like a room with like a sofa, not like a GP surgery."

Lucy, Positive experience of support services

One in ten (n=5; 11%) recalled having to pay for any part of their treatment, with all but one doing so for psychotherapy provided by a private practitioner (not specialising in child sexual abuse). Of the eight interview participants who had positive experiences, half paid for treatment: three for counselling with private therapists and one who paid a 'nominal fee' for group support from a specialist support service for male victims of sexual abuse.

The group of survey respondents identifying a most helpful service attended approximately 875 sessions between them, with the most common (modal) response being six sessions (mean=21; median=12; range=2-104; SD=24.6; N=41). Contact typically occurred 'once a week' (n=27; 61%) or 'once every couple of weeks' (n=8; 18%). While half were in contact with this support for less than six months (n=22; 50%), around one in three remained so for at least two years (n=13; 30%). Two respondents indicated a period of engagement lasting five or more years.

Interview participants who were in contact with support services – typically private counsellors – for longer described the benefits of not feeling rushed:

"One of the things I liked was you had no pressure in terms of, 'you've got six weeks,' because I was paying for it. There was, therefore, no kind of 'talk fast because we've got a lot to get through.' I think it's really important. At first, I didn't tell her the whole story. I didn't blurt it all out in one go ... I had to learn to trust her and learn to trust the process."

Lara, Positive experience of support services

"I feel that they didn't give me, or make me feel like, 'you've only got a set couple of sessions.' As long as you feel you need to see somebody. I felt comfortable."

Olivia, Positive experience of support services

4.3.1 Reasons for leaving helpful support services

Around one in five survey respondents said that they had left the form of support they considered the most helpful, either having got all the help they wanted (n=10; 24%), or because they felt they had achieved their treatment or therapeutic goals (n=9; 21%). This was observed by several interview participants with positive experiences of support services, who told how they had achieved what they had set out to do and therefore no longer required support. This was more likely to be participants who had paid for services themselves:

“It was kind of, for me, ‘well I’ve done what I need to do here.’”

Nic, Positive experience of support services

“It helped me to come to a point where I could accept emotionally, psychologically, mentally, physically, all the different ways of how it happened.”

Lara, Positive experience of support services

“She [the counsellor] gave me the confidence to feel I have dealt with this.”

Abigail, Positive experience of support services

However, most respondents (n=27; 64%) cited no longer attending the form of support that they had identified as being most helpful,³³ with 13 of them saying they left because they weren't offered any further support (n=13; 31%). Interview participants with positive experiences of support services, which they did not pay for, elaborated on how they discontinued support because no more help was on offer:

“Unfortunately, there were time constraints on the length of time that I got the help that I felt I needed. I wish I could have got more really but they were very positive while I went there.”

John, Positive experience of support services

“There was a little bit of a barrier that you were only permitted so many [sessions of counselling] at a time.”

Kit, Positive experience of support services

Other survey respondents described leaving as a consequence of the service(s) being difficult to get to (n=4; 10%), finding the experience too traumatic (n=4; 10%), needing to prioritise other things (n=3; 7%), it no longer being convenient to attend (n=2; 5%), or thinking the service was not helping them (n=2; 5%).

One in three of those who accessed support, reported leaving this support for ‘some other reason’ (n=13; 31%). These reasons were linked to a range of issues, such as: having completed an allocated number of sessions (n=4); having an onward referral (n=4); reasons linked to the legal process (n=2); the respondents’ life circumstances having ‘moved on’ (n=2).

³³ Two respondents told us they still attended the forms of support they considered to have been most helpful. N=42.

Some of these reasons are illustrated in the quotes below, provided by survey respondents:

“I accessed this service numerous times over 15 years. A lot of funding cuts have affected the support that I received. I also accessed them when I was going through the courts with the perpetrator, but they couldn’t offer help because of the case. Now I have recently finally made it down the waiting list and I am now seeing a counsellor, but it has taken a very long time to get to this point.”

Survey respondent #40; female

“Just got on with life. Emotional abuse from men in my adult life has far outweighed the sexual abuse [as a child] and still continues to damage me greatly.”

Survey respondent #148; female

“Therapist moved away and I had a child – lack of time to continue accessing service.”

Survey respondent #110; female

4.3.2 Reasons for good ratings of helpful support services

Perhaps unsurprisingly, most respondents rated the service that they considered the most helpful³⁴ as either ‘very good’ (n=22; 50%) or ‘good’ (n=11; 25%). That said, one in four were more equivocal, describing this support as ‘neither good nor poor’ (n=11; 25%). This degree of ambivalence was largely reserved for child sexual abuse-related support provided by a GP (n=7), or counselling provided through a GP or hospital (n=2).

One of the most important areas that emerged from the qualitative interviews as being strongly associated with having a positive experience of support services was feeling believed, heard and understood by professionals who were caring and empathetic:

“She [the counsellor] was empathetic. She’d studied it. She’d looked at it. She understood it.”

Kit, Positive experience of support services

“I felt the person [counsellor] that I was talking to really cared about what happened and was giving me the courage to open up about it.”

John, Positive experience of support services

“[What’s most important is] making the person feel believed. Being sympathetic and allowing them the time to open up.”

Olivia, Positive experience of support services

34 Respondents were only prompted to comment on the one most helpful service.

Some participants felt that these qualities were more likely to be present in professionals for whom working in the area of child sexual abuse was a 'vocation' as opposed to just a 'job':

"It's got to be somebody who wants to do the job, not just [earning] a crust. Somebody has got to have that flair for it. It's got to be a vocation."

Kit, Positive experience of support services

"I didn't feel as though I was just another number. I felt the person that I was talking to really cared about what happened."

John, Positive experience of support services

Not feeling judged was another important consideration related to having a positive experience of support services:

"I didn't feel that she was judging me in any way."

Caroline, Positive experience of support services

"I think it really helped talking to someone who was a complete stranger because you don't feel like they're going to judge you."

Lucy, Positive experience of support services

Related to not being judgemental, participants with positive experiences also talked about how professionals had helped them to understand that they were not to blame, at fault, or responsible, for what had happened to them:

"We did a couple of weeks' exercises looking at responsibility and shame and who held that. Those exercises were structured in such a way that, at the end of it, it was very clear to me that I bore no responsibility - and therefore, need hold no shame - for what happened to me, because it was things done involuntarily to me by other people who had no right to do that."

Nic, Positive experience of support services

"I always blamed myself; thought it was me. Like, I shouldn't have allowed it to happen ... They made me realise that I was a child and wasn't in control of that ... They did really help set my mind on a better path."

John, Positive experience of support services

"The way they explained things to you, like how someone else in that situation would have the same feelings or maybe react the same way. You think, 'it wasn't just me, someone else would have done the same thing,' and it kind of takes that blame away from yourself."

Lucy, Positive experience of support services

4.3.3 The role of helpful support services in the healing and recovery process

Finally, although one in five were 'unsure' or 'did not know' (n=5; 11%) if the support had helped in the healing and recovery process, or felt the support had not helped at all (n=4; 9%), four-fifths told us that the support received from this source had helped either 'completely' (n=5; 11%) or 'to some extent' (n=30; 68%). Illustrating this, interview participants with positive experiences spoke of how counselling services had given them tools and techniques to help manage their symptoms:

"She taught me ... some techniques that you can use to ground yourself to take yourself out of the moment and give yourself a moment. To practise self-care, all these kinds of things. It made a huge, huge difference to me and my life."

Lara, Positive experience of support services

"They would make you write down your feelings in a book and then you would go through those feelings the next time you met. On a different day you'd look at those feelings and think, 'that's not how I feel today so that's not really real'."

Lucy, Positive experience of support services

While others felt that their trauma symptoms had either been reduced or that they were better aware of, and able to manage, them:

"My hyper-vigilance, which used to be a very strong sense, is hugely reduced. Generally, I sleep better. I am more relaxed. I'm not as twitchy."

Nic, Positive experience of support services

"The sort of physical reactions; the startle, the fight/flight/freeze reflex, all those sorts of things ... I can at least be aware of them, know how to stop them and to deal with myself afterwards."

Lara, Positive experience of support services

Some went even further in their assessments of how support services had helped their recovery and led to some degree of closure. One participant, for example, told how he reached closure on an exact time on an exact day:

"When I finished speaking to this other group of men to whom I had become very close, one of them said to me, 'you look different,' and I realised I felt different. I was standing differently and I have stood differently ever since."

Nic, Positive experience of support services

While another participant said that her counsellor

"made me feel good about the whole thing, if that's possible"

Abigail, Positive experience of support services

4.4 Forms of child sexual abuse-related support considered least helpful by respondents

Survey respondents were also asked which *one* service they considered to have been the least helpful overall.³⁵ Of the 46 respondents who had accessed services, 33 identified a service they considered the least helpful. Thirteen different types of support were identified, with some form of counselling accounting for over half (full details can be found in Appendix J). Counselling provided through health services such as a GP or hospital was the least helpful form of support reported by these respondents (n=12). It should be noted that, as reported in section 4.3, other respondents found this form of support to be the *most* helpful overall. A range of possible reasons for this are considered in Chapter 7.

The other forms of child sexual abuse-related support most frequently mentioned as the least helpful were:

- Counselling provided by a charity/voluntary organisation not specialising in child sexual abuse (n=4).
- Police (n=3).
- General practitioner (GP) (n=2).
- Counselling provided by a private practitioner not specialising in child sexual abuse (n=2).
- Psychotherapy provided through health services like a GP or hospital (n=2).

As noted earlier, the small number of respondents accessing support within the survey sample means it is not possible to draw any conclusions or inferences about the helpfulness of particular support services more widely.

Similar to survey respondents who identified counselling provided through health services as the least helpful form of support they had received, interview participants who had negative experiences of support services also described this as the least helpful form of support:

“I saw someone through the NHS – the GP surgery, like an onsite counsellor. I’ve seen a couple of them and I find that while I’m doing it it’s helpful, but it’s a short thing, isn’t it?”

Edna, Negative experience of support services

“I didn’t feel I could engage with [the counsellor]. I didn’t feel that she understood. I don’t know. I just couldn’t ... You want to be able to feel that you are able to talk to this person, but I didn’t feel that way.”

Carly, Negative experience of support services

The most common ways respondents accessed these least helpful support services were via a GP (n=15; 46%) and following a self-referral (n=9; 27%). Some participants with negative experiences of support services told how they were referred for counselling through their GP:

³⁵ Nine respondents indicated that they could not “think of or identify a most helpful service” while three responded “Don’t know” N=33.

“I actually went to the doctors and explained to the doctors what happened, and they said, ‘we will put you in contact with people that can help you.’ So, I was basically referred for counselling.”

Carly, Negative experience of support services

“My GP asked me if I wanted to have in-house counselling with the GP surgery counsellor.”

Ruth, Negative experience of support services

The time reportedly taken to access this support from initial referral ranged from less than a day (1 hour) to 365 days (one year), with an average (median) of 38 days (mean=89; SD=101.2; N=32). Typically, the shortest times to access this support were following a referral from the police (median=3 days) or a GP (median=4 days). The longest times were following a referral made by psychotherapy services provided through health services like a GP or hospital (median=302 days). Issues raised by interview participants concerning long waiting times to access support are explored in section 5.1 on barriers to accessing help.

Most respondents (n=24; 73%) identifying a least helpful form of intervention reported that they had declared or disclosed their experience(s) of child sexual abuse to someone when they first accessed this advice, treatment or support. However, some interview participants reported being unable to disclose their child sexual abuse to professionals:

“I wasn’t able to discuss, to even disclose.”

Ruth, Negative experience of support services

“I don’t feel I actually spoke. I suppose I, sort of, held back because I didn’t feel comfortable saying things that happened to me.”

Carly, Negative experience of support services

Participants reported that this non-disclosure was related to various issues, such as a lack of rapport with the counsellor or therapist; an insufficient number of sessions; and uncongenial or uncondusive physical environments:

“Twelve weeks isn’t enough time for me to trust someone.”

Edna, Negative experience of support services

“My doctor referred me to a specialist for assessment which was held in a corridor with people walking past ... I just did not feel comfortable so, clearly, I didn’t give the full answers.”

Emma, Negative experience of support services

“The room was very, very bland. Not hugely clinical but it was just a magnolia-walled room with a window to the car park which wasn’t necessarily obscured by a blind, so that didn’t feel like I was as safe as I’d like to have felt. It’s interesting because when you do need to disclose anything there is always an element of vulnerability.”

Ruth, Negative experience of support services

Only two respondents (6%) of the 33 who identified a least helpful form of intervention recalled having to pay for any part of the support, which involved either counselling provided by a private practitioner not specialising in child sexual abuse or 'other' (unspecified) hospital services.

This group of respondents (N=33) attended an estimated total of 210 sessions, with the most common (modal) response being one session (mean=7; median=2; range=1–104; SD=18.4; N=31). Contact with this least helpful service occurred 'once a week' (n=12; 36%), 'once every couple of weeks', or 'less frequently' (both n=8; 24%).³⁶ While three in five were in contact with this support for less than three months (n=20; 61%), around one in five remained in contact for between six months and four years (n=6; 18%). One respondent reported being in contact with this support for over four years.

4.4.1 Reasons for leaving least helpful support services

The single most common reason respondents gave for disengaging from support was thinking that it was not helping them (n=16; 50%). This reason was also cited by interview participants who had negative experiences of support services:

"I did feel as though it was a waste of time because I didn't feel comfortable. I wasn't able to discuss, to even disclose."

Ruth, Negative experience of support services

"I didn't feel as if I was getting anywhere to be honest. I didn't feel it was achieving anything."

Carly, Negative experience of support services

More than two in five survey respondents reported leaving because they were not offered any further support (n=14; 44%). This reason was also cited by participants who had negative experiences of support services:

"You know [after finishing with the Child and Adolescent Mental Health Service] I would've liked – even a referral or told about an adult service to go to. It was literally just, 'you're done now. You're going to have to find out if you need someone else', kind of thing."

Annie, Negative experience of support services

Other reasons for discontinuing support included finding the experience too traumatic (n=4; 13%) and not feeling ready (n=3; 9%). Around one in three respondents reported leaving this support for 'some other reason' (n=12; 38%). These were linked to a range of issues, such as: the reactions of professionals to a disclosure of child sexual abuse; the quality of counselling support; and the capacity of services to offer any additional or ongoing support. Some of these factors are illustrated in the quotes below provided by survey respondents:

³⁶ A number of respondents stated that they 'Don't know/Can't remember' (n=3; 9%) or 'Don't wish to answer' (n=1; 3%) this question on frequency of contact.

“Counsellor ... stated she did not believe I had been sexually abused as a child.”

Survey respondent #173; female

“Funding was cut to this service so it was withdrawn.”

Survey respondent #40; female

“I could not cope with the pitying looks and reactions of counsellors.”

Survey respondent #90; female

“I didn't feel the counsellor understood, so I didn't engage fully. I didn't build a trustworthy relationship so didn't feel it beneficial.”

Survey respondent #55; female

4.4.2 Reasons for poor ratings of least helpful support services

Inevitably, these forms of least helpful support received low overall ratings from respondents, with more than two-thirds (n=23; 70%) assessing them as either 'poor' (n=9; 27%) or 'very poor' (n=14; 42%). Over half these ratings were allocated to some form of counselling, either provided through health services like a GP or hospital (n=7), a charity/voluntary organisation not specialising in child sexual abuse (n=3), or provided by a private practitioner not specialising in child sexual abuse (n=2).

The qualitative interviews with victims and survivors who had negative experiences of support services provided more insight into the reasons why and how they considered support services to be unhelpful, rating them as poor or very poor. Mirroring those with positive experiences, one of the most important factors that emerged as being strongly associated with having a negative experience of support services was *not* feeling believed or understood by professionals:

“Because it was another child, she didn't see it as abuse ... I used the word abuse and she said to me, 'it's not abuse'.”

Susan, Negative experience of support services

“I remember her [the police officer] calling me a liar because she'd spoken to my family ... and nobody else could corroborate what happened.”

Holly, Negative experience of support services

“I didn't feel that she understood.”

Carly, Negative experience of support services

“I suppose you get on with them if you feel they understand what you talk about. Suddenly they come back with a question and you just think, 'hang on a minute, you haven't got this ... you're not going to be able to help me because you don't get it'.”

Susan, Negative experience of support services

Interview participants who had negative experiences also spoke of feeling that they were being rushed and that professionals just wanted to 'do their job' and 'move on', without necessarily caring about the outcomes:

"It seemed more like they were like, 'ok, we've been referred this person. We'll see them until they're 18, that's our job,' and not really caring whether it had worked or not."

Annie, Negative experience of support services

"I had the feeling she just wanted to do the prescribed six sessions with me and just get me out of the surgery to move on to other people."

Ruth, Negative experience of support services

4.4.3 The role of least helpful support services in the healing and recovery process

Due to such reasons, four-fifths of respondents told us that the support received from these sources had not helped at all in the healing and recovery process (n=26; 79%), with around one in seven (n=5; 15%) saying they had helped 'to some extent'.³⁷ Interview participants who had negative experiences of support services were, perhaps unsurprisingly, most likely to report that the services had not helped in the healing process:

"In terms of the symptoms, they were still very much there. They rumbled around. I didn't really get anything in terms of closure."

Ruth, Negative experience of support services

"I still get the flashbacks, I still have the nightmares, I'm still unable to form relationships. I'm still a bit terrified all the time."

Edna, Negative experience of support services

"What she [the counsellor] was doing was really messing my head up. I was all over the place. I knew the effect it had had on me. It was an awful experience."

Susan, Negative experience of support services

"It made me feel kind of bad about myself because I was struggling a lot - still do - with present anxieties and things. I'd tried really hard, do all the techniques they told me to do and it just wouldn't help."

Annie, Negative experience of support services

Thus, it is apparent that some victims and survivors felt as bad, or even worse, after accessing services.

³⁷ Two respondents were 'unsure' about the contribution of these forms of support to the healing and recovery process (n=2; 6%).



CHAPTER 5: Barriers to accessing support and unmet needs

5.1 Barriers to accessing support

Survey respondents were asked to reflect on a series of statements about the accessibility, availability and quality of information and support around child sexual abuse. Statements were developed from those used in previous research, including systematic reviews, and practitioner and academic literature, regarding both child sexual abuse and wider domains of psychological support.

Over half said that they ‘strongly agree’ or ‘agree’ that they had experienced long waiting lists when trying to access services (n=54; 55%).³⁸ Time taken to access support services was a key theme talked about by interview participants with negative experiences, with many feeling that waiting times – typically for counselling – were too long:

“It feels as though it took too long [to be referred for counselling]. Far too long. I would say months. I actually felt it was too little too late. It just felt as though I needed to talk when I felt almost at boiling point.”

Ruth, Negative experience of support services

“I was waiting and waiting and waiting and I never got any letter. I just got lost off the system and I just – I don’t know. I didn’t try again.”

Edna, Negative experience of support services

“The NHS wait was too long ... I didn’t know how long the waiting list was going to be, but I was desperate. I was in a really bad way. Even a week was too long for me.”

Susan, Negative experience of support services

Some participants with positive experiences of support services also reported long waiting times on the NHS, with this being a factor in their decision to access private support instead.

Survey respondents also reported that it had been difficult to find information about the services available to them (n=95; 54%).³⁹ Around one in three felt that services they needed were not available locally (n=41; 36%).⁴⁰ One participant, who had a negative experience of support services, said:

“I’ve looked in my area for services specific for child sexual abuse and it’s very thin on the ground.”

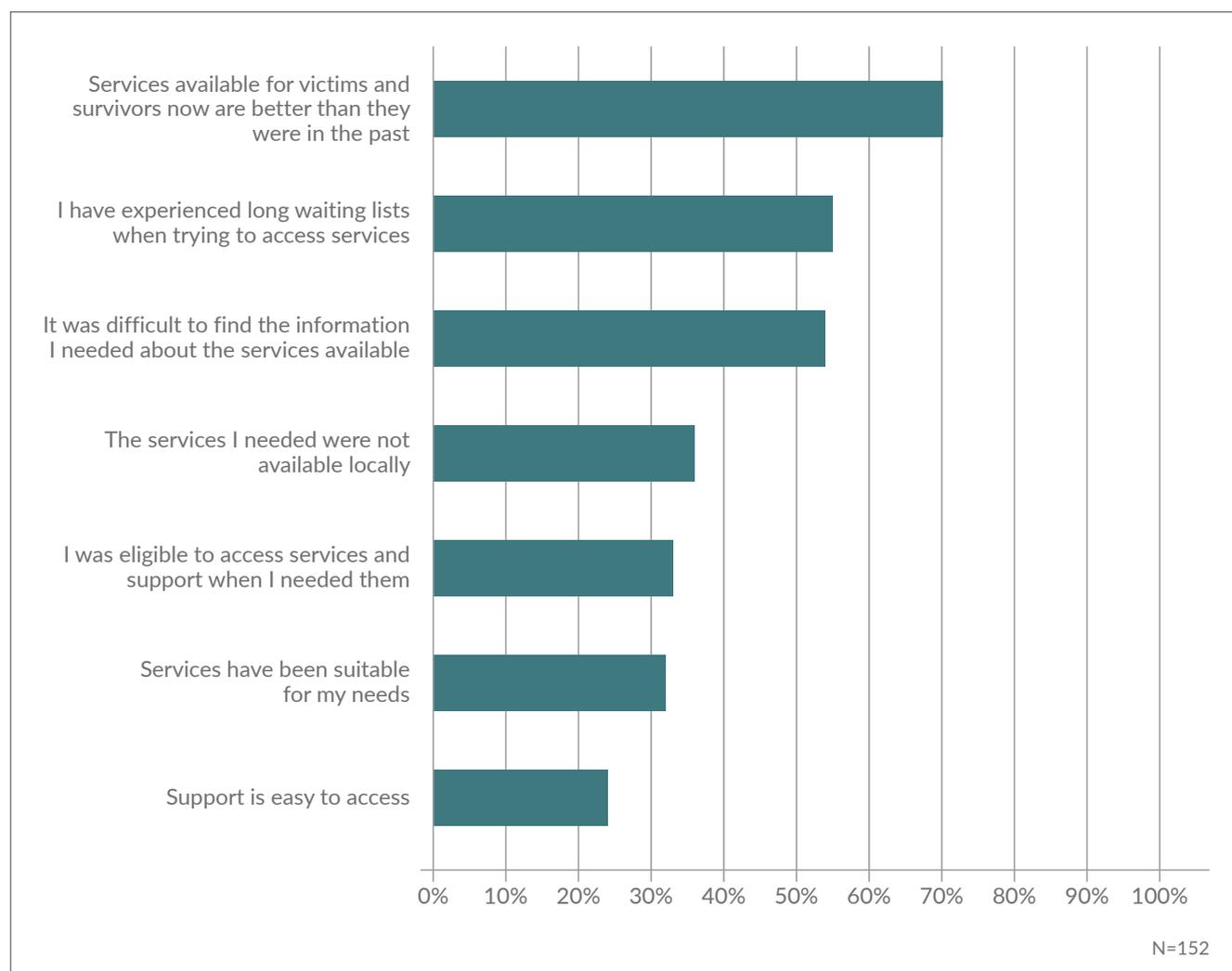
Annie, Negative experience of support services

38 Excludes cases where the response was ‘not applicable’ (n=67; 37%) or missing (n=16; 9%). N=98.

39 Excludes cases where the response was ‘not applicable’ (n=37; 20%) or missing (n=16; 9%). N=128.

40 Excludes cases where the response was ‘not applicable’ (n=52; 29%) or missing (n=16; 9%). N=113.

Figure 5.1: Views on the accessibility, availability and quality of information and support around child sexual abuse



One in four survey respondents said any support they sought had been easy to access (n=26; 24%).⁴¹ Around a third of respondents felt they were eligible⁴² to access services and support when they needed them (n=35; 33%)⁴³ and that services were suitable for their needs (n=30; 32%).⁴⁴ Nevertheless, most thought that the services available for child sexual abuse victims and survivors are better now than they were in the past (n=100; 70%).⁴⁵

The distribution of survey responses is illustrated in Figure 5.1.

41 Excludes cases where the response was 'not applicable' (n=56; 31%) or missing (n=16; 9%). N=109.

42 This was an item specifically asking about eligibility taken from the 'Barriers to Access to Care Evaluation Scale' (BACE v3) (Clement et al., 2012) <http://discovery.ucl.ac.uk/1347471/>

43 Excludes cases where the response was 'not applicable' (n=60; 33%) or missing (n=16; 9%). N=105.

44 Excludes cases where the response was 'not applicable' (n=72; 40%) or missing (n=16; 9%). N=93.

45 Excludes cases where the response was 'not applicable' (n=22; 12%) or missing (n=16; 9%). N=143.

Interview participants expanded on the idea that services (both for children and adult victims and survivors) are more easily accessible, and better, than they were in the past:

“There weren’t those sorts of services available then. They should be available now.”

Aaron, No experience of support services

“When I was a lot younger, I wouldn’t have known anywhere to have turned in all fairness, in them days. I know that was a long time ago now and, hopefully there is a lot more support out there, people are more inclined to come forward.”

John, Positive experience of support services

“If you’re going to somebody like a counsellor or your headteacher and you went there, they would believe you. Whereas, when I was young they wouldn’t believe you. That’s the difference. I think that sums it up really. If I could sum up that question, I would say, today you’ll be believed. When we were young, we were not believed.”

George, No experience of support services

“Kids are so much more clued up about it now. They wouldn’t have to speak to their teacher about it. There’s accessible information at school. They can just write down the number and access it.”

Kerry, No experience of support services

“I suppose, maybe if it happened now, maybe social services would have been involved.”

Maya, No experience of support services

“I don’t think, back then, it was advertised that you have agencies that you can speak to about this. Now it’s more advertised and kids are more aware. You’ve got social media and the TV adverts and stuff. Back in 19 [XX], if something hadn’t happened to you before you wouldn’t look out for it.”

Olivia, Positive experience of support services

5.1.1 Personal, practical, financial, family, community and service-specific barriers

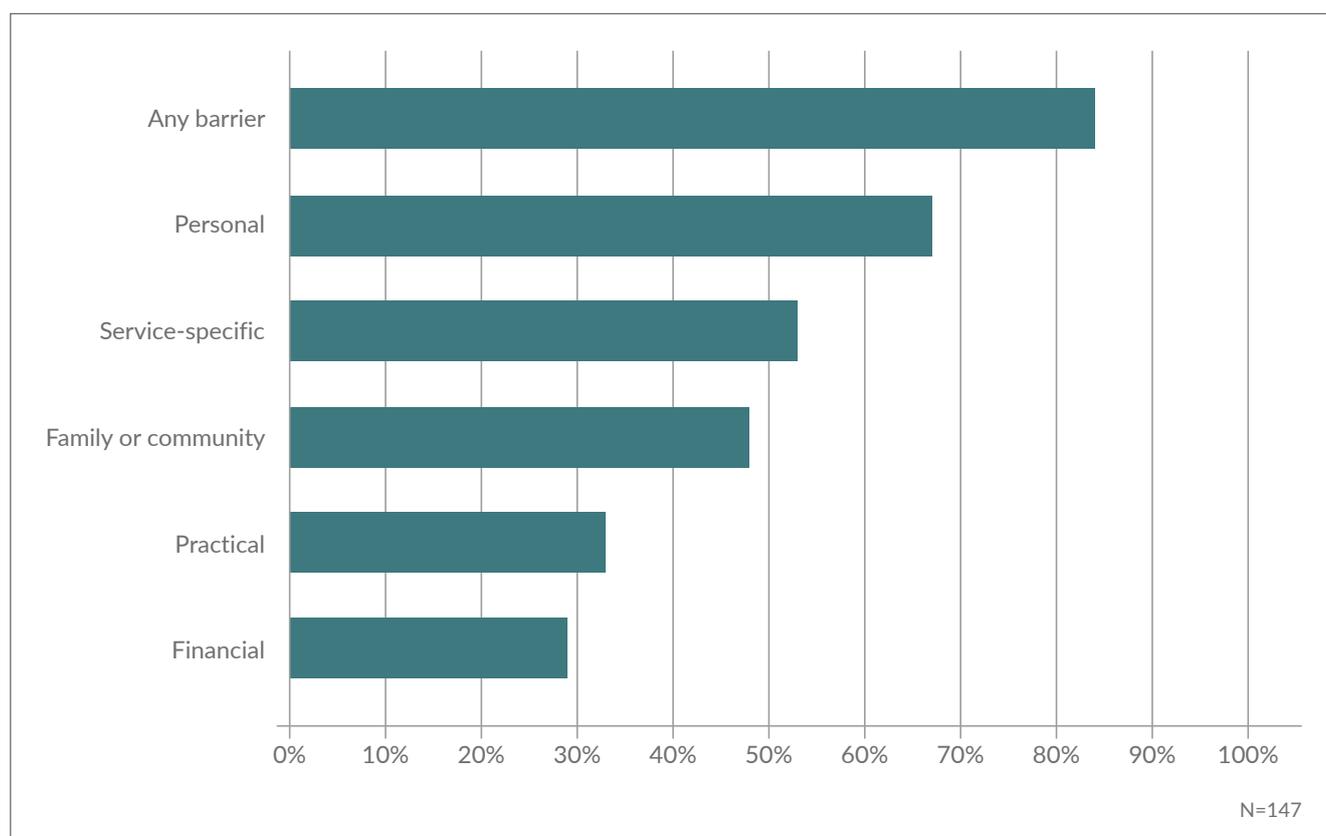
More than four in five (n=124; 84%)⁴⁶ of the survey respondents identified at least one form of personal, practical, financial, family, community or service-specific issue which they felt had stopped, delayed or discouraged them (either ‘quite a lot’ or ‘a lot’) from getting, or continuing with, any services linked to their experiences of child sexual abuse. Respondents experienced a mean of two such barriers from the five distinct areas they were questioned about (median=2; range=0–5; SD=1.5).

As illustrated in Figure 5.2, the most common type of barrier identified related to those arising from personal issues (eg not wanting help or not feeling ready for it; thinking the service probably would not help; and/or feeling embarrassed or ashamed) (n=96; 67%).⁴⁷

46 Excludes cases where responses to these questions were missing (n=34; 19%).

47 Excludes cases where the response was ‘not applicable’ (n=21; 12%) or missing (n=16; 9%). N=144.

Figure 5.2: Types of issues encountered by respondents which served as a barrier (either 'quite a lot' or 'a lot') to accessing or continuing with child sexual abuse-related forms of support



Interview participants expanded on the different types of personal issues that prevented them from accessing support services. Probably the strongest theme that emerged from those with no experience of support services was that they had not accessed support because they did not feel they needed it, as they did not think that the abuse had had a detrimental impact on them:

"I've never felt it necessary...I suppose I wasn't that affected by it."

Barbara, No experience of support services

"There's been no harm to me ... I don't feel that it's caused me any problems. I'm quite a strong-willed person."

Aaron, No experience of support services

"I wouldn't have thought it would be any psychological help to me ... I don't feel mentally scarred in any way."

Fred, No experience of support services

"I don't know that I need any support with it. I think I'm kind of alright with it now."

Kerry, No experience of support services

"It didn't do me any lasting harm ... I suppose, deep down, I don't feel that I've got a problem."

Wendy, No experience of support services

Participants with no experience of formal support services spoke of how, particularly in older generations, people tended to 'bury' such issues, not make a 'fuss', and simply 'get on with life':

"I'm the sort of person that, you just get on with life, that's how I was brought up."

Wendy, No experience of support services

"I think the thing to do is just to bury it in your mind. Boxed up. The place it'll stay really."

Aaron, No experience of support services

"A lot of people would just bury it. That would make it very, very difficult for them to access any help, I think."

Maya, No experience of support services

"These two things happened and you get over it. You don't make a big fuss or a dance about it. Get on with life."

Barbara, No experience of support services

"You have to survive it and, to do that, you have to do what you have to do."

George, No experience of support services

Another strong theme relating to personal barriers to accessing support, from those with no experience of support services, was feeling that the abuse they suffered was not 'serious' or 'severe' enough in comparison to others, particularly if they had sustained no physical injuries:

"Things did happen a little bit. Some people had it much worse than I did. I just, kind of, parried it off really."

George, No experience of support services

"There was no real harm caused to me other than the mental scar of this gentleman. There were no injuries."

Aaron, No experience of support services

"I think if they physically hurt me, regardless of what they said [about not telling anyone about the child sexual abuse], I think I would've then mentioned it."

Fred, No experience of support services

"I suppose, in the grand schemes of things, when you look at continued abuse in some cases, it was nothing really."

Barbara, No experience of support services

Around half of survey respondents identified 'service-specific' issues (eg being unsure where to get help; bad experiences of services in the past; and/or limited services on offer) (n=68; 53%).⁴⁸ This may be related as much to the suitability of services as it is to their availability. Again, interview participants shed further light on such service-specific issues. Some of those with no experiences of support services cited being unsure of who they would approach for help if they thought they needed it:

"I know that everyone can go and get some counselling if they need it, but I wouldn't know who to go to; who would be specialised, experienced in that kind of thing."

Maya, No experience of support services

"If you had suicidal thoughts, we all know you could speak to the Samaritans. But when it's something like a sexual matter, who would you speak to? I can't think of anything that springs to mind."

Aaron, No experience of support services

"I don't know what's out there. I don't know what I would be able to access. I suppose a quick Google search would probably answer those questions for me, but I wouldn't know where to start looking really."

Kerry, No experience of support services

While some participants who had negative experiences of support services in the past reported that these had put them off accessing future services:

"I felt I was never going to get to the real issues with her, so what was the point? I'm not going to be able to open up with this woman. Let's just bring it to an end. Let's just bury it again. Does that make sense?"

Ruth, Negative experience of support services

"There was one [group] session, the last session, where I was just genuinely – I can't even describe it. It made me very ill ... I didn't go back and it put me off any kind of group type situation."

Edna, Negative experience of support services

A novel theme that arose in the interviews related to service-specific issues was that some participants were afraid of engaging with the very services that were meant to help them:

"They tape recorded all the [counselling] sessions. Then they used them later at the court case ... I think what it did was put me off ... seeking further help because it wasn't useful, it wasn't helpful ... I couldn't be truly myself because I was aware they were recording it. Any, kind of, vulnerabilities I showed were then used against me. It has made me quite distrustful."

Edna, Negative experience of support services

"There's a few different aspects to it, the stress of the police and the court case. The thought of having to give evidence in a courtroom was just too much."

Maya, No experience of support services

48 Excludes cases where the response was 'not applicable' (n=36; 20%) or missing (n=16; 9%). N=129.

“People are very scared of social services because they think they’re going to get judged and people are going to take away their kids or something.”

Lucy, Positive experience of support services

Nearly half of survey respondents identified ‘family or community factors’ (eg fearing that other people in their family/community would find out) (n=67; 48%)⁴⁹ as barriers to seeking or continuing with support. Some interview participants spoke of not disclosing the sexual abuse, or seeking support, through fear of their family finding out:

“Because of where I live [rural area], it’s quite difficult. Had I gone to the doctors, it would’ve got back to my parents: ‘I saw Kerry at the doctors the other day, is everything all right?’ and then I would have got, ‘why were you at the doctors the other day?’ If I had accessed stuff through school, I don’t know that I would’ve trusted school not to have told my parents.”

Kerry, No experience of support services

Others were also concerned with protecting their parents and wider family from the truth and its potential repercussions:

“If I say something, it then doesn’t just involve me. My ex-husband at the time, he didn’t know ... My sister was abused by the same uncle and she’s six years older than me, and to this day, her husband still doesn’t know.”

Wendy, No experience of support services

“One abiding thought I’ve always had is; I was aware of protecting my parents, or at least my father, from knowing some of the worst things my grandfather did, so I didn’t say everything. I kept some of it – I’ve always kept some of it back.”

Abigail, Positive experience of support services

Around one in three survey respondents cited practical issues (eg problems accessing services in the local area; arranging childcare; and/or having to take time off work) (n=39; 33%)⁵⁰ and financial issues (eg covering the cost of childcare; having to take unpaid leave from work; being unable to afford treatments; and/or cost of travelling to appointments) (n=32; 29%)⁵¹ which served as barriers to seeking or continuing with child sexual abuse-related forms of support.

49 Excludes cases where the response was ‘not applicable’ (n=24; 13%) or missing (n=16; 9%). N=141.

50 Excludes cases where the response was ‘not applicable’ (n=48; 27%) or missing (n=16; 9%). N=117.

51 Excludes cases where the response was ‘not applicable’ (n=48; 27%) or missing (n=16; 9%). N=110.

5.1.2 Other barriers to accessing support

Other barriers to accessing support that came through less prominently in interview participants' accounts included: not feeling brave enough to access support; fear of not being believed; feeling to blame or at fault for their victimisation; mental health issues; gender stereotypes and norms around masculinity; and (often guilty or confused) feelings of gaining something positive from the experience. These are illustrated in some of the quotes below:

"I don't know if I'm brave enough to."

Kerry, No experience of support services

"People don't always want to access them [support services] because they don't think they think they'll be believed."

Pam, No experience of support services

"You've got to want to go to talk about it and you've got to be able to deal with it and talk about it. Say if you're a person in a vulnerable situation with a lot of problems and you're trying to keep it all together, that's not necessarily going to be the right time to go into them. It could be damaging."

Maya, No experience of support services

"A man's a man sort of thing ... I've got other friends that are really vocal about things and they'll cry ... I've never been like that. It's probably from the way my mother brought me up to be a – you know, 'you're a bloke.'"

Aaron, No experience of support services

"In the past, I never would have told anyone because I felt it was my fault, I didn't walk away ... He made it pleasurable. His stock words were 'naughty but nice,' and he gave me money for it. We were quite a poor family and, as a child, I liked money. That's why I carried on doing it and that's probably why I never told anybody."

Wendy, No experience of support services

5.2 Unmet needs

Two in five survey respondents (n=70; 43%) felt that they currently had unmet needs linked to their experience of child sexual abuse.⁵² When asked if they could identify any service(s) which could potentially be useful to them now, but which they were currently unable to find or access, over half identified at least one form of intervention (n=103; 57%). These respondents were able to highlight an average of four distinct types of potentially beneficial support (median=4; range=1–25; SD=4.0).

The most commonly mentioned forms of individual support identified as being of potential use or benefit to respondents are summarised in Table 5.1.

⁵² Data relating to ongoing needs were missing for 17 respondents (N=164). Three participants did not wish to answer this question (2%) and around one in seven (n=25; 15%) replied 'Don't know'.

Table 5.1: Type of support identified as being of potential use/benefit

Type of support	Frequency	Percentage
Counselling provided by a charity/voluntary organisation specialising in child sexual abuse	43	42
Counselling provided through health services like a GP or hospital	33	32
Psychotherapy provided by a charity/voluntary organisation specialising in child sexual abuse	27	26
Mental health services provided by the NHS	22	21
Counselling provided by a private practitioner specialising in child sexual abuse	21	20
Psychotherapy provided through health services like a GP or hospital	21	20
Sexual abuse and/or rape support services provided by a specialist charity/voluntary organisation	21	20
Victims' support services	20	19

N=103.

Of the 426 mentions of different forms of support which respondents felt they could benefit from, but were currently unable to find or access, counselling (n=118; 28%) and psychotherapy (n=71; 17%) accounted for nearly half.

As the survey findings show, victims and survivors thought that counselling provided by a charity/voluntary organisation specialising in child sexual abuse would be of particular benefit/help. This was expanded on by interview participants:

“One day I’d like to have my own charity ... like an office with people you can call or text in and get a response instantly, but have people working on those phones or emails that have been trained ... in sexual abuse and how to deal with victims.”

Holly, Negative experience of support services

While two participants specifically mentioned that a support group ‘similar to AA’ but for victims and survivors of child sexual abuse would be of help:

“A little bit like Alcoholics Anonymous ... almost a support group.”

Susan, Negative experience of support services

“You know, like drug users and AA groups and stuff like that ... It would be nice for someone who has gone through what I’ve gone through, abuse of any type, to have a centre. Even if it was just one day a week for those people to have those appointments to feel safe going in and out of that building.”

Emma, Negative experience of support services

Some participants also spoke of the importance of such services being gender-specific (ie some services for females only and some services for males only), having had poor experiences of mixed support groups or counsellors of a different gender:

“It [the group attended] was a mixture of female and male which I have a little bit of trouble with ... I think what it did was some of the people there reminded me of the person that had abused me.”

Edna, Negative experience of support services

“I think there should never be the option of a male counsellor for a woman because I don’t believe that men can understand how a woman feels when she’s violated.”

Ruth, Negative experience of support services

“There just needs to be more of it; more services like X [a specialist sexual abuse support service for men, run by men] ... men are under-represented, not always as believed.”

Nic, Positive experience of support services

Linked to the idea that has arisen throughout this analysis of long waiting times to access services, interview participants also talked of the importance of therapeutic help being immediately accessible when it was asked for:

“I think there should be almost immediate help because as soon as a person is in a position, or feels they can open up, there should be somebody there as soon as possible. Not months and months of waiting ... You shouldn’t have [to] get to the end of your tether, or the end of yourself, for someone to say, ‘I can help you now.’”

Ruth, Negative experience of support services

“It took an attempted suicide, kind of, to be taken seriously.”

Susan, Negative experience of support services

“It would be nice to have – I know it’s like a dream – an immediate offer of service. At that point when you ask for it, you’re desperate.”

Edna, Negative experience of support services

This immediate help, some participants expressed, should not only apply to standard talking therapies, but also those that they perceive as being the most cutting-edge therapeutic treatments available for treating child sexual abuse:

“The modern treatments for PTSD.”

Edna, Negative experience of support services

"I've also had EMDR.⁵³ That was amazing."

Susan, Negative experience of support services

Such treatments were sometimes mentioned as a substitute for quick, and often unsuccessful, fixes of medication:

"I had so many worries and things but they just gave me anti-depressants. I don't really like taking them."

Holly, Negative experience of support services

"They dosed me up ... I felt like a zombie. I felt emotionless. Me and my partner nearly split up. It was disastrous, absolutely disastrous. By my own choice I came off them ... I was getting suicidal on them and I was telling doctors this and nothing was being done, so I come off them."

Emma, Negative experience of support services

It was also important to participants that therapeutic services be both free and available for as long as victims and survivors need them, offering ongoing support:

"I think ongoing counselling or assistance should be available to people. It shouldn't be a set period of time because circumstances in people's lives change. Sometimes they can trigger memories, or you might feel you're doing well and then you can have a set-back and you need that assistance again."

Olivia, Positive experience of support services

"It was almost the attitude was 'well, the NHS is going to pay for six [sessions of counselling] and then go away. We might just extend to 12.' I was one of the lucky ones who extended to 12, but again there was that finite that you've got to get it resolved in that time."

Kit, Positive experience of support services

"Maybe ongoing support even once the treatment ends. That's the thing, you have whatever the amount is and then you try and implement it into your life, and when you hit a bit of a rut you've got nowhere to go to say, 'I've hit a bit of a sticking point, what's the best way for me to look at this?'"

Edna, Negative experience of support services

"The police were great but ... once their investigation was over, I was on my own. That's when the real torment started. That's what made it really, really difficult. There was no follow-up or aftercare and it's difficult because they don't have the resources."

Karen, Negative experience of support services

"Top-up sessions probably would be quite helpful to go back over some stuff."

Lucy, Positive experience of support services

53 Eye movement desensitisation and reprocessing (EMDR) therapy is a treatment used for trauma and post-traumatic stress disorder (PTSD).

5.3 How services could be improved for victims and survivors

We asked the survey respondents how they thought services, in general, could provide a better experience for victims and survivors of child sexual abuse. The most common suggestions for improvement included:

- better education around child sexual abuse (n=19; 17%)
- more specialist training/services (n=16; 14%)
- more information about services (n=15; 13%)
- more responsive services (n=14; 12%)
- ensuring victims feel believed (n=12; 10%).

Responses from respondents and participants under these themes are summarised in the infographic.

Interview participants across all three groups talked about the importance of better education around child sexual abuse, with a number of participants thinking that this should start at schools:

“For me, I think education in schools, education in colleges. I know it’s a difficult subject to broach but there should more prevention in terms of educating people that when a family member makes you feel uncomfortable, that isn’t right.”

Ruth, Negative experience of support services

“If support services could make it an honest conversation, like we do about so many other things, that’s really what we really need to do, even in schools really.”

Karen, Negative experience of support services

The idea of more specialist training and the importance of knowledge around trauma generally, and child sexual abuse specifically, was also expanded on by participants with negative experience of support services:

“Specifically trained counsellors. People that are trained in child sexual abuse. Not a generalised counsellor that may use CBT, may use this, may use that, talking therapy, but somebody that is specifically trained. Not just one person but a whole army of them trained in how to support somebody that has been traumatised by this.”

Ruth, Negative experience of support services

“Knowledge, I suppose. Knowledge ... and the impact it actually has on individuals. Not just for that period of time that the abuse took place, but basically their life after that, and the journey that that person has made.”

Carly, Negative experience of support services

Service improvement

Respondents' and participants' ideas about how services for victims and survivors of child sexual abuse could be improved

Better education around child sexual abuse

"Educating people that when a family member makes you feel uncomfortable, that isn't right"

"An honest conversation ... even in schools really"

"It can be verbal, it can be mental or physical ... children might not always realise what is happening to them if they're being groomed"

More specialist training

"Specifically trained counsellors ... a whole army of them trained in how to support somebody that has been traumatised by this"

"Training for that first point of contact ... You know teachers, GPs or whoever really"

"They [the police] obviously need more training"

More information about services

"Some kind of central body who can triage the situation and signpost people"

"You as a group could now go to these people so that they can offer advice, helpful advice"

More responsive services

"More funding. More appointments"

"I think it would be nice to think that there was a plan ... a plan of action that involves like a holistic look at it ... it seems like no one knows what they are doing"

Ensuring victims feel believed

"I was called a liar by a police officer and don't recall being offered any kind of support"

Another suggestion around ways of improving services that arose during the interviews, which was not considered in the survey, was multi-agency working and collaboration. Participants spoke of the idea of one central agency that could ensure that victims and survivors are signposted to the most appropriate and comprehensive support available:

“Some kind of central body who can triage the situation and signpost people to access the services that they would need ... To have a one size fits all service for people who have suffered child abuse, whether it's happening to them now or is historic, it's not a one size fits all kind of thing. There's so many different levels to it and it can leave people with so many different problems, mental or physical. I think the signposting service would be great.”

Kerry, No experience of support services

“I think it would be nice to think that there was a plan, you know. Like when you go in and say to someone, 'this is what's happening,' if they could be like, 'ok, this is normal. I've heard of this before. There are ways to deal with this' ... A plan of action that involves like a holistic look at it ... I don't know. It seems like no one knows what they are doing.”

Edna, Negative experience of support services

Some of the survey respondents' quotes also illustrate these points:

“More funding. More appointments. Better trained counsellors. Hours that meet the needs of the client not the service. CPS should engage with victims around their decisions not to prosecute. No aftercare from the police.”

Survey respondent #173; female

“I think that police officers and social workers need more education on how to deal with children who have just been through something so traumatic. I was called a liar by a police officer and don't recall being offered any kind of support.”

Survey respondent #59; female

5.4 Comparative analyses

Finally, comparative analyses tested a series of 12 hypotheses or questions⁵⁴ relating to associations between the views and experiences of victims and survivors of child sexual abuse and their:

- demographic characteristics;
- the type of child sexual abuse experienced;
- the types of services accessed (statutory, voluntary or private);
- the types of support accessed (justice, recovery or healthcare-based).

54 These were set out in IICSA's original specification for the research.

The main outcomes which served as the focus of these comparative analyses were: (i) whether support services had been accessed; (ii) perceptions and experiences of these support services; (iii) having experienced barriers to accessing support services; and (iv) reporting any current unmet need for support. The statistically significant findings were:

- Female respondents were more likely to report having experienced child sexual abuse in a family setting than men (45% vs. 24%), and men were more likely to have experienced child sexual abuse in institutional settings compared to women (30% vs. 7%).
- Victims and survivors who reported having ever tried to get help or support from a service or organisation because of their experience of child sexual abuse, but were unable to, or had been prevented from doing so, were found to be significantly younger than those experiencing no such barriers (mean 43 vs. 49 years).
- Those victims and survivors who reported having ongoing unmet needs linked to their experiences of child sexual abuse were significantly younger (mean 43) compared to those who had no unmet needs (mean 51 years) and more likely to identify as gay, lesbian or bisexual (68%) (compared to 39% of heterosexual respondents who reported having ongoing unmet needs).⁵⁵
- Victims and survivors who experienced child sexual abuse within the family setting were significantly more likely to report having accessed any form of support, advice or treatment as a consequence (41%), when compared with respondents abused in institutional contexts (25%), both family and institutional contexts (33%) and other settings (13%).

For the full results of the comparative analyses, please see Appendix K.

55 There were though no differences based on age ($r=-0.139$, $p=0.063$) or sexual orientation ($t(177)=-0.80$, $p=0.423$) in the number of services which respondents felt could potentially be useful to them now in response to the child sexual abuse they had experienced, but which they were currently unable to find or access.



CHAPTER 6: Network mapping

In order to better understand the service landscape, network mapping was undertaken using some parts of the survey data. This included whether the survey respondent had received any form of support, advice or treatment from a service or organisation because of their experience of child sexual abuse; whether they had tried to get help or support, but were unable to or were prevented from doing so; types of services used by those accessing help or support; and services respondents thought they would benefit from now as a consequence of their earlier experience of child sexual abuse.

The results of the network mapping are shown in Figure 6.1. A key is provided below the diagram that explains the colour-coding used for different respondents/services and relationships in the network. The size of each shape reflects the relative number of connections to or from each service or respondent.

The network mapping reveals several groups of respondents:

People who did not access services

- As per the overall survey findings, 73% of those in the network map did not access any kind of service (these respondents are connected to 'None' in the network diagram).

People who did not access services and who did not try to access services⁵⁶

- Over half of all respondents (56%) did not access services and had not tried to access services as a result of their experience of child sexual abuse.
- Of those who did not access services, the vast majority (94%) had not tried to get help or support from a service or organisation as a result of their experience of child sexual abuse.

People who did not access services but who attempted to do so

- Only 6% of respondents who had not accessed services had tried to get help or support from a service or organisation, but were unable to or were prevented from doing so (shown by respondents with red lines connecting them to 'None').
- This perhaps reflects other research findings from the survey that people who did not access support services were more likely to report personal and family/community-based barriers to accessing services. This suggests a potential focus on preparing the psychosocial ground for victims and survivors of child sexual abuse in helping them to engage with services if they wish to do so.

People who identified services they would currently benefit from

- The network map shows that unmet need, as expressed by respondents who identified a service they thought they would benefit from, that they were currently unable to find or access (shown by the yellow lines in the diagram), is twice as large as the total number of engagements with services made by respondents to date (shown by the green lines).

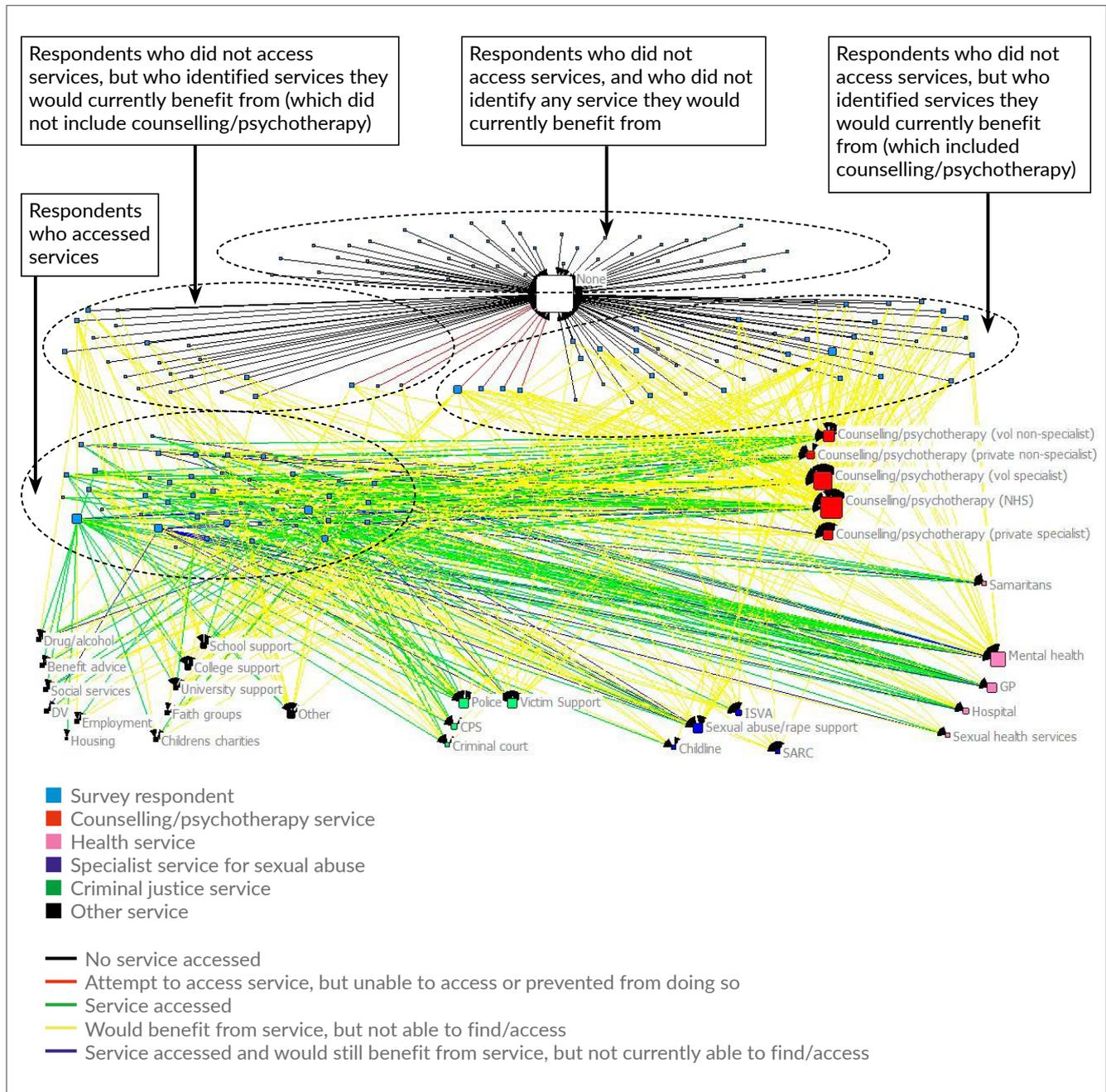
56 Respondents were categorised as not having tried to access services if they answered 'No' to the question: 'Have you ever tried to get help or support from a service or organisation because of your experience of child sexual abuse, but were UNABLE TO or were PREVENTED from doing so?'

- Counselling and psychotherapy were the most common services identified by respondents as being helpful to them now (as shown by the size of the symbols representing services in the diagram).
- All those who had not accessed services but who had tried to do so identified services they thought they would currently benefit from.

People who had accessed services

- As per the overall survey findings, 27% of those in the network map accessed some kind of service. Counselling and psychotherapy were the most commonly mentioned.
- The network mapping shows that few respondents would currently benefit from services they had already accessed – only 8% of unmet need was associated with services that clients had already engaged with (as shown by the blue lines in the diagram). Respondents reported that their current need could best be met by a range of other services they had not yet engaged with in connection to their experience of child sexual abuse. This suggests that there is a need for improving referral pathways and connections between different types of services.

Figure 6.1: Network map of services accessed and required as a result of experiencing child sexual abuse





CHAPTER 7: Key research findings

Below we set out what we consider to be the key findings of this research.

1. Most victims and survivors have not accessed support services

Nearly three-quarters (73%) of survey respondents reported not having accessed any support services, with only 27% having received some form of support, advice or treatment because of their experience of child sexual abuse. These figures are in stark contrast to previous research. For example, Smith et al. (2015) found that 90% of respondents had accessed support.

The large discrepancy between these figures is hypothesised to be due to the sample being recruited through the Crime Survey for England and Wales, rather than through support services, the latter sampling method over-representing those who have accessed support. The sampling method of this study thus brought the additional strength of presenting views from a group – victims and survivors who have not accessed, and are not accessing, any service – not normally represented in research.

2. Victims and survivors who do access support services take a long time to do so and rate the usefulness of services as mediocre

For the one in four (27%) victims and survivors who had actually accessed support services, the average time between first child sexual abuse victimisation and contact with support services was nearly two decades: 19 years (N=46). Those respondents with prior experience of services had accessed between 1 and 21 different forms of support, with an average of 4 services accessed. These figures are virtually identical to Smith et al.'s (2015) findings (20 years and between 4 and 5 services), despite nine in ten of their sample being service users.

The average helpfulness rating across all support services accessed was 5.3 (on a scale of 0–10 with 0 being 'Not helpful at all' and 10 being 'Extremely helpful').⁵⁷ This is again consistent with Smith et al. (2015) who measured support on a 5-point scale (0–4), with the median satisfaction score being 2.5. Although these scores are very slightly more positive than negative, it is still worth asking whether this satisfaction score is satisfactory?

The literature reviewed in the Introduction, and the findings of this research, suggest that service improvement may come through the increased availability and accessibility of specialist trauma-informed support for victims and survivors.

57 The overall mean (5.3), median (5) and modal (5) scores are identical for the 46 respondents who had accessed support (SD=2.9).

3. The most highly rated forms of support were those provided by voluntary sector specialist services

Across *all* support services, the most highly rated were counselling provided by a charity/voluntary organisation specialising in child sexual abuse, and sexual abuse and/or rape support services provided by a specialist charity/voluntary organisation. This finding is consistent with the recent All-Party Parliamentary Group for Adult Survivors of Childhood Sexual Abuse survey (APPG ASCSA, 2020).

Interview participants also stressed the importance of specialist support from counsellors/therapists with training in, and particular knowledge of, trauma generally, and child sexual abuse specifically. This finding is similar to other relevant literature (eg APPG ASCSA, 2020; Chouliara et al., 2012; Chouliara et al., 2011).

The way in which service pathways operate may be relevant here. For example, at specialist services – such as rape crisis centres – the focus is on healing from trauma, specifically sexual trauma. Whereas at generic adult mental health services, the focus may be more generally on symptom reduction and may not seek to address the underlying trauma. This was observed by some participants in this research who commented that there was an over-reliance on medication to treat symptoms of, for example, anxiety or depression, but that the cause of these were not adequately addressed.

4. Counselling provided through health services was considered the least helpful service overall by some respondents, and the most helpful service overall by some other respondents

When asked what one service was the most helpful overall, survey respondents identified the most commonly accessed form of support – counselling provided through health services like a GP or hospital – as the most helpful.

However, it is notable that when asked which one service was the least helpful overall, counselling provided through health services was again the most frequently mentioned service.

While this finding may seem counterintuitive or contradictory on first reading, there are a number of potential explanations. First, it should be noted that these findings are in response to two separate questions, asked in different parts of the survey. Secondly, it is important to note that this form of support is the most commonly accessed. Therefore, more respondents had experience of the service on which to judge it. Thirdly, we should remember the diversity of people who have experienced child sexual abuse and the range of their experiences. It is not unreasonable to expect them to have different needs and/or experiences of support provided.

There are many different factors that might impact on how different individuals perceive the helpfulness of services and these can vary between services of the same ‘type’. These include the individual needs and preferences of the respondent, where and when they accessed the support service, and the reason for accessing the service. For example, relating to the time periods during which such support was accessed, there were some indicative findings to suggest that those who accessed support more recently had better experiences; however, these findings were not statistically significant. Yet it seems likely that, given the growing awareness of child sexual abuse in recent times among both the public and professionals, victims and survivors who accessed counselling decades ago may have experienced less informed/specialist help – and thus had a poorer experience – than those who encountered support services more recently.

In addition, respondents' relationships with individual counsellors may have differed, as might the type of counselling (eg trauma-informed versus generic mental health), and the number of sessions offered and attended. For example, one participant who had a positive experience of counselling through health services said: *"I felt the person [counsellor] that I was talking to really cared about what happened and was giving me the courage to open up about it."* While a participant who had a negative experience of counselling said: *"I had the feeling she just wanted to do the prescribed six sessions with me and just get me out of the surgery to move on."*

Given the findings regarding the helpfulness of a trauma-informed approach, whether or not the counselling received was trauma-focused may also have made a difference to participants' perceptions of its helpfulness. The individual, unique, relationships between victims and survivors and their particular counsellors/therapists may also be a factor here, as well as the amount of time/sessions victims were offered/able to access.

5. Victims and survivors stressed the importance of being heard, listened to, understood, believed and not judged, by caring and empathetic professionals

Interview participants with positive experiences of support services stressed various factors that made services helpful, including: care and empathy; feeling heard, listened to, understood and believed; a lack of judgement; understanding they were not to blame; feeling professionals had 'a vocation'; and being given enough time to talk. The importance of feeling heard, believed and respected was also a key finding by Smith et al. (2015), and is a fundamental principle of the Inquiry's Truth Project, based on a trauma-informed model.

Participants with positive experiences also talked of the importance of the physical environment in which support is received, with private, warm and welcoming environments being favoured over ones that felt colder and/or more clinical. This finding is, to our knowledge, a relatively novel one, although something already noticeable in the physical set up of several SARCs. Mirroring these findings, participants with negative experiences talked of: how they were *not* heard, listened to and believed; how they felt rushed, judged and misunderstood; their perception that professionals were just doing a job; and of environments that were impersonal or where privacy could not be assured.

Ensuring victims and survivors are in as conducive a physical environment as possible is clearly important. As online/virtual counselling is something increasingly being offered in generalist mental health services (and which may become a more routine feature of support and intervention in light of social distancing measures required in response to COVID-19), future research might consider the idea of such support for victims and survivors of child sexual abuse and the various pros and cons to such an approach.

For example, victims and survivors may feel more comfortable and in control in their own physical environments. However, issues with privacy, whether their home was also the site of their abuse, and whether talking about their abuse might in some way 'stain' or 'contaminate' their own environments (rather than leaving it behind in a clinical setting) are all considerations.

6. The vast majority of victims and survivors reported at least one barrier to support

More than four in five (84%) victims and survivors identified at least one form of barrier to accessing, or continuing with, support, which included personal (67%), service-specific (53%), family or community (48%), practical (33%) and financial (29%) issues.

Personal issues included: not feeling in need of support; just 'getting on with it'; 'burying' it; fear of not being believed; feeling at blame/fault; not feeling the child sexual abuse was severe/serious enough; and not feeling brave enough to access support.

Service-specific issues included: long waiting times; being unsure how to access support; difficulty finding specialist support; fear of the 'system'; and previous bad experiences of support services.

While family and community issues included: protecting the family; parental attitudes; and fear of family/community reactions.

As previous research has articulated, such barriers may be categorised as internal (eg shame and fear of not being believed) (Nelson and Hampson, 2008), and/or external (eg long waiting times and the cost of services) (Smith et al., 2015).

7. A key personal reason for not accessing support was victims and survivors not feeling they needed it

A particularly interesting finding in this research was a personal issue reported by victims and survivors who had no experience of support services. Participants who took part in qualitative interviews reported not feeling that they needed support and not having been adversely affected by their experiences. It should be noted that those who reported not needing or wanting help tended to be older, and repeatedly stressed the idea of resilience and their ability to cope with adverse life events without help and support. This idea of individual differences mediating the impact of child sexual abuse (Fisher et al., 2017; Allnock, 2016) is one that was noted in section 1.7.

Some researchers and clinicians have argued that victims and survivors who say that they do not feel they need support, may simply not realise that they do and will often benefit from help if and when they receive it. For example, Nelson and Hampson (2008) observe that the negative effects from being subjected to child sexual abuse may manifest in victims and survivors' lives in many different ways without them consciously realising this. Speaking to those who work with victims and survivors, they say:

People who try to kill or mutilate themselves, seek oblivion in drink or drugs, sometimes lose their children into care as a result, suffer frightening hallucinations, have endless nightmares and flashbacks, or chronic physical pain, are not feeling OK. They are also trying to tell us something, and it is hard to imagine what more they have to do. As one experienced CSA counsellor remarked with regards to the clients that came forward for this work: 'Survivors don't talk about the can of worms, because for them it's already open and they're in the middle of it.'

(Nelson and Hampson, 2008, p. 15)

However, there is also concern that narratives around those who say they do not want or need support can often become paternalistic or patronising. For example, it may be argued that telling victims and survivors that they must, almost by definition, need help, arguably disempowers them and/or

undermines or discounts the strength of personal resilience and how this differs among individuals. For instance, a systematic literature review by Domhardt et al. (2015) found that many victims and survivors have normal levels of functioning, which may be attributed to their resilience in various areas, with protective factors including “*education, interpersonal and emotional competence, control beliefs, active coping, optimism, social attachment, external attribution of blame, and support from the family and the wider social environment*” (p. 476).

8. A substantial minority of victims and survivors have unmet needs relating to their experiences of child sexual abuse

Two in five victims and survivors (43%) felt that they currently had unmet needs linked to their experience of child sexual abuse. The perceived importance of organisations that specialise in child sexual abuse was again highlighted by the research finding that, of these two in five respondents, the most commonly mentioned type of support desired, or perceived to be of potential benefit – identified by four in ten (42%) – was counselling provided by a specialist organisation.

In addition to specialist services and professionals with knowledge of child sexual abuse, participants also talked of how support services could be improved by: help being available immediately; better training; less reliance on medication; services for females only and services for males only; specialist support groups; multi-agency working; ongoing support; free services; and up-to-date treatments.

More broadly, unmet needs may be partly attributable to the often fractured nature of support or intervention after child sexual abuse, with some participants reporting that services were not joined up and did not cross-refer or work together to provide continuous support. One challenge with providing such support is how there are different paradigms to understanding the impact of child sexual abuse in different sectors and services, and how this is mirrored in service priorities. For example: justice, power deconstruction, diagnostic/psychiatrically-driven disordered models, and trauma-informed working. Problems also lie in the multiple pathways for commissioning and the different technical language that the support services and providers speak.

9. Significant relationships were found between the views and experiences of victims and survivors of child sexual abuse and their demographic characteristics and the type of child sexual abuse experienced

In our comparative analyses and hypothesis testing of the survey data, no significant relationships were found between the views and experiences of victims and survivors of child sexual abuse and types of services (statutory, voluntary or private) and support accessed (justice, recovery or healthcare-based).

However, in relation to demographic characteristics, females were more likely to report having experienced child sexual abuse in a family setting and less likely to report experiences in institutional settings. Furthermore, those who tried to get support but were unable to (43 vs. 49 years), and those who reported unmet needs (43 vs. 51 years), were younger.

Those experiencing child sexual abuse within family, institutional – or both – contexts, were more likely to report barriers to accessing services than those experiencing child sexual abuse in other settings (eg where child sexual abuse was perpetrated by a friend, acquaintance or neighbour). However, those who experienced child sexual abuse within the family were also more likely to report having succeeded in accessing support.



Appendices

● Appendix A: Support service categories

Table A.1: Support service categories

Justice	<p>Police</p> <p>Crown Prosecution Service</p> <p>Criminal court</p> <p>Civil court</p> <p>Victims' support services</p> <p>Sexual assault referral centre (SARC)</p> <p>Independent Sexual Violence Advisor (ISVA)</p> <p>Gang-related services provided by the government, council or NHS</p> <p>Gang-related services provided by a charity/voluntary organisation</p>
Recovery	<p>Counselling – provided through health services like a GP or hospital</p> <p>Counselling – provided by a charity/voluntary organisation specialising in child sexual abuse</p> <p>Counselling – provided by a charity/voluntary organisation not specialising in child sexual abuse</p> <p>Counselling – provided by a private practitioner specialising in child sexual abuse</p> <p>Counselling – provided by a private practitioner not specialising in child sexual abuse</p> <p>Psychotherapy – provided through health services like a GP or hospital</p> <p>Psychotherapy – provided by a charity/voluntary organisation specialising in child sexual abuse</p> <p>Psychotherapy – provided by a charity/voluntary organisation not specialising in child sexual abuse</p> <p>Psychotherapy – provided by a private practitioner specialising in child sexual abuse</p> <p>Psychotherapy – provided by a private practitioner not specialising in child sexual abuse</p> <p>Sexual abuse and/or rape support services provided by a specialist charity/voluntary organisation</p> <p>Samaritans</p> <p>Faith groups</p> <p>Other support service based on your sexuality</p> <p>Other support service based on your gender</p> <p>Other support service based on another aspect of your identity</p> <p>Children's charities (eg NSPCC, Barnardo's)</p> <p>Childline</p> <p>Residential care for children provided by the council/local authority</p> <p>Residential care for children provided by a charity/voluntary organisation</p> <p>Residential care for children provided by a private company</p> <p>Social services</p> <p>Employment services provided by the government</p> <p>Employment services provided by a charity/voluntary organisation</p>

<p>Recovery (continued)</p>	<p>Benefit services/advice provided by the government Benefit services/advice provided by a charity/voluntary organisation Support provided in a school Support provided in a college Support provided in a university Domestic violence services provided by the government, council or NHS Domestic violence services provided by a charity/voluntary organisation Housing services provided by the government or council Housing services provided by a housing association, registered social landlord RSL, or charity/voluntary organisation Other statutory services Other voluntary services</p>
<p>Health</p>	<p>Hospital accident and emergency (A&E) Hospital gynaecology services Hospital maternity services Hospital surgical treatment Other hospital services GUM (genitourinary medicine) clinic Sexual health services General practitioner (GP) Mental health services provided by the NHS Mental health services provided by a charity/voluntary organisation Mental health services provided by a private company Drug and/or alcohol services provided by the NHS Drug and/or alcohol services provided by charity/voluntary organisation Drug and/or alcohol services provided by a private company</p>

● Appendix B: Method of survey analysis

In addition to descriptive statistics, chi-square (χ^2) tests were used to examine the distributions of categorical variables (eg relating to whether a support service had ever been accessed) and determine whether these are the same across any groups examined (eg based on respondents' gender or ethnicity). Assuming normal distribution of continuous data (eg relating to number of services accessed or 'helpfulness' rating), a two-sample (independent groups) A Student's t-test (assuming equal variances using a pooled estimate)⁵⁸ was undertaken to test the null hypothesis that the mean numbers observed were not significantly different between two groups. Alternatively, continuous numeric variables were examined using one-way analysis of variance (ANOVA) to determine whether there were significant differences in mean values between three or more groups.

As set out in the research specification developed by the Inquiry for the project, we also undertook comparative analyses to assess how respondents' views and experiences varied according to their:

- demographic characteristics
- the type of child sexual abuse experienced
- the types of services accessed
- the types of support accessed.

The main outcome variables which served as the focus of the comparative analyses were: (i) accessing support services; (ii) perceptions and experiences of these support services; (iii) having experienced barriers to accessing support services; and (iv) reporting any current unmet need for services.

Access to support was measured in two ways: a binary/categorical variable relating to whether the respondent reported any prior experience of accessing support services and a continuous variable relating to the number of different support services that had reportedly been accessed (drawing on responses to Q3.5 – ranging from none to 58).

Perceptions and experiences of these support services were measured by: (i) calculating an average (mean) score or rating for the 'helpfulness' of all services accessed; (ii) a binary/categorical variable to indicate whether any support service has been rated as 'good' or 'very good'; and (iii) a binary/categorical variable to indicate whether any support service had helped in the healing and recovery process ('completely' or 'to some extent', in response to Q3.16).

Experiencing barriers to accessing support (either being unable to or prevented from doing so) was defined and measured as a binary/categorical variable using responses to Q3.4.

Current unmet need for services was measured in two ways: a binary/categorical variable relating to whether the respondent reported any current, ongoing needs linked to the child sexual abuse they have experienced (in response to Q4.4) and a continuous variable relating to the number of different support services the respondent reported being unable to find or access (in response to Q4.5 – ranging from none to 58).

⁵⁸ Results from Levene's test were examined to determine equality of variances in all such cases.

Details of the independent/explanatory variables – relating to demographics, the type of child sexual abuse experienced, and the types of services and support accessed are set out in Table B.1. This includes reference to the relevant survey question and comments on technical or definitional issues.

Table B.1: Explanatory variables used in comparative analysis

Explanatory variables	Relevant survey question(s)	Comments
Age	Q1.1	This was analysed as a continuous variable.
Gender	Q1.2	Female (1=Yes, 0=No, with additional option(s) for further other category(s) depending on relevant number of replies).
Ethnicity	Q1.4	For analytical purposes responses were compared between 'White' and 'non-White' respondents'.
Sexual orientation	Q1.9	We compared outcomes between 'Heterosexual' and 'Other' respondents.
Types of child sexual abuse experienced	Q2.4	Responses to this question were recoded to create a single categorical variable to compare outcomes for those with experience of familial abuse, institutional abuse, both, or child sexual abuse in other settings.
Types of services accessed	Q3.5	Based on the service mapping document, responses were recoded into two categorical variables in order to understand outcomes experienced by those accessing: (i) private, statutory, or voluntary services and (ii) justice, recovery/support, or healthcare services.
Types of support accessed	Q3.5	Our analysis of types of support was data led eg focusing upon the modal support types reported by respondents.
Decade services first accessed	Q3.6	We used responses to Q1.1 (current age), and Q3.6 (age first accessed support) to determine the year different services were first accessed. Responses to Q3.7 ('helpfulness' rating) then allowed us to determine experiences of support across periods of time.

● Appendix C: Method of qualitative analysis

The interview data were analysed thematically, exploring patterns and ideas to emerge under each research aim, from each sample, as summarised in Table C.1. Some question areas overlap different research aims, and some prompts in questions refer to specific research aims. Data from additional questions from the interviews (eg final reflections from interviewees) informed all research aims, according to the focus of the replies in each case.

Table C.1: Thematic analysis against research aims

Aim	Sample A: No experience	Sample B: Positive experiences	Sample C: Negative experiences
1. Reasons for not accessing support services and any barriers to access	Q2 (why did not access support) Q4 (would services have been helpful) Q5 (more likely to access services) Q7 (offered services)	Q4 (aspects that did not work well) Q5 (reasons for stopping)	Q4 (service improvements) Q6 (reasons for stopping)
2. Perceptions of support services	Q4 (what might have been helpful) Q6 (considering services)	Q3 (experience of service) Q8 (most important things)	Q3 (experience of service) Q5 (aspect that did work well) Q9 (most important things)
3. What services victims and survivors think are available to them and how to access them	Q3 (what is available) Q9 (other support)	Q3 (experience of service)	Q3 (experience of service)
4. Unmet need for services	Q8 (needs unmet by services)	Q6 (needs unmet by services)	Q7 (needs unmet by services)

The interview data were analysed using the qualitative method of thematic analysis. This was chosen in preference to other methods of analysing textual data such as discourse analysis, as it concentrates on *what* was said as opposed to *how* it was said. A method essentially independent of epistemology and theory, thematic analysis is used to organise data into thematic sets as determined by the researcher.

The process of conducting a thematic analysis that was followed in this study follows the six phases articulated by Braun and Clarke (2006). In phase 1 the researcher familiarised and immersed themselves in the data, which involved reading and re-reading the transcribed interviews in an active sense, recording initial ideas and being alert to possible patterns within the data. In phase 2 the researcher generated initial codes, identifying aspects within the data that were of interest and organising the data into meaningful sets. This was done manually, by means of marking copies of interview transcripts with colour-coded pens.

In phase 3 the codes generated in phase 2 were sorted into themes, both broader, overarching 'master' themes, and narrower 'sub-themes'. The four master themes were derived deductively, corresponding with the four main research aims, while the sub-themes were identified inductively, being driven by the data. In phase 4 the themes were refined; some discarded (through lack of supporting data), some merged, and some broken down further. In phase 5 the themes were defined and explicitly given names to identify them and set out in tables with accompanying quotes. Finally, in phase 6, the themes were integrated into the survey analysis to tell a coherent story, using participant quotes embedded within an analytical narrative to tell the story of the data in relation to the research aims and questions.

As the interview participants were a sub-set of the survey respondents, it was inevitable that many of the sub-themes that emerged corresponded to the survey questions. However, some came across more strongly than others in the interviews, and some novel themes also arose that were not identified in the survey. Thus, while quotes from interviewees illustrated and expanded upon the findings from the survey, they also offered contrasting findings/experiences where these existed.

● Appendix D: Full qualitative analysis results

Table D.1: Aim 1 – Barriers to accessing support services: master themes and sub-themes

Master themes	Sub-themes
Personal issues	Did not feel they needed support
	Just 'got on with it'/buried it
	Fear of not being believed
	Not feeling brave enough to access support
	Feeling to blame/at fault for child sexual abuse
	Mental health issues
	Not feeling child sexual abuse severe/serious enough
	Gender stereotypes/norms of masculinity
	Perception of gaining something positive from the experience
	Differences in societal attitudes then and now
Family/community issues	Fear of family/community finding out
	Protecting family
Service-specific issues	Unsure where to go/how to access support
	Difficulties finding specialist support services
	No support being proactively offered
	Previous bad experiences with support services
	Fear of the criminal justice system/process

Table D.2: Aim 2 – Victims and survivors' perceptions and experiences of support services

Master themes	Sub-themes
Qualities of helpful support services	Professionals who are caring and empathetic
	Feeling heard, listened to, understood and believed
	Lack of judgement
	Understanding they were not at fault/to blame
	Feeling professionals had 'a vocation'
	Not feeling rushed/having time
	Welcoming environments
	Being seen quickly

Master themes	Sub-themes
Reasons for leaving helpful services	Achieved therapeutic goals/no longer needed support
	Not offered any further support
	Achieving closure
Extent to which helpful services aided in recovery	Being given useful tools/techniques to use in everyday life
	Reduction of trauma symptoms
Qualities of unhelpful support services	Long waiting times for services
	Having to visit service repeatedly to access support
	Having to start again (eg re-referred/waiting lists)
	Feeling professionals just doing a job
	Not feeling believed or understood
	Unwelcoming environments
	Short courses of sessions
	Feeling dismissed/experiences minimised
Reasons for leaving unhelpful services	Felt it was a waste of time/not getting anywhere
	Not offered any further support
Extent to which unhelpful services aided in recovery	Services helping in the short-term but not long-term
	No reduction in trauma symptoms
	Feeling worse after receiving support

Table D.3: Aim 3 – What services victims and survivors think are available and how to access them

Master themes	Sub-themes
What support services victims and survivors think are available	Not knowing what support is available
	Perception that services are easier to access these days
	Victims using their own initiatives to find services
	Finding out about services through the media
How victims and survivors think they can access support services	GP
	Police
	Childline

Table D.4: Aim 4 – The extent of unmet needs and ways services could be improved

Master themes	Sub-themes
The role of professionals within existing services	Professionals having specialist knowledge of trauma and child sexual abuse
	Better training for professionals
	Professionals relying less on medication
Different types of services	Specialist support groups for victims and survivors of child sexual abuse
	Gender-specific services
	Drop-in centres
Enhancing existing services	Immediate help being available
	New/specialist treatments being available
	More access to free services
	Multi-agency working/collaboration
	Ongoing support being available
	Top-up sessions being offered
	More education around child sexual abuse generally

Table D.5: Barriers to disclosure

Master themes	Sub-themes
Barriers to disclosure as a child to family or professionals	Did not know the behaviour was not okay/little understanding of child sexual abuse
	Feelings of shame
	Fear of not being believed
	Parental attitudes
Barriers to disclosure as an adult to professionals	Lack of rapport/not feeling comfortable with professional
	Insufficient number of sessions/feeling rushed
	Uncongenial/unsafe physical environments
	Fear of not feeling believed

● Appendix E: Crime Survey for England and Wales (CSEW) recontact sample and survey participants

Table E.1: A comparative assessment of key demographic characteristics of the CSEW recontact sample and the online survey respondents

	CSEW recontact sample (N=634)	Survey respondents (N=181)
Modal age group (45-54)	21.8%	23.2%
Female	81.4%	81.8%
White ethnicity	92.4%	91.8%

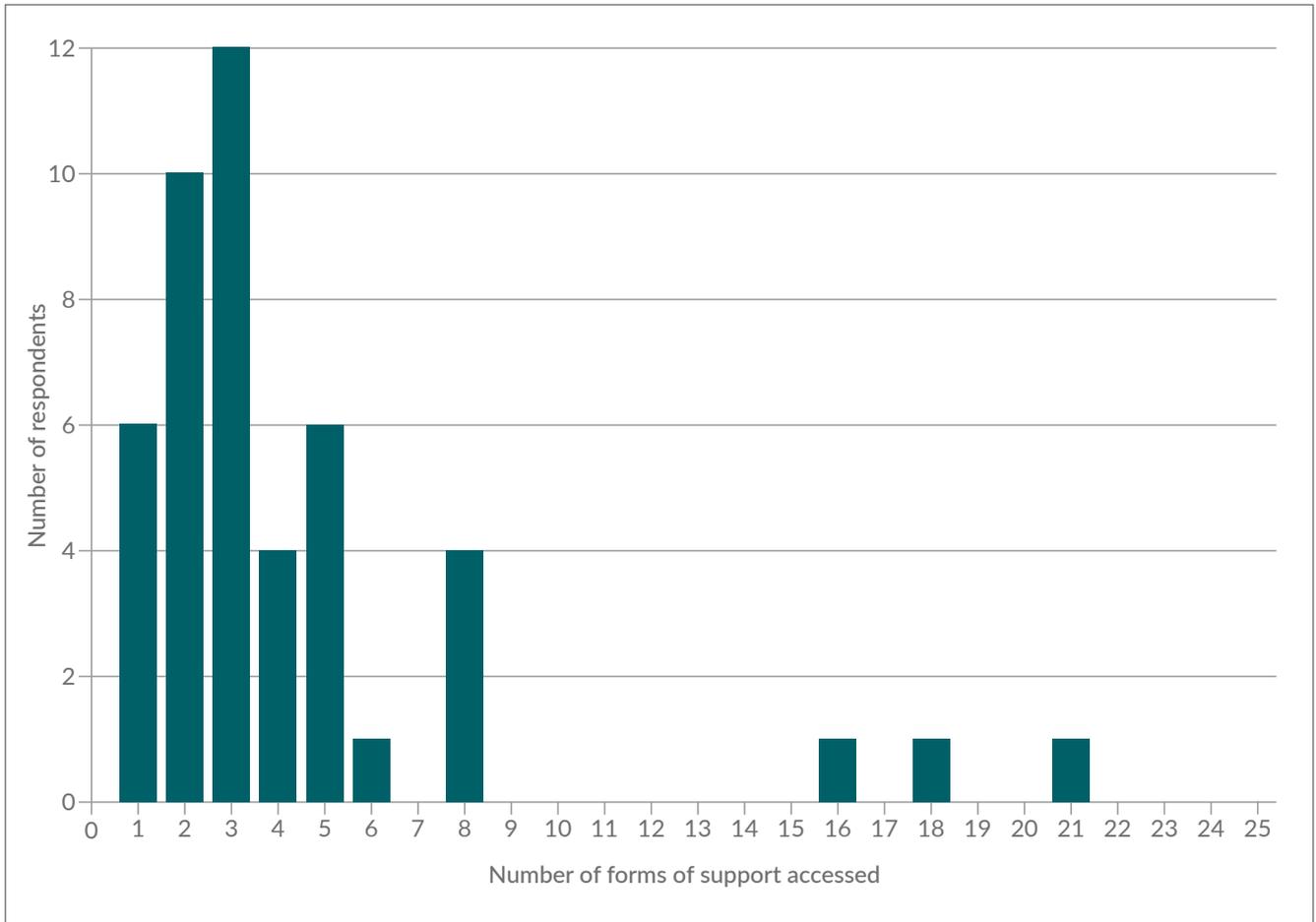
● Appendix F: Relationship between perpetrators and victims and survivors

Table F.1: Relationship of perpetrator to victims and survivors of child sexual abuse (N=181)

Relationship of perpetrator	Frequency	Percentage
Friend, acquaintance or neighbour	78	43.1
Other family member	40	22.1
Stranger	36	19.9
Partner or previous partner	23	12.7
Someone else	22	12.2
Step father	20	11.0
Person in position of trust or authority	18	9.9
Father	14	7.7
Mother	3	1.7
Carer, guardian or residential care worker	3	1.7
Don't wish to answer	1	0.6
Step mother	-	-
Don't know/can't remember	-	-

● Appendix G: Use of multiple forms of support

Figure G.1: Number of forms of support accessed



Appendix H: Ratings of helpfulness

Table H1: Ratings of 'helpfulness' for support and services accessed because of child sexual abuse (N=46)

Type of support	Mean	Median	Min	Max	SD	N
Domestic violence services provided by a charity/voluntary organisation	10	10	10	10	-	1
Counselling provided by a private practitioner specialising in child sexual abuse	10	9.5	9	10	0.7	2
Mental health services provided by a private company	10	9.5	9	10	0.7	2
Drug and/or alcohol services provided by charity/voluntary organisation	9	9	8	10	1.4	2
Support provided in a school	8	9	6	9	1.7	3
Benefit services/advice provided by the government	8	8	6	10	2.8	2
Psychotherapy provided by a private practitioner not specialising in child sexual abuse	8	10	0	10	4.4	5
Sexual abuse and/or rape support services provided by a specialist charity/voluntary organisation	7	9	3	10	2.9	10
Counselling provided by a charity/voluntary organisation specialising in child sexual abuse	7	8	1	10	3.3	11
Mental health services provided by a charity/voluntary organisation	7	10	1	10	5.2	3
Benefit services/advice provided by a charity/voluntary organisation	7	7	7	7	-	1
Counselling provided by a charity/voluntary organisation not specialising in child sexual abuse	6	8	0	10	3.7	12
Samaritans	6	7	0	10	3.8	6
Drug and/or alcohol services provided by a private company	6	6	2	10	5.7	2
Victims' support services	6	6	3	9	2.6	6
Children's charities (eg NSPCC, Barnardo's)	6	7	0	9	4.0	4
Psychotherapy provided through health services like a GP or hospital	6	6	2	10	2.3	9
General practitioner (GP)	5	5	0	10	3.6	21
Hospital gynaecology services	5	5	0	10	7.1	2

Domestic violence services provided by the government, council or NHS	5	5	0	10	7.1	2
Counselling provided by a private practitioner not specialising in child sexual abuse	5	3.5	0	10	5.0	6
Other voluntary services	5	4.5	3	6	2.1	2
Counselling provided through health services like a GP or hospital	4	5	0	10	3.2	23
Other hospital services	4	4	1	7	4.2	2
Mental health services provided by the NHS	4	4	0	8	2.8	15
Sexual health services	4	3.5	0	7	4.9	2
Police	3	3	0	9	2.7	11
Social services	3	2.5	1	6	2.2	4
Employment services provided by the government	3	3	0	6	4.2	2
Crown Prosecution Service	3	1	0	8	3.8	4
Hospital accident and emergency (A&E)	2	2	0	5	2.5	3
Criminal court	2	2	0	5	2.5	3
Support provided in a university	2	2	0	4	2.8	2
Housing services provided by the government or council	2	2	2	2	-	1
Support provided in a college	1	1	0	2	1.4	2
Hospital maternity services	0	0	0	0	0.0	2
Hospital surgical treatment	0	0	0	0	-	1
Independent Sexual Violence Advisor (ISVA)	0	0	0	0	-	1
Childline	0	0	0	0	-	1
Drug and/or alcohol services provided by the NHS	0	0	0	0	-	1

● Appendix I: Overall most helpful service

Table I.1: Forms of child sexual abuse-related support considered most helpful (N=44)

Type of support	Frequency	Percentage of responses	As percentage of those accessing support
Counselling provided through health services like a GP or hospital	9	21	39
Counselling – provided by a charity/voluntary organisation specialising in child sexual abuse	4	9	33
Psychotherapy provided through health services like a GP or hospital	4	9	40
Psychotherapy provided by a private practitioner not specialising in child sexual abuse	4	9	80
Sexual abuse and/or rape support services provided by a specialist charity/voluntary organisation	4	9	40
Counselling provided by a private practitioner specialising in child sexual abuse	3	7	67
Mental health services provided by the NHS	3	7	19
General practitioner (GP)	2	5	10
Counselling – provided by a charity/voluntary organisation not specialising in child sexual abuse	2	5	15
Police	2	5	17
Other hospital services	1	2	50
Counselling provided by a private practitioner not specialising in child sexual abuse	1	2	17
Crown Prosecution Service	1	2	25
Victims' support services	1	2	17
Faith groups	1	2	-
Children's charities (eg NSPCC, Barnardo's)	1	2	20
Domestic violence services provided by the government, council or NHS	1	2	50

● Appendix J: Overall least helpful service

Table J.1: Forms of child sexual abuse-related support considered least helpful (N=33)

Type of support	Frequency	Percentage of responses	As percentage of those accessing support
Counselling provided through health services like a GP or hospital	12	36	52
Counselling provided by a charity/voluntary organisation not specialising in child sexual abuse	4	12	31
Police	3	9	25
General practitioner (GP)	2	6	10
Counselling provided by a private practitioner not specialising in child sexual abuse	2	6	33
Psychotherapy provided through health services like a GP or hospital	2	6	20
Mental health services provided by the NHS	2	6	13
Other hospital services	1	3	50
Counselling provided by a charity/voluntary organisation specialising in child sexual abuse	1	3	8
Independent Sexual Violence Advisor (ISVA)	1	3	100
Crown Prosecution Service	1	3	25
Social services	1	3	25
Support provided in a university	1	3	50

● Appendix K: Full results of comparative analyses

H1: Demographic characteristics of victims and survivors and experiences of child sexual abuse

There was no association between the (average) age ($F(1,181)=1.59$, $p=0.193$), ethnicity⁵⁹ ($\chi^2(3, N=181)=3.0$, $p=0.387$) and sexual orientation⁶⁰ ($\chi^2(3, N=181)=3.4$, $p=0.334$) of the online survey respondents and whether child sexual abuse had been experienced in a familial, institutional, both (familial and institutional) of these contexts, or in other settings. However, female respondents were significantly more likely to report having experienced child sexual abuse in a family setting (45.3% vs. 24.2%), but were less likely to have done so in institutional settings (6.8% vs. 30.3%) ($\chi^2(3, N=181)=18.0$, $p=0.000$).

H2: Demographic characteristics of child sexual abuse victims and survivors and experiencing barriers to accessing support services

Victims and survivors who reported having ever tried to get help or support from a service or organisation because of their experience of child sexual abuse, but were unable to, or had been prevented from doing so, were found to be of a significantly younger age (mean 42.6 vs. 48.8 years) ($t(156)=-2.11$, $p=0.036$). There were, however, no associations observed between gender (18.0% vs. 13.8%) ($\chi^2(2, N=168)=1.3$, $p=0.500$), ethnicity (17.3% vs. 16.7%) ($\chi^2(2, N=168)=0.84$, $p=0.656$) and respondents' sexual orientation (16.1% vs. 26.3%) ($\chi^2(2, N=168)=2.2$, $p=0.318$) and experiences of barriers in accessing child sexual abuse-related services.

H3: Demographic characteristics of victims and survivors of child sexual abuse and access to support services

There were no significant associations found between respondents' age (mean 44.5 vs. 48.7 years) ($t(159)=-1.65$, $p=0.100$), gender (28.1% vs. 24.1%) ($\chi^2(3, N=168)=0.42$, $p=0.935$), ethnicity (28.2% vs. 16.7%) ($\chi^2(3, N=168)=1.49$, $p=0.683$) or their sexual orientation (25.5% vs. 42.1%) ($\chi^2(3, N=168)=2.9$, $p=0.401$) and the likelihood of having ever received any form of support, advice or treatment from a service or organisation because of their experience of child sexual abuse.

59 White vs. Others.

60 Heterosexual vs. Others

H4: Demographic characteristics of victims and survivors of child sexual abuse and experiences of support services

There were no significant associations between age (mean 43.1 vs. 43.6 years) ($t(39)=-0.85$, $p=0.932$), gender (77.8% vs. 100.0%) ($\chi^2(1, N=41)=1.38$, $p=0.240$), ethnicity (79.5% vs. 100.0%) ($\chi^2(1, N=41)=0.51$, $p=0.475$) or sexual orientation (80.0% vs. 83.3%) ($\chi^2(1, N=41)=0.03$, $p=0.849$) and the likelihood of having experienced and rated at least one support service as either 'good' or 'very good'.

This was also true for associations between average (mean) overall service ratings (with scores ranging from 0 to 10) and age ($r=-0.114$, $p=0.450$), gender (5.2 vs. 6.0) ($t(44)=-0.65$, $p=0.520$), ethnicity (5.2 vs. 7.5) ($t(44)=-1.0$, $p=0.294$) and respondents' sexual orientation (5.2 vs. 5.6) ($t(44)=-0.31$, $p=0.758$).

H5: Demographic characteristics of victims and survivors of child sexual abuse and current unmet need for services

Those victims and survivors who reported having ongoing unmet needs linked to their experiences of child sexual abuse were significantly younger in age (mean 42.8 vs. 50.7 years) ($t(134)=2.3$, $p=0.001$) and less likely to identify as heterosexual (39.3% vs. 68.4%) ($\chi^2(3, N=164)=8.2$, $p=0.042$).⁶¹ By contrast, there were no statistically significant differences in levels of unmet need based on gender (45.6% vs. 28.6%) ($\chi^2(3, N=164)=3.08$, $p=0.379$) or ethnicity (41.2% vs. 63.6%) ($\chi^2(3, N=164)=2.2$, $p=0.529$).

H6: Type of child sexual abuse experienced and encountering barriers to accessing support services

There was a significant association between the type of child sexual abuse experienced and being unable to access support, or being prevented from doing so. Those respondents experiencing child sexual abuse within family (21.6%), institutional (25.0%), or both familial and institutional contexts (50.0%) were significantly more likely to report such barriers than those experiencing child sexual abuse in other settings (7.4%) ($\chi^2(6, N=168)=16.3$, $p=0.012$).

H7: Type of child sexual abuse experienced and access to support services

Victims and survivors who experienced child sexual abuse within the family setting were significantly more likely to report having accessed any form of support, advice or treatment as a consequence (40.5%), when compared with respondents abused in institutional (25.0%), both familial and institutional contexts (33.3%) and other settings (13.2%) ($\chi^2(9, N=168)=45.6$, $p=0.000$).

⁶¹ There were though no differences based on age ($r=-0.139$, $p=0.063$) or sexual orientation ($t(177)=-0.80$, $p=0.423$) in the number of services which respondents felt could potentially be useful to them now in response to the child sexual abuse they had experienced, but which they were currently unable to find or access.

H8: Type of child sexual abuse experienced and perceptions of support services

There was no apparent link between the type of child sexual abuse experienced and perceptions of support services, in terms of the likelihood of at least one form of support being rated as either 'good' or 'very good' by respondents (χ^2 (3, N=41)=1.4, $p=0.698$), it having helped them in the healing and recovery process either 'completely' or 'to some extent' (χ^2 (3, N=42)=4.3, $p=0.224$), or in the average (mean) overall service rating awarded ($F(3,46)=0.59$, $p=0.625$).

H9: Type of child sexual abuse experienced and current unmet need for services

There were no significant differences in levels of unmet need identified, based on whether the respondent reported experiencing child sexual abuse within a family (52.1%), institutional (45.0%), both familial and institutional environments (83.3%), or in some other setting (28.4%) (χ^2 (9, N=164)=14.4, $p=0.108$).

H10: Type of service accessed and experiences of support

Having accessed statutory-based forms of support was not found to be significantly associated with respondents' perceptions of services, in terms of the likelihood of at least one form of support being rated as either 'good' or 'very good' (78.4% vs. 100.0%) (χ^2 (1, N=41)=1.0, $p=0.300$), or with regard to it having helped in the healing and recovery process either 'completely' or 'to some extent' (84.2% vs. 100.0%) (χ^2 (1, N=42)=0.7, $p=0.391$).

A similar pattern emerged for those accessing voluntary sector-based services: this was not significantly associated with ratings of either 'good' or 'very good' (86.2% vs. 66.7%) (χ^2 (1, N=41)=2.0, $p=0.151$), being seen as helping the healing and recovery process (86.2% vs. 84.6%) (χ^2 (1, N=42)=0.01, $p=0.892$), or in the average (mean) overall service rating awarded by respondents (5.7 vs. 4.6) ($t(44)=1.1$, $p=0.246$).

Finally, this lack of association was also observed for private provision with regard to at least one form of this support being rated as either 'good' or 'very good' (92.9% vs. 74.1%) (χ^2 (1, N=41)=2.0, $p=0.150$), it having helped respondents in the healing and recovery process either 'completely' or 'to some extent' (100.0% vs. 78.6%) (χ^2 (1, N=42)=3.5, $p=0.061$), or in the average (mean) overall service rating awarded by them (5.5 vs. 5.2) ($t(44)=2.6$, $p=0.796$).

H11: Type of support accessed and perceptions of 'helpfulness'

Having accessed any justice-based services was not found to be associated with victims and survivors of child sexual abuse reporting that the support they had received had been helpful in the healing and recovery process – either 'completely' or 'to some extent' (75.0% vs. 90.0%) (χ^2 (1, N=42)=1.5, $p=0.209$). This was also true for healthcare services (83.3% vs. 87.5%) (χ^2 (1, N=42)=0.14, $p=0.703$).

H12: Decade services first accessed and experiences of support

Notwithstanding a general upward trend in the average (mean) overall service rating awarded by victims and survivors of child sexual abuse over time, these ratings were not found to be significantly different between those respondents first accessing services in the 1980s (3.7), 1990s (4.6), 2000s (6.3) and 2010s (5.8) ($F(3,46)=1.6$, $p=0.185$).



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