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Adults Recovering from Childhood Sexual Abuse: A Salutogenic Approach

By

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Abstract

There is a great deal of research into multiple aspects of childhood sexual abuse, including prevalence, effects, treatment and recovery. However, very little research focusses on the knowledge held by people who have experienced CSA, and far fewer studies are designed by people who have experienced it.

This thesis outlines insider designed and delivered research. It employs a salutogenic approach to examine what helps and hinders recovering. These issues are explored through thematic analysis of a qualitative survey (n=140) and 21 interviews. Participants described three types of harm caused by the abuse they had experienced, including physical and mental health consequences but also an underlying, enduring sense of danger.

The results demonstrate that adults who have experienced CSA are active in their recovering, which they conceptualise as a movement towards health and well-being, rather than a binary of either being ill or well. Health services were very useful, particularly counselling and therapy. Respondents also valued personal relationships and interactions in supporting recovering. Finally, they described a sense of flow, a pleasurable absorption in a task, as being highly beneficial.

However, they also described the ways in which society, at every level from micro to macro, inhibited recovering. Thus, they called for fundamental societal change, challenging destructive discourses around CSA and inhibiting structural issues. Further research is required to establish if these beneficial actions and challenges apply equally to individuals who identify as being in earlier stages of recovering.

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Chapter One - Introduction

My Experience

I grew up in the 1970s in a Midlands city beset by redundancies and factory closures. My Mum was a housewife and my Dad worked in a factory. I have two older sisters. My best friend lived in the house over the alley from mine. She had an older brother and later a younger sister. Her family life was troubled. Her father was violent and an alcoholic. I remember seeing him grab his son by the ear and smash his head into a wall.

In the hot summer of 1976, when I was 6, I was playing with my friend in her garden when her father carried me into the house, threatened to hurt my parents if I told anyone, and raped me. I remember this in a visceral way, feeling confused, humiliated, pain and terror, struggling to breathe, panicking, thinking I was going to die and then…pop...I went somewhere else. The rest is a blur. As the abuse continued, I got better at going elsewhere in my mind and could do this as soon as something abusive began. It protected me from having to experience it and was a way of running away, albeit internally.

I did not tell my parents because I was terrified, and I literally did not have the vocabulary to describe what was happening. I tried to manage the situation by only going to my friend's when I thought that he was absent. We played in her attic, with the ladder drawn up, to hide from him and had agreed an escape route if he came up, of running across the beams on the unboarded side of the attic floor. These plans did not work, of course, as I was using my 6-year-old cunning to avoid a grown man.

Because of the dissociation, I grew better at denying that it was happening. When the thoughts would come into my head, I would push them away, like a child thinking that if they close their eyes they cannot be seen. If I did not remember it then it was not happening. After the abuse ended and after many times of pushing the memories away, they faded to be replaced by 'unexplained' fears and nightmares. I had a recurrent nightmare, from about age 7, of being in a room with a man who was acting normally and then he would reach up to rip his face open. A monster with bulging eyes and many sharp teeth would emerge. I would wake up terrified. I never felt safe. I slept with a tiny penknife next to my bed.

Straight after the abuse, I became reluctant to wash and brush my hair. I felt unheard, invisible and tiny. I wanted to be bigger because bigger felt safer. I wanted to be a 'grown up' and be far away from the situation I was in. I used to watch the main road out of my town at night, watching the lights of the cars escaping and wished that I was with them.

Many things helped in my recovery. My escape was different worlds either created by others, in the form of books, films and TV, or my own worlds manifested through art or writing. I day-

dreamed a lot and would imagine a different, safer, better world. My body was the shell that carried me around, a utilitarian object that I cared for vaguely, but my mind was where the pleasure and wonder was.

I was uncomfortable in my gender because the message I received was that girls were weak and needed to be feminine to attract a man. I didn't want to be weak. I wanted to be strong – to be capable of protecting myself. As a teenager, I started dressing as a punk and felt the safest I ever felt in that armour. I found being attractive to every man, as the media suggested I should be, a terrifying prospect, as I knew some men were violent rapists.

Leaving home was a very positive thing for me. Out of the city where I was born and abused, my anxiety levels reduced. I felt safer. I went to University, loved higher education and made good close friends. After university, my memories started returning, which was extremely confusing. They were very specific in some ways: I can remember clothing, furniture, speech, feelings, what I was thinking and misunderstanding about what was happening. However, they were very unclear in other ways. For example, I have no idea when the abuse occurred, beyond a vague idea about it being summer. However, each memory contains a specific facet of spatial awareness. I always know where the door was.

I entered counselling and worked through these memories to the point where I felt I had to contact the police. I could not have the knowledge that I had without informing the authorities. Making a police report felt extremely empowering and the fact they took me seriously was very positive, although they said that as there were no other known victims they could not continue with a prosecution. It was also at this time that I told my family.

After these experiences of disclosure, I felt much better, as keeping his secret had been exhausting. I started to meditate and explored alternative spirituality, being particularly drawn to concepts of self-responsibility and power. The abuse I experienced then went backstage. I felt more in control of my life and safer in my world. I met my husband. I have found that being optimistic about the future has been very important in my recovering.

However, life events can revive both memories and emotions. Parenting meant that the memories of abuse returned to both haunt and inspire me. I was overwhelmed by how precious my children were to me and questioned how anyone could abuse a child. It was anathema to me. I felt an overwhelming urge to protect my children and this was my motivation in returning to academia. Thus, this research was inspired by my experience of childhood sexual abuse (CSA), not to gain therapeutic benefit for myself but to contribute to a fight to create a safer world for my own and for all children.

I have decided not to hide my experience but to be open about it. This is for two reasons. Firstly, because I believe that we are all influenced by our experiences and should be open about our social location relating to the research we carry out. This knowledge enables an accurate assessment of the research. Considering the common nature of CSA, it is extremely likely that some researchers into CSA have also experienced it or, even perpetrate it. Like mine, their experience is likely to have influenced the way they have approached their research topic.

The second factor motivating this openness is the desire to counter the silencing and shaming of people who have been abused. The lack of role models or people who are open about their experiences means that it is seen as rare or even argued not to be damaging. I have nothing to be ashamed of, so I refuse to be shamed into silence.

Although mine was an extreme human experience, it is not uncommon. A meta-analysis of research studies, with a sample of nearly 10 million people worldwide, identified an average prevalence rate of CSA of 18% for women and 8% for men (Stoltenborgh *et al.*, 2011). With a UK population of 63 million, these statistics translate into an estimate of 11.3 million women and girls and 5 million men and boys that have been or will be abused (Office for National Statistics *et al.* 2016).

We live within the human world that we study and if we deny this interconnectedness we create a false separation between researcher and researched (Jenkins, 2002). That is not to deny the power imbalance between the two, but simply to state that, as inherently empathetic beings, we feel emotions about the phenomena and people that we study. My experiences do not provide me with rigorous evidence about CSA but they have afforded me some insight or a standpoint from which to approach this research (Harding and Norberg, 2005). Each person who has experienced abuse is unique and the reason I have carried out this research was to explore the commonalities as well as the exceptions in the process of recovering.

Wider Context

Definitions

Child Sexual Abuse (CSA) has been identified as a social problem for many centuries. For example, the first recorded laws prohibiting incest with female children and the rape of virgins were written nearly four thousand years ago in Babylon (Harper, 1904). However, the definition of CSA has been in flux over the centuries because social constructions such as ‘childhood’, ‘rape’ and ‘sexuality’ have changed through time (Pollock and Maitland, 1898; Tannahill, 1980; Barret-Ducrocq, 1991; Saunders, 2001).

The age of consent for children, as well as the age of majority, has shifted through the centuries (Great Britain, 1885; Beresford, 2014). Before the Victorian era, the age of consent was generally set at the onset of puberty (between 10-12 years old). However, some children were engaged and married earlier, especially in the upper classes, although consummation of the marriage was normally postponed until puberty (Ingram, 1987; Lascaratos and Poulakou-Rebelakou, 2000; D'Angelo, 2007). Abuse of boys is less visible in the law and often conflated with homosexuality (Schofield, 1965; Alcoff and Gray, 1993).

The definition of what constitutes abuse is still under debate. Presently there are different forms of abuse identified: these include incest or familial abuse (Roth, 1978; Candib, 1999; Soothill and Francis, 2002), child sexual abuse (CSA) by non-family members, which can involve contact or no contact and child sexual exploitation (CSE) of children for financial gain (Jay, 2014; Bedford, 2015). Currently, there are debates concerning the inclusion of peer abuse (Wyatt *et al.*, 1986). The internet has also resulted in increased offences of viewing or creating child abuse images and video (Cohen-Almagor, 2013; Martin, 2016), as well as webcam pornography (Açar, 2016, 2017), and the use of the internet to arrange face-to-face abuse (Cohen-Almagor, 2013). There is legal CSA in some parts of the world, in the form of child marriage, with an average of 40,000 girls married every day (Wodon, 2016). Therefore, the changing definitions of CSA are affected by cultural difference and change, individual stance, religion, law and in the case of online abuse, technological advances.

Euser *et al*. (2013) suggested a definition of CSA as 'every form of sexual interaction with a child between 0 and 17 years of age against the will of the child or without the possibility for the child to refuse the interaction' (p.221) however this is negated by Finklehor's (1979) argument that a child cannot give informed consent. For the purpose of this research, the research participants have identified for themselves what they define and, more importantly, experienced as childhood sexual abuse.

Political Context

Within both UK and international arenas, a number of high profile cases have heightened public consciousness of CSA and contributed to an unprecedented increase in the number of reported cases of historical abuse (Harker *et al.*, 2015). There has been a significant legal and governmental response to this growth in disclosure, with formal enquiries into a number of high profile cases (Jay, 2014; Lampard and Marsden, 2015). The Children's Commissioner (Longfield, 2015) has gone as far to state that current estimates of CSA incidence could be the 'tip of iceberg', and the Independent Inquiry into Child Sexual Abuse (IICSA) was established to address growing dissatisfaction with the way in which institutions in England

and Wales 'discharged their duty of care to protect children against sexual abuse' (Goddard 2015, p.3).

However, in the context of wide-ranging cuts to public expenditure in the third sector, many support-organisations have found themselves unable to cope with growing demand at a time of decreased funding. Rape Crisis estimate 100,000 more survivors have required support following the Independent Inquiry into Child Sexual Abuse (Sandhu, 2015). The Irish charity 1-in-4 reported that they saw an increase in suicides when lack of funding meant they had to close their service for a few months (Carty, 2015). Thus, there is a critical juxtaposition between the growing realisation of the problem and the contraction of available support networks.

The response to these emergent issues within the academic literature has also been slow and there is a dearth of contemporary sociological literature that examines these tensions, with respect to both the long-term outcomes of CSA generally, and the processes by which recovery is constructed by survivors specifically. For example, Whittier (2016) commented that whilst there is some limited research into the experiences of people who survive adult sexual assault, there are very few articles about CSA in the major sociological journals.

There is, of course, academic research in other disciplines, and this is explored in the next chapter. However, much of this focus has centred upon people near the start of recovery or on cases that have had devastating consequences. Indeed, Sarah Champion, MP and Chair of the All-Party Parliamentary Group (APPG) for Adult Survivors of Childhood Sexual Abuse, has emphasised that much of the current work on CSA 'looks primarily at survivors only very shortly after their abuse. It would be very useful to have more information on older survivors' (S. Champion MP, personal correspondence, 27th January 2016). Bagley and Thurston (1996) similarly point out that it is also 'important to remember that not all victims have adult outcomes as serious as the survivors described in the research summaries' (p.219) and instead go on to lead fruitful lives. In spite of the media-driven tendency to represent such individuals as 'victims' who are essentially 'damaged' with little hope of moving beyond the stigma of CSA (see Ungar 2011; Teicher *et al.* 2012), many people do find ways to process their memories and are 'far from defeated by childhood trauma' (Sandford 1990, p.xi).

This PhD has already attracted the attention of national policy makers. Tom Healey of the House of Commons Library has stated his interest in reading and disseminating the research. Tom Watson, until recently Deputy Leader of the Labour Party, has also stated 'there is little doubt more research into this area is needed' (T. Watson MP, personal correspondence, 19th August 2015). Sarah Champion, MP has similarly commented that 'I believe this research could better inform and target the right kind of support for survivors and would be very

interested to read your research' (S. Champion MP, personal correspondence, 27th January 2016). Thus, there is an identified need for this research that is acknowledged within Parliament.

Very little is known about how individual survivors respond to the stigma of CSA, including how they negotiate the social identities of 'victim' and 'survivor.' As Egeland *et al.* (1993) states, understanding how people withstand trauma could be the key to developing effective treatment strategies. Yet no studies have examined how people empower themselves as active agents in their own recovery.

Furthermore, there is a clear need for insider research, as the present research risks infantilising them, perpetuating the view that people who have experienced CSA are inherently vulnerable and without agency or the capacity to improve their own health and well-being (Downes, Kelly and Westmarland, 2014). It is my fundamental belief in the strengths and capabilities of the participants themselves, their ability to change, adapt and discover their own solutions, that underpins this research.

Therefore, the research objective is to learn from and amplify the lived experience of adults who have experienced CSA. Through the adoption of an holistic approach to health and well-being, the thesis explains how I sought to understand and explore the narratives of adult survivors of CSA, as well as how they negotiated their identity. It outlines the need for an individualistic, trauma-focussed and social model of recovering from CSA

Thesis Layout

The thesis has a nine-chapter structure. This chapter describes my experience and illustrates that victims of abuse are not preserved in aspic following the crime. They develop, evolve and attempt to move forwards. However, for me, that forward movement was not linear as, like grief, events can occur which set one back. CSA itself, as a socially defined concept, is also constantly shifting, both culturally and technologically. Furthermore, the support landscape around CSA is constrained by the effects of austerity at a time when more people are reporting the crime.

The next chapter examines the literature around CSA. It begins by examining and elucidating the main discourses around CSA before considering if those discourses have affected societal and institutional responses to victims of CSA. Following on from this, the methodological chapter will outline the salutogenic theoretical approach and why this was chosen as the appropriate basis for the research. There is also a discussion around insider research and why it has clear benefits in areas where the sample population fear stigmatisation. Finally, I explore how the salutogenic approach was put into practice during data collection and analysis, including an examination of ethical behaviour within the research process.

There are five chapter exploring the results. Firstly, there is a chapter examining how the sample population match or differ from previous research samples. It will argue that there are types of CSA that are currently underestimated, particularly, but by no means exclusively, the organised sexual exploitation of children and the abuse of children by women and/or other children. The next four chapters examine the qualitative data in depth, specifically the areas of identity, relationships and embodiment. However, it should be noted that these subjects interrelate and co-exist, influencing and altering each other.

In the identity chapter, it will be demonstrated that people who have experienced CSA define their identity internally, in reaction to discourses around CSA and gender constructs. The following chapter outlines the effects of societal discourses upon people who have experienced CSA, as well as the people around them, negatively affecting their ability to recover. It demonstrates the similarities between those societal reactions and perpetrators' manipulation of victims. In contrast to this, the following chapter explores how social connections can, if they are supportive, significantly contribute to well-being and happiness. The final data chapter ties together these ideas of identity and connection into an embodied recovery.

These overriding themes are explored in a combined discussion and conclusion which argues for a social model of recovering. It argues that the present dominant discourses and reactions to disclosure of CSA are in themselves harmful, creating significant barriers to recovering. Finally, I highlight my contribution to the field and elucidate the potential for further research emerging from this data.

Chapter Two - Literature Review

This chapter explores the academic landscape around recovery for adults who have experienced CSA. It demonstrates that the current literature is limited in terms of examining the way in which discourses around CSA affect recovery. There is also a paucity of literature exploring how recovery is defined by people who have experienced CSA, particularly those who are not currently accessing mental health services. Research has indicated the significance of the social context of CSA within recovery, but this topic is little explored. Finally, there are preconceptions about adults who have experienced CSA within the medical and research community that influence how patients are treated.

Literature was found through a systemic search using appropriate key words i.e. for general research around CSA, the terms 'child' and 'sex*' and 'abuse' or 'molest*' or 'rape' or 'paedophil*' were used. For each specific subject, terms were then added to that search to narrow down the results i.e. 'perpetrators' or 'offenders.' Results were ranked by citation and I read the ten highest-ranked articles in each category. I also took the top 5 cited articles, about any aspect of CSA, from each decade from 1900 to understand the development of CSA research over time. From there a hand search resulted in the addition of frequently mentioned literature in those articles as well as key articles that addressed significant points.

The structure of the chapter is as follows. I will briefly address some of the changing discourses around CSA. The most relevant to recovery are the denial and minimising of abuse; conceptualisations of perpetrators and victims; debates around memory; ACEs and moral panics. This chapter will argue that CSA is defined within its social, cultural and temporal context. As a cultural construct, it not only changes through time and culture but also, in turn, influences the society in which that construct dwells. I also begin to elucidate how these discourses might influence recovering, which is a topic explored further in the data chapters.

The main body of this review will not concentrate on the abusive act or the perpetrator but the abused individual and their subsequent experiences. Thus, the research landscape around recovering from CSA will be explored, commencing with an examination of the importance of disclosure and, following on from that, debates around appropriate treatment. Conceptualisations of recovery are explored, including recovery, resilience, posttraumatic growth and well-being. Finally, there is a discussion of the discourses and themes arising from this review, followed by an identification of the gaps in current research.

Discourses

Discourses are social practices through which phenomena are not merely described but are imbued with meaning and, sometimes, created (Foucault, 1989). Foucault (1980) argued that all discourses are not privileged in the same way within society. Instead, he asserts that dominant discourses are utilised by the powerful to govern social groups and maintain their power. Thus, the dominant discourses have power and impact. As a social phenomenon, CSA is a subject of discourse. In a report commissioned by the Independent Inquiry into Child Sexual Abuse (IICSA), Lovett, Coy and Kelly (2018) examined the dominant discourses relating to CSA. They divided these into discourses of deflection, denial and disbelief, all of which are taken as truths. These are delivered by perpetrators, individuals and institutions.

They also identified two counter-discourses which are not privileged in society to the same extent. The first of these explores the role of power in CSA, such as patriarchy or institutional dominance. The second involves creating spaces where CSA disclosure is believed (Lovett, Coy and Kelly, 2018). Finally, they assert that these discourses have all fundamentally influenced institutional responses to the issue of CSA. Thus, they tie these discourses and their influence directly into the development of support for those recovering from CSA.

The next sections will examine six discourses around CSA that affect recovery and create a picture of these influential concepts. It starts with a discussion looking at the enduring denial of CSA and the harm it causes. This is followed by an examination of research around perpetrators, including theories of causation. There is then a brief exploration of the changing concepts of the victim and the influential debate around recovered memories. The Adverse Childhood Experiences (ACEs) approach is then explored as an emerging discourse that reflects an ancient message. Finally, this section examines the concept of moral panics and concludes by outlining the major discourses revealed by this review.

Denial and Minimising

There has been a cultural reluctance to acknowledge or address the issue or extent of CSA, influenced by both politics and psychiatry (Anon, 1885b, 1885a; Freud, 1953; Masson, 1984). This culture of denial impacts adults who report CSA, particularly those who name prominent people as perpetrators. For example, the Saville reports highlight the way in which victims were ignored or dismissed because of his high status in society (Lampard and Marsden, 2015; Smith, 2016). This is reinforced by the argument that even if abuse does occur, it is not harmful to the child. For example, in the 1960s Schofield (1965) argued that 'isolated events are unlikely to have a profound effect on a child and he would soon forget about sexual interferences if it were not for the significance given to it by parental concern and legal

proceedings' (p.12). Kinsey *et al.* (1948, 1953) also concluded that a negative reaction to CSA was culturally created, and they described the fear of sex offenders as 'hysteria.'

Similarly, concepts such as social constructionism can be utilised to deny or minimise the harmful effects upon children by asserting that harm is caused by the response, not the act itself. As an example, Rind and Yuill (2012) argue that adult male interest in children between 11-14 (hebephilia) has a long history, providing examples of older men marrying younger girls in other cultures and historical eras. They assert that the identification of hebephilia as a disorder is a cultural construct and any evidence that abuse is harmful is 'flawed' as well as being politically motivated. Our 'sharply negative attitudes about immature sexuality' contribute, amongst other factors, to 'perceived harm' (Rind and Yuill, 2012, p.819). Thus, their argument employs social constructionism to argue that our current belief that CSA is harmful is merely an historical aberration.

To reify such denial of the negative effects of abuse, some academics have recommended changing the terminology utilised to describe CSA. For example, Rind *et al.* (1998) suggested 'adult-child sex' to replace 'child sexual abuse' thus erasing any acknowledgement of harm. Ken Plummer (1991) used the term 'intergenerational sexualities' to illustrate his argument that children are sexual beings, actively developing a 'sexual script' through sex with adults. This assumes, without any empirical evidence, that children want such contact. Denial of harm is also commonly utilised by perpetrators, as Finkelhor observes (1979). Indeed, such academic arguments are utilised by perpetrators to justify their actions and, as such, are ethically questionable (Pilgrim, 2018). Thus, denial of CSA or the harm it causes is an enduring discourse that benefits perpetrators, enabling them to justify the abuse they carry out. It also encourages wider society to turn a blind eye to CSA.

The Perpetrator

Until relatively recently, perpetrators were conceptualised as strangers, rather than members of the family and community (Finkelhor, 1980; Russell, 1983; Finkelhor *et al.*, 1990). Child sexual abuse was initially thought to be caused by the perpetrator's lack of access to sex with adults (Schofield, 1965). In the 1970s, CSA was located within the family and was seen as an expression of patriarchal dominance and power (Brownmiller, 1975; Whittier, 2016). This concept means that perpetration is firmly rooted in masculinity (Brownmiller, 1975). Other theorists have suggested that abuse is also caused by a desire for power or as the expression of anger, which deletes the sexual aspect completely (Groth and Burgess, 1977; Groth and Birnbaum, 1978).

More recently, ethnicity has re-entered the debate around CSA and, more specifically, CSE. Offences in Rotherham and other cities has led to a discourse of Asian men abusing white girls (Jay, 2014), which has been exploited by far right organisations (Britton, 2019). All these discourses have affected conceptualisations of CSA and CSE. For example, there is a reluctance to accept that most abuse is perpetrated by family members or acquaintances. There is also a history of ignoring of female offenders or minimising their complicity (see Groth and Birnbaum, 1978; Abel *et al.*, 1987; Gilgun and Connor, 1989; Robinson, 1998).

From the 1990s onwards, the focus of research has been on the 'cycle of abuse': the theory that victims of CSA become offenders (Haywood *et al.*, 1996). This asserts that childhood abuse is a model for the victims' behaviour in adulthood (Haywood *et al.*, 1996). However, the evidence does not appear to support this theory. For example, an adult follow-up study of 908 child neglect and abuse cases found no greater rate of perpetration of child sexual abuse in CSA victims than in the population at large (Widom and Ames, 1994). Furthermore, Glasser *et al.* (2001) observe that if the majority of abused children are female then one would expect the majority of abusers to be female, which does not appear to be the case (see Finkelhor 1994; Bourke *et al.* 2014; Finkelhor *et al.* 2014; Gorey & Lesley 2016). The 'cycle of abuse' theory is predicated upon the supposition that the experiences of childhood have a direct relationship to the actions of adults, which negates the ability of individuals to learn from or indeed reject their history (Edward *et al.*, 2017). This does not preclude the fact that some perpetrators will have experienced abuse but there is little proof that abuse creates abusers on a significant scale. However, this unproven theory affects adults who have experienced abuse, particularly men, who are more likely to be labelled as potential offenders (Glasser *et al.*, 2001).

The Victim

Attitudes towards victims have changed somewhat in the past few centuries, from children being seen as consenting or even instigating abuse, to an acknowledgement that children cannot give informed consent (Savage, 1881; Bender and Blau, 1937; Kinsey, Pomeroy and Martin, 1948, 1953; Finkelhor, 1979). However, the concept of the complicit child remains culturally vital. Recently, it has been applied specifically to older children and boys. For example, it clearly influenced the poor response to more recent CSE incidents (Jay, 2014; Bedford, 2015). The Jay (2014) report includes a child described by a police officer as '100% consensual in every incident' (p.38) and a different child assessed by social services as 'placing herself at risk of sexual exploitation and danger' (p.39). Such judgements of the child's actions inhibited an effective response to their exploitation. Furthermore, children have been rejected for criminal injury compensation on the grounds that they consented to the abuse

(Bowcott and Rawlinson, 2017). Thus, there is an ongoing and damaging discourse that children can be complicit in the abuse they endure.

Lerner and Miller (1978) proposed the 'Just World Hypothesis', which is a belief that people get what they deserve in life. They argue that people need to believe this in order to feel safe and secure in an unpredictable world: if they follow 'the rules', they will be safe. This belief can then be used to explain why others suffer misfortunes: because they broke the rules. In general, children are socialised to believe that if they are good then they will be rewarded (Rubin and Peplau, 1975). Victim blaming is an essential component of this world-view because it reassures an individual that they will be safe if they follow 'the rules' (Hockett *et al.*, 2016).

Idisis and Edoute (2017) explored attitudes using examples of adult and child rape victims. They found evidence of victim blaming, to a greater or lesser degree in all of the 88 people they interviewed including 58 therapists in the sample. Virgins were rated as less blameworthy than sexually active people but, in all cases, victims were judged according to whether they physically fought the attacker. Maintaining a belief in the victim's complicity is important, as it reassures the individual that the world is safe, and that victims only become victims through their own actions or inactions (Lerner and Miller, 1978). In contrast, Cialdini *et al.* (1976) found victim blaming increased when the individual felt in some way complicit in the victim's suffering. They hypothesised that this was a way to minimise guilt.

The 'Just World hypothesis' is also internalised and influences victims of abuse. Janoff-Bulman (1979) found evidence for rape victims blaming themselves for behaviour which they perceived as contributing to their victimisation. She argued that this was an attempt to make the danger more controllable: if they could understand and change their behaviour then they could make themselves safer. Thus, victim blaming influences both society in general and also the victims themselves.

Victims are also conceptualised as female, with the imagined few male victims of CSA assumed to be willing participants (Kemi Badenoch, 2015). However, in 2016 the UK Crown Prosecution Service reported that 25% of the 10,000 victims of CSA, where gender was recorded, were male (Crown Prosecution Service, 2016). Thus, there is a significant population of boys being abused. Therefore, the construct of victim can result in some abuse being ignored or minimised as well as being subject to increased victim blaming. This affects responses to disclosure as well as how the victim recovers.

Memory Wars

Memories are not, usually, eidetic. They may not be complete recollections of any events but partial vignettes subject to interpretation and later re-interpretation (Saunders, 2014). As abuse can occur at a young age and/or be extremely traumatic a child's or adult's recollection of CSA is particularly subject to debate. Memories of abuse can be fragmented and over time fade. Such memories can then re-emerge later in the individual's life. Recovered memories are not a new phenomenon. They were the basis of Freud's seduction theory, where he concluded that his patients had been abused as children by adult men, often their father (Freud, 1953). However, after a negative reaction to this theory and its implications regarding the extent of CSA, Freud abandoned the theory and concluded that the stories were fantasies (Masson, 1984).

In the later 20th century there was a growth in adults reporting CSA to the police and claiming they had recovered memories (Scheflin and Brown, 1996). One common criminal defence was the idea of false or implanted memories, which then developed into an influential discourse. The concept was first proposed by Peter Freyd, a mathematician, himself accused of CSA by his daughter (Rydberg, 2017). False memories of CSA are often asserted to be created by the individual at the prompting of a therapist (Loftus and Pickrell, 1995)

The most significant proponent of this theory is Loftus (1993), a psychologist, whose research has been used in many criminal cases, including the Cosby trial (Rydberg, 2017). In their most cited research, Loftus and Pickrell (1995) carried out a study with 24 participants where they were given a booklet reporting four memories gathered from an older relative. One memory, of being lost in a shopping mall, which was untrue, had been developed using information gathered from the relative regarding shopping habits etc. After reading the booklet, 6 participants were reported to have claimed that they did remember the manufactured event. This was concluded to be proof that memories can be 'altered by suggestion' (Loftus and Pickrell, 1995, p.725).

However, Loftus has been dogged by claims of unethical research. Regarding the 'lost in the mall' case, she later admitted disregarding and not publishing a first iteration of the research which failed (Blizard and Shaw, 2019). Blizard and Shaw (2019) also point out that there was no transcript of the interviews, thus no way to repeat or validate the research, and even their own data rated the 'false' memories as far less detailed than the subjects' real memories.

Furthermore, there are differences between a mildly upsetting childhood incident and trauma. CSA, as a traumatic event, is known to cause dissociation, which then affects memory (Malmo and Laidlaw, 2010). It is much more likely in children (Kolb, 1987). There is also extensive

evidence that repressed memories are possible. Williams (1994) interviewed 129 women with previous documented experience of CSA and found that 38% did not remember them. In a recent Australian case, a perpetrator who had been convicted of assaulting multiple victims, confessed to abusing a boy. The victim, now an adult, did not remember, although he did have symptoms of trauma (Rydberg, 2017). Two individuals who Loftus described as 'proving' false memories later achieved convictions for the abuse they experienced (Brand and McEwen, 2016). Repressed memories have been demonstrated to be just as accurate as other trauma memories (Scheflin and Brown, 1996). There is also evidence that they can occur spontaneously as well as in a therapist's office (MacIntosh, Fletcher and Collin-Vézina, 2016).

Thus, whilst the concept of memory recall as a curated event seems evident, there is a large leap between there and the implantation of false trauma memories. However, the idea of false memory syndrome, even though it was proposed by a man accused of CSA, is still under debate within the academic and medical community as well as wider society. In general, the pendulum has swung from disbelief of memories in the 1990s towards greater acceptance (Rydberg, 2017). However, this enduring discourse continues to affect reactions to disclosure and individuals' confidence in their own memories.

Adverse Childhood Experiences (ACEs)

As raised in the perpetrator's section above the victim's childhood experiences are viewed as a model for later adult behaviour. One recent example of this concerns the family environment and how this affects the child's outcomes in adulthood. 'Adverse childhood experiences' (ACEs) include home environment factors such as mental illness, domestic violence, substance abuse in the home, divorce or a parent in prison, as well as physical, emotional or sexual abuse of the child.

The original study in this area reported a 4- to 12-fold increase in the risk of alcoholism, drug abuse, suicide attempts and depression in adults who reported four or more ACEs (Felitti *et al.*, 1998). Experiencing ACEs has also been linked to poorer economic and educational outcomes (Metzler *et al.*, 2016). This evidence has been utilised to screen adults and children for ACEs with the aim of preventing later illnesses and effects (Finkelhor, 2018). It is also used to identify a child's risks of further ACEs (Edward *et al.* 2017).

There is indeed evidence that an unhappy family situation can create the opportunity for abuse to occur and also influence the individual's later health or well-being (Finkelhor, 1980). However, critics argue that many factors determine the effects of abuse and ACEs do not necessarily lead to trauma symptoms that require treatment (Lalor and Mcelvaney, 2010; Finkelhor, 2018). Furthermore, Edward et al (2017) point out that there is 'little reason to think

that seeing oneself as determined by past experiences is at all helpful in finding a way out of current difficulties' (p.6).

Thus, the ACEs discourse can be accused of being too deterministic and not helpful to those recovering from CSA. Gupta *et al.* (2016) argue that a strength-based approach may be more effective. Such an approach builds upon the strength in and around the individual alongside an acknowledgement of the structural influences upon them. Although the ACEs approach is relatively new, the concept of CSA ruining a child's life, permanently and irreversibly, is old and enduring (Anon, 1680; Stead, 1885; Lascaratos and Poulakou-Rebelakou, 2000). As a discourse, it continues to influence responses to disclosure.

Moral Panics

The term 'moral panic' was developed by Cohen (2011), who defines it as a social problem that the media and others define as a threat to society and exaggerate beyond the size of the issue itself so that the perpetrators or participants become 'folk devils'. It was developed in response to debates around youth cultures, such as Mods and Rockers (Cohen, 2011). Frequently, responses to CSA have been characterised as moral panics (see Scott 1998; Soothill & Francis 2002; Cree *et al.* 2014; Piper 2014; Jewkes & Wykes 2012). Altheide (2009) argues that the accusation of moral panic is used in the media and popular discourse to discourage what is perceived to be an over-reaction.

Moral panic, as a term, is an accusation utilised by academics who argue against the idea that CSA is harmful (see Plummer 1991; Kincaid 1998; Haaken & Lamb 2000; Angelides 2004). For example, Angelides (2004) asserts that concerns over CSA and, indeed, its labelling as abuse was created by 'the child protection lobby and feminism' (p.141). This has created a panic that, he argues, is not justified and denies 'child sexuality'. Campaigning paedophile groups also frequently use the term moral panic (Pilgrim, 2018). Altheide (2009) also argues that moral panic can be utilised to avoid both personal and institutional criticism or scrutiny. This may be an additional motivation in these cases.

Therefore, the term moral panic has expanded beyond its original definition to become a political tool. There are, however, individual examples of CSA where the term may be correctly applied, such as the media coverage and societal responses of 'ritual abuse' in day care settings in the 1980s. In an analysis of these cases, De Young (2008) claims that the 'sexual threat to children posed by satanic day care providers was wholly illusory' (p.1721). However, there is complexity even in such cases. Cheit (2014) argues that there were cases within this furore where there were clear evidence of abuse. Even some of the more bizarre aspects, such as children describing masks were found to be accurate (Faller, 2017). However, the

conclusion that this abuse was ritual or satanic does appear to have been created or conflated by moral entrepreneurs and media sources. Thus, even in cases where there was clearly a media furore, a fundamental sign of a moral panic, there may still be some basis in fact.

There is clear evidence that the loaded term 'moral panic' is often is wrongly applied to CSA in general. As stated, Cohen's definition of moral panic lists media exaggeration as an important factor, however, CSA prevalence research suggests that it is underestimated not exaggerated (Pilgrim 2018). There is strong evidence that there is widespread perpetration of CSA (see Finkelhor, 1993, 1994; Stoltenborgh *et al.*, 2011; Ji, Finkelhor and Dunne, 2013; Pereda, Abad and Guilera, 2016). Bray (2009) asserts that the term moral panic can be used to dismiss and silence legitimate concerns, and this argument could be applied in the case of CSA in general.

Moral panic is a concept that is clearly defined by Cohen and he himself warns that it is misapplied to social issues that are not exaggerated (Cohen, 2011). It is also a discourse and, as such, is a means to deny the extent or harmful effects of societal issues including CSA (Pilgrim, 2018). This discourse affects people who have experienced CSA, because their disclosures are less likely to be believed, particularly if they contain any aspects redolent of specific media-created moral panics. Thus, whilst moral panics are a valid concept, they are also a political tool, used to defend paedophilia, silence concerns and minimise debate.

The Power of Discourse

Discourses around CSA are multiple and intertwined. Each specific discourse combines with the others to create the constructions of perpetrator, victim, effects and consequences. Ultimately, those discourses influence, create and are, in return, shaped by the social issue of CSA. Within these discourses, perpetrators are pushed conceptually to the edges of society, becoming the permanent stranger, rather than a loved one. The idea of the cycle of abuse predicts that the victims will be guilty of later perpetration. ACEs further create a cursed atmosphere around the abused child, doomed to never escape from the effects of early experiences. Even disclosure itself is brought into question by the concept of false memory syndrome. Concepts such as moral panics and social constructionism are further utilised to deny or minimise CSA. Behind all this is an unwillingness to acknowledge and consequently take effective action to prevent CSA. Furthermore, attitudes towards CSA reflect patriarchal attitudes towards gender: women are prone to delusions and cannot be abusers unless compelled. Men cannot be denied sex without negative consequences. There is a dearth of literature examining the effects of these discourses beyond the highly politicised moral panic approach. However, these discourses and debates have tangible effects. The next sections

will evaluate the consequences to the victims of CSA of what can be mere moments in their lives.

The Aftermath

The sections above have examined discourses regarding the abusive act of CSA. It is clear that the environment around the victim of abuse is redolent with these discourses, and it is impossible for them to be unaware of them. It is also unlikely that they, their families and the professionals treating them will be unaffected by those underlying messages. This section begins by discussing the consequences of disclosure, followed by the effects of abuse. It outlines the evidence for the harm caused, before moving on to discuss how the individual attempts to recover by disclosing the abuse, accessing treatment and trying to be happy.

Disclosure

A key part of coping with trauma involves the process of disclosure, which is defined here as the act of informing others about the experience of CSA (Allnock and Miller, 2013). Disclosure is a lifelong and repeating event, with willingness to disclose further being influenced by the response from the listener (Reitsema and Grietens, 2015). Therefore, each interpersonal interaction around CSA disclosure is vital in the significant impact it has upon the individual (Lamb, 1994).

Smith *et al.* (2015) suggests that disclosure usually first occurs when the individual is in their 20s, but this is contradicted by other research which finds that half of those who had experienced CSA had disclosed their abuse at the time (Kelly *et al.*, 1991). The reason for the disparity in these results could be a lack of response to that disclosure. For example, Allnock and Miller (2013) report that 42% of the disclosures their participants made as children were not acted upon. Palmer *et al.* (1999) had a similar result in their study of childhood reports of physical and/or sexual abuse. In 384 cases of disclosure to professionals, only 12% were acted upon. The first time disclosures are *heard* may well be when the individual is in their 20s, but this may not be the first time the disclosure has been made. However, Wattam and Woodward (1996) found 13% of adults taking part in their study reported that they had never told anyone before.

There are many reasons why people do not disclose, both at the time of abuse and later. Perpetrators threaten severe consequences if abuse is disclosed and leave children fearing the resulting effect upon their family (Ussher and Dewberry, 1995; Lovett, 2004). There is, in actuality, significant potential for harm in disclosing abuse, as the child or adult may be disbelieved, blamed or rejected or even put in physical danger (Summit, 1983; Herman, 2003).

For example, child and total family homicides have been perpetrated to cover up or prevent exposure of CSA (Alder and Polk, 1996).

The family is also an emotive arena for disclosure. Hershkowitz *et al.* (2007) found that half of the 30 children they interviewed feared their parents' reaction to disclosure and, further, that this fear was indeed justified, as some parents did blame the children or react angrily. Although this was a small-scale study, there is further evidence to support these findings. For example, in one study of 384 adults, 39% of mothers disbelieved their child when they disclosed any type of familial abuse, and in only 26% of cases did the abuse end after disclosure (Palmer *et al.*, 1999). In a synthesis of previous literature, Lovett (2004) identified that the maternal response to disclosure is vital. A protective and supportive response is important for recovery but, seemingly, rare. This may be because abuse revelations are described as 'shattering' for the mother, whose protective response may be inhibited when the abuser is a family member (Lovett 2004). Therefore, parental reactions are often not supportive.

There are also cultural, religious and gendered influences on disclosure. For example, disclosure may be inhibited by norms regarding modesty, fear of retributional violence and shame around the loss of virginity (Fontes and Plummer, 2010). Another factor is gender, with lower rates of disclosure in males both at the time of the abuse and subsequently (Easton, 2013). Gender also affects responses to disclosure, as professionals may feel ill equipped to treat men who have experienced abuse (Easton, 2013). Furthermore, there are gendered themes in the way disclosure is responded to and, specifically, minimised. Alcoff and Gray (1993) argue that women are labelled as hysterical or having a victim personality, men are silenced through fears of homophobia and subsequent loss of masculine status. Thus, the response to disclosure as well as the conceptualisation of the victim are influenced by culture and gender.

Smith, Dogaru and Ellis (2015) surveyed adults who had experienced CSA and highlighted the importance of support services responding positively to disclosure because a poor response in therapy would inhibit individuals from trying to access services again. Livesey (2002) found evidence to suggest 60% of disclosure incidents (of 80 incidents in total) were met with a negative response, with 25% of those being verbally abusive, including responses from professionals. It is theorised that being disbelieved, minimised or rejected after disclosure can increase feelings of powerlessness and subsequent negative effects (Finkelhor and Browne, 1985).

Clearly, the response to disclosure, each and every time that happens, is crucial. However, it is often not a positive experience, and this includes responses from those more emotionally

involved, such as family members, as well as, theoretically more emotionally detached, professionals. Therefore, there are many inhibitions placed upon disclosing CSA and reacting to that disclosure. Many are dependent on culture, religion and gender, as well as the recipient's relationship to the victim. Overlying, creating and influencing these intersections are the prevalent discourses outlined above.

Effects of Childhood Sexual Abuse

The next sections examine the effects of abuse, which may be visible to the people around those who experienced it. Indeed, there is some overlap between this section and the previous one, as some effects and coping mechanisms can be viewed as, in themselves, wordless attempts at disclosure (Felitti *et al.*, 2010). This will be explored further below and in the data chapters. There has been a great deal of research into the effects of CSA, including the physical and mental health effects of abuse, as well as what are judgementally termed 'risky' coping behaviours. Where the effects of CSA are concerned, there are also underlying discourses and judgement inherent within them. These are explored in the next sections.

Mental Health

CSA may be particularly destructive to a child's mental health. Lebowitz *et al.* (1993) argue that a child has not had time to establish positive schemas of the self. Herman (1992b) expands upon this:

> *'The child trapped in an abusive environment is faced with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness. Unable to care for or protect herself, she must compensate for the failures of adult care and protection with the only means at her disposal, an immature system of psychological defences.*' (p.70)

In short, an adult has had time to develop defences against trauma, but a child has not.

Oz (2005) theorised that the family has a shared reality separate from the outside world. Abuse creates a 'world of trauma' that the child enters and this separates them emotionally from their family. If the abuser *is* a family member then the child creates a conceptual split between the loving family member and the monster. The child wants to keep the family member and lose the monster. Within the 'world of trauma', the child is faced with extreme emotions, such as pain, terror and rage, which are too intense to bear, so the child dissociates to survive. This results in feeling cut off from the familial shared reality by what Oz terms the 'wall of fear' and

can lead to memory loss. However, feelings from the 'world of trauma' continue to leak into the shared reality (Oz, 2005).

Finkelhor and Browne (1985) suggested that the betrayal inherent in abuse initially leads to 'grave disenchantment and disillusionment' (p.535). This progresses to the child developing a sense of powerlessness which results in fear, anxiety and nightmares (Finkelhor and Browne, 1985). A potential lack of action when a child discloses may well compound such emotions and effects. Without treatment and support, these feelings can negatively affect mental health in both the short and long term, leading to a raised incidence of mood and anxiety disorders (Heim *et al.*, 2010).

Although they often occur concurrently, research suggests that there are differences in the long-term effects of physical and sexual abuse. For example, people who had experienced CSA have higher rates of depression, eating disorders, anxiety and suicide attempts compared to people who had experienced physical abuse as a child (McCauley *et al.*, 1997). In contrast, a study that compared twins, one of whom had experienced CSA and one who had not, found there was no difference in the rates of mental health issues between them (Dinwiddie *et al.*, 2000). This suggests that a discordant family also creates potential mental health issues (Dinwiddie *et al.*, 2000). Thus, whilst mental health is clearly impacted by CSA, to a greater or lesser extent, the child's familial environment is also very important. As such, their environment and experiences need to be assessed in their entirety.

Physical Health

There is the potential for physical health impacts from CSA. As an immediate effect, there is a risk of venereal diseases, such as genital herpes (Reading *et al.*, 2011). There is also, for older children, a risk of pregnancy. Indeed, one study found that 44% of 535 pregnant adolescent girls had been raped (Boyer and Fine, 1992). As stated in the previous section, CSA can occur in adjunct with other types of violence. For example, there is also an increased risk of parental violence as a child and of intimate partner violence in adulthood (Boyer and Fine, 1992; Cohen *et al.*, 2000; Coid *et al.*, 2001). There is a connection between child murder and the threat of exposing CSA, as demonstrated in the recent murder of 13-year-old Lucy McHugh (Morris, 2019). Furthermore, it appears that experiencing CSA is associated with a higher risk of rape in adulthood (Coid *et al.*, 2001). Thus, there are apparent connections between CSA and other types of physical or emotional abuse.

Furthermore, childhood stress is linked to poor physical health in adulthood (Shields *et al.*, 2019). It is theorised that CSA, alongside other ACEs, raises long term threat awareness which changes endocrine and autonomic functions (Miller, Chen and Parker, 2011). This leads

to a susceptibility to long-term inflammation and consequent auto-immune conditions (Miller, Chen and Parker, 2011). For example, Dube *et al.* (2009) found, in a study of 8293 individuals with auto-immune diseases, that 26% reported experiencing CSA. This is higher than the 7% reporting abuse in a national crime survey, although it may reflect more realistic prevalence rates (Office for National Statistics, 2018).

There are critics who assert that harm is not universally experienced and that it is gendered. Rind *et al.* (1998) argue that female reports of the negative effects of CSA have been assigned to males. They carried out a meta-analysis of 59 studies of college students and concluded that, although participants who reported CSA had more negative outcomes, this could not be attributed to the experience of CSA but instead to their family environment. They argued that 'negative effects were neither pervasive nor typically intense, and that men reacted much less negatively than women' (Rind, Tromovitch and Bauserman, 1998, p.22). Finally, they concluded that the term 'abuse' should not be applied to 'consensual' experiences.

There were many critics of this article and its methods (see Haaken and Lamb, 2000; Dallam *et al.*, 2001; Ondersma *et al.*, 2001; Sher and Eisenberg, 2002). Ondersma *et al.* (2001) point out that none of the studies measured the occurrence of PTSD and thus the ongoing effect of trauma. Furthermore, many of the studies included a sexual proposition by an adult, as well as contact abuse, although these are likely to have a different effect upon the child. Dallam *et al.* (2001) also highlighted significant errors in data analysis.

In contrast Young *et al.* (2007) carried out a study of 406 undergraduates and reported that there were no gender differences in the harm reported by participants. This reflects other research that found that the negative effects of CSA are similar for males and females (Dube *et al.*, 2005; Cromer and Goldsmith, 2010). For example, there are similar levels of self-harm for both genders (Gratz, Conrad and Roemer, 2002). It is also worth noting that all of these studies consider gender in binary terms.

There is a large body of literature that demonstrates that, in the majority of cases, CSA does cause harm. Maniglio (2009) undertook a meta-analysis of 587 studies with over a quarter of a million participants, and concluded that CSA is indeed a significant risk to mental and physical health. An American longitudinal study found that child abuse (physical and/or sexual) had educational and economic consequences, with an average $5000 per year reduction in earnings (Currie and Spatz Widom, 2010). This is reflected in a recent parliamentary survey of 365 adults who had experienced CSA, where 72% said it had negatively affected their career and 65% their education (The APPG for Adult Survivors of Childhood Sexual Abuse, 2019a). These outcomes may further affect the physical and/or emotional health of individuals

not able to fulfil their potential. Therefore, there is strong evidence that CSA is a risk to health. There are also further consequences from CSA concerning how the individual relates to other people, their environment and themselves following abuse. These will be explored in the next section.

'Risky' Behaviour/Coping Mechanisms

Research into the choices made by people who have experienced CSA may include an element of judgement. For example, research into the later sexual behaviour of victims concludes there are more 'risky' behaviours (Finkelhor and Browne, 1985). Evidence for this includes more than 10 sexual partners, partners at risk of HIV and sex work (Cohen *et al.*, 2000). There are other behaviours also labelled 'risky.' These include substance abuse (McCauley *et al.*, 1997), smoking (Kristman-Valente, Brown and Herrenkohl, 2013), self-harm (Briere and Gil, 1998) and obesity (McCarthy-Jones and McCarthy-Jones, 2014). Research into these areas use terms such as 'risky' or 'maladaptive' to describe them and thus are indicative of a negative judgement of people who have responded to their experience of CSA in these ways (see Lacelle *et al.*, 2012; Vandello and Bosson, 2013; Krahe and Berger, 2017).

However, research suggests that such actions should be understood as attempts to cope with trauma (Jarvis, Copeland and Walton, 1998). For example, Briere and Gil (1998) reported that 68% of their study group asserted that self-harm relieved their symptoms. Bal *et al.* (2003) found a similar result, with avoidant coping strategies reducing stress in adolescent CSA victims. Indeed Felitti *et al.* (2010) argue that, in terms of eating disorders, 'obesity is even the solution - to problems that are buried in time and further protected by shame, by secrecy, and by social taboos' (p.28), as it reduces sexualised attention. Therefore, such behaviour may be effective in the short term in reducing anxiety and fear, though they clearly have negative long-term consequences.

What is also highlighted in this review is that there are two strands of effects of CSA. The first includes the physical and mental health consequences of the abuse itself. The second concerns the individual's attempts to manage and reduce those symptoms. This second aspect is subject to judgement by researchers and professionals. However, it is important to note that such behaviours may well occur in the absence of better solutions and this is an area that needs further exploration.

It is clear that most people who have experienced CSA will report some impact and that these effects can be very diverse and debilitating. The very diversity of the effects of CSA creates issues for the medical community because the unpredictability makes it difficult to devise an

effective treatment strategy (Feinauer, 2003). The section below explores debates around diagnosis and treatment.

Diagnosis and Treatment

There are two main epistemological approaches to treatment for people who have experienced CSA: the first approach treats individual symptoms and the second is more holistic. The diverse conditions resulting from CSA, as described in the effects section above, mean that many of these are treated in isolation, without consideration of the effects of trauma. However, research suggests a previous experience of trauma is prevalent in many people with addiction issues, mental health problems and eating disorders (Kilpatrick *et al.*, 2003; Felitti *et al.*, 2010; Gielen *et al.*, 2012; McCarthy-Jones and McCarthy-Jones, 2014).

Psychological and psychiatric approaches to diagnosing the mental health conditions of people who have experienced CSA reflect the discourses highlighted above. For example, in the mid-1980s the American Psychiatric Association proposed a diagnosis of 'masochistic personality disorder', to describe people (predominantly women) who were repeatedly victimised. Eventually this was renamed 'self-defeating personality disorder', which is still a pejorative term (Herman, 1992a). Another problematic diagnosis is that of borderline personality disorder (BPD) which is often applied to women who have experienced CSA. This label implies that the problem was always inherent in the person and their personality rather than being caused by the abuse (Lloyd and Brown, 2019). Indeed, evidence suggests that it is also used as medical shorthand for a ‘difficult’ patient (Sulzer, 2015). Therefore, there are judgements inherent within these diagnoses. The label is not there just to summarise the symptoms and causes but also to define the person as either inherently flawed in some way, as troublesome or inherently vulnerable.

A more constructive diagnosis for adults that ties together both aspects of the effects of CSA is that of complex Post Traumatic Stress Disorder (cPTSD) (Herman, 1992a). This is a chronic version of PTSD more common in adults (Lonergan, 2014). It includes both the effects of CSA such as hyperarousal, irritability, poor sleep, flashbacks and nightmares, but also the individual’s attempts to cope with them through dissociation, avoidance and numbing. The symptoms of cPTSD and what are labelled as ‘risky’ behaviours are viewed as the individual’s futile efforts to protect themselves or avoid the effects of a danger that no longer exists.

This approach was revolutionary as it viewed the effects identified above as resulting from the trauma and, therefore, suggested that treating cPTSD would reduce or remove both facets. Lebowitz, Herman and Harvey (1993) developed a three-stage approach to treatment. These stages included establishing a safe living environment, connecting with others, discussing and

grieving the traumatic incident/s. Two research studies have found that the symptoms of cPTSD fluctuate throughout an individual's life but there was an overall lifetime prevalence rate of 86% for adults who have experienced CSA (Rodriguez *et al.*, 1996; Johnson, Pike and Chard, 2001).

Treatment

In the UK, cognitive behavioural therapy (CBT) is the recommended treatment for cPTSD for both genders, although eye movement desensitisation and reprocessing (EMDR) is also listed as a potential treatment (NICE, 2005). CBT is a talking therapy aiming to deal with the present effects of past experiences (NHS, 2016). EMDR theorises that memories of trauma are inappropriately processed and stored (Shapiro, 1995). During EMDR therapy, the client recalls traumatic memories whilst experiencing bilateral sensory input, such as side to side eye movement. NICE (2005) views it as clinically effective, however, research has suggested that the process of discussing the memories may be more therapeutic than the eye movements (Davidson and Parker, 2001).

There are gendered differences to responses to therapy. Group therapy has been identified as useful for women but less so for men (Knight, 1990; Kessler, White and Nelson, 2003). For example, Friedrich (1995) argued that group therapy can be overwhelming for boys because they are reluctant to discuss their feelings in a group. Men have difficulty viewing themselves as victims and may be confused about their own sexual identity, particularly if they reacted physiologically to same sex perpetrators (Alaggia and Mishna, 2014). They may also fear being viewed as a potential offender and, for these reasons, may feel too uncomfortable discussing these issues in group therapy (O'Leary, Easton and Gould, 2015).

For children, CBT has been found to be statistically effective in reducing the symptoms of PTSD (King *et al.*, 2000; Trask, Walsh and DiLillo, 2011). This can be delivered either individually or as group therapy (Cantor, 1995). More recently a game-based version of group CBT has been developed which has also been successful in reducing symptoms in children (Springer, Misurell and Hiller, 2012; Liotta *et al.*, 2015). Although CBT has been shown to reduce symptoms of PTSD, particularly in children, it appears to be less effective when treating adults with cPTSD (Lonergan, 2014).

Van der Kolk and Najavits (2013) argue that when people relive trauma their thinking brain is de-activated, and they cannot apply the techniques of CBT. They argue for a return to Herman's (1992) original stage in recovery, of feeling safe, and suggest yoga, meditation and mindfulness. This is the theory behind Acceptance and Commitment Therapy (ACT) a more recent version of CBT (Batten, 2012).

There are potential issues with the therapeutic relationship itself and a risk of re-victimisation. For example, Gil (1988) surveyed 99 adults who had experienced CSA and 27% reported being further abused by their therapist. There are also risks that the client will become too dependent upon the therapist and that the therapist may share too much personal information with the client (Salter, 1995). Furthermore, it can be argued that there is a power relationship inherent within psychotherapy:

> *'the speaker discloses her innermost experiences to an expert mediator who then reinterprets those experiences back to her using the dominant discourse's codes of "normality"'*
>
> (Alcoff and Gray, 1993, p.260).

Alcoff and Gray (1993) conclude that a person who has experienced CSA does not have any autonomy or control over their medicalised recovery, which is therefore a relationship of discursive subordination. As such, it can be a negative experience for people who have experienced childhood trauma and are particularly sensitive to feeling powerless (Miller, 2002).

Furthermore, there are questions regarding the measurement of treatment and recovery. Kolk and Najivits (2013) question whether CBT is viewed as effective because it reduces 'miserableness' rather than leading to happiness or well-being. In this way, they question how recovery is being defined: as a reduction or an eradication of symptoms rather than an improvement in well-being. Masten (2001) argues that treatment should go further and include the promotion of competence as well as an amelioration of symptoms. However, at present no therapies appear to aim for happiness or well-being as an achievable goal.

All the therapies discussed above are evaluated through the use of clinically developed evaluation methods, but none asked the clients themselves for their subjective experience. Smith *et al.* (2015) surveyed 395 adults who had experienced CSA about their experiences of support services. Respondents highlighted the importance of interpersonal relationships. Counselling from voluntary and community organisations was rated higher than statutory services because people felt better listened to (Smith, Dogaru and Ellis, 2015). A bad response to disclosure or a poor therapeutic experience would inhibit people from trying to access services again. Finally, there were issues of consistency and reliability, as they reported long waiting lists, a small number of permitted sessions and limited support afterwards (Smith, Dogaru and Ellis, 2015).

Reflecting these results, Van der Kolk and Najavits (2013) argue that current treatment approaches ignore relational factors:

> *'We do things because we are a part of tribes, communities and groups. Yet the interpersonal dimension of trauma is being entirely ignored by the current paradigm that says, "You have a disorder and I am going to fix it"' (p.519).*

There is some evidence that this approach actually inhibits recovery by ignoring interpersonal relationships. For example, a study of 246 people using mental health services found people with cPTSD had less social support and also that a lack of social support made them more likely to develop cPTSD in the first place (Simon *et al.*, 2019). Thus, a social dimension to recovery appears to be significant but there is a lack of research in this area.

To conclude this section, there is, in the UK, a clinical consensus regarding cPTSD treatment to reduce the sequalae of CSA, although symptoms that are not diagnosed as cPTSD-related may still be treated in isolation. CBT is the recommended treatment and shows some efficacy, particularly for PTSD in children. However, there are questions about how effective it is for adults with cPTSD. Underlying these debates is the question of what recovery actually means, and the academic definitions are discussed further below.

Recovery

Although treatment approaches appear to consider a complete recovery virtually impossible and aim instead for a reduction of symptoms, a systematic review of CSA literature found between 10-53% of CSA survivors had a 'normal' level of functioning, defined as an absence of psychopathy (Domhardt *et al.*, 2015). An area of research has developed examining this, aiming to understand how people can experience severe trauma and not be negatively affected or even be positively affected. This research can be divided into trauma-specific research into resilience, post-traumatic growth and wider research into well-being.

Resilience

In physics, the term resilience describes the property of a material to regain its form after stress (Dufour, Nadeau and Bertrand, 2000). However, within trauma-based research, the definition of resilience is not clear, changing from a competence that develops over time (Egeland, Carlson and Sroufe, 1993), 'good outcomes in spite of serious threats to adaptation or development' (Masten, 2001, p.228), educational achievement (Phasha, 2010) and no physical symptoms or mental health problems (Bouvier, 2003). Thus, the definition utilised can significantly affect the number of trauma survivors judged to be resilient (Domhardt *et al.*, 2015).

With this limitation in mind, research studies have identified three areas that appear to protect an individual from severe post-trauma outcomes and these mainly relate to interpersonal relationships (Scott Heller *et al.*, 1999). Factors within the individual include a sense of hope (Singh *et al.*, 2010), religion, spirituality and reclaiming sexuality (Singh, Garnett and Williams, 2013). Dufour *et al.* (2000) identify higher intelligence and good communication skills. Specifically for male survivors, gender self-acceptance and renegotiating their masculine identity was highlighted (Graves, Borders and Ackerman, 2017).

The main familial factor is a good relationship and attachment to one's mother:

> *'repeated interactions with a sensitive caregiver means the child sees themselves as lovable and capable of mastery of their environment'*
>
> (Egeland, Carlson and Sroufe, 1993, p.525).

This reflects the importance placed upon maternal reactions to disclosure. Fathers do not appear to be valued in the research to the same extent and there is a lack of research into a non-abusive father's effect upon a child's mental health.

Useful extrafamilial support includes good engagement with school (Williams and Nelson-Gardell, 2012), a strong sense of community (Nurius *et al.*, 2015) and satisfaction with one's social roles (Cromer and Goldsmith, 2010). Overall:

> *'a sense of being unique, having purpose, and finding meaning in a "hostile and hurtful" world moderates the amount of damage that results from sexual abuse'*
>
> (Feinauer, 2003)

However, Masten (2001) questions the usefulness of such resilience research because it identifies factors that are not alterable, rather than identifying potential treatments.

Resilience has been theorised as very rare, depending upon the restrictiveness of the definition. Masten (2001) disagrees, resilience is 'ordinary magic' arising from dynamic interactions between individual and environment (see also Kolk, 2013). Severe adversity only has a major effect if there are also issues with intelligence, comprehension and parenting either prior to or resulting from trauma (Masten, 2001). Therefore, there should be many people who are resilient to trauma. There is some evidence for this in the prevalence rates discussed above (see Finkelhor, 1994; Stoltenborgh *et al.*, 2011). The absence of millions of people accessing mental health services suggests there is a large population of people who have experienced CSA that are capable of functioning in society, if not happily. There is very little research accessing their lived experience and knowledge.

Post-Traumatic Growth

Beyond the ability to withstand trauma, there is also the possibility of positive development as a result. Post-traumatic growth is not a new concept: two thousand years ago Aristotle (2002) argued that suffering gives meaning to our lives. More recently, the concept of post-traumatic growth has been developed, including positive changes in the self, better relationships and a new philosophy (Tedeschi and Calhoun, 1996).

Tedeschi and Calhoun (1996) developed a scale to measure post-traumatic growth. Living through trauma can make people feel stronger and more self-reliant, as well as strengthening their religious beliefs. This, they argue, does not dismiss the negative effects of trauma but acknowledges the human capacity to draw positives from it. Overall, they identified optimism, extraversion and an openness to experience as positive factors (Tedeschi and Calhoun, 1996). Women reported more post-traumatic growth than men. Easton *et al.* (2013b) found that men who were less tied to traditional ideas of gender were more likely to experience post-traumatic growth. Thus, there may be a gendered aspect to growth after trauma.

There is a lack of research into post-traumatic growth for people who have experienced CSA. Indeed, only one study could be identified, involving 93 college students from Israel. Lev-Wiesel *et al.* (2005) found higher rates of PTSD as well as post-traumatic growth in students abused by a family member. They concluded that the higher rates of PTSD related to a lack of social support inherent in familial abuse. Furthermore, they hypothesised that the raised levels of post-traumatic growth were influenced by higher rates of dissociation (Lev-Wiesel, Amir and Besser, 2005). The ability to escape an abusive situation, albeit only mentally, may help the individual re-evaluate their attitude to life and restructure it in a positive way (Lev-Wiesel, Amir and Besser, 2005). This is significant because it ties dissociation, often seen as a negative response in the long-term, to positive later growth.

Janoff-Bulman (2004) proposes a process of development after trauma. Initially trauma shakes or destroys the individual core beliefs, leading to a struggle to make sense of existence. Following on from this, the individual has to restructure and rebuild their beliefs. She outlines three models of post-traumatic growth which can exist simultaneously. The first is a ‘sense of strength’ through suffering, where trauma is seen through a redemptive script. Experiencing pain and/or negative emotions leads to the individual realising their strengths and developing new ones. The second model is ‘psychological preparedness’, where the individual creates better defences against future trauma. People who have not experienced trauma are aware that negative events occur but do not expect to experience them, which relates to the just-world hypothesis above. This means that they are not prepared for trauma.

Someone who has experienced trauma is more prepared and thus they aim to reduce the effects of future trauma (Janoff-Bulman, 2004).

Finally, after a traumatic experience people question their former belief in a just world, as this relies upon the certainty that existence is benevolent and meaningful. Instead, Becker (1973) explained that it is terrifying to:

> *'see the world as it is…it places the trembling animal at the mercy of the entire cosmos and the problem of the meaning of it'* (p.26).

This compels the traumatised individual into a re-evaluation of the meaning of life and eventually leads to an appreciation of it as fragile and precious (Janoff-Bulman, 2004). There is however, mixed evidence that post-traumatic growth leads to any improvement in well-being and happiness (Janoff-Bulman, 2004). Thus, whilst post-traumatic growth can lead to wisdom, it does not necessarily result in happiness. The next section examines what evidence there is regarding well-being and happiness after CSA.

Well-being and Happiness

There is a significant amount of general research into happiness and well-being, although again there is little that looks at CSA survivors. In general, research is informed by debates around concepts of happiness with two types identified: hedonia - fleeting pleasure and eudaimonia - a lifelong sense of flourishing (Cieslik, 2015). Studies have tended to argue that a more lasting sense of flourishing is 'real' happiness (Cieslik, 2015).

Happiness and well-being are not always seen as positive concepts. Ahmed (2010) argues that the concept of happiness can be negative when it is utilised to justify oppression, for example, by displaying a happy housewife or slave. Indeed, White (2017) argues that the present promotion of well-being is utilised by society to focus blame upon the individual and their 'failure' to create a sense of well-being regardless of circumstances, rather than the effects of inequality or of austerity upon the services provided by the state or other institutions. Thus, the definition of happiness itself is both under dispute and politicised.

Research into well-being is based upon the principle that there are some universal psychological needs that are not culturally created. Tay and Diener (2011) carried out a Gallop World Poll of 123 countries asking 60,865 participants about their well-being needs. Across all cultures, they found that the strongest predictors of positive feelings were feeling respected and having one's social needs met (Tay and Diener, 2011). Conversely, a lack of respect and autonomy as well as not having basic needs met related strongly to negative feelings (Tay and Diener, 2011). Thus, again interpersonal connections, having autonomy and respect are highlighted as important for well-being.

There has been some limited research relating to well-being in people who have experienced ACEs, although there is a scarcity of research specifically addressing well-being and CSA. McElroy and Hevey (2014) found that well-being was lower in people who had experienced any ACEs. In an attempt to combine both conceptualisations of happiness, they conceptualised well-being as an individual's history plus the more transitory present moment. Despite negative experiences, people who were more extraverted and 'agreeable' reported higher well-being, although 'agreeableness' is not clearly defined (Mc Elroy and Hevey, 2014). The lack of research into happiness or well-being for people recovering from CSA suggests that it is not even conceptualised as attainable.

The theories above of resilience, post-traumatic growth and well-being all conceptualise recovery as a far wider experience than simply the reduction of symptoms, yet treatment focuses exclusively on that. Thus, there is a mismatch between concepts of recovery and theories of how it is actually created or measured. One promising alternate concept is coherence, as discussed next.

Coherence

An innovative approach to research into recovering from childhood abuse was taken by Sandford (1990) who used a salutogenic method to investigate recovery. Salutogenics is an approach that focusses on what moves the person towards health, rather than on the illness which is causing the symptoms (Antonovsky, 1979). This is directly in contrast of the medical approach of 'pathogenesis' which is the study of how a disease develops. Salutogenics is the theory that humans have an innate impulse towards health. Although this may be disrupted by illness or traumatic events, the individual aims towards 'coherence' (Antonovsky, 1979).

The sense of coherence is:

> *'a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can be reasonably expected'*
>
> (Antonovsky, 1979, p.123)

This differs from the idea of being personally 'in control' but instead is a trust that authority is based where it should be, in individuals or institutions (Antonovsky, 1979). Coherence is not conceptualised as something inherent but is created repeatedly throughout the life-course. Indeed, Antonovsky (1979) argues that a focus upon a perceived weakness can lead to a reduction in coherence, and the example he provides is a psychiatrist focussing upon their patient's poor decision-making and thus reinforcing it. Instead he argues for a focus upon

strengths to shore up coherence, which reflects the argument for a strength based approach in supporting people who have experienced ACEs (Edward *et al.*, 2017).

The final part of the definition begins to answer the problem raised by Janoff-Bulman (2004). Namely, how can a person trust existence when they have experienced trauma? Antonovsky (1979) argues that a person with a sense of coherence will believe that things will work out, not with blind optimism but a realistic assessment of their specific circumstances. This concept echoes Masten's (2001) idea of resilience as 'ordinary magic': that it is a common occurrence and, by implication, something any individual will move towards unless seriously impeded. What it grants, above and beyond that, is an approach to exploring that phenomenon.

This is demonstrated by Sandford (1990) who, as previously stated, utilised this approach when interviewing 20 participants who had experienced childhood trauma, of any type. Her approach was to discover:

> *'what went right in these survivors' lives, and what had they done right for themselves?'*
>
> (Sandford, 1990, p.6)

Thus, there was a focus on the move towards health that viewed the individuals involved as active agents in their own recovery. Although this was a small-scale study and did not claim to deliver empirical, generalisable evidence, there were interesting results. The participants were very aware of the prevailing attitude that they were 'ruined' but found recovery through healing the body and mind, relationships and spirituality (Sandford, 1990). They also demonstrated an improved attitude to, and appreciation of, life (Sandford, 1990).

Dube and Rishi (2017) utilised the principle of salutogenesis to examine well-being in people who had experience CSA. In this study, which took a quantitative approach, they utilised secondary data from a five-state telephone survey of over 12,000 adults in the US who had experienced CSA, to measure positive behaviours and characteristics. They found a connection between higher well-being and the following factors: non-smoking, physical activity, socio-emotional support and a higher educational level. The potential applications of this contrasting approach are explored further in the following methodology chapter.

Aims and Objectives

Overall, it is evident that treatment and recovery from CSA is influenced by the overlying discourses outlined above. Hook (2001) asserts that the most effective discourses are those that are grounded in science. Academic research has initiated, reflected, amplified and legitimised these discourses. Pilgrim (2018) reasons that this is why academic research is

used to justify or minimise abuse. For example, health, recovery and resilience are all defined by the observer not the person experiencing it. Terms used to describe actions to reduce stress and anxiety such as 'risky behaviour,' 'maladjusted coping strategies' and 'self-soothing' are laden with infantilising judgement. Hacking (1991) quite rightly describes child abuse as 'extraordinarily medicalised' (p.265).

As Foucault (1980) asserts, discourses around CSA are created and maintained by the powerful, but there is little examination of their effects upon the relatively powerless, specifically children and adults recovering from abuse. People who have experienced CSA live in societies and families formed by the constructions of victim and perpetrator, effects and consequences. As Kolk (1998) and Masten (2001) state, recovery is an interplay between individual and environment. The current environment does not appear to be assisting recovery and the voices of those who have experienced CSA are lost within more dominant discourses.

This is a significant gap in the research. Few researchers have asked people who have experienced CSA for their opinions or valued their lived experience. This may be precisely because their voices attack the dominant societal discourses (Alcoff and Gray, 1993). The stories of people who have experienced CSA are co-opted by others for their own agenda, for example, used for titillation and voyeurism by the media or to further political ends (Alcoff and Gray, 1993; Britton, 2019). People who have experienced CSA therefore struggle for autonomy within the debate.

There are alternate voices suggesting that a more social model should be adopted (Herman, 1992b; Masten, 2001; Van der Kolk and Najavits, 2013). The research discussed above hints at a wider concept of a positive life after CSA, including the importance of hope, autonomy, respect and a sense of mastery. Interviews with survivors demonstrate that therapy is just part of the road to recovery: there is also a need for social connections and spirituality. Herman (1992b) and Kolk (1998) emphasise a sense of safety as vital. These areas need to be explored further.

Each society has their own approach to CSA, including its definition and legality. However, whilst all concepts are socially constructed, defined both temporally and culturally, this does not necessarily mean that they do not have a basis in reality (Hacking, 1991). CSA is indeed a socially constructed term, but beyond that construct, and sometimes obscured by it, there is the harm caused to a child by that abuse. There are perpetrators and victims. CSA exists, it occurs, and it is harmful. This is the foundation of this research because, without the concept of harm, there would be nothing to recover from.

Therefore, the aims and objectives of this thesis are to:

1) Explore how people who have experienced CSA define and experience recovering.
2) Examine how the dominant discourses regarding CSA influence both people who have experienced CSA and the people around them.
3) Consider the importance of interpersonal relationships in recovery

These will be explored utilising a salutogenic, insider-research methodology. This methodology is outlined, and its implementation discussed in the next chapter.

Chapter Three - Research Methodology

The previous chapter highlighted significant unresolved debates around both the definition and measurement of recovery from CSA. It also highlighted that the current discourses affect recovery but that there has been little examination of this beyond the politically charged moral panic debate. There are hints in the literature regarding what enables trauma recovery, but these have not been fully explored, particularly not by consulting individuals who have experienced CSA. Finally, there is a promising concept and method in salutogenesis.

My PhD addresses these gaps by asking adults who have experienced CSA and consider themselves some way through recovery, what they believe helped or hindered them in that process. The research also aims to understand how people who have experienced CSA define recovering. Furthermore, it seeks to understand how that recovery was either facilitated or obstructed by interpersonal relationships and interactions.

This chapter will focus on salutogenics, as the chosen approach. From there, it will further explore the theoretical underpinning of the research before moving on to consider methodology in both principle and practice. The main body of this chapter is a detailed and reflexive description of the process of fieldwork and analysis.

Conceptual Framework

This section describes the process by which the ontological and epistemological basis of the research was established. It begins with an examination of how salutogenesis can be applied to this research. Following on from there, it explains the decision to take an interpretivist epistemological stance informed by a methodological combination of standpoint theory, intersectionality and social constructionism. Finally, there is an assessment of the benefits and potential pitfalls of insider research.

Salutogenics

Salutogenics emerged as a potentially effective approach to exploring the gaps around recovery from CSA precisely because of its inversion of the medical approach to health.

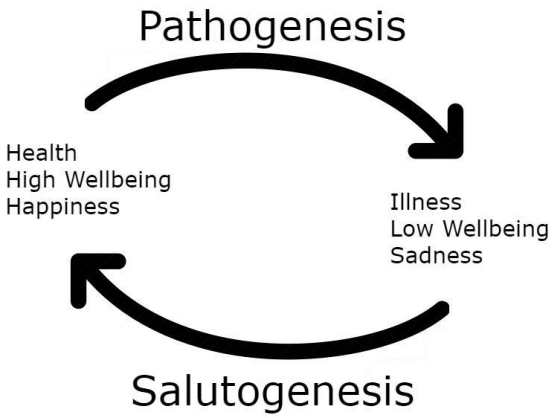


Figure 3.1 The Salutogenic Model

Salutogenics conceptualises health as a continuum, rather than dividing it into a binary of health and illness (Figure 3.1). Instead the individual slides between the two poles of what Antonovsky (1979) terms 'health-ease and dis-ease'. Thus, this approach engenders an investigation into what moves a person towards health. Furthermore, it includes the concept of well-being within its design. This is useful, because it means that a person can have chronic physical or mental health problems but still be closer to the health, well-being and happiness pole. This addresses the issue of defining health or resilience in a very restrictive way as discussed in the previous chapter.

Antonovsky (1979) was studying menopausal women in Israel and he noted that a section of his research sample were women who had survived Nazi concentration camps. He was amazed to discover that, notwithstanding their experiences, 29% of those women were evaluated as being mentally healthy. He subsequently studied this cohort to understand how they had managed to process the trauma and recover (or never lose) good mental health. From this research, he then developed the idea of salutogenics and coherence, as discussed in the previous chapter.

A salutogenic approach puts people with lived experience at the centre of the research process. This has been applied before in health-related initiatives. For example, it is reflected within the NHS Expert Patients scheme, which follows a similar rationale to encourage people to negotiate recovery (Department of Health, 2001). This scheme works by recruiting patients who have been in treatment longer to support patients who are commencing treatment. Employing Bandura's (1977) self-efficacy model, it puts the patient's needs at the centre of care and, crucially, the management of that care.

Finally, and fundamentally, a salutogenic approach addresses the problem with the pathogenic or medical approach to the cause of individual issues around CSA. The cause is

clearly trauma, which is self-evident, but the effects cannot be resolved by medicine. The trauma has occurred, and memories cannot be erased. Thus, the cause cannot be removed. A pathogenic approach aims towards an eradication or reduction of the cause of ill health but this cannot be achieved. Therefore, I would argue that a salutogenic approach focussed upon better health and well-being is more relevant in this case. It may also be more effective at gathering the data I require.

Ontological Position

Social Constructionism

Berger and Luckmann (1967) argue that to study the sociology of knowledge, an understanding of the social construction of knowledge is essential. Knowledge is both created and maintained through social interactions. Social reality is built from both 'objective facticity' and the subjective meanings society attaches to them (Berger and Luckmann, 1967). Thus, it is quite possible to have a real event, such as child sexual abuse, and for this also to be rich with social meanings which can then transform people's understanding of it.

Abbott and Wallace (1997) agree that 'truth' is always a social construction, used to define and control the world, as well as being born within its time and society. However, they take this further, by arguing that there is no objective reality and that researchers should look for 'many truths' (Abbott and Wallace, 1997). This postmodernist approach is useful for researching CSA to a certain extent.

As the literature review demonstrated, there are a rich landscape of discourses around CSA. The dominant discourses regarding CSA have certainly changed throughout history. For example, in 1881, in the British Journal of Psychiatry, Savage describes children suffering from moral insanity 'exhibiting itself in self-abuse, unrestrained sexual intercourse, even with near relations' (p.152). This suggests a different attitude towards the causes of child abuse. Hacking (1991) argues that CSA is intrinsically a social construct and identified a campaign against child abuse that started in Denver Colorado, in 1961, as the start of the modern definition.

However, the main issue with the postmodernist approach, as it relates to research into CSA, is the supposition that there is no objective reality and simply individual experiences. This has been used to argue that CSA is not abusive in all circumstances and can therefore be justifiable in individual cases, a position adopted by campaigning paedophile organisations such as NAMBLA (Plummer, 1991; Pilgrim, 2018). This stance is in direct opposition to the political and social aims of this research.

There is, however, a recognition within this thesis of the construction of narrative. Haaken (1996) argues that narratives of abuse reinforce a 'good victim' discourse, by avoiding any perceived complications of the idea of innocence. This can lead to questions regarding the veracity of individual experiences. However, a narrative of CSA can be both true and constructed (Reavey and Brown, 2007). Narratives of abuse contain spatial information, objects and sensations (Reavey and Brown, 2007). The child was there, the event occurred but it may be packaged by the adult to reflect accepted tropes and defend against accusations of complicity.

This is described by Hacking (1999) who argues that there are two types of categories; indifferent and interactive. The indifferent category is one which the subject does not interact with; a tree is a tree. An interactive category is one that affects the subject; being diagnosed as an alcoholic will affect the individual, their view of themselves and potentially how they or others act. Thus, he argues that there are real phenomena, such as electrons, but how we describe and interact with them is socially constructed.

Attitudes to and narratives of CSA are certainly socially constructed within their own time and culture, but behind that there is the reality of abused children. Thus, whilst there is clearly a socially constructed 'truth' around CSA that is rooted within its time and culture, there is also an actual reality of abuse, experienced by its victims. It is expressed by people who have experienced CSA and, therefore, can be recorded. This research accepts the socially constructed nature of CSA but rejects the suggestion that there is no underlying reality.

Epistemological Stance

A salutogenic approach can be employed with either a positivist or interpretivist epistemology. In the main, it has been utilised in a more positivist epistemology. For example, Antonovsky (1987) developed a scale to measure a participant's level of coherence which has been utilised in a number of psychological research studies (see Soderhamn, Dale and Cliffordson, 2015; Hansen *et al.*, 2017). However, this research adopted an interpretivist salutogenic approach, reflecting Sandford's (1990) stance and this section will explain the rationale behind that decision.

Much of the research into CSA, in any discipline, is based upon a positivist epistemology. Positivist sociology aims to create value-free facts, modelling itself upon the natural sciences (Hammersley, 1995). For example, CSA treatments are measured through assessment scales, such as Antonovsky's (1987) coherence scale, prevalence through large scale surveys and effects through mental health service usage. Such research collects valuable data for

planning and developing services, but what is missing is an understanding of the diversity of human experience.

Furthermore, science itself is not necessarily value-free. For example, in reflection of Foucault's (1980) position on discourses of power, Haraway (1988) asserts that:

> *'science...is rhetoric, a series of efforts to persuade relevant social actors that one's manufactured knowledge is a route to a desired form of very objective power'* (p.577).

Thus, science can be argued to be, in itself, a performance designed to create and maintain power. A positivist approach may not be the most effective way to explore the effects of discourses, because it has maintained those discourses. Therefore, a positivist approach was concluded to be not appropriate as it would not address the influences of power and discourse. Abuse, in actuality, involves treating its victim as an object, therefore, I felt that it was important to ensure, as far as is possible, that my research design did not reproduce or entrench objectification.

I aimed for a relationship between researcher and subject that was more reciprocal and balanced. I wanted to treat participants, both conceptually and in practice, as adults capable of making decisions, rather than taking an infantilising approach by assuming that they were inherently and fundamentally damaged by their experiences (Downes, Kelly and Westmarland, 2014). To achieve this, an interpretivist approach, based upon Weber's (2001) concept of verstehen, to understand the social conditions that give rise to particular perspectives, seemed most appropriate. This approach would assist me to elucidate the kind of data I wanted to gather and, more importantly, to maintain the respectful relationship with participants that I aimed for.

Furthermore, an interpretivist approach recognises the role of values in research, something a positivist approach would aim to reduce or deny (Becker, 1967). This research does indeed have political aims: to critically assess societal responses to disclosure, current service provision and increase the sense of agency of people who have experienced CSA. Finally, as I experienced CSA, my claims to objectivity would clearly be open to dispute. However, when studying highly emotive subjects such as CSA, it would be hard for any researcher to claim a value-free approach. Becker (1967) argues that value-free research is impossible. The question is, therefore, what side we choose to be on. This is particularly relevant to CSA research, as there are clearly sides: those who view it as harmful and those who do not (Kelly, 1988; Plummer, 1991; Herman, 1992b; Bauserman and Rind, 1997; Van der Kolk, 1998; Angelides, 2004a).

CSA is clearly a highly political construction, utilised by many factions to further their ends (Goode and Ben-Yehuda, 1994; Haaken and Lamb, 2000; Cheit, 2014). As a result, it is likely that any researcher studying CSA will have been influenced by the discourses raised in the previous chapter. Jenkins (2002) acknowledges that it is unlikely that a researcher can be value-free and further argues that value-free objectivity is not desirable as it can lead to a lack of ethical standards. However, he defends objectivity as a goal which can be achieved by a systematic approach to data collection and honestly reporting results. Thus, this research acknowledges my insider status as well as systematically obtaining and clearly reporting the results.

Following on from this, Harding (2005) suggests including reflexivity in reporting the method and circumstances of any research. She argues that such openness makes one's position explicit so that it can be included in an assessment of the research produced. This candid approach is the stance taken within this thesis. Thus, an interpretivist stance, including these approaches, better reflects the aims of this research because it includes an understanding of the power differential inherent in research. The facility to acknowledge values and political intent in this approach, as well as its use of methods that allow collection of the rich data will best enable me to answer my research questions.

Methodology

'The only way to find a larger vision is to be somewhere in particular'

(Haraway, 2004, p.590)

Following on from the interpretivist epistemology, a qualitative methodology was warranted to engender the understanding of the lived experience of people who had experienced CSA. I did not want to constrain people's responses, except for sticking to the topic, nor did I want to tightly define terms. This section explains the development of my insider-research methodology with an exploration of the advantages and disadvantages of such an approach.

Insider research is research into a population that the researcher is also a member of (Kanuha, 2000). This is in contrast to Malinowksi's (2005) concept of 'going native', when an anthropologist lives within the community they are studying and adopts their way of life but is not a member of that community beyond the research period. Haraway (1988) argues for what she terms 'situated knowledges', which is objectivity formed from a specific and stated perspective, as the quotation at the state of this section illustrates. Insider research can provide such an approach and, through this alternate viewpoint, create different knowledge.

The majority of CSA research is carried out *on* people who have experienced CSA rather than being created and driven *by* them. This approach may hamper progress in CSA research as

Harding and Norberg (2005) suggest that dominant groups may not be equipped to recognise and change their oppressive practices. This is addressed by standpoint theory, which argues that studying the oppressed, rather than the powerful, produces more effective and pertinent data (Harding and Norberg, 2005). Insider research can be argued to be an extension of standpoint if it examines an issue from the position of the abused.

However, it is important to note that people who have been abused may not, at the time of the research, be oppressed. Indeed, they may be in positions of power. Thus, a standpoint approach needs to be tempered by the recognition that a victim of abuse can be oppressed at the point of abuse but does not necessarily remain in that state. However, they will have the memory, albeit reinterpreted through the lens of time, of that oppression.

Intersectionality is a useful way to address the changing circumstances of the individual over their life course. Simien (2007) argued that individuals are marked by their membership of various social groups, such as race, gender, sexuality and class, which she terms their 'social location.' Therefore, an intersectional approach can encompass the differing social locations of the research participants over their lifetime by reflecting the changing power circumstances between a person as a child and as an adult.

An intersectional approach can also be utilised to examine social location in terms of gender, ethnicity and disability. For example, both male and female children are relatively powerless, although a gender disparity exists. However, this may well change in adults, as the relative power balance shifts further, in a patriarchal society, towards men. This imbalance may affect reporting the crime and accessing help, as well as recovery for both adult male and female survivors. An intersectional approach, by considering factors other than the individuals' experience of CSA, can provide a clearer picture of the effects of both disadvantage and advantage. Thus, intersectionality is a key component of this research.

As stated, insider research can grant a different perspective from that of researchers who have not experienced the phenomenon being researched. It can provide greater familiarity with some research participants, although this cannot be assumed (Kanuha, 2000). There may also be advantages in terms of accessing the community and recruiting volunteers. Brannick and Coghlan (2007) point out that there is an element of pre-understanding of the group's everyday life, jargon and taboo subjects, for example.

There are, however, practical and methodological issues with insider research. Firstly, a sense of shared understanding can mean that questions that an 'outsider' might ask will remain unspoken. The precarious position of being both insider and researcher also demands an

rigorous examination of positionality (Fine, 1994). Wilkinson and Kitzinger (2013) argue that as humans studying the human world, researchers are all insiders, in one sense, yet even within our own communities, we are also outsiders, excluded by differences in age, race, gender etc. The intersectional nature of any group means that it is important to be aware at all times that being an insider delivers *a* perspective upon an issue not *the* 'truth' of it (Kanuha, 2000). Regardless of the lived experience of the researcher, there is an imperative upon them to report the opinions of their participants, including and especially when they disagree with their own.

A more reflexive approach is useful for researching people who have experienced CSA. Robinson *et al.* (2007) argue that:

> *'the research interview is a social situation where both interviewee and interviewer participate as social beings, each brings to it their own identities, experiences and implicit assumptions about the other'* (p.181).

Therefore, being aware of the effect of this emotive research on both researcher and the researched, both people who have experienced CSA, is essential to ensure that there is a reduced risk of negative consequences.

However, insider research can be valuable and provide data that traditional research cannot (Brannick and Coghlan, 2007). The concept of situated knowledges provides a useful way to steer through the tensions inherent in insider research (Haraway, 1988). This involves clearly stating and rigorously interrogating one's positionality as well as an acknowledgement of the constructed nature of 'truth' (Haraway, 1988). Further, it includes being rational, responsible and ethical with a goal of providing 'better accounts of the world' (Haraway, 1988, p.590).

Poole *et al.* (2004) highlighted the potentially detrimental effects upon the researcher of insider research if they identify with participants' emotions. Strategies for reducing these risks include good preparation before fieldwork, support and debriefing (Poole, Giles and Moore, 2004). It is worth commenting, however, that any researcher looking at such sensitive subjects, regardless of circumstances, might need similar strategies.

Wilkinson and Kitzinger (2013) list four different ways to address an insider status: one can ignore it, utilise it strategically, maximise it (as in autoethnography) or incorporate the researcher's experience directly into the research. Each option engenders a differing relationship to the data and the participants. I decided to take a strategic approach to revealing my insider status, which is discussed further below.

Therefore, my insider status provided initial data with which to commence designing the research methods. However, this was complimented by the research available within the field, as well as by my awareness of the need to be reflexive in my decision-making. Moving on from there, theories of power and inequality, standpoint theory and intersectionality were utilised to expand the methodology. Finally, an awareness of discourses and social constructionism also fed into the survey and interview question design. The next sections explain how these were combined.

Methods

The specific methods used in this research were developed in relation to the literature review and the conceptual stance elucidated above. The decision to take an ethical insider trauma-based approach meant that these ideas were woven within the design and delivery of the fieldwork, therefore, the majority of the information regarding how these were put into practice is covered in the relevant fieldwork sections.

The fundamental approach taken in the fieldwork was belief in what the participants told me. This decision was taken for three reasons. Firstly, by stating that I would believe respondents I wanted to encourage them to be honest and open about their experiences. Secondly, as Hacking (1999) argues ones understanding of an experience forms ones responses to it. If you believe that you were abused then you will feel abused. Finally, I do believe in the reality of abuse, however it is socially constructed.

The fieldwork was conducted in accordance with the University of Sheffield's guidelines on research quality and ethical practice. Key ethical issues in studies of this type are the potential vulnerability of participants and effects upon the researcher. As suggested above, the potential for participants to have c-PTSD was built into the design. Pseudonyms are used for all participants and interview participants were given the opportunity to choose their own name. As ethical practice is woven tightly within the research design and methods it is more appropriate to incorporate its further discussion within the appropriate section.

Salutogenic Approach

Following the salutogenic approach, this study aimed to recruit people who identified as being further through recovering. As much of the wider research in this area is quantitative, there is a gap in data on the subjective experiences of people who have experienced CSA. I wanted to understand how the people I recruited were positioned within the researched landscape and whether they identified as further through recovering because of some difference in experience or personal characteristics. To enable such a comparison some qualitative data was required.

I also wanted to provide a platform for people to express their thoughts and experiences, without any limit beyond the subject matter. This was to address the research gap mentioned previously and to gather as many different contributions as possible to try to understand the complexities of human experience in this area. Thus, I wanted to take a wider approach to sketch out the landscape but also to focus upon specific factors.

Creswell (2013) suggests a sequential approach to encompass such requirements, by which one method is used to gather initial findings, followed by different methods, if appropriate, to facilitate further exploration. This pragmatic approach can include both qualitative and quantitative methods, providing the different types of data required to construct a more detailed picture. This approach was a good match for my requirements. Therefore, a decision was made to take a sequential explanatory research design approach to the field work.

I chose to commence with a survey that contained both closed and open questions. This approach was adopted because the information on recovering was so sparse and medically focussed that I did not want to limit my participants' responses. I wanted to understand what, if anything, helped recovering outside of the medical approach. Thus, as there was very little previous data on this, I decided to keep the questions as open as possible to encourage responses that reflected the individuals' reality, rather than fitting within predefined boxes. This data would then be analysed, and the results used to form open-ended questions for interviews that further explored the issues raised. However, I utilised closed questions for the demographic section to gather some comparative data.

The focus of the fieldwork was on recovering, not the abuse itself or the effects of it, although both areas could be discussed if the participant felt it was relevant. I want to understand what helped and hindered recovering, which I conceptualised as moving closer to the salutogenic health and well-being pole. Thus, the design of the data collection methods was structured around salutogenesis, rather than pathogenesis.

Insider Research

As stated, insider research can mean a greater understanding of the experiences and issues faced by the community but also risks over-identification and the exclusion or suppression of research findings that do not resonate with one's own experience. I wanted to ensure that, as far as possible, my insider status would benefit the research relationship and not inhibit it, thus I followed a strategic approach as stated above. I felt that it was important that people knew that I was also someone who had experienced abuse, as there appears to be serious issues around disclosure to people who have not (Livesey, 2002). However, I did not want to influence individual narratives by talking about my own experience, as I thought this might prevent them

from speaking of understandings, thoughts and feelings that did not correspond with my own. I also wanted to concentrate on participants and not appear to be interviewing them as an opportunity to talk about my own experiences. Furthermore, I was aware that I was the researcher, not a participant, and should have some distance from the research.

I achieved the strategic approach suggested by Wilkinson and Kitzinger (2013) by being open about my insider status but, where possible, not talking about my perspective and experiences. I hoped that insider designed research might engender a more open relationship with the subjects of the research, particularly with the area of sexual abuse, as subjects may fear being pre-judged because of their experience (Livesey 2002). My personal experiences led me to identify trust as the most important building block of the researcher/researched relationship. I hoped that they would feel 'safe' to talk to me without this fear or rejection and judgement. However, I wanted to go further than this. I was also determined that I would *be* safe and trustworthy. Thus, it would not just be a stance to convince them of, a performance, but also inherent in my actions. This basis of ethical behaviour was fundamental to the research that I wanted to carry out.

The potential for issues of over-identification between researcher and participant was clear in this case and was discussed openly with my supervisory team. I wanted to carry out the research precisely because I wanted to hear different opinions and experiences but was open to supervision addressing this on both a critical and supportive basis. My previous experience in welfare advice was invaluable here as Citizens Advice Bureau training includes a focus upon separating the interviewer from the interviewee and not over-identifying, whilst also empathising. I had experience of applying that when working as an advice worker as I frequently talked to people about the effects of childhood abuse, as part of completing Disability Living Allowance forms. Thus, I had frequently experienced people talking about issues I had myself faced and learnt to detach from my own feelings about it, as not relevant to their experience, until after the interview when I had learned that a debrief could be helpful.

It is also worth further elucidating my approach to the relationship between the researcher and the researched. As Fine (1994) suggests, I carefully considered my positionality with regard to the participants. Stanley (1997) argues that it is vital that research participants are conceptualised as people with agency, not passive objects. This is particularly pertinent in this case, as any objectification reflects the perpetrator's attitude within the abuse situation so should not be repeated within the research relationship. I aimed to treat participants, both within the design and personal interactions, as capable, intelligent adults. Furthermore, as other academics were taking part in the research, I did not assume any greater knowledge or insight. Some of my participants worked in trauma research, thus I could not even assume a

greater knowledge of the specific field. Thus, my approach was to consider that I had my 'truth' but not to prioritise that above any other 'truth'.

This leads on to the question of the potential effect of the research upon me, having experienced CSA myself. There was clinical support available, via the University counselling service, if required, although I did not avail myself of this. The design of the research itself benefited me, as it did not focus upon the effects of trauma or indeed require in-depth descriptions of abuse.

I felt sure that I could handle difficult interviews, as I have carried out many of these in the past. For example, when working for a Community Health Council, I often supported bereaved families who were making complaints against the NHS. However, I was aware of the potential effects upon me of such emotive interviews, so I drew up a 'self-care' plan to improve my health and well-being should the experiences 'in the field' become overwhelming. My identified emotional outlets or distractions were reading news or celebrity gossip websites and conversations with friends.

However, in October 2017 the #metoo movement hit global prominence. This was useful for my research as it made it very timely and allowed me to ask people, in interviews, what they thought about it. However, it also meant that the emotional outlets from the research that I had identified on my self-care plan were ineffective, as most of the websites that I visited, or conversations I had, were discussing #metoo and sexual trauma. I adapted by finding the same effects of distraction, that I needed, by researching a historical case of CSE and doing a craft project. By carrying out tasks that were absorbing, as well as challenging, my health and well-being remained good. Although I planned for 'every' eventuality, I could not have predicted a social movement relating directly to my research. This demonstrates the need for a more fluid approach to researcher health and well-being, that reacts to unexpected events as well as preplanning for potential risks.

Another issue that occurred during fieldwork happened towards the end of data collection. I received an email from one of the survey participants and, upon opening it, I saw that it was a pornographic video. The next day I got another email from the same person, but this time the email discussed his traumatic experience of being abused by his mother and didn't mention the previous email at all.

I discussed it with my primary supervisor. He suggested that I block the sender and remove his data from the data sample, but for my own mental health and well-being I wanted to respond. I sent an email stating that it was unacceptable and almost immediately received an

apologetic reply. The participant had been abusing drugs and was not aware of his actions. Although this meant that I was left concerned about his health and hoping that he would seek assistance, it also meant that I was pleased that I had maintained the researcher/researched relationship that I wished to forge: one that was mutually respectful, but with clear boundaries.

The research also had unexpected positive benefits upon my own mental health and well-being. This was not my intention in carrying out the research as I thought I had 'recovered' as far as was possible. However, whilst researching cPTSD, during the literature review stage, I realised that it was likely I suffered from it. I had previously not been aware of its symptoms and had thought it always involved visual hallucinations replaying the trauma, which I did not have. However, when I sought assessment, I was diagnosed with c-PTSD and commenced treatment for it.

Furthermore, there were benefits to finding out more about people's experiences and comparing them to my own. Not being isolated and talking to other people who had experienced a similar trauma was, in the main, a positive thing. I think it is important to highlight this to underline the therapeutic benefits of being heard and being more knowledgeable about the long-term effects of abuse even upon someone immersed in this area. This also suggests two therapeutic avenues: education about trauma effects and establishing a supportive community. These issues also emerged in the research data, as will be discussed in the results chapters.

Trauma-Focussed Design

Research suggests that around 86% of people who have experienced CSA will have cPTSD, with fluctuating symptoms during their life-course (Rodriguez *et al.*, 1996; Johnson, Pike and Chard, 2001), so it was vital to take a trauma-focussed approach to research design and delivery. Therefore, there was a balance to be made between understanding that participants may well have some lingering and even permanent effects from the abuse they experienced, with the acknowledgement that they identified as further through recovering and were, literally, adults. Their maturity is self-evident, but it was also important to underline and incorporate it in my research design. Thus, participants were conceptualised as actors: active agents not a passive thing or an object to be studied.

Much of the trauma-focussed approach to the design and delivery was informed by my own experienced of cPTSD, although I did gather evidence regarding the condition. As stated in the literature chapter, people who have experienced CSA can experience feelings of powerlessness (Finkelhor and Browne, 1985) and, therefore, the first decision made was to ensure that participants were fully informed throughout. All participants were given the

opportunity to watch videos, with subtitles, explaining the research, as well as reading an information sheet before giving written consent. The videos explained who I was, my insider status, what the survey was for and what I wanted to do with the research. Social media messages were designed with a link to a website where there was more information about the survey, some videos that explained the aims and methods employed, and information about ethics. The interview consent form and research information sheet are in Appendix 3. I posted the survey questions on my website for people to read beforehand if they wanted to. The other choices made are recorded within the relevant sections below.

Recruitment and Dissemination

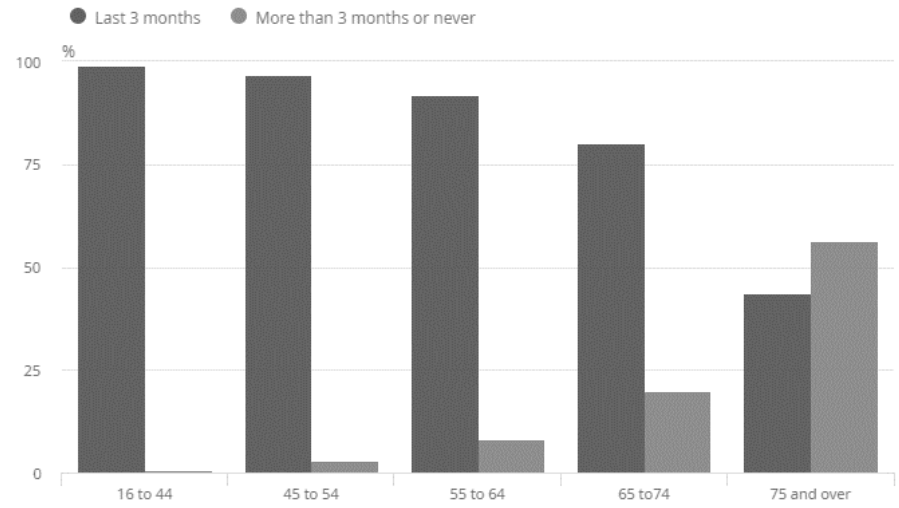
Different methods of recruitment were assessed to find a method that recruited participants who were not in an acute phase of recovering. This was not to exclude people with mental health issues but rather was an ethical choice to reduce the risk of exacerbating recovering at a potentially vulnerable stage. A traditional recruitment method, in this area of research, involves recruitment via psychiatric units, charities or GP lists (see Connor & Davidson 2003; Ross *et al.* 2005). However, as I was looking for people further through recovery, who may not be involved with mental health services, I felt that a more general approach was warranted to collect a more representative sample of potential participants.

Another recruitment method samples specific populations, usually students (see Finkelhor 1980; Tang 2002; Janoff-Bulman 1979), but I wanted participants of differing ages and education levels. Well-funded studies are able to build large-scale national surveys (see ONS 2015; Finkelhor *et al.* 2014; Finkelhor *et al.* 1990), but this was beyond my scope both financially and practically. People who are further on in recovering from CSA do not tend to congregate in real life, but one avenue for recruiting similarly 'hard to reach' groups is online research (Wilkerson *et al.*, 2014). I was aware that there were communities of people who had experienced abuse on the internet, therefore, I decided to disseminate the research online.

I developed a threefold plan. Firstly, I contacted agencies, including those specific to CSA support and more general ones. Secondly, I wanted to disseminate the survey via a snowball sample, to the general public via Twitter, where I had noticed a community developing. Additionally, there were groups I specifically wanted to target. These were older people and men.

I was particularly interested in trying to talk to older people, as an underrepresented group in this type of research. As stated above, many research studies consult younger people recruited through universities, and there is little in the literature regarding older adults' experiences of CSA and its long-term effects. I was concerned that going online would limit

the number of older adults taking part in the survey, but as the percentage of older people with recent internet use is quite high up to age 74, only decreasing significantly after the age of 75 (Figure 3.2).



Source: Office for National Statistics

Figure 3.2 UK Internet Users by Age Group, 2018

However, this does not indicate how often or how skilled older people are in using the internet. To combat this, one of the agencies I wanted to contact was Age UK, to see if they would share the survey via their more traditional methods, as well as online. I was also willing to skip the survey and do interviews if that would work better for older people who were less confident in responding online.

Previous research has concentrated on women who have been abused (see Russell 1983; Rinehart & Yeater 2011; Jewkes & Abrahams 2002), although there is a growing area of research into the experiences of male abuse victims (see Glasser *et al.* 2001; Dhaliwal *et al.* 1996; Kemi Badenoch 2015). I was interested to see if gender affected recovering, as the research suggested (see Talmon & Ginzburg 2018; Javaid 2014; Krahe & Berger 2017). To assist in the recruitment of men, I intended to contact agencies that specifically supported males.

I drew up a communication plan which covered different arenas for communication (Facebook and Twitter) as well as draft messages that were general and more specifically aimed at the key groups discussed above. Example are given in Appendix 2.

Design and Fieldwork

This section covers choices around nomenclature and the rationale behind those choices. It also elucidates my approach to survey design before going through the fieldwork process itself.

Survey Design

I designed the survey with as few mandatory questions as possible and reminded participants they did not need to answer all of the questions if they chose not to. In this way, I wanted to ensure that they felt some power over the research and their participation, whilst also recognising my privileged position as researcher. I was led by participants, as far as possible, with regard to terminology, as explained below.

My aim with the survey was to take a salutogenic approach by asking what helped or hindered recovery in a holistic way. Firstly, I asked some demographic questions and a few questions about the abuse itself. Next, I identified areas to encompass this 'whole person' approach. These were: legal redress, medicine, relationships, creativity, religion and spirituality, career, body care and exercise, campaigning or politics, gender and identity. Finally, I requested that people who were willing to be interviewed leave their contact details. The survey questions are listed in Appendix 1, which includes a research information cover page.

As the research concerned recovering from abuse, and therefore was focussed upon the time period afterwards rather than the abuse, I felt very strongly that any questions about the abuse itself should be both necessary and brief. This was to reduce the risk of triggering cPTSD. Thus, when examining each question, I considered what the data generated would be used for. If was not required for the research, then it was not included. For example, there are debates about whether the majority of abuse is carried out by family or acquaintances, so this seemed a valid question. There are also very few research studies that look at abuse by peers or older children, so I felt that a question about the age of the abuser(s) was relevant. I did not ask specifics about the abuse itself, for example, if it involved penetration because I thought these questions may well trigger cPTSD and I did not need the answer for my research purposes. I decided that although the rest of the survey was mostly text boxes, which enabled free text answer of any length, this section would be mostly multiple choice. This was to make filling in this section faster for participants and to facilitate quantitative summaries.

I felt that it was important to consider and explain why specific information was required as well as what I was going to do with the data. Thus, at the start of each survey page I added a sentence explaining the subject matter of the questions on that page and why I was asking them. I also decided that (apart from the consent questions) none of the questions would be

compulsory, as I wanted participants to be clear that they had a choice in what they wanted to share. Therefore, if people chose to talk about the actual abuse, they could do so in the appropriate text box.

It is impossible to avoid all triggers, as these are unique to the person, but by pre-warning people about the topics covered and not asking unnecessary questions, I hoped to avoid this as much as possible. In my own experience, if I know in advance that a triggering subject will be discussed, I can mentally 'brace' myself and reduce the risk of being distressed by it. Therefore, the aim was that information on upcoming questions allowed participants to similarly prepare themselves for questions, which they knew might be triggering. The aim of this approach was to try to ensure that people felt informed and respected, particularly that they felt respected to make their own choices as to what they wished to share and disclose.

Terminology

The definition of CSA used in this research are self-defined by the participants. This was to encompass participants' experiences without defining any characteristics of the perpetrator or the abuse itself. Therefore, there was no statement specifying what CSA is, although the survey included the Government's definition of CSE:

> *'Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology'*
>
> (Department for Education, 2017, p.5)

This was used because it is broader than the idea of the child being sexually exploited to earn money for an adult.

Within this thesis, phrases are used that are informed by the research participants. For example, the strength of feeling around the terms 'victim' and 'survivor' have meant that, unless specifically talking about the fact of being a victim, terms such as 'person who has experienced CSA' is used instead. Secondly 'recovering' is used more frequently than 'recovery' to acknowledge the unending nature of the experience. These terms are further explained in Chapter Five. Finally, I have not used the possessive 'his' or 'her' abuser as one participant pointed out how inappropriate this was. Instead I have used 'the' abuser. Part of

the rationale behind these decisions was to avoid excluding any participants through an alienating use of language. Secondly, it was to respect the value of lived experience and avoid triggering cPTSD through a thoughtless use of judgemental or emotionally destabilising language.

Pilot

After obtaining ethical approval from the University of Sheffield, I commenced recruitment of people to pilot the survey at the beginning of November 2017. To achieve this, I posted on Twitter where there were people who were very open about having experienced CSA. Three people agreed to take part, but two did not find time to do it. One did complete it and gave great feedback. If I had more time, I might have continued trying to recruit participants in this way, because I really wanted people from different demographic groups to pilot the survey to ensure that it was accessible. However, as I had limited time, I asked on the Women in Academia Social Network (WIASN) site on Facebook and seven people volunteered. Their feedback was really useful, particularly as they questioned my assumptions about the recovery process being a move from 'victim' to 'survivor'. Many felt this was reductive and would deter some participants. Their comments on this improved the survey immensely.

Another issue they raised was the concept of recovery. This was seen as problematic as it suggested an end point where the individual was 'fixed.' I had not considered this inference and it enabled me to redesign my survey banner.

Figure 3.3 Survey Banner

Their comments led to a header that used different words to encompass the idea of a more fluid state of recovering by using words such as searching and improving, as well as happiness, wellbeing and health (Figure 3.3). They also gave feedback on the phrasing of individual questions and how to standardise them to make their meaning clearer. Thus, in these ways, they contributed to making the survey much better and more accessible.

One issue to raise is that this meant the survey was mainly piloted by women who had undertaken postgraduate study, who are hardly a representative sample of the population. On the other hand, it did mean that I subsequently had quite a few survey responses from

academics, who, as people potentially further through recovering, may represent the sort of population I was trying to reach. Finally, the survey was proofread by another academic and minor changes made. A copy of the survey is in Appendix 1.

Survey Launch

The survey was open for a period of just over 10 weeks between 21st November 2017 and February 2018. I contacted lots of agencies and colleagues at the University of Sheffield, Department of Sociological Studies contacted agencies on my behalf. None of the more general agencies replied. It is not known why they did not reply: they may have been too busy or did not see it as important to their agenda. There was, however, an enthusiastic response from agencies that specifically support people who have experienced CSA, for example, Rape Crisis England and Wales and NAPAC (The National Association for People Abused in Childhood) who included the link in their newsletters and retweeted it.

It was suggested that I try disseminating the survey via Mumsnet and was informed that there was an area for research requests, but I could not find it. I asked on an academics' area and received an unfavourable response. Below are some examples:

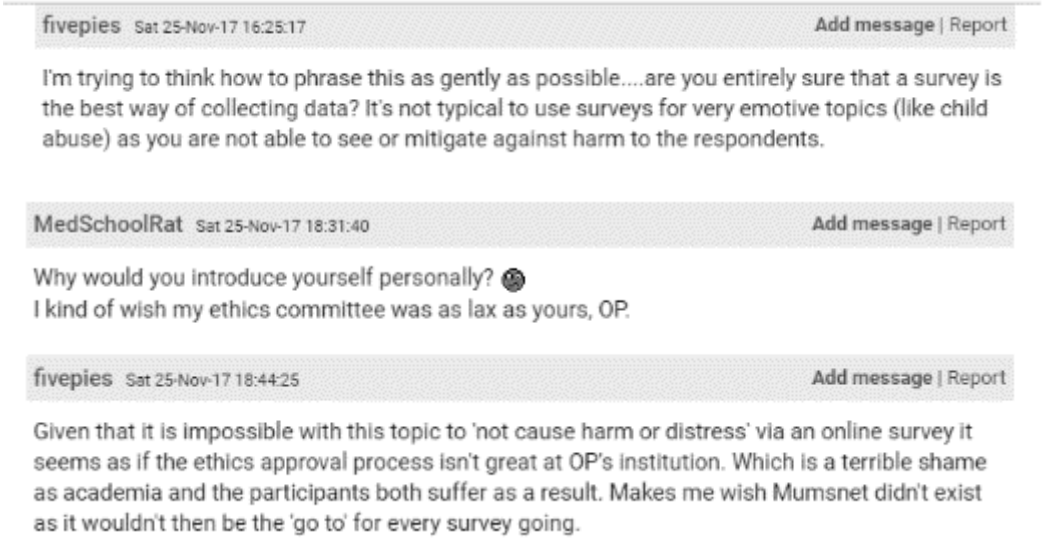


Figure 3.4 Posts from Mumsnet

Thus there were negative reactions to my methodological approach of researching child abuse online through a survey. I responded regarding ethics approval and my methodology but did not think that there was a way to further recruitment there. I conclude that I should have investigated this environment before attempting any contact. I did find this event rather concerning as it felt patronising and silencing, particularly as people questioned my methods and insider stance. It did, however, help clarify my opinion regarding the potential benefits and careful ethics of my methodology.

On Twitter there was an enthusiastic response to the research from individuals who had experienced CSA/CSE, as well as key organisations within that community. An organisation called Men's Movement that focusses on male mental health were very helpful and retweeted it to their 136,000 followers. Sarah Champion, Rotherham MP, who had already written a letter supporting my PhD, was very supportive and retweeted the link to her followers. A community of people who had experienced CSA on Twitter have a regular Tuesday night chat around various issues including recovering. They were also very helpful in retweeting the link. By the 22nd of November, the link had been retweeted by individuals or organisations to over 200,000 followers. However, it should be noted that, as the retweets were from people or agencies involved in mental health and CSA/CSE, their followers might well overlap so this does not necessarily represent a reach to 200,000 unique individuals. Thus, overall, I found that individuals and agencies involved in CSA were very supportive of the research, whereas those not specifically involved were not.

I shared the survey on Facebook, which raised an issue vital to consider in such insider research. By sharing my research to my friends and acquaintances, I was also disclosing my status as someone who has been abused. I noticed a pattern, which has continued whenever I share something related to the research on Facebook or Twitter. Social media communication from me results in retweets and comments on Twitter but very few comments or likes on Facebook. However, there are often frequent clicks through to the website from Facebook as the image below, of hits on the research website during the survey period, illustrates.

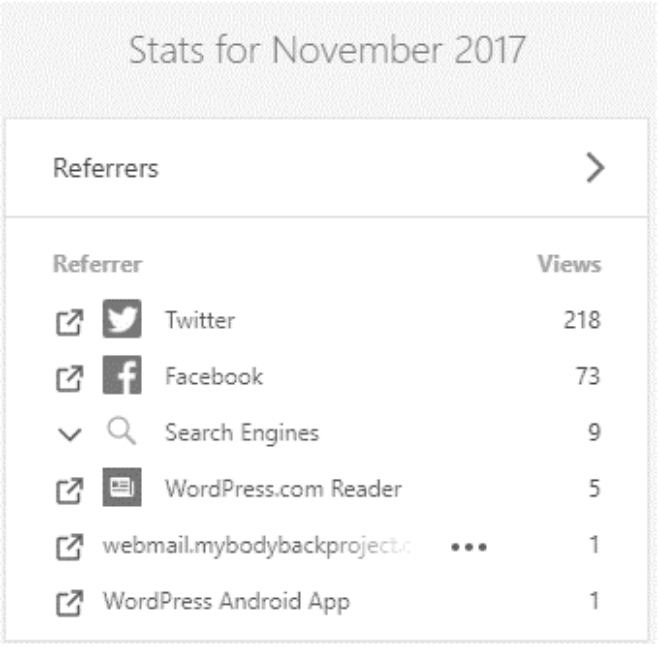


Figure 3.5 Referrals to the Website

It seems that people on Facebook were engaging with what I was posting but did not want to be seen doing it. By not commenting or 'liking' posts they imply that they do not want to be seen by their family and friends to be doing so. This implies a stigma around CSA/CSE that extends beyond victims.

The frequency of survey responses dropped over Christmas so, in early January 2018, I contacted NAPAC again and they retweeted the survey. Responses rose swiftly from 89 to 131. I closed the survey on the 1st February 2018 with a total sample size of 142. One response was blank after completing the consent form and another was a duplicate, so the total usable sample was 140. Google forms does not record uncompleted responses so I cannot estimate how many dropped out before reaching the end of the survey and pressing 'complete'.

The survey itself provided feedback from respondents, who commented on it. Examples include:

> *'I think it's a good idea to have surveys, as every CSA survivor has a different story to tell.'*

> *'This survey has now become an effective moment in my recovery. Thank you for the opportunity to reflect on my strengths in recovery, and on those external elements which inhibit it.'*

> *'Your questions are excellent. It is making me think. You are empowering me and I am SO grateful. Even though (I'm on the computer) doing your survey…I feel listened to.'*

There was only one negative comment regarding the survey itself, which was a pithy '*crappy survey'*, but overall the response was positive. Therefore, I would conclude that the survey recruitment and design was successful, although there were lessons learnt for future engagement with this specific population.

Initial Data Analysis

The aim was that themes from the survey stage would be explored further in the interviews. Facilitated through NVivo11, data from the survey was subjected to thematic analysis (Braun and Clarke, 2006). Thematic analysis identifies emergent themes from the data as well as those actively chosen by the researcher. Analysis involved a sequential process, as outlined by Braun and Clarke (2006). Firstly, I read through all of the survey responses to become familiar with them before doing some initial coding on subjects that were apparent during the initial read-through. For example, I coded responses to a node entitled 'family.' As I describe

the process of analysis, I will continue to use family and relationships to illustrate the method in practice. Parallel processes also occurred in the other themes studied.

As I continued coding, it became clear that there was more granulation required. The responses discussing family of origin were, in the main, much more negative than those concerning later family members, such as husbands, wives and children. Thus, responses were further divided into family of origin and later familial relationships. Friends and peer groups also emerged as important thus a larger classification of personal relationships was created to contain all of these interactions. Therefore, through this process themes emerged as a collection, or a higher classification, of codes.

These themes were then reviewed to ensure clarity and usefulness. Some themes were consolidated as appropriate, for example, comments regarding the police and court processes were consolidated in a 'law' theme. This analytical approach worked particularly well to curate over 4000 individual comments into usable themes. After this first stage of analysis various key survey themes became apparent. The emerging themes were issues around stigma, identity and embodiment plus the positive as well as negative factors involved in treatment, law, work, religion and relationships. These themes were then used to develop a semi-structured interview schedule.

Interviews

Interviews were an opportunity to explore issues in more depth and capture narrative data. They were also more interactive and so the interview codebook aimed to adapt to the differing circumstances of the participants. For example, some participants had reported the crime to police and others had not. Questions about family needed to take into account whether the abuse was incestuous. Similarly, questions about religion were differently designed depending on whether the abuse was within a religious setting. There were also survey respondents who had particularly interesting perspectives on CSA, for example being trans or having Dissociative Identity Disorder, and I wanted to ask them specifically about that. The Interview questions are in Appendix 4.

I aimed to take the research further than simply identifying issues. I also wanted to utilise the lived experience of people who had experienced abuse to suggest improvements and solutions. Therefore, I included questions about what could be improved or what they would like to tell people in power. As part of my aim to power-share as much as practical, I also asked them if they wanted to choose their own pseudonym, which 14 out of 21 interview participants did. Three requested that I use their own first name. After consultation with the

Departmental Ethics lead, it was decided to respect their choice by including them in the thesis without highlighting how each individual name was chosen.

There were 93 volunteers for interview from the survey responses. This was 66% of the total number of responses, indicating that participants really wanted to contribute. Potential participants were then selected with reference to the principal of maximum variation (Quinn Patton, 2015). This method of qualitative sampling is specifically designed to sample across a diverse range of characteristics, chart the complexity of their experiences, and identify central themes and interests (Patton, 2015). The specifics of this are covered below.

21 participants were interviewed in total. Some respondents requested the opportunity to read the interview questions beforehand and I was pleased to comply. In future, I would offer this option as a matter of course, as it did not negatively affect responses and was favourably received by those interview participants who requested it. Furthermore, I would also, in future, offer interview transcripts for checking and information.

The first interview took place on the 11th of December 2017, before the survey closed, and was a pilot for the interview schedule. It was useful to trial the questions and also my stance as an insider researcher. In this interview, I felt that the balance I struck, of sharing personal information, needed adjustment because I felt that I shared more than was appropriate. For example, when discussing relationships, I was asked about my marriage and did discuss this. Such a disclosure felt more like a conversation than an interview and as a result I did not think that I had maintained an appropriate distance from the subject.

This was useful, however, because it enabled more thought on my part both in terms of questions and stance before commencing the main body of interviews. When it came to the main set of interviews, I endeavoured to keep any personal information of my own out of the interview and then only mentioned relevant facts after the interview schedule was complete. I think this approach did work well, and it is worth reporting that some of these later conversations, which were also recorded, did result in useful data.

On the 7th of February 2018 I met my primary supervisor Dr Tom Clark and we agreed the interview codebook. From there, interview requests were sent out in tranches to manage the workload. These tranches were: responses that strongly reflected or challenged the themes identified in the survey (n-13), every tenth response (n-9), men (n-6), female perpetrators (n-2). The latter two tranches were added when it seemed that males who had experienced CSA and people who were abused by women were under-represented. In total, I sent out 31

requests for interview participants and interviewed 21. There were other people who initially responded but then dropped out. Therefore, the response to interview requests was positive.

Interviews were carried out over an eight-week period between March and May 2018. All interviewees were offered and chose the following options for interview: face to face (2), telephone (5), email (6), Messenger (0) or Skype (8). Where applicable, interviews were recorded via the iTalk app on an iPhone, if they were carried out by Skype, or recorded using Microsoft Voice Recorder if they were telephone interviews. Therefore, conversations on the computer were recorded on the phone and vice versa. I carried out test recordings to ensure that these methods were effective and reliable.

Consent forms and research information sheets were sent to all interview participants prior to the interview. Completion was a prerequisite to the interview. I also commenced the interview by repeating some of the information, particularly about data security, confidentiality and their right to withdraw at any time. I scheduled in no more than two in a day. After the interviews the recording was transcribed.

For email and chat interviews, the transcripts were already completed as part of the data collection and required only formatting and anonymising. Email interview responses were much briefer than other methods and this may have been because of the lack of interaction. Once consent was received, I sent the questions in a single email. In future, if using this method, I would endeavour to establish a rapport beforehand and use more than one email for question dissemination to facilitate interaction.

Transcripts were reproduced as accurately as possible. Pauses were recorded but not timed. Habitual words or phrases such as ‘look’ ‘yeah’ or ‘you know’ were not included. Following transcription, the accuracy was checked by listening to the recording at the same time as reading the transcript. Finally, all participants’ names were anonymised, unless they had specifically requested otherwise, and any identifiable data, such as location or specifics of occupation, were removed.

Data Analysis and Reporting

Data from the 21 semi-structured interviews was subjected to thematic analysis again facilitated through NVivo11 (Braun and Clarke 2006). The aim was to understand how survivors created and recreated their identities in the light of societal stigma, as well as how they expressed the relationship between self and society. As with the 140 survey responses, the same six-stage process was then followed with the interview data and further themes emerged. These were parenting, disclosure and terminology. These themes will be explored in the data chapters.

Graphs and bar charts were created to illustrate the results. These show the exact numbers responding to each question. Percentages were only used to compare different sized groups, such as comparing male and female responses or for comparison with other research findings. Wordles of the data themes were created within NVivo using the word count function. Wordles show more common words larger. The word count function can aggregate words at different levels, for example combining stemmed words and synonyms. In some cases, this was used where related words were dominating the picture, for example, mum and mother were combined. There is also the option to stop words appearing in the wordles and this was done to exclude people's names and words (e.g. think, erm, yeah) that did not add anything substantive to the message from the participant. These were used for analysis but are also included below where they illustrate themes.

A decision was made to include, as far as possible, quotes from the participants to illustrate the themes identified. This was for two reasons. Firstly, each of the participants has shared their perspective and experience, including choosing their own vocabulary to explain and express it. It is important to facilitate this expression. Secondly, as an insider researcher, I am aware that my perspective could be seen as suppressing differing opinions, and by using participant voices I want to ensure that what they wanted to say is heard. The quotations used were chosen for two reasons. Firstly, they summed up the other responses in that code or theme, disconfirming cases being described elsewhere in the text. Secondly, I chose the most illustrative or eloquent to better explain the point. Thus, it should be acknowledged that research is a curated process, with some quotes chosen and others excluded. It should be noted, however, the data is will be available under The Wellcome Trust's open data policy.

Limitations and Issues

One significant gap in the research was that I omitted to ask, in the survey, was about the gender of the abuser(s). Theories of perpetration are built upon the pre-supposition that perpetrators are overwhelmingly male. For example, the theory that patriarchal culture is responsible for CSA (amongst many other effects) is predicated upon the belief that men are overwhelmingly the perpetrators of abuse. The vast majority of research studies focus upon male perpetrators. Indeed, when attempts are made to research female felons, the prison population is so small that this affects the sample size significantly. For example, when Darling (2017) researched female perpetrators, she found that only 1.5% of the sex offender prison population were women. However, the level of convictions may not be reflective of the number of female perpetrators. For example, Dube *et al.* (2005) found, in a large scale household survey, that women made up 40% of abusers of boys and 6% of abusers of girls.

The endemic belief of male perpetration also affected my research, as I did not even consider asking a question (in the survey) regarding the gender of the perpetrator. This error was also not noted by any of the academics from the Women in Academic Social Network (WIASN) who piloted and proof-read the survey. I realised this omission afterwards and tried to ensure that my interview participants included those who had mentioned that the person who abused them was female. A careful read-through of the interview and survey data identified six female perpetrators, which is unlikely to be representative of the proportion in the general population. This error would be rectified in any subsequent research.

Furthermore, I would have liked to have piloted the survey with people from different demographic groups to ensure usability, but this was not practical due to the time constraints. It would also have been good to translate the survey into other languages and formats to increase its accessibility. If the survey had remained open longer, it is likely that the responses would have increased in number and additional themes might have emerged.

There were also technical limitations, particularly that Google forms do not record uncompleted forms. Whilst this enables people to return to half-filled surveys to complete at their leisure it also means that it isn't possible to access data on how many people abandoned the survey. Therefore, any assessment of its efficacy in accessing this group needs to take this into account.

Finally, Payne and Williams (2005) point out that every research study involves a sample population, as it is impossible to survey every individual affected by a social phenomenon. They argue that modest and pragmatic 'moderatum generalizations' can be drawn from qualitative examinations of everyday experiences. They caution that such generalisations of experiences can lead to claims that are modest and subject to refutation, noting that such phenomena alter over time (Payne and Williams, 2005). In this way qualitative research can raise themes or issues which can be further researched using quantitative or qualitative methods. This is a useful approach to this research and its survey population. It is not representative of all people who have experienced CSA, but the responses do break down into clear themes which warrant further examination.

Working the Hyphens

Carrying out insider research is indeed 'working the hyphens' (Fine, 1994) as it involves a frequent re-evaluating of one's own positionality. There were numerous occasions, particularly during interviews, where I would evaluate how much to reveal or whether to reference my insider status at all. My previous experience negotiating such issues was invaluable here and, in the main, I am happy with the balance I drew. Such reflexivity is vital in insider research

(Haraway, 1988). I would argue, however, that a reflexive approach should be carried out whatever the researcher's social location to the area studied.

I do feel that my insider status was a benefit to the research. It enabled me to design the research with cPTSD in mind, as well as understanding how questions about abuse might be received. That is not to claim that I could predict responses but that it was easier to scope out eventualities and plan for them. When it came to respondents, I think that my insider status disinhibited responses, as I was, by my status, demonstrating knowledge of the area and indicating that I would not respond negatively.

The effect of the research upon me was, in the main, positive. There were negatives particularly in responses to the research on Mumsnet and the emergence of #metoo during the fieldwork period. However, there was an unexpected therapeutic benefit in identifying my own cPTSD. Secondly, the research itself has educated me upon my own condition and contextualised the experience of abuse.

Therefore, I would argue that there is a place for insider research in this area. I do think it is important that researchers disclose their relationship to their research if they feel able to, but they certainly should not be compelled to in the current potentially judgmental climate. Insider research does not replace traditional research but compliments it and challenges it by providing a different viewpoint of the area. Hopefully this will enable a more nuanced understanding of recovering: one that is informed and designed more directly by people who have experienced CSA.

Avoidance of research with what are viewed as 'vulnerable' groups can mean a lack of an evidence base, which thus affects practice (Downes, Kelly and Westmarland, 2014). Indeed, participation in research itself can be a positive experience for the individual, if designed with the target audience in mind. The resultant high levels of participation and clear willingness to be interviewed for this research indicate the value placed upon being heard. Insider research was useful in this case as participants did not have to fear a poor reaction to their disclosure. This is not to say that it is of therapeutic benefit in a clinical sense but that, as Downes *et al.* (2014) suggest, it can have a positive impact on people who have experienced CSA/CSE. This has been demonstrated in my research by the many positive comments about the benefits of taking part in the research itself.

Underlying this research design was my commitment to ethical research, not just in theory but in practice. I have endeavoured to reduce the risk of harm to participants, utilising my own experiences to do so. Further than this, my conceptualisation of the survey and interview

respondents as actors and adults was grounded in ethical practice which aimed both to empower and to power share. However, there were some tensions between ethical theory and practice. An example of this is the respondents who did not want to use a pseudonym where the ethical guidelines considered this essential. Thus, there can be a tension between respecting participants' autonomy and practices designed to protect them from harm.

Ultimately, I would conclude that this methodological approach was successful as it recruited a useful number of participants both for the survey and interviews. The trauma-focussed approach was a benefit as it considered and addressed the potential barriers for respondents. Furthermore, the salutogenic framing of the questions, focussing upon recovering, has also provided rich and coherent data which contributes to the debates around treatments and support. There are, as with any research project, issues that would have been improved with more time and/or experience but, overall, the methodological approach yielded good results. The next chapters outline the identified themes and illustrate the richness of the data gathered.

Chapter Four - Demographic and Experiential Data

This chapter examines the data the research participants provided regarding their lives and circumstances to explore the ways in which the sample population approximates with or differs from previous research cohorts. This is not to generalise from the data and is instead an attempt to contextualise the qualitative findings. As stated in the literature review, great importance is placed upon certain characteristics of people who have been abused. For example, in resilience studies a more extensive education is seen as a marker for higher levels of resilience (Phasha, 2010; Domhardt *et al.*, 2015). Participants in this research identified as recovering, which could be viewed as either analogous with resilience or caused by it. Therefore, the question arises whether they are benefiting from better circumstances than others or demonstrating recovering/resilience through greater achievement. The aim of this chapter is to answer the following question: Does the sample population differ from previously researched populations and, if so, how? Any differences could be the key to recovering.

The chapter is split into two sections. This first covers four basic demographic characteristics of the participants: age, gender, ethnicity and country of residence. The second section explores the circumstances of the abuse itself, to see if participants experienced any differences from those reported in the wider literature. The factors considered divide into two main themes. The first is the characteristics of the abuser in terms of their age, gender and relationship to the victim. The second relates more to the victim and considers their familial circumstances, whether they experienced CSA/CSE and, finally, participants' assessment of the harm caused by the CSA.

It should be noted that there are no claims made here of statistical representativeness. Due to the nature of qualitative research and data, the sample sizes are not large enough to make such claims, as discussed in the methodology chapter. However, the rich 'micro level' of qualitative data can provide insights that can contribute to an understanding of the macro level (Williams, 2000). Indeed, this is the basis of C Wright Mills' (2000) sociological approach, that of using individual experience to infer and understand the effects of public issues. Therefore, while this data should not be used to generalise, it can be argued to raise potential areas for further research, and these are highlighted below.

Demographic Questions

At the start of the survey, following the compulsory consent questions, were general demographic questions. These were followed by a brief section asking questions about the abuse experienced. All were multiple choice and, where appropriate, some also offered the chance to choose multiple answers, for example, where there was potentially more than one

perpetrator. The survey was completed 140 times, but respondents did not necessarily complete all the questions, so the number completing each question are stated. The general demographics of the survey participants is explored because the sample population may have different demographic characteristics. For example, it may be that women are more likely to view themselves as recovering.

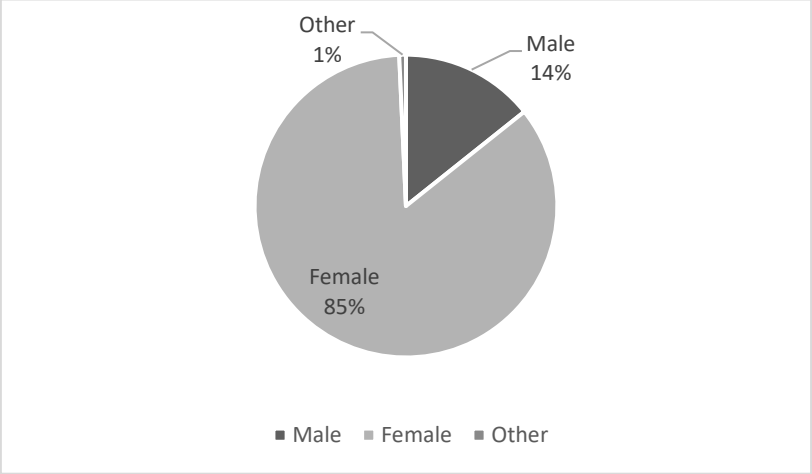


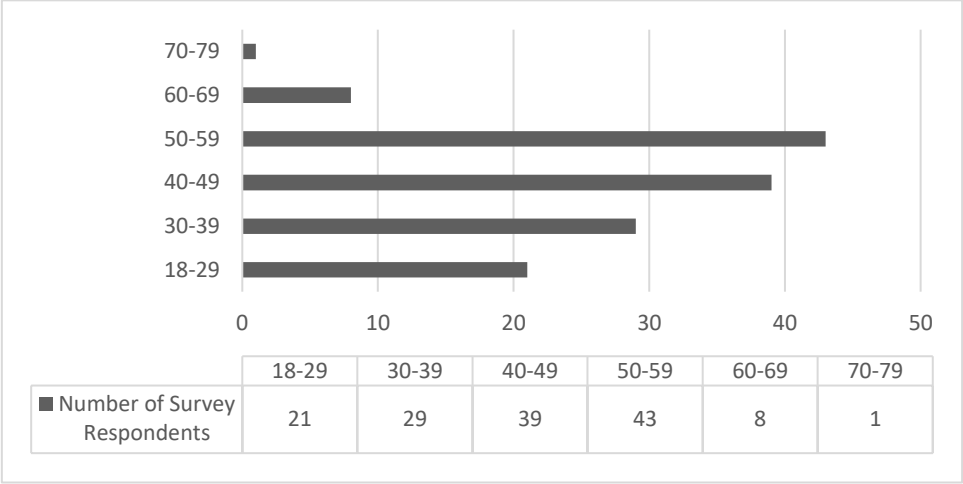
Figure 4.1 Gender of Respondents. N=140

The gender profile of the survey was 199 (85%) responses from women, 20 (14%) from men and 1 (1%) trans (Figure 4.1). Although gender percentages can vary, possibly due to methodological factors, it appears that the gender split is broadly similar to previous research. The 2018 UK crime survey reported a gender split of 85% female and 15% male (Office for National Statistics, 2018).

However, neither survey records trans people's experience of CSA. There has been some limited research into the prevalence of CSA in transgender people. For example Singh and McKleroy (2011) interviewed 11 transgender people of colour and reported a 45% prevalence rate of CSA. This rate was echoed by a study of transgender sex workers in New York that reported a 41.5% prevalence rate of CSA (Parsons *et al.*, 2018). However a study of 120 transgender people from Spain found a lower prevalence rate of 24% (n-29) (Fernández-Rouco *et al.*, 2017). These are not general population studies, but ones that actively recruited only trans people. Flores *et al.* (2016) estimate that 0.6% of the American population identify as trans, and the response rate in this research is broadly in keeping with this proportion.

Overall, the gender split of this research population is similar to other research in the area, perhaps indicating that, for this group, recovering is not more likely for any particular gender. It does, however, highlight that there is a need for more research into trans people's experience of CSA.

Next, participants were asked their age at the point they were completing the survey (Figure 4.2).



	18-29	30-39	40-49	50-59	60-69	70-79
Number of Survey Respondents	21	29	39	43	8	1

Figure 4.2 Age of Respondents. N=140.

21 people were between 18-29 and 29 between 30-39. The largest group of respondents were between 50-59 (n=43) and the second largest between 40-49 (n=39). This differs from many previous research studies, which actively recruited college students (see Tang 2002; Graves *et al.* 2017; Krahe & Berger 2017). Nine people responded who were aged 60+ and this age group, as well as the other respondents over 30 may have a different perspective than college students, not least because they will have had more time for recovery. The recruitment strategy did aim to target older people and there was a concern that an online method might restrict that. However, despite a lack of response from the general agencies specifically involved in supporting older people, eight respondents were aged 60-69, with one 70+. However, nearly one in five people in the UK is over 65 (Office for National Statistics, 2019), and whilst this method did recruit people over 60, it did not recruit anyone 80+, so other recruitment methods might be necessary in future to access this population.

Overall, the age distribution does differ from the general age spread across the UK. The age profile provided by the ONS (2019) indicates that each age group (20-29, 30-39 etc) is relatively similar in size, at around 6-7% of the population, with the percentage dropping after 55. This differs from this survey results, where there are larger groups in their 40s and 50s. This may reflect issues in the recruitment process, for example, Facebook and Twitter may not be the appropriate places to recruit people under 40. Instagram or other newer social media sites might have been more effective. However, it may indicate that there is indeed an ongoing age-related effect on recovering. Research suggests a delay before people disclose abuse and seek help thus it might be hypothesised that older people would be further through

recovering (Harker *et al.*, 2015). This may make them more likely to respond to a survey recruiting people who define themselves as recovering.

The next demographic question was about the country of residence for the survey participants.

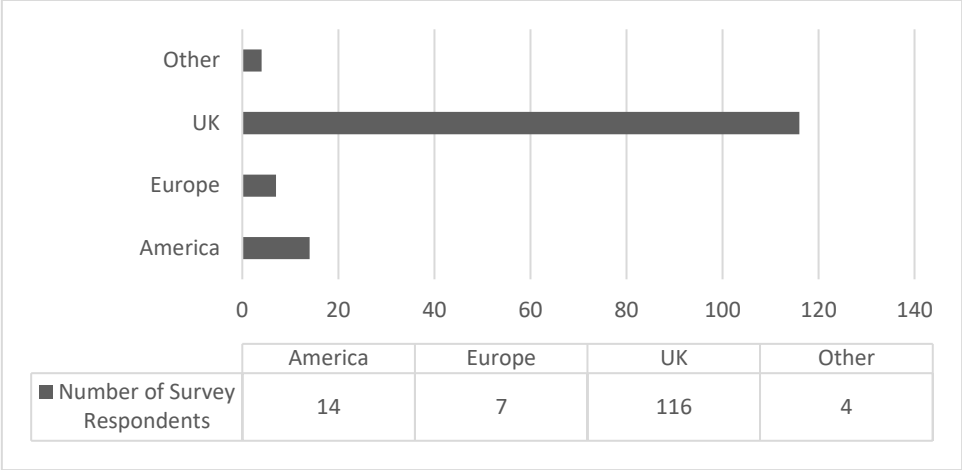


Figure 4.3 Country of Residence. N=140

The largest group of respondents were from the UK (n=116), followed by America (n=14), Europe (n=7) and others (n=4). As recruitment was carried out on the internet, respondents could theoretically be resident world-wide. However, the recruitment plan did not specifically aim to recruit from any country other than the UK and the support agencies contacted were only within the UK. Thus, is it not unexpected that the majority of respondents were from the UK. With a longer term and larger funded study, it would be interesting to compare the effects of differences in health care systems, particularly in America.

	Country of residence
America	14
Australia	2
Canada	1
Croatia	1
France	1
Ireland	2
Israel	1
Norway	1
Poland	1
Spain	1
UK	115
	Total: 140

Table 4.1 Country of Residence

The participants' specific country of residence were the UK (n=115), America (n=14), Australia (n=2), Ireland (n=2), Canada (n=1), Croatia (n=1), France (n=1), Israel (n=1), Norway (n=1),

Poland (n=1) and Spain (n=1) (Table 4.1). The survey did not receive any responses from the global south. This may have been influenced by the method of distribution, the specific social media and language used, as well as possible cultural differences around disclosing CSA. With more time and funding, a larger, more genuinely international survey would be valuable, enabling an in-depth comparative analysis by country, and this would have required an in-depth consideration of the barriers to completion worldwide. However, this was not a realistic aim for this project.

One area where results differed from the general population was the ethnicity of participants. A question was asked about ethnicity using the categories used by the UK Office for National Statistics.

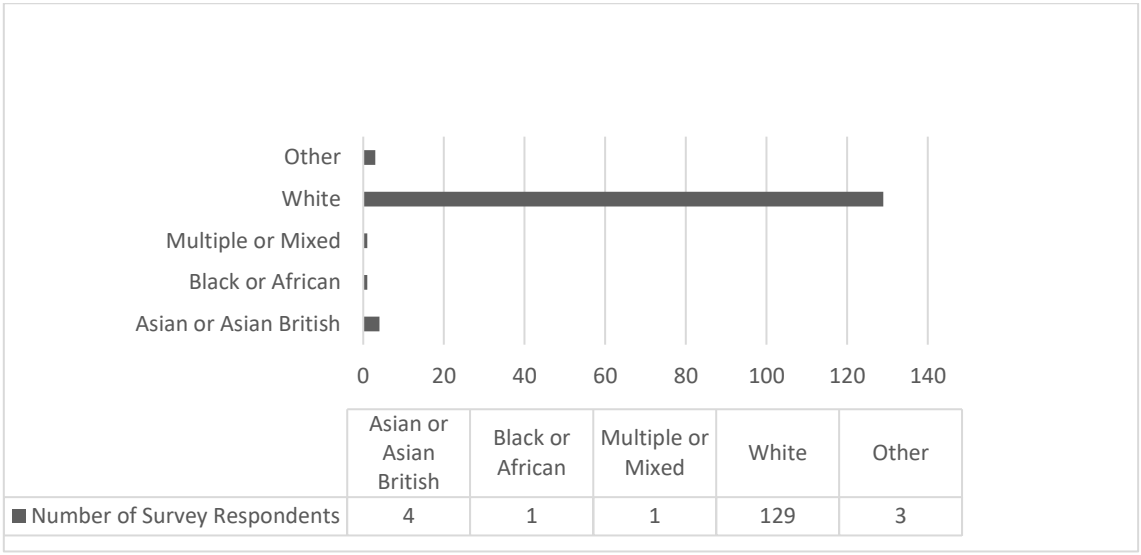


Figure 4.4 Ethnicity. N=138

129 people described themselves as White, four were Asian or Asian British, three described themselves as Other, one person as Black or African and one person as multiple or mixed (Figure 4.4). At 93% of the total the white participants represent a larger proportion than the 86% reported in the latest UK census (Office for National Statistics; National Records of Scotland; Northern Ireland Statistics and Research Agency, 2016). This could be because of the online recruitment method, amongst other potential factors, but as there is limited data available on the ethnicity of social media users, this cannot be established (Sloan *et al.*, 2013). The difference may also be influenced by cultural differences regarding disclosure but, again, there is little data on this.

As discussed in the literature chapter, there have been research studies examining CSA prevalence world-wide, many concentrating on specific countries. There seem to be possible geographical differences in prevalence rates, with reports of lower rates in Asia (Stoltenborgh

et al., 2011). There are, however, few research studies examining CSA prevalence amongst the non-indigenous residents of a country, although some do consider specific cultural and societal influences upon CSA disclosure (see Sanjeevi *et al.* 2018; Ji *et al.* 2013).

This could have great significance as, for example, assumptions about the ethnicity of children experiencing CSE in towns such as Rotherham have been utilised by far-right organisations to further a racist agenda (Britton, 2019; Halliday, 2019). Targeting different ethnicities was not part of the research design, due to limited time and resource, however, this is acknowledged to be a significant omission.

Of the nine people describing themselves as of a non-white ethnicity, there was no abuse perpetrated by strangers, and six were abused by a family member. Four people reported that they were definitely or 'maybe' a victim of CSE, which challenges the prevailing narrative that CSE is perpetrated by Muslim men against white female victims. Further research in this area is warranted.

There are some issues with the demographic information collected. There were no questions asked to establish class, occupation or educational level and these would have contributed to the overall analysis, particularly around the structural issues affecting recovering. In any subsequent research, I would include such questions, though it should be noted that these are not standard questions in the wider literature either. Although I would have been unlikely to find comparative data in other research, gathering such data could have been useful to expand the data available in the field.

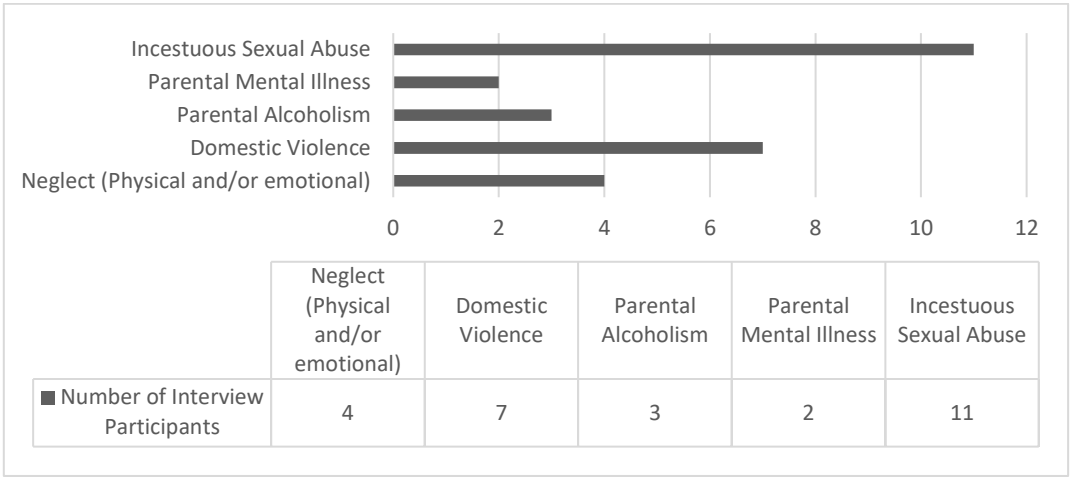
Overall the data above demonstrates that the sample population reflect previous gender profiles, with the exception of recording the inclusion of a trans participant. Participants are not evenly distributed across UK age bands with more responses received from people over 30. This may reflect the time taken to disclose and begin to address the experience of CSA. The other two demographic results, that of mainly UK responses and less people from ethnic minorities, may well be as a result of methodological choices rather than reflecting any differences in recovery for these groups.

Therefore, as regarding the question raised at the start of this chapter, this section suggests that people who regard themselves as further through recovering appear to be older. They have had more time to recover and have figuratively as well as perhaps physically more distance from the abusive experience/s. This will be discussed further in the following chapters. The next section examines the circumstances and people involved in those events.

The Experience and Circumstances of the CSA

This section considers various characteristics of the perpetrator including how the victim met the abuser, if they were an acquaintance, and how old the abuser was at the time of the assault/s. It also examines the social location of the respondents, specifically regarding their age, gender, if they were disabled at the time of the abuse and if they experienced CSE. Finally, it ends with an assessment by the participants regarding the harm caused by the abuse.

Firstly, there is an examination of the victims' familial circumstances when the abuse occurred. Previous research has demonstrated that the presence of other ACEs can raise the risk of abuse (Dong et al, 2004). Many of the research participants mentioned other adverse childhood experiences (ACEs) in their family at the time of the abuse, although this was not in response to a specific question. In three quarters of the interviews (n-16), people spoke about one, or a combination of, incestuous abuse (n=11) parental violence (n=7), neglect (n=4), alcoholism (n=3) or mental illness (n=2)



	Neglect (Physical and/or emotional)	Domestic Violence	Parental Alcoholism	Parental Mental Illness	Incestuous Sexual Abuse
Number of Interview Participants	4	7	3	2	11

Figure 4.5 Interview Participants Reports of Adverse Childhood Experiences (ACEs). N=21

Therefore, out of the 21 interviews, 19 participants described a family situation that involved either other ACEs in the family and/or incestuous abuse (Figure 4.5). Only two interview participants had a family situation that did not involve any ACEs, although they personally experienced an ACE (CSA). Seven people described the presence of incestuous abuse as well as other ACEs in their family.

As will be discussed in Chapter Six, there is a noticeable lack of involvement by health and social care services during the childhood of the research participants. This ACEs result, which, as stated, reflects previous research, indicates 'red flags' within the family environment that could have merited service involvement and investigation. As will be seen in Chapter Six,

these family issues were visible and noted by others. This combination, of familial ACEs and lack of service involvement, requires further research.

Continuing on from the issue of childhood ACEs, the victims' relationship to the perpetrator/s is significant, as often this is also a family member. This is one of the most common measures applied in CSA research. As explained in the literature chapter, historically assumptions were made regarding the characteristics of perpetrators, mainly that they were strangers to the victims, however, this appears to rarely be the case (see Ullman, 2007; Azzopardi *et al.*, 2018).

When designing this survey question, it was acknowledged that respondents may have been abused by multiple people in childhood, such as a family member and then later by a stranger, for example. For this reason, participants were given the option to tick multiple boxes for this question. However, it should also be noted that this is not the total number of perpetrators, as people may have been abused by multiple family members, for example, and this would not be reflected in their responses to this question.

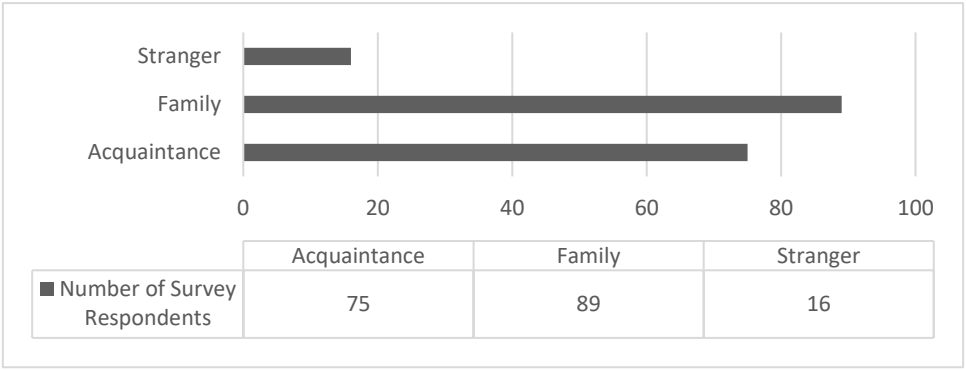


Figure 4.6 Relationship (if any) to the Perpetrator. N=183 (from 140 respondents)

In total there were 183 responses regarding relationship (if any) to the perpetrator from the 140 people who completed the survey, which reflect multiple abuser types. 89 (49%) of respondents experienced familial abuse, 78 (42%) acquaintance and 16 (9%) abuse by strangers (Figure 4.6). This differs from other research, where the majority is often acquaintances, although familial abuse is also a very large percentage (Finkelhor *et al.*, 2014; Office for National Statistics, 2018). For example, in the studies listed, the percentage for familial abuse was between 18-44% of the totals. However, most studies agree than strangers are the perpetrators only in a small minority of cases. One exception is Baker and Duncan (1985), who reported 51% of victims in a UK MORI survey were abused by a stranger, but in most studies this figure is much smaller. Thus, in this area, participants differ, in that they reported higher rates of familial abuse, which is one of the characteristics of abuse that is considered to be more severe (Ullman, 2007).

Participants who were abused by acquaintances were asked how they met the perpetrator and the results are below. Again, respondents could select multiple answers to reflect more than one abuser type.

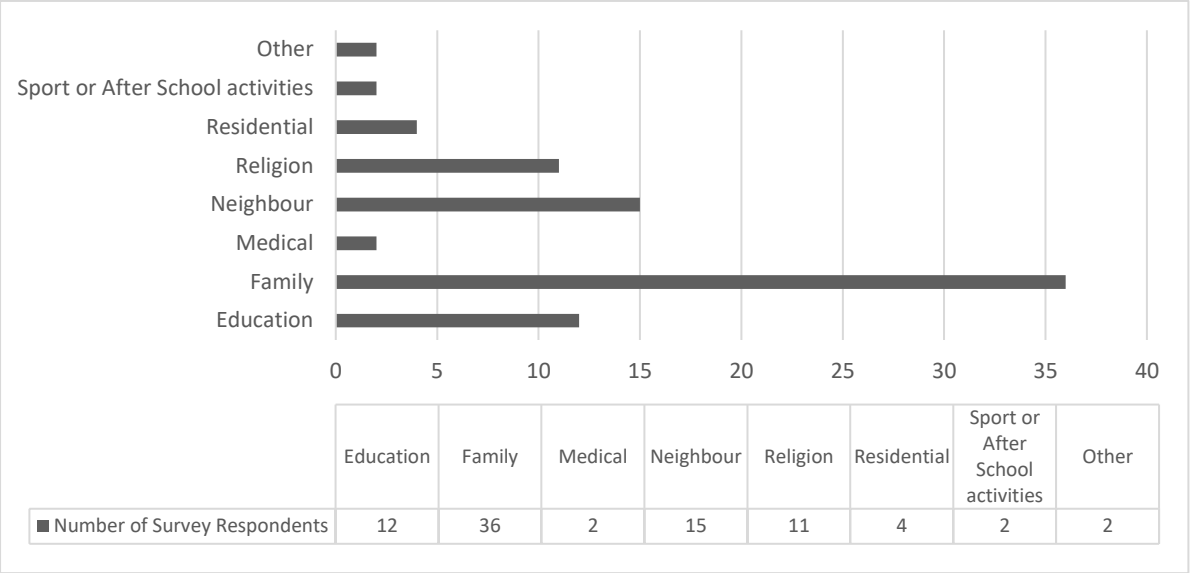


Figure 4.7 How the Child Came into Contact with the Abuser (if Acquaintance). N=84

The largest category was people met through the family (n=36). Examples of perpetrators in this category included a babysitter and the son of a mother's new partner. The next largest group was neighbours (n=15), followed by perpetrators involved in education (n=12) and religion (n=11), residential care (n=4), healthcare (n=2) and other (n=2) (Figure 4.7). The two 'other' responses were 'play area' and 'responsible adult in an organisation I belonged to' thus were difficult to categorise further. Thus, from the responses it appears that, as people integral to community life, perpetrators are very likely to be known and, potentially, respected by the family. This result and the data regarding the relationship of perpetrator to victim is important, because abuse by trusted perpetrators has been demonstrated to be associated with more severe mental health symptoms (Ullman, 2007). Therefore, in these cases respondents appear to have, in general, experienced more 'severe' abuse and yet still view themselves as recovering.

Another crucial characteristic of perpetrators is their age. As discussed previously, many research studies focus on adult perpetrators or include a set definition of the age gap between perpetrator and victim (see Finkelhor, 1980; Wild, 1989; Fuller-Thomson *et al.*, 2012). However, there has been an increase in studies addressing peer abuse (see Radford *et al.*, 2011; Timmerman and Schreuder, 2014). Thus, it was appropriate to include a question relating to the age of the perpetrator/s.

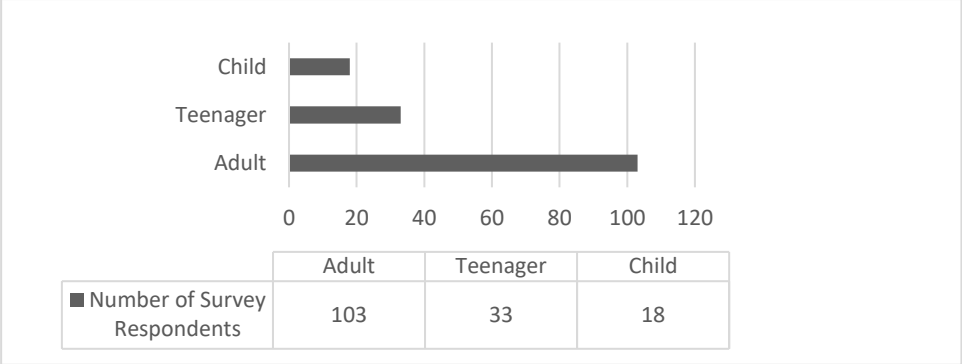


Figure 4.8 Age of Perpetrator/s. N=154

This question allowed multiple answers, to reflect multiple abusers, and in total there were 154 answers chosen. 103 (67%) of participants were abused by adults, 33 (21%) by an adolescent and 18 (12%) by another child (Figure 4.8). As discussed, this does not reflect most research, as questions regarding the age of the abuser is not usually included. This may be because sexual activity between children is not always viewed as abusive. However, one older study did ask about the age of participants. In a 1929 research study, perpetrators were reported as 38% adult males, 20% adult women and 42% adolescents or peers (Hamilton, 1929). This is a larger proportion of adolescents and peers than in this study. This current data does, however, suggest that abuse by children or adolescents does occur and, furthermore, because it is reported by participants that it is experienced as abusive, as opposed to 'experimentation,' by their victims. This does not exclude the possibility of consensual 'experimentation', but merely suggests that not all peer activity is viewed positively by those involved.

A fundamental area for enquiry is the age at which the abuse began, because abuse at a younger age is hypothesised to be more damaging (Ruggiero, McLeer and Dixon, 2000). Therefore, a question was included regarding the age of the victim when the abuse commenced.

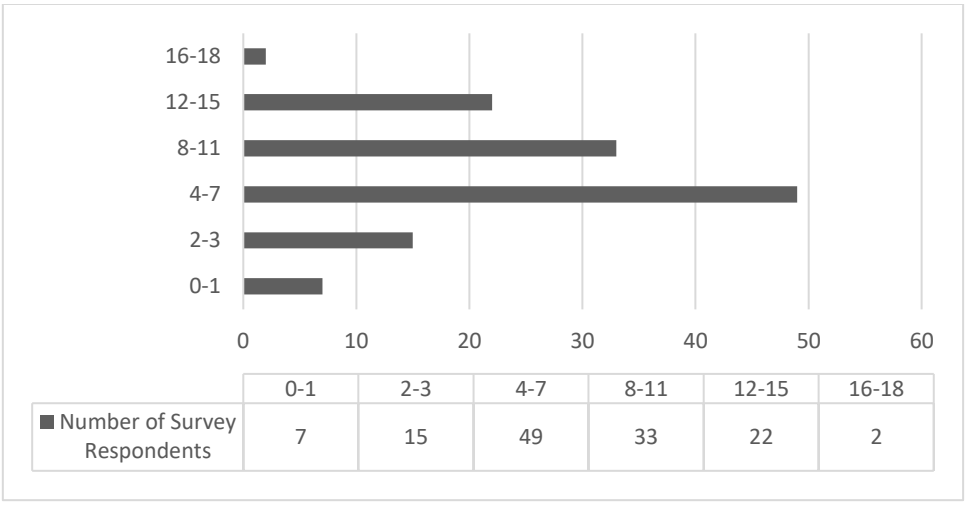
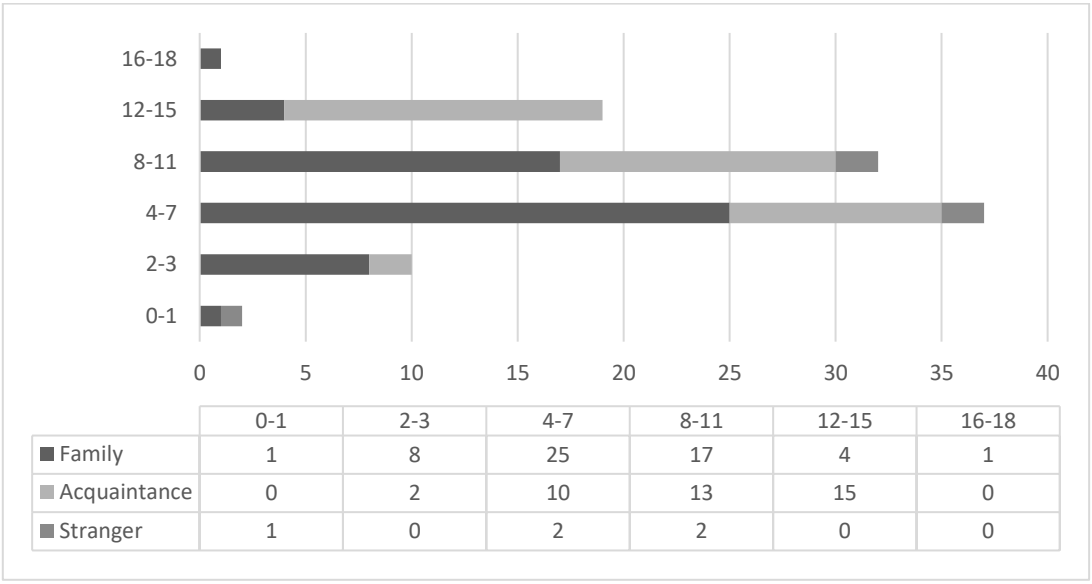


Figure 4.9 Age of the Victim when the Abuse Commenced. N=128

The largest group of respondents were abused starting when they were between four and seven years of age (n=49), followed by age 8-11 (n=33), 12-15 (n=22), 2-3 (n=15), 0-1 (n=7) and 16-18 (n=2) (Figure 4.9). The majority (55%) were under eight when the abuse commenced and over three quarters were under twelve. This reflects data from the recent crime survey for England and Wales carried out by the Office for National Statistics (2018), where half of adults reporting CSA had been abused by age nine and three quarters by age twelve.

One important difference in this data is in abuse starting at under the age of four. The ONS Crime Survey for England and Wales (2018) reports 5% of respondents were abused under four, whereas this data has 17% reporting that the abuse commenced when they were under four years old. Differing methodologies might explain this disparity. The crime survey for England and Wales is carried out face to face, whereas this research was online and thus more anonymous. There may be a fear of being disbelieved when reporting such early trauma.

However, there is evidence that children can encode and, therefore, potentially remember trauma from as early as six months (Gaensbauer, 2002). Therefore, there may also be a real difference in the reported onset of abuse, which requires further research. The child's relationship, if any, to the perpetrator and the child's age when the abuse started was explored.



	0-1	2-3	4-7	8-11	12-15	16-18
Family	1	8	25	17	4	1
Acquaintance	0	2	10	13	15	0
Stranger	1	0	2	2	0	0

Figure 4.10 Age Abused Started and Relationship to Perpetrator. N=101

NB: Twenty-five women and two men reported that they were re-victimised as a child by multiple offender types. Eleven of those re-victimised people were under four when the abuse started. Where multiple abuser types were listed, the cases were removed from the figure because there was no means of identifying which abusive experience was earliest.

The data suggests that familial abuse starts earlier, in general than other types of abuse. Of the twelve people reporting abuse onset earlier than four years old, where perpetrator type was recorded, nine were abused by a family member. This may reflect who can easily access younger children. Abuse by acquaintances and strangers appears to be more likely at an older age.

Girls report being more likely to experience familial abuse. The gender of the victim was examined with their relationship to the perpetrator (Figure 4.2). Percentages are used here to enable comparison because the numbers of responses from each gender differ greatly, but this is not a claim of any statistical significance.

	Women	**Men**
Family	82 (54%)	7 (32%)
Acquaintance	58 (38%)	11 (50%)
Stranger	13 (8%)	4 (18%)
	153	22

Table 4.2 Gender of the Victim and their Relationship, if any, to the Perpetrator. N=175

Girls report the majority of the abuse they experienced (54%) was perpetrated by family members, followed by acquaintance abuse (38%) and stranger abuse (8%). In contrast boys appear to be more likely than girls to be abused by acquaintances (50%) or strangers (18%) whilst being less likely than girls to be abused by family members (32%) (Table 4.2). This reflects previous research. For example, one study, in Switzerland, put familial abuse as a majority at 56% for female victims (Finkelhor, 1994).

The age of the victim at the onset of the abuse may also be affected by gender.

Age	**Women**	**Men**
less than 2	7 (7%)	1 (6%)
2 to 3	13 (12%)	2 (12%)
4 to 7	42 (40%)	3 (18%)
8 to 11	25 (24%)	7 (41%)
12 to 15	17 (16%)	4 (24%)
16 to 18	1 (1%)	0%
	105	17

Table 4.3 Age of Abuse Onset and the Gender of the Participant

The peak in girls reporting abuse onset is 40% at between four and seven whereas boys report that they were more likely to be abused later than girls, with a peak at 41%, between eight and eleven (Table 4.3). This does reflect wider literature, for example, O'Leary *et al.* (2015) studied twenty men who reported experiencing CSA and found an average age of commencement of

9.3 years old. This is reflected by a meta-analysis that identified an average age of onset for boys between 8 and 9 (Dhaliwal *et al.*, 1996). This may be related to the fact that, as above, gender affects whether the abuse is committed by a family member (see Pereda *et al.*, 2009; Stoltenborgh *et al.*, 2011). It may also be that acquaintance abuse is harder to facilitate in younger children. Previous research does indeed suggest that boys are less likely to be abused within the home (Office for National Statistics, 2018).

There are other risk factors for CSA, for example, previous research has indicated that disability raises the risk of experiencing CSA (Kvam, 2000). In this research, 8% of 140 respondents reported that they were disabled when they were abused. This is lower than reported in previous studies (Sobsey and Doe, 1991). However, attempts to contact charities that support disabled people who had been abused failed so this may reflect those recruitment difficulties.

This result does, however, reflect national percentages. The Shaw Trust reports that 7% of children in the UK are disabled (The Shaw Trust, 2017). Of the eleven people reporting being disabled as a child, five were abused by a family member, five by an acquaintance, one by both a family member and an acquaintance. One disabled child was abused by a doctor or other medical professional and one by a perpetrator working in education. No-one was abused by a stranger. This reflects previous research where 96% of disabled children knew their abuser (Sobsey and Doe, 1991). Again, a respected and known perpetrator is tied to the experience of more serious abuse (Ullman, 2007).

One increasingly significant area of CSA research is child sexual exploitation (CSE). There is very little data on the prevalence of CSE as a percentage of CSA. For example the Crime Survey for England and Wales does not ask a question about CSE (Office for National Statistics, 2018). Studies looking at CSE tend to research children already in contact with CSE focussed services (Wild 1989; Selvius *et al.* 2018). Therefore, survey respondents were asked if the abuse they experienced included CSE.

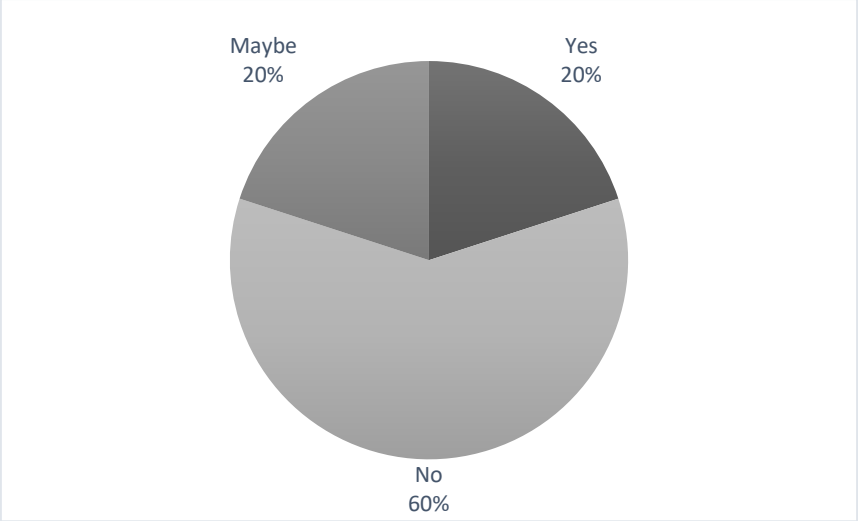


Figure 4.11 Did the Abuse Include CSE? N=135

Of the 135 survey responses to this question, 84 (60%) said they had not experienced CSE, 28 (20%) said they had and 28 (20%) were unsure (Figure 4.11). 62% of those who were unsure whether they had experienced CSE were under 10 at the time the abuse started. Therefore, this confusion may be due to not comprehending the situation clearly as a child. The possibility of experiencing CSE so young raises the question of how access to the child was accomplished. Research suggests that many child abuse images online are made by family members, therefore the CSE may have been facilitated by a family member (Mitchell, Finkelhor and Wolak, 2005). In the wider literature, there is an assumption that CSE is a crime perpetrated on adolescents (see Selvius *et al.*, 2018), and this result suggests that some victims may in fact be much younger. Overall, this result cannot be compared to the wider literature, as a similar study regarding the percentage of CSE in people who have experienced CSA could not be identified.

There may, however, be a methodological explanation for the relatively large number of positive, or potentially positive results. The inclusion of the phrase 'in exchange for something the victim needs or wants' expands the definition of CSE from being for the financial or otherwise benefit of the perpetrator. Considering that the majority of respondents reported abuse by a family member, gifts or other benefits are common in a familial relationship. Indeed, a family member might manipulate a child by denying food or love, for example, which could fit within this definition but does not fit a more conventional understanding of the definition of CSE, as an updated term for child prostitution. Sixteen people responding to this question reported only 'family' as a perpetrator type. This does not exclude exploitation within the family but may indicate a confusion created by this definition. However, one female participant, who was abused by a family member described herself as a 'pre-school porn star' so clearly familial involvement in exploitation even for the very young is possible.

There is a potential issue if the definition is altered to exclude family members. Sixteen people reported abuse by 'family' as well as 'acquaintances', which either indicates re-victimisation or familial facilitation of CSE. However, it may be that respondents understood the intention of the definition of CSE, to mean child prostitution, and may have disregarded any issues they identified in it. Taking these confusions into account, this research does raise the possibility that CSE may be experienced by a significant percentage of people who have experienced CSA, but this requires a far more extensive examination. Furthermore, there may be a need for a re-examination of the standard definition of CSE. At present, the 2017 definition remains in use in the UK (Department for Education, 2017).

CSE is viewed as something experienced more frequently by girls (Department for Education, 2017; Selvius *et al.*, 2018). Therefore, the data was examined to see if there were any gender differences in reports of CSE.

CSE	**Women**	**Men**
Yes	24 (21%)	5 (25%)
No	70 (60%)	12 (60%)
Maybe	23 (20%)	3 (15%)

Table 4.4 CSE and Gender of Participant

60% of both men and women reported no CSE, 21% of women and 25% of men stated that there was CSE, 20% of women and 15% of men were unsure (Table 4.4). Therefore, gender does not seem to affect whether a child experiences CSE. It should be noted, however, that there were fewer responses overall from men so comparisons should be taken with caution. Taking into account the issues with the definition raised above, this does raise the question of whether there is a larger than previous thought numbers of boys experiencing sexual exploitation. This is a potential area for future research. These results do suggest a requirement to explore the definition, prevalence and characteristics of CSE.

Finally, as the survey focussed upon recovery, many respondents mentioned the effects of the CSA that they experienced.

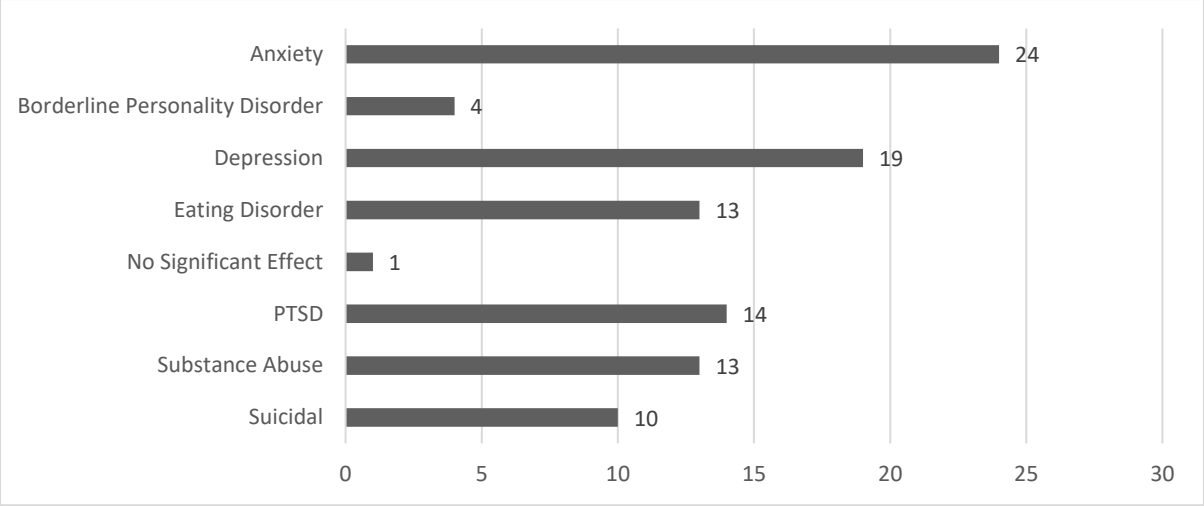


Figure 4.12 Effects of Abuse. N=112

112 survey respondents described CSA as harmful in some way, by listing in the survey the sometimes multiple effects it had on their mental or physical health either currently or in the past. These were mentions of anxiety (n=24), depression (n=19), PTSD (n=14), substance abuse (n=13), eating disorders (n=13), suicidal feelings (n=10) and a diagnosis of Borderline Personality Disorder (n=4) (Figure 4.12). Only one person thought that their experience was not particularly harmful. She stated:

'Not everyone considers their sexual abuse as a child to be significantly damaging.'

Although this participant, abused at age 6 by a family member, appears to consider that their own experience of CSA was not significantly damaging, they are not arguing that it did not cause any harm at all.

As far as diagnosis, four had been diagnosed with borderline personality disorder and fourteen stated a diagnosis of cPTSD. Six of the interviewees had been diagnosed with cPTSD, and the remaining fifteen did not report being assessed. However, they described some negative trauma effects including substance abuse, anxiety, eating disorders, poor self-care and mental health issues. One participant had a diagnosis of Dissociative Identity Disorder (DID). These are the medical and emotional issues mentioned by participants. It should be noted that there was not a specific question about diagnosis or conditions, so the actual numbers may be higher.

This suggests that CSA is experienced as harmful by the vast majority of the 140 respondents who had experienced it. This challenges the argument that CSA is not usually harmful (Bauserman and Rind, 1997; Angelides, 2004b; Malón, 2011; Rind and Yuill, 2012) or indeed that harm is not intrinsic to CSA (Woodiwiss, 2013, 2018). However, since the focus of the

survey was recovering from CSA, it is possible that respondents who did not consider harm to be intrinsic to the experience would not have participated.

As stated in the literature review, there is evidence for a significant level of 'functioning' in the average CSA population, if 'functioning' is defined as the absence of any adult mental health issues (Domhardt *et al.*, 2015). However, in this study, it is clear that people view themselves as recovering regardless of the presence of any mental and/or physical health issues. This brings into question the current definitions of resilience and recovery, by suggesting that health may not be, by itself, an adequate measure of recovering.

Emerging Questions

Overall, the participants broadly matched previous research or general population data. They were of the average young age when abused and the gender split is typical. Furthermore, they were just as likely to be abused in, or near, the home as participants in other studies. There are gender differences in the demographics relating to the abusive incident(s). Girls are more likely to be abused younger, by a family member and have further victimisation as children. Boys are more likely to be abused later, although still younger than 11, and by an acquaintance or stranger. All these results reflect the findings of wider research.

The main differences are that the research participants were more likely than in other studies to be abused by a family member. There is also a larger proportion of very young children being abused. Both genders report an equal risk of CSE. Furthermore, there is a potential that CSE is experienced by young children, the largest group being age 4-7, which raises the possibility of familial facilitation. CSA is viewed as harmful by the vast majority of respondents, with diverse effects including fear, anxiety, depression, substance abuse and eating disorders.

The participants in this research are not representative of all people who have experienced CSA. They cannot represent the multiplicity of differing experiences influenced by ethnicity, country, culture, gender, ability, education, class and life chances. Furthermore, the circumstances and experience of CSA is also unique, as is the aftermath. However, what this research does aim to do is map these differing stories, reporting the similarities and divergencies. These are 'modest, pragmatic generalisations drawn from personal experience' (Payne and Williams, 2005, p.296). However, the lack of statistical significance does not negate the very real experiences described above.

The results reported above do raise questions which can be further explored using quantitative methods. They also suggest the potential for a much larger systematic study to examine the areas raised above. These include general characteristics of the perpetrator, including age

and gender. There are also questions regarding the experience of CSA in different countries and by differing ethnicities, as well as the prevalence of CSE and the gender of its victims.

There is little difference between this sample population and previous research subjects. They are similar in terms of gender, age of the commencement of abuse and relationship to the abuser. They report harmful effects from the abuse. Therefore, it appears that the difference between this population and others is not related to being older when abused, for example, or experiencing 'less serious' abuse. Thus, recovering does not appear to be specific to a particular group of adults who experienced CSA in terms of the areas examined above.

Two questions then emerge – what makes this population identify as recovering? What characteristic, experience or quality enables them to be recovering? The next four data chapters explore the rich qualitative data generously provided by the respondents to identify potential answers to these questions, as well as identifying any barriers to recovering. It begins with the effects of trauma on identity.

Chapter Five - Defined

SHATTERED

He. Dropped. Me.

The shards
scattered like frightened birds, seeking shelter in
dark corners: shed all human thought for pure instinct. They
became sentient silences: gaps when time seeped through cracks
where I could not follow, stealing my life to keep me safe.

There were years when I would hear the foot on the first tread
of a staircase never climbed: the first notes of songs which
drew desperate tears although I never heard their end. I rose, shaking,
from unremembered dreams that scarred me with their shame: and still
I lay, frozen on that cold stone, eternally hearing
the glassy crash that made me who I am.

The broken places ache. Sometimes, I find myself
Searching in the darkness; reaching out for something I don't recognise. Pieces
have returned: have been gathered into me: mirrored slivers nicked
and raw-edged, rattling in place like feet in too-loose shoes: altered to new
shapes that do not fit. I borrow
memories; senses that I do not own remind me there is so much
that I have missed: I almost see the faces of those
I have never met: who know me well; who laugh at the jokes I never told
in places I do not recognise, but find
myself returning to a dozen, dozen times looking for answers I already have.

Listen: I am walking. You can hear the crack and tangle as I pass;
the grating of my old life and the new, as tumbling fragments
fall to place, and slip away. I am kaleidoscope: all colours, all designs
mixed and separate, minds jumbling now like
buttons in a bag... reach in: pick one: see it shine, captive to the thread that keeps it close:
it has a place, no matter how obscure.

The stone is cold.
I fell so far, and fled so wide... Hush – can you hear
the scrape of mirrored glass on tile: the breach of shadow as a voice escapes? I
see the glint in darkness: the arrowdagger silver as it seeks and creeps:
another prodigal: another remnant coming home.

Ruth

The poem above, by one of the research participants, called Ruth, is included here because it evocatively describes the effect of trauma upon identity and mental health as well as the process of recovering. Abuse involves the individual being treated as an object, merely existing for the perpetrator's pleasure, without any acknowledged needs, wants or rights (Gilgun and Connor, 1989). One's identity, the knowledge of and definition of the self, is

shattered. Recovering, therefore, involves rebuilding the self after such momentous and destructive trauma.

This chapter explores four aspects of this internal process of recovering, firstly by examining how people who have experienced CSA conceptualise recovery itself and whether that differs from the medical approach. Next, the chapter considers the interplay between individual and environment in the on-going creation and re-creation of one's identity. There is an examination of how participants conceptualise themselves following the abuse they experienced, specifically in terms of whether they define themselves as a victim, survivor or reject both terms. Following on from this, the influence of gender constructs upon recovering are considered and the influences of traditional gender constructs are explored. There is then a consideration of the effects of dissociation and memory upon participants, particularly influenced by the dominant discourse of false memory. The chapter ends, as it began, with Ruth and her shattered identity.

Defining Recovery

The central theme of this thesis is recovery, which means that the focus is not on the trauma event/s but life after that abuse. However, there is a lack of clarity in the literature concerning the definition of recovery. This is important because it significantly alters the number of people viewed as recovered. Also, as discussed in the literature chapter, within resilience studies, definitions can, in themselves, be seen as judgemental of victims. This section examines how participants defined their own recovering.

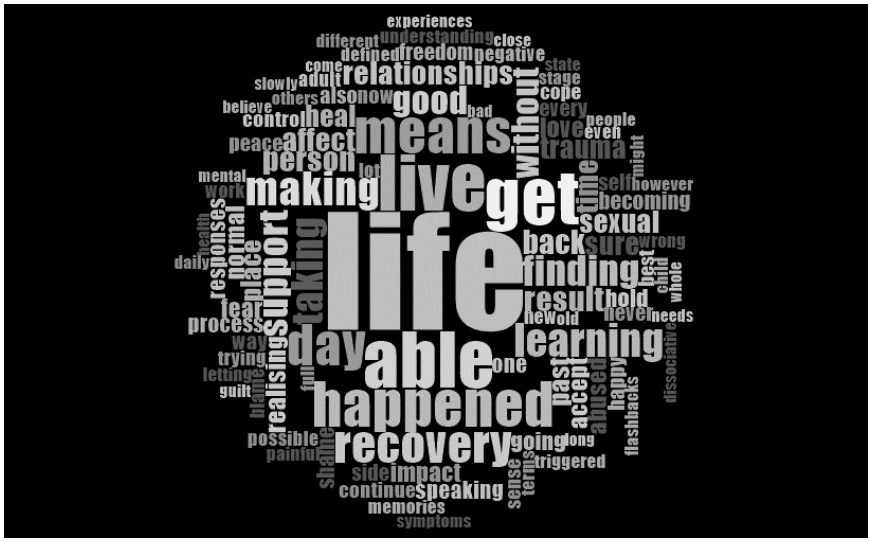


Figure 5.1 What does recovery mean to you? N=130

Participants were asked what recovery meant to them and the most common terms were 'life' and 'live', suggesting that recovering is integral to existence, not something that exists within one facet of life (Figure 5.1). It is also worth noting how many words are active words, for

example, ‘learning’, ‘realising’, ‘making’, and ‘get’. These demonstrate that participants view themselves as an actor in their recovery. Recovering is not something *done to* them but something they *do*.

When examining the relevant text in more detail it became clear that the term ‘recovery’ was viewed as problematic because it indicated a point where the individual was fully ‘recovered’. This was not viewed as realistic and instead participants conceptualised recovering as an ongoing process, as Carly now in her 20s explained:

> *‘recovering’ (is) a verb, constantly ongoing, a lifetime of work...it’s unfair but it’s also immensely empowering...I’m in control of my own life and my own body, in a way I wasn’t when I was being abused.’*

Therefore, ‘recovering’ was preferred as it was conceptualised as a life-long experience, as the wordle above implies. It also involved re-establishing autonomy over the self and specifically the body.

The term ‘recovery’ was also rejected for implying a return to a previous healthy place as this survey respondent explained:

> ‘*it implies getting back to a state you were in before. I would like to use a different word that implies recreating something new from things that have been painful and shouldn't have happened.’*

For this participant, ‘recovery’ does not encompass the lasting changes caused by traumatic experiences. Instead, ‘recovering’ was viewed as a journey, but not a linear one. Participants described a process where they initially felt worse when entering counselling or approached the police but, over time, experienced improvements in their mental health. There was not, however, a cessation of symptoms. All participants said that they still had some effects from the trauma and that some days were worse than others, but that ‘recovering’ meant that the precedence of the trauma over other aspects of their life was diminished. Carly put this eloquently:

> *‘The best way I can describe recovery is the shift from being a big bundle of trauma with just a bit of person on the side, to a person with an amount of trauma on the side’*

Therefore, ‘recovering’ is a non-linear process that is iterative in nature. This concept of ‘recovering’ rather than a more binary ‘recovery’ directly reflects the salutogenic theory of health, as people viewed themselves as permanently moving, sliding one way or the other,

between the two poles. Thus 'recovering' is moving, in general, from poorer health and lower levels of well-being closer to better health and higher levels of well-being.

Many of the research participants did have mental health issues and a salutogenic approach worked well for their conceptualisation of their own health. Recovering was not conceptualised as being about elimination of these potentially permanent conditions, as these three survey responses illustrate:

> *'Learning to live with and manage life-long mental health condition caused as a result of the abuse'*
> *'Surviving day to day, getting on with life and leading a relatively normal life'*
> *'taking baby steps every day overcoming and healing myself physical mentally and spiritually.'*

Instead, these responses reflect daily decisions towards better self-care, choices that moved them closer towards the 'healthier' pole. Therefore, participants utilise an inner, experience-led model to express their concept of 'recovering' and reject the idea of 'recovery'. They self-identify as 'recovering', a concept that can be applied in all circumstances whereas 'recovery' cannot. It is a more hopeful, strength-based concept and one which is inclusive not exclusive. One is not always recovered, but one can always be recovering.

Conceptualising Abuse

There are many aspects to individual identity and the first is a fundamental, ontological question of nomenclature. It concerns what words we use to describe ourselves and our experiences, including what those words means both to ourselves and others. Part of recovering from CSA involves a reassessment of one's identity and deciding whether to include the experience of trauma within it.

We are inherently social beings with our lives characterised by the interplay of self and society. Our social identity is based upon what social groups we belong to or are assigned to (Tajfel, 1981). This can be through either an internal process of identifying with a group or through being categorised into one by others (Jenkins, 2000). Therefore, our identity is assembled both internally and externally. These facets occur concurrently and interact with each other. The abused person has various words to choose to describe themselves: victim or survivor, for example. Each has its own meaning on an etymological level, but the choice is also political, in that it delineates a group of people with a similar viewpoint towards abuse.

Participants felt very strongly about the words used to describe them and their experience of CSA. ‘Victim’ was seen as a very stigmatised identity, defined by victim blaming and not one that they want. For example, Melissa, now in her 50s, was told:

‘stop being a victim. This happens to a lot of people, grow up. Get over it.’

Thus, there is a damaging discourse around the concept of a victim. It is used as a pejorative term. Ruth, also in her 50s, expanded upon this:

> *‘when someone's in a situation where they're being abused they are the victim then, it's happening to them but they're not...it's really difficult sometimes not to talk about them as some sort of helpless, broken, damaged little thing.’*

Thus ‘victim’ is characterised as a weakness and this conceptualisation can lead to the person being viewed as fundamentally, irreparably damaged. It is also, in some ways, seen as a choice: that an individual who continues to identify as a victim is viewed as wallowing in their pain.

In response, many people saw ‘victim’ as something that they were, at the point where the crime took place, but over time have chosen not to remain in that position. Therefore, recovering is defined by a conceptual movement away from ‘victim’ as Alice, now in her 40s, explained:

> *‘Although I was working through the childhood abuse, I hadn't really begun-- I was still feeling like a victim. I didn’t want to let go of that.’*

A survey respondent agreed:

> *‘I thought religion would help, but it kept me as a victim.’*

However, Sarah questioned this interpretation:

> *‘it's always presented as if you move from one to the other in a kind of very linear journey rather than a sense that you are both at once or at different times or you know...but it’s this kind of a sense of a journey and if you don't survive, in inverted commas, whatever that means, then you are always a victim’*

However, others are welded to the concept of being a victim as Alice, who runs a CSA support charity explained:

‘There's a lot of emphasis on noticing that ‘we must call them survivors’ and when I work with my clients, I'm always saying, "It's okay where you are, if you feel like you are a victim and you're not ready to let go of that, that's where you are at and that's okay". Sometimes when you say survivor, they're almost offended “I was victimized, I'm a victim of it”’

Thus, in some way the term ‘victim’ is an acknowledgment of the enormity of the violation and its enduring nature. Mary, for example, views herself as a victim and explained this by quoting Roxane Gay (2017):

‘"I am marked in so many ways. I survived it but that isn't the whole story. Over the years, I've learned the importance of survival and claiming the label survivor. I don't mind the label victim. I don’t think there's any shame in saying that when I was raped I became a victim. To this day, whilst I am also many other things, I'm still a victim. I took me a long time but I prefer victim to survivor now. I don't want to diminish the gravity of what happened. I don't want to pretend that I'm on some triumphant uplifting journey. I don't want to pretend everything's okay. I'm living with what happened, moving forward without forgetting, moving forward without pretending I am unscarred."

To me, that is a phenomenal quote…We don't have to be survivors. I like this. I don't want to pretend on I'm some triumphant uplifting journey. Yes. Exactly. That's a fabulous phrase. If you think of how, for example, let's take the Paralympics. How disability is portrayed in the press. It's overcome heroically. It's always the heroic diminishing of the effect of disability, rising above it. It's not living with it.’

For Mary the term ‘victim’ encompasses the idea of living with the permanent effects of abuse and rejects the notion of a heroic journey to overcome trauma. Mary views the term ‘survivor’ as more of an external performance, designed to satisfy society’s requirement for the heroic defeat of adversity.

For most of my participants, ‘victim’ is a rejected, externally imposed category bringing with it discourses of passivity, weakness and defeat. Others accept this category and view it as the best of the available terms, as it reflects their conceptualisation of the effect of the trauma on their life. Thus, they are accepting membership of this pre-defined passive group but also subverting through their active denial of the trope of the heroic survivor.

In contrast, many participants favoured the word ‘survivor’ to both define and understand the abuse they experienced. ‘Survivor’ as a term was developed as part of the feminist movement

and is part of a counter discourse, challenging the dominant discourse of 'victim' (Kelly, 1988; Dunn, 2008). Becoming a 'survivor' is seen as an active choice as Alice, explained:

> *'I just made a conscious decision, "I can either let what my grandfather did to me, into this wonderful marriage, wonderful relationship or I need to work through it." That's what it is. …There is no shame. Literally, there is no shame…I see it as that's what he did. They were his actions. He's responsible for that. It's not something I did…I'm no longer going to be a victim from what he did.'*

So 'survivor' is created by placing the blame and shame upon the perpetrator, as the person who instigated and carried out an assault, or more than one assault, that the abused individual survives. It is conceptualised as a battle the individual 'chooses' to 'win'. Thus, it is an active term.

The transition to 'survivor' status is seen as a mark of accomplishment in a 'hero's journey'. First identified by Joseph Campbell (1949), this is a storytelling template about a person who is separated from their home/world in some way, triumphs over adversity and returns home transformed. Campbell identified it in many myths and legends. It is also utilised to design many film and TV drama scripts, thereby reflecting or creating dominant discourses. The success of the treatment of adult survivors has been measured by that conceptual movement from 'victim' to 'survivor' (von Fraunhofer, 2006).

Lynne, now in her 40s, explained why this concept resonates with her:

> *'people who survive it are really strong…that's what I'd want other victims to know, right at the beginning of their journey. Just keep moving, even if you feel like you're treading water right now. I can't tell you what's going work for you, make you feel better, or feel like better is even possible. Just keep moving and trust yourself that better comes. You're a survivor - you survived something awful, it's not going to defeat you now. You've got this, I believe in you.'*

The hero's journey was specifically rejected by some of the participants quoted in the previous section but it is clearly important to Lynne. However, regardless of the label itself, Lynne and Mary, who identified strongly as a victim, are both actively choosing the best fit for their identity.

Many participants dislike the idea of being a permanent 'victim' as Agata, now in her 30s, stated:

> *'I think it's harder to identify with 'victim.' I mean it states a fact and you have to look at the facts. I think 'survivor' puts more emphasis on your strength now and I*

feel…That was bad but it doesn't define my life for ever and frankly who wasn't traumatised by something in their childhood, that's what happens in childhood right? So it's just better for me to, I don't know, I just feel more like a person not, like a case…I accepted the identity of a survivor (as opposed to "victim")'

Thus, there is an awareness that a person can be both a 'victim' and a 'survivor' and can choose which label to identify with. Both terms are externally defined categories, and an individual who has experienced abuse can make the choice to adopt the label, alongside of the group membership, that works best for them.

Being a survivor can also be a way to make an external statement of identity, as Fred, now in his 50s, explained:

'I have my chances to go on the telly and get all gobby and challenge people and be an in-your-face, gobby, angry survivor. I mean cathartic is a silly word I suppose, but it's empowering perhaps. Yes, I do that and I guess now for me, I am an out survivor and I've been all about it for quite a long time, people who know me know that.'

Fred is describing being a 'survivor' as a performance, a way to visually and verbally express anger, an external identity designed to challenge the status quo.

The term also reflects political and social intentions. The survivor movement itself is a campaign designed to challenge that status quo. 'Survivor' movements whether they are concerned with domestic violence, mental health or CSA aim to democratise and politicise support services to include people who have/are experiencing these issues (Swerdfager, 2016). Thus, choosing the moniker 'survivor' is also identifying with this visible group (Jenkins, 2000).

However, there are issues around being open. Some people talked not being open about their experience of CSA as, for example, this survey response explained:

'I am involved in various general feminist activist things. This gave me a context for understanding issues of power imbalances and so on that are relevant to CSA. But I am not out as a survivor and so I am not involved in activism on this issue specifically as a survivor.'

Here this woman is defining her identity as someone who has experienced trauma by choosing her own terminology but is inhibited from expressing it externally, even in a presumably sympathetic environment. She is choosing the identity but does not want to visible belong to

the group. The next chapter will examine endemic problems with the disclosure of abuse.

The term ‘survivor’ reflects Janoff-Bulman’s (2004) ideas around post-traumatic growth (Janoff-Bulman, 2004). Adopting the term reifies this conceptualisation: self-development and growth following trauma means that you are a ‘survivor.’ The war is won, or at least you are winning more battles than you are losing. ‘Survivor’ is an externally defined group, but as it symbolises an active, political journey counter to the dominant discourse of passive ‘victim’, it is popular with many people who have experienced CSA.

Finally, some participants did not choose to be a member of any externally orientated category as this anonymous survey participant explained:

> ‘*I don't like terms like 'survivor'. I think finding my own language will be important. I don't feel like I've survived and I don't feel like a victim.’*

The terms and their inherent meanings do not reflect individuals’ personal experience of trauma. Such respondents viewed both ‘victim’ and ‘survivor’ as problematic as this survey response explains:

> *‘I personally have found that identifying as a victim/survivor it is hard to think of myself as anything else and move on, because even as an adult, I still expect bad things to happen to me. I would rather think of myself as a normal person with terrible experiences.’*

This participant views any label as defining their identity by reference to past events.

There is also a concern that this ‘label’ can affect one’s own individuality:

> *‘I fought so hard for the trauma to be recognised just so I could get the help, support and treatment I needed but it's a double edged sword as it keeps you in trauma often resulting in you getting re-traumatised or triggered. So you become the 'victim' and that is reinforced by asking for help or you become the "child abuse survivor" and the expression of who you are is lost.’*

This respondent rejects the idea of defining the self by either term as the primary expression of identity, because it subsumes any other valued facet of the self. They fear being defined by the discourse.

Others consciously rejected the dichotomy between victim/survivor, as George, now in his 50s, described.

'I don't like the word 'victim' and I don't like the word 'survivor' either. I consider myself to be someone who has experienced something bad. I am an experiencer of something. I haven't survived it, I live with it, it is part of my life experiences. (pause) To me...I have an aunt who was in a railway accident and was one of three people who survived in the railway carriage she was in…That, to me, is a survivor because the alternative is death. I wasn't going to die, even in the times when I was feeling suicidal. You know, I didn't die, I just felt suicidal, so survivor to me doesn't quite work… I would say that I have gone through a period of my life where my abusive experiences have dominated my life and I have had periods of my life, where I am now, where they don't …I am very much aware that what has happened to me has influenced how I have done things and how I have evolved over my life time but if you were to see me in the street today I am not a 'victim' or a 'survivor' of sexual abuse - I am just me. I am definitely not a victim.'

A rejection of the labels 'victim' and 'survivor' can be a means by which people reassert their own identity and minimise the importance of the trauma within their life narrative. In this way, they are creating their own internal identity by rejecting the externally defined categories available to them. However, participants also considered the choice of definition, or rejection of that choice as an individual choice, as George described:

'if someone feels they are a victim its they are feeling 'I can't do anything about this.' Well actually they are wrong, they can. If they are saying they are a 'survivor' they are implying that 'Ah! I'm like Robinson Crusoe, I have arrived on the sandy beach. I have been out at sea for however long and I am exhausted but I have survived.' …I think the terminology is so linked to your mental feeling at the time. Some people feel they are victims, some people will absolutely feel that they are not. Some people will feel they are survivors, some people will absolutely feel that they are not. There's no rightness or wrongness about it.'

Ultimately, the issue is about how much significance participants choose to give the trauma in affecting their life. 'Victims' see the trauma as fundamental to their lives and identity rejecting a heroic life story. 'Survivors' see CSA as something influential and a challenge that they battle with, viewing themselves as the hero in their life narrative. 'Individuals' see it as one in a series of events that has happened in their lives and not the sole significant factor in their identity. Each choice is as valid as the others, as it is in this way that people begin to take control of their life narrative and define their own identity.

Therefore, how one classifies the abuse reflects how the abuse is placed with the internal landscape, whether it is foregrounded or set to one side. An individual may change 'labels' as a means by which to indicate their current attitude towards their trauma experience, 'victims' may become 'survivors', 'survivors' – 'individuals' or 'victims'. This is initially an internal choice, which may then be expressed and performed externally, as discussed in the next chapter. Goffman (1959) views identity as something imposed by others, arguing that we are defined by how others respond to our 'performance'. However, here people consider and re-adjust their internal sense of self before deciding whether to express it externally.

This examination of nomenclature highlights why institutions using inclusive or personalised terminology is important and that using the wrong term can be viewed as offensive. It could be a barrier that prevents people accessing services and further affect their experience of the support provided, as external categories affect their treatment from others (Jenkins, 2000). For example, if 'survivors' are viewed as being further through the recovery process, people who identify as 'victims', will be judged as responding less successfully to their trauma and to the treatment provided. Therefore, what begins as an internal choice has implications for the individual's social identity and experience of support services.

Gender

One of the foremost ways to distinguish ourselves from others and one of the largest social group we can belong to, is gender. Childhood is the time where children learn about their gender roles (Martin and Ruble, 2010). Trauma at this time, particularly sexual trauma can lead to a questioning of their gender and gender roles (Lisak, 1993; Krause and Roth, 2011). To study CSA without considering gender ignores the impact sexual violence has upon the individual's concept of their femininity or masculinity. There are gender differences in both its after effects and recovery for all genders (Cantor, 1995; Tolin and Foa, 2006; McCarthy-Jones and McCarthy-Jones, 2014).

There is a growing awareness that CSA can affect boys as well as girls in terms of prevalence and impact. Recent meta-analysis suggests that around 8% of boys report being abused (Pereda *et al.*, 2009; Stoltenborgh *et al.*, 2011). Child sexual abuse is theorised as potentially leading to a crisis of masculinity, as being a passive 'victim' is not seen as a valid male experience. Lisak (1993) illustrates this concept with the following quote:

> *'I'm either a man or I'm a victim'* (p.578)

The implication is that one cannot be both. This belief has a long history. For example, in Athenian Greece, experiencing penetrative CSA was a legal disqualification for citizenship, the right of all free Athenian men (Bloch, 2001). Vandello *et al.* (2008) conceptualised

manhood as an impermanent state requiring frequent revalidation. Without such validation, men overperform manhood through risk taking, aggression and homophobia (Vandello and Bosson, 2013).

Some of the male research participants reflected this concept of questioning their manhood. There are questions associated with a male not defending themselves, even as a child, as George explained:

> *'from a societal point of view it is probably more embarrassing, I don't know because I'm a man, so I can't really compare but people expect a man to stand up for himself I think...and that makes it a little bit tricky…everybody thought that if you were raped they'd been in a dark alley and attacked over the head with brick or something and it was violent and in my experience both personally and you know being involved with other victims is that most sexual abuse is not violent, it's a violation'*

George is explaining that the abuse of boys can challenge traditional ideas of rape, such as it being a violent act. Javaid (2014) argues that male rape cannot be understood without considering the societal construct of masculinity influencing the reluctance of male rape victims to disclose the crime. Male rape is contextually bound to constructs of masculinity.

One emotion that the male participants expressed was shame, which Stearns (2017) argues is not a basic emotion but instead one that is taught. As such, the concept of shame can encompass an imposed idea of guilt and/or complicity. Humiliation is something that is done to a person, whereas shame is something a person may have contributed to in some way. Penia, now in his 50s, identifies as gender neutral and was abused by two older children. He (he prefers this pronoun) describes the effects of shame:

> *'I still see male sexual abuse is still very, very taboo and I think that is because of the victims themselves and you can get right here to this idea of shame…there is this shame about homosexuality, in terms of 'because my body reacted in a certain way does that make me homosexual?' and of course in traditional white Anglo society…that stigma and that shame means that male victims don't come forward'*

Here shame is tied into a fear of being homosexual, also noted in other research studies of men who experienced CSA (Lisak, 1994; Dhaliwal *et al.*, 1996). Where the individual's masculinity is threatened, their homophobia can increase as a result (Vandello *et al.*, 2008).

Michael, now in his 50s, typifies this concept of a crisis of masculinity. He was abused by his

father from when he was a toddler and struggles to understand what happened to him:

> *'men are always after women anyway and it's like it's less likely the other way, I guess. I mean at least from a male standpoint. The men are pursuing the women and it's like a prize, I guess...it's a perversion for a little boy to be molested by a man that he trusts and then he is perverted in his thinking 'well gee I see you with Mommy all the time but now it's you and me. I guess I don't quite understand that'*

Therefore, he struggles with this criminal departure from the traditional 'man as pursuer of women' norm. He has been married four times and explained his concern about his son's homosexuality:

> *'he says he is gay because it's...I think and I feel kind of guilty...I take responsibility, I won't say guilty that he'd been exposed to, there was a guy who used to hang around, an older guy used to hang around with him and his friend and I thought that he was just a little mentally challenged but he was just a nice guy. I mean he helped them put the bikes together and I'd met him before and I kind of got wondering whether 'I wonder if he's really a pervert' you know and then come to find out that that same son has made a choice to go with other men'*

Here there is a clear parallel drawn between homosexuality and paedophilia, reinforced by society, for example, in 1960s research comparing prisoners convicted of paedophilia or homosexuality (Schofield, 1965). Michael fears that his son's homosexuality is indicative of early abuse.

Michael wants a return to traditional values where:

> *'the government needs to support the family to the best of their ability and...it doesn't even need to be religious but it needs to be, it needs to be coming from the standpoint scientifically, let's go scientifically - man, woman, child - I mean you can't deflect from that and anything other from that is perversion so I mean they don't want to step on the 2%s toes but it seems like the interest is more upon those who aren't the norm, than they are those that are the norm and what they need to do is focus on the normal family'*

Vandello *et al.* (2008) argued that a similar entrenchment in traditional values can be a reaction to a feeling of threat to one's masculinity. The abuse Michael experienced, within a 'traditional' family appears to have led to him retreating to traditional patriarchal views. This entrenchment

may help him feel safer, less likely to be abused, because as stated above 'real' men cannot be victims (Lisak, 1993).

Other male interviewees were homosexual and thus had a different response to this threat to their masculinity, albeit linked to the same reasoning. They had questioned whether their sexuality was as a result of being abused as this survey respondent explained:

> *'I realise I have carried a lot of shame around with me since the abuse. I am currently working on reframing and healing the shame I feel about being gay as it links with the abuse by a male teacher*.'

Here shame and homosexuality are explicitly linked with abuse. This participant explains that his feelings about being gay are coloured by the idea that the abuse he experienced may have affected his sexuality. This is not an uncommon thought. Indeed, Fred who works with people who have been abused stated:

> *'I know some men who are gay who have always been gay, some men who have learned to be gay as a result of abuse, some men who are gay but are still guilty about being gay.'*

Fred links homosexuality with CSA and accepts that abuse by a male can make the victim homosexual. The purpose and mechanisms of shame are explored further in the next chapter.

In contrast, others found happiness by accepting their sexuality. Penia stated:

> '*I am who I am. Part of, you know, me being able to be attracted to different types of genders I think does come down to a sustained period of sexual abuse in my formative years but instead of being ashamed of it I'm saying ok, it was something that I felt so desperately ashamed of to the point of not going to the police until I was 50, then that part of me no matter how or how horribly that was born it's still part of me it's something to celebrate and rejoice in. I am probably very unusual in the road that I have taken.'*

Here Penia is rejecting the script that sees homosexual feelings as something to be ashamed of. Penia, also rejects traditional gender roles:

> *'I identify as pangender but I'm happily married for 25 years, part of that is that I don't want to be identified when I start to talk about this as 'well you are male, you are female.' No, I am just me.'*

Penia has rejected hegemonic masculinity and its concomitant homophobia as not helping

with his recovering or his identity re-creation. Indeed, he rejects binary gender roles as demonstrated by his choice of pronouns:

> *'In terms of pronouns I am happy for you to mix it up - use a female name and male pronouns.'*

Thus, his solution to his crisis of masculinity is to consider himself to be pangender, a member of all genders.

Trauma does appear to result in an earthquake in the foundation of manhood, as suggested in the literature (Gillmore, 1990; Vandello *et al.*, 2008; Vandello and Bosson, 2013). Manhood is defined, in part as a binary opposition to femininity: being 'antifeminine' (Vandello *et al.*, 2008). Being a victim, which is conceptualised as a female state, leads to the questioning of one's masculine status and each male participant had to resolve this, reject it or encompass it into their identity, as part of recovering (Lisak, 1993). Lees (1997) found that male rape victims were more likely to report feeling angry when assaulted, indicating differing gender reactions to the crime itself. Ignoring masculinities and male experience of CSA could be damaging both for the individual and society, particularly if men are more likely to express their distress through anger (Lees, 1997).

Female participants were also influenced by traditional gender constructs. For them, the struggle was not about being a victim, as the anonymous survey response below wearily demonstrated:

> *'Being a woman is hard enough. You experience sexual violence at some point anyway.'*

Victim is intrinsically connected with femininity in patriarchal societies, as demonstrated by representations of crime (Meloy and Miller, 2011). Thus, there was an acceptance from female participants, as shown above, that this was an inherent risk of their gender. This suggests that, in the same way that men who have experienced CSA find their sense of their own 'manhood' to have been challenged by it, women also find that CSA causes them to reflect on their sense of 'womanhood'.

Woman talked about being judged for 'inviting' the abuse:

> *'The only things I "knew" about rape were that women usually made it happen to them by dressing incorrectly, and that if you didn't scream and fight as hard as you could, you were as good as asking for it.'*

One important aspect of this cultural pressure was clothing. Participants saw this as being part of victim blaming, even for children, as a survey respondent repeats:

> *'if you were dressed like that you can only blame yourself.'*

Janoff-Bulman (1979) found that victim blaming tropes were internalised by victims, and it may be that this is more common in children who are yet to develop any critical thinking skills.

An example of the connection between gender, sexuality and danger is given by Lynne who was in foster care after her mother died:

> *'when I got to about 12, yeah 11 or 12, yeah 12 and then the dad of the family... I had been made to start wearing a bra. I had really big boobs and I didn't want to because I had been sexualized and people talked about...they would say about my boobs. They would say 'oh your backside' and I was just a kid but they still did it, you know, and it made me self-conscious so I didn't want to do that. I didn't want to start wearing a bra and make myself more sexual in a way and he started stroking my back and I was like 'woah! That's just not right' you know on my bra and I just knew. I started to be really bad behaved and misbehave and I ended up in a children's home because I just, you know...I went really bad because I knew, you know the look in the eye of somebody, when you know what they are thinking and I was like 'right.' I had been free of it for 3 years and er, ewww, you kind of keep a sense of it don't you?'*

Here clothing is viewed as reflecting availability for sex, rather than simply a maturing body. At a relatively young age, Lynne had developed strategies to protect herself from abuse, which she recognised by other people's reactions to her body.

There are different ways to manage this gender pressure. Melissa conforms to her gender role:

> *'You know you feel obligated to present yourself a certain way, at least, maybe other people don't, but I do. I feel most of the time a lot of pressure to appear in clothes that display my shape in a very feminine way that people respond positively too. So, I definitely feel like I'm a prisoner of my own body.'*

Societal pressure to dress 'attractively', highlighting a female body shape, is inherent within Western culture (Wolf, 1991). Melissa feels an obligation, a duty, to perform femininity and earn a positive response.

However, other women reject this imperative and choose to dress in a less feminine way as Anon states:

> *'I tended to dress and behave in a non-gender specific way and still do. I don't like to draw attention to my appearance.'*

Thus, for women, their appearance is directly tied to the abuse and their attempts to avoid it happening again, either by conforming to or rejecting societal norms.

Lynne fought societal and work pressure to wear clothes that she felt comfortable and safe in:

> *'**Lynne**: At that time, it was 1990, women weren't allowed to wear trousers. Anyway I thought 'stuff you' so I went to get myself some smart trousers because I used to do death notices there within a team and we used to take turns to going in really early, six in the morning, to proofread, there were loads of errors in the paper and on death notices that's not nice. I started wearing flat shoes like Dr Martens shoes and they started looking at me a bit funny and then this woman said to me 'Lynne I need to talk to you about your office wear' I went 'why?' She was like one of the trainers she wasn't one of the managers. I said, 'Who has asked you to do that?' And I said 'so sue me I am not walking to work. I lived in _____ I said I'm not walking down there at quarter past five in the morning in a skirt and clippy cloppy shoes.' I said 'I've even started walking like a man because I'm nervous' because the buses didn't even start till 5:50 so I had to walk I said 'anyway I don't even see customers and they're not jeans. I am not wearing jeans' Yeah, I got a few words about the trousers 'but they are smart trousers and why do I have to wear heels?' so that the men could go 'ooh you've got tight calves' it's just not nice. When I started working there people would say that about my legs and I didn't want it. So they changed it; well they didn't insist that we all had to wear skirts anymore or dresses because there wasn't nothing they could do about it.*
>
> ***Claire**: It would be hard to enforce it.*
>
> ***Lynne**: Yeah.*
>
> ***Claire**: So, it's about then, dressing for a male gaze. You are not interested in that?*
>
> ***Lynne**: Yeah. It's just - let me do my job.'*

Lynne explicitly connects 'walking like a man' as creating more safety for her when walking through what she describes as a dangerous part of town in the early mornings. She is taking

action to protect herself.

Therefore, for women, as well as men, the experience of abuse leads to a questioning of gender roles. As this survey respondent said:

> *'being a woman doesn't really help one scream power.'*

Therefore, through clothing and body language, female participants tried to reclaim some sense of power as well as ensuring safety from assault. As shall be seen in the later chapters, the body and how it is displayed is fundamental to these attempts to create a sense of safety.

Thus, patriarchal gender roles impact upon people who have experienced CSA. For men, there are two aspects. CSA shakes the foundations of their masculine identity: they must resolve the conceptual opposition of being a man and being a victim. There is also a confusion between paedophilia and homosexuality, sadly often made in wider society too. Men who have experienced abuse may question any physical reactions to it and, if they are gay, question the origins of that. For women, a concept of familial and societal ownership of their body creates the pressure to be beautiful and to perform femininity, often through clothing. To minimise attention, women may play down their sexual attractiveness.

As Stephen pointed out, the issue is not about the actuality of the abuse or its effects:

> *'In speaking to other survivors of abuse of all sexes and genders I am struck with the fact that our experiences of abuse and the impact on our physical and mental health is far more congruous than it is different.'*

Instead, the difference is formed by how trauma and its effects are experienced or performed within these gender roles. Discourse around traditional gender roles creates tension because of what it indicates about people who have experienced abuse: males are not truly masculine because they must have 'allowed' it to happen and females are not passively feminine because they must have 'invited' it. Thus, gender and one's expression of it is central to recovering.

The Fractured Self

Part of identity is a continuity of experience and memory. However, when experiencing trauma, it is common for the individual to dissociate, which may result in an altered sense of reality, self, time and memory (Scaer, 2001; Möller, Söndergaard and Helström, 2017). Ruth explained how this felt:

'If I was dissociative enough I wouldn't feel that pain at all, would have no feeling of heat or cold or anything.

This can then have an impact on one's identity. Children are more likely to dissociate (Scaer, 2001). Amnesia is common and an individual can struggle to recall facts about the incident(s) (Scaer, 2001; MacIntosh, Fletcher and Collin-Vézina, 2016). As covered in the literature review, this has resulted in people's memories being questioned and the development of a false memory discourse (Loftus, 1993; Rydberg, 2017).

However, Van de Kolk (2014) argues that during trauma memories are encoded differently in the brain. Declarative (factual) memory may be lost, but sensory memories, emotions and actions related to the event(s) are retained. Dissociation during trauma makes cPTSD more likely, and the memories of fear, anxiety, pain etc can be re-experienced once an individual is triggered. Triggers are emotions or sensations relating to the trauma which cause the individual to re-experience the emotions associated with that trauma (Van der Kolk, 2014).

The implication of this is that individuals seeking to consolidate their identity following CSA may have gaps in memory and, consequently, unexplained emotions such as anxiety or fear. Eight of the twenty-one interview participants reported either recovered memories or memories that were unclear or fragmented. This can lead to doubting oneself and affect self-esteem as well as identity as Helen explained:

'it is difficult when you have no memories of the abuse at first (like I did)…I feel my experience is an odd one... I think I found it hard to accept - still do, sometimes - that I was abused, because there is still a part of me that dismisses recovered memory.'

Thus, for some, recovering involves accessing these memories and deciding whether to 'accept' them, indicating the influence of the false memory discourse. However, research suggests that memory loss is common. In childhood sexual abuse it occurs in up to 39% of cases and is more likely if the individual is young and/or the abuse is extreme (Van der Kolk, 1998). Within familial abuse, the child is faced with trying to maintain relationships that are important to them, may in fact be essential for their existence, and are also abusive. Freyd (1997) argues that familial abuse is more likely to lead to memory loss precisely because of this dissonance. Indeed, she states that memory loss can be seen as an appropriate adaptation to a traumatic and unmanageable environment.

As can be seen above, the experience of trauma and resulting memory loss affects one's self-image in adulthood. If a person cannot fully remember their past, how can they define their

identity? How can they trust themselves or the people around them if they might not remember it all? How can they define their present reality? How can they trust reality? This results in an ontological insecurity: a questioning of the basis of reality and the self (Giddens, 2013).

This is exacerbated by the general lack of knowledge around this area. Although Hart (2013) states that psychology and psychiatry now, in the main, accept that traumatic memory loss is possible and even likely in some situations. This is more frequent in childhood (Dube *et al.*, 2005; Finkelhor *et al.*, 2014), However, the general public, and consequently many people affected by the condition, are still informed by earlier debates around recovered memories. Therefore, this is another aspect of the trauma experience, over and above CSA: the individual may question the validity of their own recovered memories and this may well result in a poor response from others. It can also affect their ability to commence recovery. If they cannot accept or fully remember what has happened to them how can they classify it (see Hacking, 1999)? This lack of a consistent self, or a consistent memory of self, can fundamentally affect the reconstruction of one's identity. Indeed, as the next section will demonstrate, it can lead to the question of whether one actually has a single identity.

Ruth Incorporated

Extreme and prolonged trauma can result in what is currently diagnosed as Dissociative Identity Disorder (DID), where the individual has long periods of memory gaps alongside multiple personalities or 'alters' within the same body. This is a phenomenon fitting Hacking's (1999) concept of an interactive category. Regardless of the objective reality of the diagnosis the individual's lived reality is influenced by it. One research participant, Ruth, whose parents were both violent and father sexually abused her, has a diagnosis of DID and explained its aetiology:

> *'when I was very, very tiny, before I was three, I became aware that there was a grown-up lady who lived in my head and that lady would help me when I got frightened because the parents were very abusive and aggressive from very early on. She would talk to me and she would tell me how to be safe. In very child-safe language this very grown-up lady in my head would tell me...she would warn me when my parents were getting dangerous. She would basically tell me 'you must go to sleep' or 'put your toys away, put them in the box and then Mummy and Daddy won't be cross.' As I got older, she was still there. I didn't know that it wasn't normal to have a grown-up lady living in your head. I thought everyone had that.'*

Masten (2001) theorises that children are more resilient if they have one safe person or place to reach out to, whether they disclose the abuse to that person or not. The fact of having

someone to trust is extremely important in coping with and recovering from trauma. Ruth grew up in a situation without any safe place or person:

> *'there was no safe place that I could go, there was no safe place at school, home wasn't safe. I wasn't even safe walking between the two.'*

As a result, as a very small child, attempting to manage multiple traumas alone, Ruth's identity fractured, and she created her own safe adult.

As the trauma continued, she developed dissociative identity disorder (DID) and had significant, long term memory gaps:

> *'I remember going to sleep on a couch when I was just 5 years old. I have no memory there until something happened at school and I was six and a half and I remember...I have very faint flashes of things in that big gap but most of that 18 months is gone. I have no memory of it and I couldn't understand why but when the other abuse started and the bullying started to get worse at school that would get worse. I would lose weeks or days or hours and I had no way of accounting for it.'*

Each of her 29 alters split off at a particularly traumatic moment, as this example of the creation of an alternate personality demonstrates:

> *'my father was beating my younger brother when he was 18 months old. Beebie, who was me at 3, tried to protect him. She remembers my mother having him on her lap, singing to him when he was a baby, and he had this romper suit on, like a romper suit with rabbit ears on it...Beebie constantly talks about rabbit and how she has to look after rabbit.'*

Her alters exist to protect her and her family. Over time, they have developed different roles: some take over 'the body' to defend her in crisis situations and there is also has an alter who does 'the admin,' ensuring that she gets to appointments in time. Thus, there are positive aspects to the condition:

> '*There have been times when it's been a real comfort when I've been alone. I'm never really alone, there's always someone and one or two of the parts are actually kind of (pause) sympathetic. It's actually like having a friend that you can sit down and have a coffee with. Not everybody with DID has that. I guess everyone finds a way of coping with it differently and this is how I deal with it…It really is like a flat share and there are there are a couple of them that really loathe each other so if*

they get together...if they get to be out, around the same time, it's fireworks but it's no difference to living in a shared house (laughs)'

However, there are negatives too:

I've had people say 'It must be really nice to have people do those things for you' Well yeah but we've only got one body between us so you've got 29 people all trying to do things with the same body...it's kind of exhausting. And it's also frightening when you don't know what someone else is doing with your body. You have to...I have to be able to trust them, just as they have to be able to trust me, that none of us is going to do anything that is going to put us in jeopardy; no drugs, no alcohol, no strangers. If someone else is going to be out they have to tell me who they are and what they are going to be doing because that way at least I've got some kind of…It kind of limits what I can do (inaudible) being that vulnerable because also there are predators who will take advantage of that and I can't allow myself to be in that position. I can't.'

However, over time she has developed ways to live with 'Ruth Incorporated' as she calls it.

'I'm like the one everybody recognises. I'm Ruth - That's who the body is recognised as. I get to be Ruth...We have an agreement that if Gem wants to have a day out, she wants a day in charge and go do her thing then as long as I know and as long as she is not doing anything dangerous or could cause problems for us that's fine…if I'm having a bad day and I'm scared or I'm down, one of the others can step up and deal with the things that I can't deal with'

Hart (2013) argues that DID is an extreme form of post-traumatic stress disorder, caused by multiple dissociation events. It can also be seen as a coping strategy: a way to manage repeated trauma and ongoing existence. The alters keep the memories and prevent them from overwhelming Ruth. They help her manage her life and step in when she needs it. As with many coping strategies, it works but has significant negative aspects, particularly in terms of the consolidation of her identity. However, it does work *in the absence of other, better solutions*.

An Active Identity

Abuse shatters identity. Identifying as a person who has experienced childhood sexual abuse firstly involves accepting that it happened. This is influenced by the individual's memory of it, which may be coloured by the effects of trauma on memory and also the concomitant ontological insecurity that comes from memory gaps. This is further negatively affected by

discourses around false memory. The individual has to decide whether to express these memories and accept the resulting criminal or social implications.

In response to ontological insecurity, participants described an internal struggle to rebuild their identity. In the process of recreating one's social identity, including re-establishing a sense of autonomy and power, it is remarkable how much of this process is defined and controlled externally. Externally defined, hegemonic gender roles shape and create gendered responses to abuse, especially regarding ongoing personal safety. Goffman (1959) argues that all individuals seek to increase their status and do so by consciously performing to impress others. The participants in this research do indeed discuss performing gender, including the selection of clothing and body modification. After experiencing abuse, this research suggests, people re-evaluate their gender and how they perform gender, as defined by their culture. It appears, from the examples given above, that men may be more likely to entrench in their gender and women to reject theirs. Participants indicated that they do this as a form of communication, not to achieve an increase in status but to increase a feeling of safety. The performance is not to attract attention and acclaim but to deter predators. Thus, men display more traits of traditional masculinity to distance themselves from the potential of being a victim again, while women downplay their sexual attractiveness in an attempt to reduce their risk of re-victimisation.

Labelling of people who have experienced abuse, as victim or survivor, is conceptualised and illustrated by others including the media. Thus, the choice of a label is also the acceptance of membership of an externally defined category (Jenkins, 2000). However, the participants of this research are not mere passive recipients of a stigmatised social role. They are actively engaged in rebuilding their identity, even if this identity is transformed by their experiences of trauma. It involves actively choosing nomenclature which may or may not include the trauma experience as part of their identity. People make choices regarding their gender expression, albeit influenced by an ongoing sense of danger, and process memories that may be severely fragmented. At some point, they may decide to express this identity externally. The next chapter examines the negative influences the external world can have upon people who have experienced CSA.

Chapter Six - Disconnected

Abuse exists and thrives in silence. Indeed, in most cases, it depends on silence. That silence can extend across the entire life of those affected. Many people who have experienced CSA will try to disclose the crime, but evidence suggests that the response may well not be positive (Livesey, 2002). This chapter will examine how children are socialised into being victims of CSA and into protecting abusers by keeping it secret (Becker, 1963, 1993). It will then examine how the perpetrator, family members and wider society reinforce this secrecy through techniques of neutralisation (Sykes and Matza, 1957).

The theory of neutralisation was proposed by Sykes and Matza (1957). It was developed to explain how teenagers became delinquents despite societal pressure to conform. Following on from this, it has been applied to many deviant behaviours, including paedophilia (De Young, 1988; Christensen, 2010). The theory lists five rationalisations used by individuals or group to overcome objections to deviant behaviour: denial of responsibility, denial of harm, victim blaming, questioning or blaming authority and, finally, arguing that the individual should be loyal to the group (Sykes and Matza, 1957). De Young (1988) argues that these rationalisations are used not just to impel and encourage deviant actions but also to reduce societal objections to that behaviour.

Although Christensen (2010) criticised the theory for ascribing motive to individuals carrying out deviant behaviour, it is a useful approach to interpreting the reaction of individuals and society to the victim of CSA. As an example, De Young's (1988) analysis of the media produced by pro-paedophilia organisation contains all the rationalisations above. Such organisations argue that children should be free to express their sexuality, thereby denying that CSA is harmful and, in consequence, that it actually produces victims (De Young, 1988). In this way, the pro-paedophile literature is remarkably similar to the academic literature on the subject of child sexuality (see Plummer, 1991; Kincaid, 1998; Angelides, 2004; Malón, 2011). Both minimise, ignore or deny any negative effects upon the child.

However, one fundamental factor in the crime of CSA and the silence following on from it is the emotions it engenders in the victim. Specific emotions were mentioned by participants in the survey or interviews and these were counted.

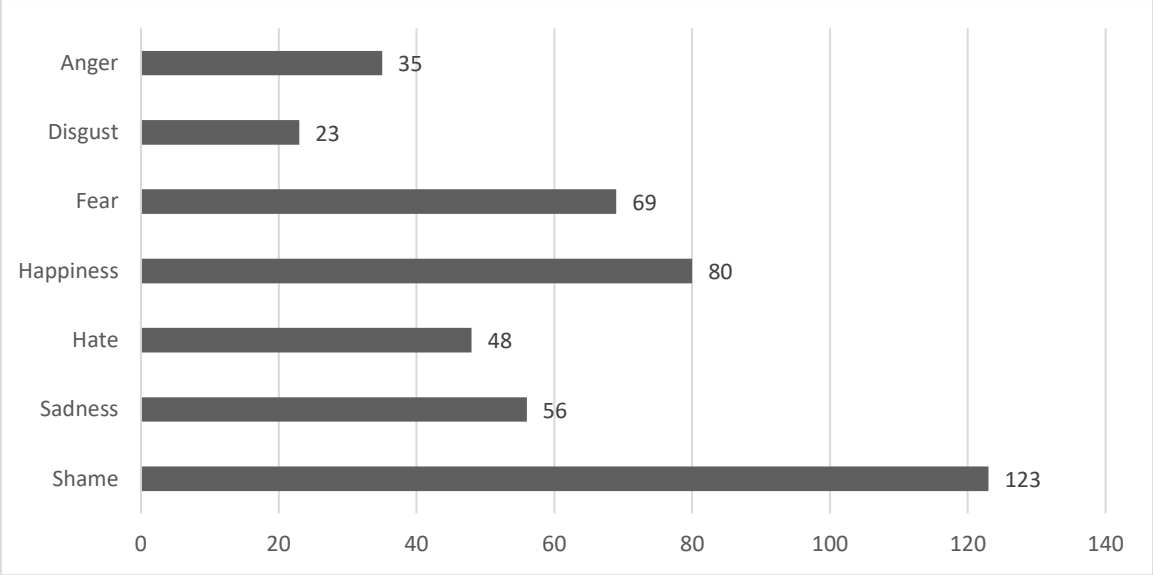


Figure 6.1 Number of Times Emotions were Mentioned by Participants

Clearly CSA does have a negative effect, as by far the most frequent emotion mentioned was shame (n=123). Happiness follows (n=80), but it should be noted that this was always discussed in the context of recovering, not the experience of abuse. This was followed by fear (n=69), sadness (n=56), hate (n=48), anger (n=35) and disgust (n=23) (Figure 6.1).

As the most mentioned emotion, shame is important to understand as a technique of silencing people who have experienced CSA. Deonna, Rodogno and Teroni (2011) define shame as a social creation: one cannot be shamed without an audience. They describe it as heteronomous, being managed and created outside the individual. It exists to reflect societies' values and punish what is socially undesirable. Therefore, Deonna, Rodogno and Teroni (2011) view it as vital for social control and cohesion. In the context of CSA, the social control aspect of shame, is utilised to punish those who perpetrate abuse, ostracising them from society once they are labelled as a 'paedophile'.

Shame is usually conceptualised as something an individual feels because of something they have done, a rule they have broken or a social norm they have transgressed, as in the case of CSA perpetrators (Deonna, Rodogno and Teroni, 2011). This explanation of shame explains why a perpetrator of CSA may feel shame and why society would describe their actions as shameful. However, it does not explain why victims feel shame.

Velleman (2001) argues that also shame occurs when we cannot manage the perception of ourselves by others and we expose something private and/or secret. Image management is vital to our self-esteem and, indeed, affects our social status (Goffman, 1959). Thus, victims of CSA may feel shame because once this experience is revealed they cannot control others' image of them. As discussed in Chapter Four, most people taking part in this research were

abused by people they knew, often by family members. Exposure of that abuse challenges the fundamental barriers between society and home: frontstage and backstage (Goffman, 1959). Revealing such a negative secret reflects upon the family and could indeed be experienced as shameful.

Shame does not always require the presence or knowledge of others (Velleman, 2001). The processes of socialisation inure people into shame. Thus, shame can be internalised, and this influences people to remain silent. Silence and shame are fundamental to the experience of CSA and, therefore, of recovering from it. When asked what hinders recovering, the most common answers were 'family', 'understanding' and 'support'. It is crucial to note that the actual effects of abuse, such as depression or anxiety, were not mentioned so frequently. This indicates that human interactions, particularly with those closest to us can significantly mould the experience of CSA and recovering from it.

Children who have experienced CSA turn to the people and discourses around them to explain or model how the world works. The individuals may not be good role models. They may, indeed, be the abusers. This chapter explores the interplay between individuals and society. It focusses upon the negative impact of human social connections and relationships beginning with, arguably, the most destructive relationship: that of perpetrator to victim. It examines how the family, close relationships and institutions can be complicit in creating a veil of silence to be drawn across both the issue and the individual experience of child sexual abuse. It will also explore how silence is created and enforced.

The Perpetrator

Unfortunately, one of the first people who teaches a child who experiences CSA about the world is the perpetrator themselves. Often, they have a close relationship to the child: as stated, 49% of respondents were abused by a family member. The prior relationship the perpetrator often has with the victim enables them to manipulate the child more effectively. The examples given below explore how perpetrators utilise neutralisation techniques, including denial of harm, denial of responsibility and blaming the victim, to control their victim and compel them to be silent.

The first example of neutralisation is blaming the victim, as this anonymous survey response illustrates:

> *'I was told repeatedly by my abuser that I was a bad girl and for that reason I was being abused. I was also told it was my fault and that I would go to jail if I told anyone.'*

Alice was also told it was her fault and that she *'came on to him'.* Here we have examples of the victim being told that they are at fault because of a perceived failing (Sykes and Matza, 1957).

Another technique of neutralisation is denial of responsibility. This is demonstrated by this survey respondent who revealed that one of the perpetrators who abused her from 6 months of age told her that he:

> *'was changing my nappy when he 'first became aroused', and that I was, according to him 'approximately 6 months old' at that time. I told the court how in that moment I recognised him as a frightened, twisted lying, predatory paedophile who had manipulated me into believing I had been responsible for his treatment of me (even in court documents he has suggested I 'instigated' the relationship with him).'*

This denial of responsibility has a further purpose, as outlined above. It benefits the perpetrator if their victim feels complicit with the abuse. The shame this creates increases the chances that they will remain silent. Therefore, perpetrators will attempt to create this emotion in their victim or victims. This highlights that one motivation for the creation of shame in a child is to silence them.

As discussed in both the literature review and Chapter Four, CSA is undoubtedly harmful to the child. In order to abuse a child, the perpetrator must ignore, deny or actively enjoy harming them. Therefore, denial of harm is the third technique of neutralisation and is identified as one of the factors that leads to overcoming any resistance in the perpetrator to committing the crime (Sykes and Matza, 1957; Finkelhor and Araji, 1986). To achieve this denial, the abuser imposes an inhuman identity upon the victim: that of object (Quayle and Taylor, 2002; O'Donohue, Gold and McKay, 2008). One cannot harm what is not fully viewed as human, with the concomitant dismissing of wants, needs, desires and right to autonomy that such objectification entails. The child simply exists for another's gratification. That identity is then communicated to the child. Carly describes this:

> *'The message I was receiving from multiple angles was that my body wasn't primarily for me – it existed for the benefit and pleasure of others first and foremost.'*

Therefore, the child learns that their needs and requirements are not important. Furthermore, as Carly stated, they are taught that their body does not exist for them but for others to utilise. The body becomes 'it'. This is reinforced by other influences upon the child which will be discussed below. The impact of this will be discussed in Chapter Eight.

Many abusers are actively respected by their community. Participants reported abuse by community leaders such as an author, teachers, police, clergy and a UN peacekeeper, as well as family members. Therefore, the child's relationship with the perpetrator can often be complex. Because abuse requires private access to a child, it is likely to be carried out by someone they or their family trust, respect and may love. This creates a situation where the child attempts to accommodate the abuse whilst maintaining relationships that may be important to them (Middleton, Sachs and Dorahy, 2017). Such an accommodation may well result in further feelings of shame and thus silence.

Society also denies harm particularly when the child is abused by a perpetrator who does not fit the traditional discourses regarding offenders. Within this research, this denial is particularly common when the abuser is a child, adolescent or adult female. 49 of the survey respondents were abused by children or teenagers. Although there has been a growth in research looking at adolescent perpetrators, children abusing children has been previously dismissed as harmless 'sex play' (Kinsey, Pomeroy and Martin, 1948, 1953; Bentovim, 2002; McGrath, Nilsen and Kerley, 2011; Krahe and Berger, 2017). This minimising discourse has influenced societal and familial reactions to disclosure. For example, one anonymous male survey respondent who was abused by a teenager was told by his family:

'*it wasn't abuse. It was just experimenting.*'

Although it seems that when people report this type of abuse it is frequently minimised, Sperry and Gilbert (2005) argue that the effects upon the individual are similar to abuse by an adult.

Female offenders are another example where the harm they cause is denied or minimised. This is because women are idealised as the caring gender, more sexually passive and thus abuse from them is seen as much less likely (Haliburn, 2017). The image given in the media, if it is reported, is of the teacher 'seducing' her pupil (Jeeves, 2014; Musumeci and Nauman, 2017). However, the participants primarily discussed abuse by their mother, which will be discussed further below. Even when convicted of CSA a women's role is conceptualised as subordinate to men and further to this Robinson (1998) asserts that women only abuse when coerced.

There are an extremely small number of convicted female abusers, which may illustrate this denial. For example, Beech *et al.* (2009) recruited 15 incarcerated female CSA offenders for interview and reported that they were half the UK female prison population for that offence at that time. This demonstrates how few prosecutions of women there are, and this creates significant difficulties researching them. However, it appears that the actual number of female

offenders is much higher at between 6-10% of all CSA offenses (Peter, 2009; Bourke *et al.*, 2014).

Within this research, five people disclosed abuse by a female, although the figure is likely to be higher, as discussed in the methodology chapter. This abuse was minimised as this survey respondent explained:

> *'with men who were abused as children by women I think society doesn't take it seriously'*

Denial around female offending can, in and of itself, cause harm. For example, Steven was abused by his mother and has faced disbelief when disclosing this, which has resulted in problems accessing any support for his recovering. Thus, this minimisation is perpetrated by wider society and this is explored more extensively below.

The techniques of neutralisation listed above are exploited by perpetrators to silence the child by creating a sense of complicity and minimising reactions to the abuse if they do disclose. Research has demonstrated that the vast majority of CSA assault incidents do not end because the perpetrator is punished in some way (Office for National Statistics, 2018). This is evidence of the effectiveness of neutralisation techniques. The aim of these techniques is to confuse, undermine and create a sense of complicity in the child which may well last until adulthood. This can be compounded by those closest to the child, which will be explored in the next section.

The Family

The family is an important arena where perpetration may occur, and also where feelings of shame are created or reinforced. 33 survey respondents said that 'family' was *the* factor that most hindered their recovering. This section examines the impact upon the child of abuse within the family, as well as the effects of poor responses to disclosure. It outlines the use of neutralisation techniques, including appealing to the child's loyalty, victim blaming, denial of harm and denial of the victim. Another avenue explored is the complex family dynamics created when the child is not safe in a situation that they are unable or unwilling to escape from.

When the abuser is a family member, the child, and later the adult, may have confusing feelings towards them as this anonymous response explains:

> '*children are terrified of their abusers and sometimes even want to protect the abusers.*'

Liotti (2017) argues that intra-familial abusers exploit the familial relationship to commence and continue abuse. The child is then torn between the natural desire to approach a parent for comfort and the equally natural imperative to flee from danger (Liotti, 2017). Oz (2005) argues that children create a separate world to manage this dissonance between loving family member and abuser. She terms the time the abuse occurs as the 'world of trauma' and within this is the 'monster'. The rest of the time, which she terms 'shared reality', is something that all the family share, but a step on the stair, or other repeated sound or sensation shifts the child into the realm where the monster stalks them.

Ruth illustrated this when she discussed her parents:

> '*I have horrific memories of both my parents but I also have memories of the fantastic times I had with them when they were behaving like people and that's when they get to be mum and dad rather than* ***the*** *mother and* ***the*** *father because for me they were different people.'*

I have added the bold here to highlight the way in which Ruth pushes away her 'monster' parents even through language. They are not 'my' parents but 'the' parents: they exist but they are not 'mine.' They are only 'mum' and 'dad' when they are 'behaving like people' not monsters.

There is evidence that even at the time of the abuse, children actively try to manage an unmanageable and often incomprehensible situation, as Ruth is doing above (Lloyd and Brown, 2019). Victims of crime are active agents in the world and, as such, attempt to reduce their level of risk. The child manages this challenging dissonance between cruelty and love coming from the same adult by creating this 'world of trauma'. This severance between abuse events and familial reality often causes dissociation as the child mentally leaves their body to experience trauma without conscious attention from the mind (Oz, 2005). The long-term effects of this division between body and mind upon the individual are discussed in Chapter Eight.

One significant but under-researched area is abuse by the person who is usually the main caregiver: the mother. Previous research has also identified the mother or maternal figure as the most common female perpetrator (Kendall-Tackett and Simon, 1987). Evidence suggests that girls abused by their mothers feel powerless, damaged and that they struggle with motherhood themselves (Haliburn, 2017). In contrast, boys abused by their mother initially feel special and chosen, only later developing negative symptomatic behaviour (Haliburn, 2017).

Within this research, Mary was subject to contact abuse by men, but this was facilitated and directed by her mother. Melissa was abused by her mother and subsequently blamed by her when she was abused by a peer in her teens. A further anonymous survey respondent was abused by his mother, who used his loyalty to persuade him to help her groom other children. This appeal to loyalty is another technique of neutralisation that is particularly effective when employed by such a significant person in the child's life. The neutralisation techniques practised upon the child further a sense of unreality in them and makes it easier for the child to deny themselves that the abuse occurred.

Care-giving adults can also actively encourage the abuse, as Mary experienced from her mother. This anonymous survey respondent also experienced this betrayal:

> '*My mother sent me to be raped at 10 - I was a present for someone she wished to please - it took me decades to blame her and not me*.'

This belies the image of the caring protective mother or the explanation of the weak female abuser manipulated by a dominant man. It also illustrates the confusion in the child and, later, the adult caused by these reprehensible actions, creating a confusion over who to blame, when to an external observer the mother's guilt is clear.

It is unclear whether Ruth's mother knew that she was being sexually abused, although she was aware of her husband's sexual interest in teenage girls, however the following story illustrates how she enabled the abuse:

> *'Once when I had managed to stay away from him for two weeks...erm... I was kind of blackmailed into going to visit and the mother... and when I got there the mother was like 'You need to go... whatever it is you have done to him, what is you have fallen out with him about you need to go fix it because he's out in the garden burning his belongings on a bonfire and he's already beaten your brother up twice' and the only way for me to placate him and stopping the beatings was for me to let him do whatever he wanted to do.'*

Ruth thought that by 'taking' the abuse she was protecting her family from further violence and abuse. She was the sexual scapegoat for the family.

Sometimes family members are aware of the CSA because they were abused by the same person, as Lynne described, when discussing her abusive Grandfather:

> *'everybody knew, everybody had been abused by him as a child. It was his sisters, his brothers, his own children, you know, it was just everybody but nobody talked*

about it and you could sense that the blame was on the children or...you knew that they knew and that it was my fault'

Families can, therefore, be extremely toxic, with adult family members maintaining this state. This can be because the perpetrator is feared by family members, as Melissa explains. Her non-abusive father was:

'a kind person, just not at all ready to intervene when my mother was out of control. More it seemed almost willing to let her take it out on the kids because he didn't want to be the focus of her ire.'

Children can be assigned the role of scapegoat, experiencing the abuse that others do not want to endure and, as above, participants may feel that they were enduring it to protect others. For example, when Ruth found out that her father had kissed her sister:

'my sister told me what had happened and I was like 'No this stops now. I'm not having gone through all the years of crap that I've gone through'...because if I managed to avoid him for any period of time he would become aggressive and violent, physically violent to my siblings. He would stop them going out, he wouldn't let them do things, he wouldn't let them watch TV, he would beat them up.'

It was at this point Ruth approached the police: not to protect herself but her sister. Families can also encourage abuse, to deflect or avoid the perpetrator's wrath. Here we have neutralisation techniques in play. The victim themselves is denied, they do not exist. Furthermore, there is a manipulation of family loyalty in the child. The harm they experience is given meaning, which is that they are the scapegoat for the family. It is their role. Therefore, families can enable abuse.

Therefore, for many people, abuse within the family is known but not known, subject to the same techniques of neutralisation used by perpetrators. Shengold (2012) describes abuse by parents as 'soul murder': 'having to bear the unbearable, alone, forsaken by parents' (p.125). Not all participants had parents who perpetrated or enabled the abuse they experienced, but many lived in unhappy family situations as covered in Chapter Four.

The presence of other ACEs in the family in some cases provided an opportunity for the abuser, as Charlotte stated:

'in three of the cases (of being abused*), my father wasn't very far from me when it happened, two in particular. Alcohol was involved and he was just…It wasn't his fault or anything. I'm not blaming him because he was doing his own thing.'*

Charlotte does not blame her father, instead she demonstrates an acceptance of her place in his priorities. ACEs can also prevent a child from disclosing abuse, as Charlotte then explained:

> '*My mom is a paranoid schizophrenic so it wouldn't quite be appropriate to say to her, "Hey mom. Guess what..." I think at least I can protect her from knowing awful things about her daughter and my dad is a functioning alcoholic. No disrespect, but he just wouldn't be interested in being enlightened or just interested in anything other than what he's doing.'*

Charlotte felt that she could not disclose the abuse to her parents because of their own issues. This was echoed by George, who was abused by a priest. He had a violent father and thought he would be beaten up if he told him about the abuse.

It can also inhibit other family members from acting on disclosures, as Judith explained when describing a memory:

> *'I was standing outside the sitting room with my grandparents, with my Dad hugely tall next to me, and I felt like I was trying to say something to him...my suspicion, and I don't know if this is the case, is that he had clues and didn't act of them and I think partly the reason was the relationships he had with my grandmother and mother who are both very demanding (laughs) And I think this was around the time that my mother was depressed...My suspicion is that I couldn't tell him something clear and he knew something...He couldn't face telling my mother because my mother was in a state and he thought that just being nice to me and comforting me that would do it.'*

Thus, some participants had disclosed as children and no action had been taken. This is reflected in the survey as well as the in-depth interviews. For example, eight of the interview participants had told someone as a child, a further three mentioned that people were aware of the abuse when they were a child, but it was unclear how they knew. Action was taken in only two of those cases to stop the abuse. Thus, in nine childhood disclosure cases, non-offending family (6), police (1), school (1) and church (1), were aware of the abuse but took no effective action to stop it.

Furthermore, when telling family later, six people discovered that their parents or grandparents had suspicions at the time. However, family members may not act upon suspicions, or may even blame the child, as this anonymous survey response illustrates:

'I remember that when I was a young teenager my grandmothers noticed that I greeted my father with a hug when he came back from work. They spoke to me about it later, telling me that I'm doing something inappropriate: "Is that how a daughter greets her father?" I guess they thought I was too enthusiastic or that we touched too much. They spoke to me about it, shifting the responsibility to a child - who they maybe perceived already as a small woman - not to the adult.'

In eighteen out of twenty-one interviews, participants reported that someone either knew the abuse was happening or had suspicions. This reflects other research in the area. NSPCC research has demonstrated that 66% of 60 children they interviewed had tried to tell someone at the time (Allnock and Miller, 2013). They report that of 203 disclosures, only 117 (58%) were acted upon. With maternal disclosures, only 30% of mothers took any action (Allnock and Miller, 2013).

Solinski (2017) argues that in families, as elsewhere, there can be a state of 'knowing and not knowing', where there is a collusion of denial. This creates a situation where child feels that the lack of response to their disclosure is because they have done something wrong that no-one wants to deal with, which then leads to shame and silence (Solinski, 2017). Previous research suggests that children do not, in general, disclose abuse (London *et al.*, 2008; MacIntosh, Fletcher and Collin-Vézina, 2016). However, the research participants told a different story.

Being heard is significant in the recovery process but, in the main, the family does not seem to be a good place to disclose abuse.

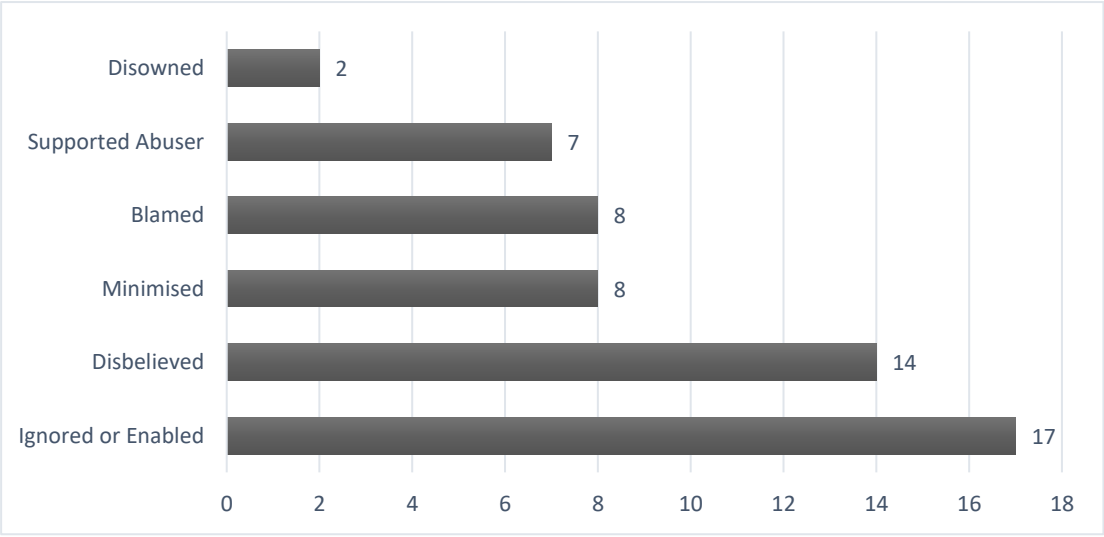


Figure 6.2 Family Reactions to Disclosure

In total nearly half (n-62) of survey respondents disclosed a poor family reaction to disclosing abuse. Where details were given (n-56) there were seventeen comments about non-offending family members ignoring or enabling the abuse, fourteen people were disbelieved, eight felt the abuse was minimised, eight people were blamed for the abuse, seven families supported the abuser over the accuser and two people were disowned for disclosing (Figure 6.2).

Therefore, reactions can be very poor indeed. For example, Grace told a shocking story from her 35th birthday:

> *'my dad was getting pissed and, erm, told me that because of the abuse that had happened he had put a gun to my head and was going to kill me, my sister and my brother and end his life'*

She had not felt able to ask him to further explain this since. Other family members can also react badly to disclosure, as Ruth explained:

> *'My older brother and sister blamed me both for the abuse and for breaking up the family...Members of my extended family basically ostracized me because I had dragged the family name through the mud and I had made everything public. I had destroyed the safe, quiet...they would rather not have known and me kept my mouth shut than actually report it and get it stopped.'*

Abuse is, therefore, seen as shameful for the whole family, who are all tainted by it. In response, family members may deny or minimise the abuse, defend the perpetrator and attack the victim to enforce their silence. Alongside the fact that family members may be the perpetrator or enabler of abuse, this demonstrates why family is the most common response to what most hinders recovery. In fact, three people said that cutting off contact with their family was very significant in their recovering. Therefore, although familial support should be crucial in recovering, it is often the opposite – a cause of harm in and of itself.

Relationships

Negative experiences in the home, as well as incidents of CSA can result in long-term problems forming positive relationships. For example, people who have been abused have higher risks of domestic violence and sexual re-victimisation (Cohen *et al.*, 2000; Lalor and Mcelvaney, 2010). Nine research participants discussed, either currently or previously as an adult, being in abusive or dysfunctional relationships and linked this directly with the abuse they experienced as a child. For example, Lorraine said she:

'got into encounters with men that I didn't want to but because I thought that I was unworthy of a decent relationship- felt ugly and still do many decades later'

Lorraine was abused by her brother, who her family supported over her. Thus, the negative messages she received were compounded by the reaction to disclosure by her family.

Ruth was in an abusive long-term relationship as an adult and explained that:

'he was as abusive, in many ways, as my father was. If I had known that there was somebody out there who missed me and cared about me and valued me and didn't see me as a problem and a...I think I probably would have been able to cope better. You know when you've got that feeling that 'my life is shit right now but at least somebody loves me.' That would have made a huge difference…I wish that there had been people that I could have gone to, not necessarily when it was happening because I was terrified of them finding out but afterward to have to have people I could go to who didn't see me as dirty, or soiled or broken or unworthy or any of things I thought about myself that were reinforced by family members (pause) to have someone say to me 'no you weren't the one, it wasn't your fault and we love you.''

Thus, the lack of a close, loving familial relationship both inhibited disclosure and affected Ruth's ability to assess the messages she received from the abuser.

There is also, in some participants, a sense of not understanding how to have a 'normal' relationship, as Michael, abused by his father from a toddler, explained:

'one of the biggest complaints I have from this sexual abuse and becoming pre-sexualized from such an early age is never being able to understand love and relationships and I've been driven to trying to find it in religion and other women'

Michael sees this search as a fruitless one, with him feeling unable to find long-lasting happiness:

'I am trying to fix myself in a relationship and that's a form of abuse...I mean whether it's mental or physical it's still abuse right...Whether I cut myself or whether I hook up and then end the marriage early, you know, it's all the same.'

Therefore, the early experiences of abuse that Michael experienced have negatively affected his life and driven his search for respite.

One difficulty raised when creating intimacy with another adult is whether to reveal one's history of abuse, as Grace discussed:

> **'***there are still those feelings of shame. That I am somehow disgusting or dirty or whatever and I don't want any partner to see me like that but in terms of why do I think I have to?(disclose the abuse) I don't know but I've felt like every relationship I have, has to at some point have this big conversation and I always struggle with that conversation. In fact, I tried to have this conversation with this new boyfriend, we went for a walk and I just couldn't find the words. He was really lovely and gentle with me and was just like 'you know whenever you're ready to talk about it.' But then he said to me a couple of weeks ago 'I'm worried what you're going to tell me, I've been imagining it in my head because I'm so worried about you what you're going to tell me.' So, of course, it's just getting worse.'*

There is a desire to explain one's history, to justify what could potentially be seen as 'bad behaviour' but this is inhibited by a fear of being judged and shamed, as Grace confirmed. Indeed, such rejection may well have been experienced in previous relationships with family, friends or partners. This identity and worldview can prevent a person who has experienced abuse from seeking relationships and human connections. This anonymous survey respondent explained:

> *'I cannot have relationships. I ended the only serious relationship I've had because I couldn't cope with how much I cared about him and how vulnerable I felt. The furthest we ever got physically was kissing with clothes on. But I would have married him if I didn't feel as scared as I did/do.'*

The chance of a loving relationship was a leap too far into the unknown. The ability of the individual to evaluate risk is affected by abuse and subsequent negative reactions to disclosure of it. This does not just affect sexual relationships but also friendships, as Rachel revealed:

> *'I struggle with maintaining friendships as well as making them. It feels like most people are in another world and I struggle to relate to them. Because I have to deal with emotional flashbacks and negative thoughts due to the abuse every day, I struggle to find the emotional energy to maintain a friendship. It's not that I don't care or don't want to either. I struggle to be with people for long and in certain and unfamiliar places as I feel 'trapped' and that makes me panicky.'*

Rachel feels separate from others, as if they are in another world, which could be related to dissociation. She also clearly does not feel safe in unfamiliar situations. In many ways Oz's (2005) concept of the abused child splitting the world into two is echoed here. There is a safe, albeit narrowly defined, world and from there an internal struggle to go out into the potentially 'unsafe' world.

The banter culture of male friendships can make disclosure or accessing supportive friendships difficult as Michael explained:

> *'when you grow up you find it guys are talking about in jesting, you know, men that haven't been abused but just in jesting they talk about touching each other's sexual parts and things like that they are like 'haha' but for the abused victim, for the victim of child sexual abuse, I know that I responded a little differently. I was like 'I can't believe that you are talking about that. It happened to me and I do not want to talk about that but you guys are joking about it.''*

Thus, this kind of joking minimises the experience of abuse and affects willingness to disclose it. Many participants thought that societal minimising and judgemental attitudes towards CSA/CSE made it very difficult to tell anyone of their experiences. Sarah explained:

> *'the focus is on the victim and what the victim did or didn't do, rather than the perpetrator' people are 'talked about as though they are always held in that position of being a child so that...we are infantilized a lot of the time.'*

The individual is both blamed for the abuse and seen as 'ruined' by it. Indeed, nearly half (66) of the 143 comments about what most hindered the process of recovering were about poor reactions to talking about CSA. Therefore, there are two main problems highlighted here when entering relationships and friendships. Firstly, abuse, and other influences within the family, may not create a situation where people make good relationship choices. Secondly there may be poor reactions to disclosure and, therefore, both can contribute to an unsupportive and unsafe environment for the individual.

Institutions

It would be expected that disclosure to institution and agencies might result in a more positive, professional response. However, recent exposures of institutional complicity and cover-ups suggest that this is not always the case. One example is the Jerry Sandusky case, where Penn State University employed neutralisation techniques to suppress and deny abuse reports (Klein and Tolson, 2015). This was analysed in detail by Klein and Tolson (2015), who argued that it could be termed institutional deviance. Similarly negative organisational cultures

have been identified in other institutions, such as the Catholic church, social care, sporting and educational establishments (Ferguson, 2007; Blakemore *et al.*, 2017; Palmer and Feldman, 2017).

The initial reaction to disclosure is key. Regrettably, participants in this research explained that disclosure to non-family often did not go well either. They described many poor responses from professionals, including social workers, teachers, doctors, therapists, police and church leaders. This section will consider the effects of institutional responses to disclosure upon an individual trying to recover, alongside an examination of how institutions may enable CSA in the first place. It will explore the areas of health and social care, work, the legal system and religion.

Health and Social Care

As key services, health and social care can have a significant part to play in recovering. Although there were positive reports of health care interactions, which are covered in the next chapter, there were very few examples of good social care. This section examines the examples given by participants of negative experiences of health and social care, beginning with primary care from the GP. It then explores psychiatric care, counselling and therapy, before assessing the effect of diagnosis upon mental health care. The social care section highlights the lack of involvement of such services in the lives of people who have experienced abuse both as a child and as an adult.

One of the first institutions a person who has been or is being abused might disclose to is via their primary care doctor or nurse. Children might well try to disclose ongoing abuse at their GPs. Eight people talked about contact with their GP and, although two had a positive experience, six reported a poor experience. For example, Ruth was terrified that she would get pregnant with a '*mutant baby'* because of her father's rapes. She tried to tell her doctor, but her mother never allowed her to go in alone. She was dissuaded from trying especially when the GP used a neutralisation technique of appealing to her loyalty to the family:

> *'the one time that the doctor actually looked at me and said to my face that 'whatever was going on with me I needed to pull myself together and sort myself out because if I didn't my mother was going to end up in the loony bin for looking after me and I needed to stop being so bloody selfish.''*

She did not try again for years. Fred told a similar story of a dismissive and minimising response:

‘I went to my GP and he basically said ‘25 years ago, well, it was a long time ago. Buddy suck it up. Get over it. I'm not surprised you've got bowel problems. Soldiers shit themselves on the battlefield."

This indicates that when people are trying to speak about CSA, they are not being truly heard, and the abuse is minimised. Contact with the GP thus continues the neutralisation of abuse by denial or minimising harm (Sykes and Matza, 1957).

As the first point of contact with health services, a good response from primary care practitioners is vital, but this was rarely remarked upon by the survey respondents despite there being a specific question about healthcare. Other examples of poor experiences were being prescribed medication without being offered any talking therapy and feeling unheard or patronised.

Seven people talked about their experience of mental health care (excluding counselling or therapy), with five seeing it as a positive experience and two as negative. One issue is the barriers to accessing services as Helen explained:

‘I had at least one, maybe more, referrals to psychiatric services as an adolescent, but given that I had no support in attending them from my family, I always bottled out and discharged myself before I was seen...I think for mental health appointments, particularly for adolescents, it needs to be recognised that just the attendance at the appointment can be a very stressful experience - in fact, just the process of getting there.’

Because the process of getting to the appointment was so stressful, and Helen clearly did not have anyone to accompany her, she did not access help. Fear of a bad reaction to disclosure as well as the potential for stigma can also make it difficult for people to even try access services. Grace said:

‘I would like to go to a group but I'm thinking what if someone sees me, what if someone in the group says ‘hi’ to me when I'm, you know, outside.’

This suggests that there needs to be more support to help people to access services, to identify and address such barriers.

Fred advocated a more holistic, trauma focussed approach to healthcare:

‘what could be improved is implementation of a trauma-informed approach across the whole of mental and physical health in the public sector. That [would] cost a bit

of money because the meds are cheap. The SSRIs, the antipsychotics, the anti-depressants etc are cheaper than the time involved in face-to-face support from counsellors and therapists who are professionally qualified and trauma-informed.'

An understanding of the effects of trauma, which should be expected in mental health professionals, is so important for people trying to access support. This would involve a consideration of the barriers described by Helen and Grace.

Another issue influencing people's desire and ability to access services is the awareness that people who have experienced abuse can be labelled. A diagnosis can have an important therapeutic effect upon treatment once an individual accesses mental health services. However, the discourses around diagnosis can also colour interactions. For example, Helen described how differently she was treated when her diagnosis changed from Borderline Personality Disorder (BPD) to Complex Post-Traumatic Stress Disorder (cPTSD):

'The stigma of a personality disorder label (I mean, just that phrase alone!) is absolutely huge and yet there's not a problem with that person's personality, there is a problem with what they experienced or how they were treated, usually as a child. I think PTSD, and particularly Complex PTSD, is a far more appropriate label for many people in this position and I do think that you are treated differently as a result. I was dx with BPD at 18, but it wasn't until I was about 28 and started having flashbacks that I was dx with PTSD. You are treated so differently by everyone, particularly medical professionals, if you tell them you have PTSD rather than BPD - I think because it makes people think of your issues in the framework of you having experienced trauma, rather than in the framework of you having something intrinsically wrong with you.'

The diagnosis given, therefore, affects how the individual's mental health is understood, defined and treated. Laing and Esterson (1964) argue that mental health diagnoses are a social and not necessarily scientific diagnosis. Thus, they can be seen as a social construct, with inherent social meaning. BPD can, as a diagnosis, be argued to be a neutralising technique as it locates the problem within the individual not the trauma experienced.

The reported levels of diagnosis of c-PTSD in interviews was quite small, including only six participants out of twenty-one, which is far below the level of 86% reported by Rodriguez *et al.* (1996) for adults who have experienced CSA. Whilst most people had approached health services, there may not have even been a discussion around c-PTSD. This may be because health professionals are not aware of the potential prevalence or characteristics. The UK

National Institute for Health and Care Excellence has not produced any guidelines for the care of adults presenting with a history of CSA therefore, treatment may be influenced by generic mental health guidelines which may not be trauma focussed (NICE, 2019).

Mary, a senior practitioner working and managing mental health services, expanded upon the issue of diagnosis and described the social creation of madness. She argued that the diagnosis of borderline personality disorder is about more than identifying efficacious treatment:

> *'I'll go on one of my diatribes here against labels such as borderline personality disorder which is usually a label given to women who have been sexually-abused. If a woman describes sexual abuse, you could bet that label is going to come along in her description, it's sort of implied. It's a very powerful label and it's a way to discredit what a woman says, it's a very powerful thing.'*

Here Mary, trained in mental health diagnosis, agrees with Helen about the social meaning behind the medical diagnosis of borderline personality disorder. There is a long history of denial of child sexual abuse entrenched within psychiatric services, influenced by Freud's argument that CSA memories were fantasies (Freud, 1953; Masson, 1984). The prevalence of this diagnosis suggests that this is an enduring discourse which has influenced psychiatric practice.

Although Mary states that attitudes are changing within her profession she has, in the past, had to listen to her colleagues' judgement of people who had, like her, experienced CSA. I have reproduced her comments in full because the examples given each illustrate different prejudices, neutralisations and judgements:

> *'when I was a trainee clinical psychologist so I was at (hospital) sitting in behind a screen, one way screen with the trainees just watching a foster family, a family of a fostered child who had been sexually-abused and the trainee says, psychiatrist I mean, "Look how flirtatious that girl is," and I hadn't noticed how any flirtation whatsoever. I was really upset thinking, wondering if I was flirtatious without me knowing it because I kind of assume he was right and I was wrong. She's like, I look back at that and think he was wrong, but it's like putting all the onus on the -- In that way psychology at that time was very crushing and profoundly destroying or controlling. It's very difficult.*
>
> *I remember stories like for example being in the car park with a group of people who were moaning about -- we were all having a moan -- about which clients we*

found hardest to work with and they all said women who have been sexually-abused because they're insistent on telling a story. They go into competition with another "My stories that I had to put up with are worse than yours," so it's a group of them vying with each other saying how awful their clients were and then a woman said, "I was just trying to comfort them," and she says "You don't want to take them seriously," she said, "They are all borderlines so don't take any notice of them."

And I'm standing there, listening to this, desperate to check that my situation is kept entirely secret. They don't know. The kind of attitude that this label - borderline.

I remember another example. I was listening to someone talking about someone who was borderline. She's describing an interaction which actually seemed perfectly fine to me, it seemed normal. Honestly, what's wrong with it? She says, "You know what it's like with borderlines. One minute they're fine but we all know that the next moment?" I stood there thinking, "What's this poor woman got to do in order not to have this all-inclusive label?" I think in many ways psychology is crushing.

It was very much us and them. You could not be on both sides. You had to keep that utterly, utterly secret because if you mentioned it, your professional status will be ruined. Your reputation will be ruined. It's too close to the raw material. You'll be seen as irreparably damaged. People would not take you credibly. Whatever your experience, you had to control as in sweep it under the carpet because if you didn't, if it leaked out at all, it showed that you weren't totally on top of it.

Somehow, we as psychologists study problems but we don't have them ourselves.'

The examples described by Mary illustrate neutralisation techniques such as a denial of the perpetrator's responsibility and a judgement of the victim. For example, in the first example the victim was viewed as flirtatious and, therefore, blamed for being seductive, which minimises the responsibility of the perpetrator. In the second, people who have been abused are dismissed as just 'borderlines', who do not deserve to be listened to. In the third, the label defines the person and subsequent interpretations of their behaviour. Therefore, these descriptions of attitudes within mental health services appear to disturbingly reflect the techniques employed by perpetrators (Sykes and Matza, 1957).

Mary also raised the potential difficulty created by mental health service staff disclosing that they have experienced the condition or trauma that they are treating. Although, in the same

way as an insider researcher, this may be an advantage in terms of efficacy of treatment it can be viewed as a weakness or undermining one's professionalism. Mary clearly describes how much the patients are seen as 'other', something to be treated but somehow 'less than' those treating them. Dismissing the individuals treated as 'borderlines,' is repeating the neutralisation techniques used by abusers and, therefore, could be argued to harm the person by entrenching the damaging objectification they experienced from the perpetrator(s).

The issue, of not being heard or seen as a victim of abuse, can be ameliorated by patient-centred treatments, such as counselling or therapy. Indeed, these services were described as the most positive aspect of healthcare for recovering from CSA, with 107 people viewing talking therapies as a positive influence upon recovering. This is explored in the next chapter. However, twenty-two people gave examples of negative experiences of counselling and therapy. One of the main issues was access, particularly related to funding, with people reporting either too few counselling sessions being offered or no access at all without payment. This is related to different countries' healthcare systems i.e. where there is no free at source healthcare or where access to it is limited. For example, this anonymous respondent said:

> *'Here in the U.S. they listen and offer nothing and then you get a bill. Years of this and then I gave up.'*

However, it also occurs within the UK, where resources and consequently numbers of sessions are limited as this example demonstrated:

> *'I found counselling a mix of traumatic experiences, constantly opening up myself to a stranger at set times, and not when I particularly felt able to talk about things difficult to deal with. Leaving a session feeling vulnerable and with what I felt were re-opened wounds was not the best for me. It was also based on a set number of sessions, which is unrealistic. I was never given any 'tips' or pointers in how to deal with having sudden (sometimes anxiety provoking) thoughts and being left from week to week with these feelings was difficult.'*

Thus, a limited number of sessions is seen as problematic because of the difficulty in dealing with complex trauma in the standard six sessions. George agreed:

> *'to suggest that somebody has come to terms with, let's say, child abuse, grooming, sexual exploitation or some hideous rape can resolve the issue in 6 one-hour sessions is complete nonsense!'*

Furthermore, as stated above, counselling entails reliving traumatic experiences that can

leave the individual feeling very vulnerable. As this survey respondent described:

> '*10 weeks here and there with the NHS or a charity meant that you felt as if you were jumping from life raft to life raft.'*

Altogether, there were twenty-six comments requesting improved funding for counselling and support services. Therefore, whilst overall counselling and therapy is viewed in a positive way, these positive effects are limited by lack of resources. A recent parliamentary report found that 89% of people who have experienced CSA reported that the trauma had a negative effect on their mental health. The All-Party Parliamentary Group (APPG) also noted that mental health services were severely underfunded, and recommended that the UK government ringfence money for mental health support services (The APPG for Adult Survivors of Childhood Sexual Abuse, 2019b).

However, other participants argued that a focus upon a medicalised response to CSA was inappropriate and illustrated a denial of societal complicity. Sarah, an academic, explained:

> *'the kind of stock answer that people give when you say you have been abused is to say 'Oh you should get counselling for that' but counselling isn't like this panacea. It's not that people who have been through it need counselling for the rest of their lives without exception and that, kind of, saying that that experience permanently causes a state of not being able to cope I think is deeply problematic and it completely ignores that most people who have experienced sexual abuse have actively tried to manage that situation and they have actively tried to manage the abuser and minimise the damage that it is doing and then there is this undermining 'oh well you certainly need counselling for the rest of your life' sort of thing, 'oh really why?'*
>
> *Of course it is important that counselling is there but it is not the only space that we should have to talk about this and we should be quite wary of medicalising it in that sense because it individualises abuse when abuse is very much a societal issue, but because it also individualises responses to it and reactions to it. So I worry about this idea that it turns from 'this is a thing that society has enabled' to 'you have been affected so much you must become a patient.' I find it very silencing and it means that we are not talking about those other issues'*

If counselling and therapy become the immediate response to disclosures of abuse, this denies larger structural and societal factors that enable abuse. As Sarah says, that is not to

diminish the need for counselling and therapy, but instead to widen the debate to address the wider more systemic issues that create an environment where abusers can flourish.

One area where wider social and economic issues might be considered is within social care services. Taking into account the information given by research participants regarding their experience of CSA and, often, the presence of other ACEs within their family environment, it is surprising how few mentioned being in contact with social care. 131 survey respondents did not mention having any social services intervention. Helen thinks this is because:

> *'there are many ways to abuse a child and the vast majority of them are ways that don't hit the radar of social services, the police, etc. because they only deal with the extremes.'*

Therefore, it could be argued that the children, trying to actively manage their unmanageable situation, did not reach the visibly damaged threshold where action would be taken.

However, there is some evidence that some who did reach this threshold were dismissed or ignored. This anonymous survey participant explained why she did not get any support at age 15:

> *'School blamed me for my bad behaviour, parents blamed me for my bad behaviour and after I took an overdose the doctors and nurses said I was an attention seeker. I fell through so many holes I got stuck at the bottom for years.*'

The people and institutions around this girl focused on trying to get her to stop her behaviour rather than asking her the reason/s for it. Action was only taken in Lorraine's case when a school nurse demanded something be done:

> *'Social services and police knew what was going on long before I was finally removed from my parents and put into care. Yet they did nothing. I was put in care only because the school nurse refused to let me return home after I went to school battered and bruised and broken one too many times.'*

Clearly this was a case where action should have been taken sooner. There was an institutional blindness to her victimisation, again echoing a perpetrator's neutralisation technique (Sykes and Matza, 1957).

Even those participants who were visible to social care did not report a positive or even neutral experience. Only nine people talked about having any contact with social care. Ruth was denied a social worker after testifying against her father:

> *'I couldn't have a social worker because I was considered too old, under child services... I wasn't mentally ill enough to come under mental health. So they were like (laughs) 'we're really sorry but you fall between the stools. We don't have anyone who can help you because you don't fall under any of these labels'…I was basically just left to fend for myself.'*

Her family, including her father, were given practical assistance (housing, benefits etc) upon his release from prison but she was not. Working in partnership with other agencies to properly support people who have been abused during and after engagement with the legal justice system is essential.

Sarah's parents were dissuaded from taking the abuser to court by a social worker:

> *'We did report to the police but between the initial report and then coming to take a statement there was also a social worker who pretty much put the fear of God into my parents about talking to the police'*

The social worker may have been warning her parents about a potentially disturbing legal experience, as described further below, but Sarah did want to report the crime. Here we have an example of a neutralisation technique 'blaming the accusers' as the social worker influenced the family by undermining their confidence in the police.

Seven participants were in residential care at some point in childhood and, of those, four were sexually abused by care home staff. Thus, this was not a safe environment. Even Lynne, who was in two children's homes and conceptualised the experience as an escape from her home or foster care environment, reported that the staff in one home were beating other children.

Therefore, there are few comments in the research data about social services and those that are made do not describe a positive, supportive or even safe experience. There are more positive comments regarding healthcare, which are explored later, but there are also crucial examples of the implementation of neutralisation techniques, particularly those concerned with victim blaming. Palmer and Feldman (2017) argue that such responses are enabled by a poor organisational culture with inappropriate norms, values, beliefs and behaviours. Such cultures, they argue are often created by a patriarchal management structure and approach. This can lead to the enabling, minimisation or denial of abuse, which results in further harm to the individual (Blakemore *et al.*, 2017). Health and social care organisations are vital in recovering from child sexual abuse, but the improvement of their services involves the provision of more resources and, fundamentally, in-depth structural change.

Work

As a significant facet of life, work can be a positive or negative factor in recovering from abuse. PTSD and the experience of trauma have been connected with a reduced working potential and the inability to work at all (Matthews, Harris and Cumming, 2009). Out of 122 responses, eleven people characterised work as a negative influence upon recovering. Eight others reported that they were unable to work due to physical and mental health conditions. These conditions may have been as a result of the CSA. This section will detail the negative effects of CSA upon employment, as well as the result of disclosure at work and overworking.

Firstly, the effects of trauma on mental health can affects people's ability to work. Amelia explained how this made her feel:

> *'My working life has been rather a disaster, due to my mental health. I have accepted that I am unlikely to be able to work full time, as each time I have tried to my anxiety has escalated to a level that I have become extremely distressed and behaved in self-destructive ways (going home sick to hide in bed, resigning from jobs and turning my phone off, occasional self-harm). I often feel shame and frustration that I cannot have a career where I can succeed when I am intellectually capable of one (I have a Masters' degree in an academic subject).'*

The effects of trauma, and ensuing shame, on an individual's mental health can mean people struggle in the workplace, which underlines the need for workplaces to be supportive and safe environments. However, despite this not being a question, two people reported being sexually abused, as adults, at work and two others experienced sexual harassment in the workplace. Therefore, work itself can be an unsafe place.

Being open about one's experience of CSA in a working environment can mean that one is subject to the discourses around CSA victims. For example, it can affect employment possibilities, as Fred explained:

> *'All the way through from teacher training, I was out front to being a male survivor…I used to put that at the bottom of my CV for all the jobs I applied for. I never got the job…I can't be sure of it. How can you be sure? I think I was discriminated against in selection for posts because I said I was a male survivor. Although no senior management or head teacher or anybody like that ever criticized me for it, some other younger teachers might say, "Are we sure that we should be leaving that bloke in a classroom on his own with kids?"'*

Discrimination is difficult to prove, but a sense of rejection affected Fred, and he gave up on his aspirations for a teaching career.

Disclosure once in work can also cause problems. George disclosed his experience of CSA to his employers, a sixth form college, to explain his rationale in objecting to aspects of their child protection procedures. In response, they compelled him to report the abuser to the police although he did not want to:

> *'I had regular weekly meetings with the Principal...so at one of these regular weekly meetings I turned up with my regular talk about the accounts file and in the meeting was the HR director and they sat me down and they said to me 'We know that you have spoken to various members of the management team about your abuse.' They said, 'We want to report it to the police and we want you to do it'…And I actually had a breakdown there and then. I went into shock, I was shaking...It was a mental breakdown, physically manifested there and then. Whilst that was happening I got some flashbacks and started fitting a little bit. They then went on about reporting to the police and what I actually said was 'ok let's get it over and done with.'*

This could not be described as freely given consent to reporting the crime. He further explained regarding his employees:

> *'I thought telling my colleagues in a sixth form college was going to be a safe place to disclose and it wasn't and I took it as a complete betrayal. Because I only told six people at the college, two of whom were in the room forcing me to tell the police and I had told them each in confidence, I just felt it was a complete betrayal and I felt more violated by those two women then I ever did by the man who actually did the abuse in the first place and the counselling that I have had subsequently has mostly focused on that date in October 2015, rather than the details of the eight years when I was a youngster.'*

Thus, again, the reaction to disclosure is vital as is a safe environment. The act of denying or preventing autonomy is clearly traumatic to the individual.

Work can also be utilised by the individual to avoid addressing issues. Five people viewed their attitude to work as negative, describing being a workaholic as two survey respondents said:

> *'I very frequently overwork to not confront pain or thinking about sad things.'*

Thus, work can be an escape, which has the potential to be a positive or negative thing.

Considering the large amount of time spent at work, it is quite possible that the effects of trauma may affect an individual's working life. Participants felt that employers should be trained in supporting people who had experienced trauma and have a more understanding attitude towards mental health issues. However, there are remaining issues around the judgement of victims and creating a safe, supportive working environment.

The Legal System

Another institution where disclosure is frequent but can be difficult is within the legal system. In a recent parliamentary report, 2 out of 5 people who had experienced CSA said that the police did not take their report seriously, and 64% did not see a charge brought in their case (The APPG for Adult Survivors of Childhood Sexual Abuse, 2019a). 90% said that the support provided to them was poor and 70% described communication as poor (The APPG for Adult Survivors of Childhood Sexual Abuse, 2019a). This section will consider participants' responses regarding disclosing the crime as a child or adult and their experiences of the criminal justice process.

Although most people who reported the abuse to police did so as an adult, two participants had tried repeatedly as children. Lynne rang the police on numerous occasions about her Grandfather, after seeing him grooming other girls, but no action was taken. One survey respondent, who was abused by a family member and a victim of sexual exploitation, contacted the police on numerous occasions but was treated as a criminal:

> *'the police never took my reports seriously when I was a child...I was also spat at by police officers, called derogatory names and laughed at while I was working on the streets in my preteens/early teens.'*

She was clearly a victim of CSE, but not treated as such. Now an adult sex worker, she reports an ongoing distrust of the police. Although some participants reported trying to tell someone as a child, be it family or support services, the majority of victims were only *heard* when they were adults. This affects the likelihood of the perpetrator being prosecuted. Therefore, an improved response when children do try to report abuse is vital to ensure a higher conviction rate and the safety of those children enduring abuse.

Unfortunately, the experience of reporting to the police as an adult may not be a positive one either. For example, George was upset that two male police officers were sent to take his statement rather than the plain clothed female officer he had requested. He found the legal process distressing, partly because of this lack of understanding of his needs. Ruth was also surprised when a police officer *'acted like a headless chicken*' when she went to report the abuse. She states that what she wanted was:

'someone who gives a toss and wants to know...a willing pair of ears, someone I could tell what happened to, who was in a position to do something about it.'

Some people wanted a female officer to talk to, but others just wanted a professional response regardless of gender.

Another factor is that, as an adult reporting CSA, physical evidence is less likely. Furthermore, many people who have been abused were very young, with half in this study being under 8 at the onset of abuse. Because of their age and the trauma, their memories may not be linear or complete. As research suggests that trauma memory is more sensory (sights, sounds, sensations) than verbal, it is difficult to package it into coherent evidence (Van der Kolk, 2014). Thus, corroborating evidence can be vital.

However, the familial or close nature of the crime also means that some families refused to provide this when the crime was reported. For example, Lorraine, who was abused by her brother, reported that her family refused to corroborate her statement to the police. As stated above, many families had other issues occurring simultaneously, such as parental substance abuse, interpersonal violence or mental health issues which could affect their willingness to co-operate with the police. There are also, as Lorraine's example demonstrates, issues of loyalty to the family which protects the perpetrator.

If the investigation proceeds further, the individual can feel swept away by the process as Carly explained:

'once the wheels are in motion, it rumbles on with fairly little input from you. I also found it difficult that communication could 'pop through' at any point and completely ruin my day – having an email come through about my case while I was at work was often a trigger for overwhelming feelings and panic attacks'

Thus, there are improvements to be made in the process of the investigation and particularly communication. This could include a discussion with the victim as to their contact preferences and outlining how the case will proceed. Further evidence of the importance of good communication was provided by Ruth, who explained that before the court case she had hoped to be prepared by being shown the court and advised what to expect. This did not happen and to compound this:

'I hadn't realised that the waiting area was a communal waiting area and that he would be there waiting.'

Ruth had to sit in the same waiting room as her violent, abusive father and her mother, who was supporting him.

It can also be very distressing to be informed that the perpetrator is not going to be prosecuted. For example, Alice was told her case wouldn't be taken forward:

> *'because I've had a mental breakdown... they said that the defence would have a field day with me. Even now, that makes me really, really angry because, when you think for a victim, the reason why they have the breakdown and they're on antidepressants and antipsychotics ... it's a consequence of what he did and that goes against me...That has got to change.'*

Thus, the effects of the abuse can count against the complainant when trying to report it. The victim can be assessed as too harmed to give evidence, which as Alice states, does not seem fair.

The trial itself can be extremely distressing. Amelia was re-traumatised by the neutralisation techniques employed by the defence solicitor:

> *'using choice in clothes, problems at school and mental health difficulties against me'*

She argues that witnesses who have been traumatised need to be properly prepared for court and supported throughout. However, there are recurring issues with poor communication. For example, Ruth was not informed when the perpetrator, her father, was given day release or released from custody, which meant that she was in danger of meeting him at her mother's house.

As argued in the APPG report, the police and CPS do not provide a consistent and professional service. People who have experienced abuse are reportedly 'losing faith' in the justice system (The APPG for Adult Survivors of Childhood Sexual Abuse, 2019a). This could be related to the use of neutralisation techniques, such as denial of the victim and denial of harm. Furthermore, the suggestion that a victim can be *too* harmed by the abuse to give evidence further limits their ability to get justice. Finally, it does not seem to be understood how intimate this crime is and how often the perpetrator is a family member. The criminal justice system, as another vital point in recovering, is another institution that appears to need to be more trauma aware.

Religion

Berger and Luckmann (1967) argue that it is impossible to examine the social construction of reality without considering religion, as it creates and maintains many discourses. Within wider research around institutional CSA, the church and religion feature heavily (see Rossetti, 1995; Kelly, 2013; Treacy, 2013; Harper and Perkins, 2018). The Christian Church has been accused of, at best, ignoring and, at worst, enabling the abuse of children (Kelly, 2013). For example, Michael Pell, an extremely high-ranking Vatican official was convicted of abusing children and the Catholic Church supported his appeal (Giuffrida and Sherwood, 2019). For many individuals and their families, religion is an important part of life, defining existence and delineating morals. Therefore, this section explores the influence of religion on recovering. It begins by examining the responses given by people who were abused within the church and the way in which church teachings can affect recovering before considering the institutional response to disclosure.

Thirty survey respondents described religion as a negative influence upon their recovering. Eleven children met the offender through religious organisations. The grooming process was facilitated and assisted by the high status of religious leaders. George was abused by a priest and explained:

> *'my mum thought that the sun shone out of his backside. Clergymen to her were superior beings.'*

This inhibited him from disclosing to her, as he was certain he would not be believed. The culture of respect for religious leaders has resulted in a reluctance to accept bad behaviour and also the desire within these organisations to cover up and deny such abuse. This has been demonstrated through many CSA scandals in recent years (see Gardner, 2012; Doyle, 2017; Gleeson, 2018).

Research participants explained how abusers utilised their status in grooming them. George explained:

> *'he groomed me in trying to explain the relationships in the ancient world between a Pederast and Catamite. How an older man would take under his wings a pubescent boy and they would have a sexual relationship and a sexual awakening and that this was a very special thing.'*

This abuser abused not only his position of power but also his privileged access to education and knowledge. Amelia was abused by a church youth leader:

‘the abuser used passages from the Bible to trap me, saying that God accepted marriage between older men and younger women and our souls were married through our ‘relationship’.’

The position of power these men held were used to entice their victims and, in Amelia’s case, the Bible itself was exploited to ensure compliance.

For a child, religion can seem to be the answer to their need for comfort and safety:

‘I have very vivid memories of praying as a child that my abuse would stop which led to many years of believing I was doing something wrong because my prayers weren't being answered.’

This survey respondent did as she had been taught and prayed to God to end her suffering. When this did not happen, she blamed herself by reasoning that if God helps good people, she must be bad.

When forced to be silent by the perpetrator, religion can cause negative effects as Alice explained:

‘I was brought up in a charismatic Pentecostal church. There was a lot of teaching around condemnation and, "If you don't ask God to forgive your sins, you're going to hell." It's as simple as that. Being raised with that as a child who was already ashamed and feeling bad to the core and hoping nobody would notice. You feel so exposed, it's harder to try to hide the shame, you constantly feel exposed, feel vulnerable.

You feel that everybody's going to notice, especially when you're in a church environment and you're looking around you and you're not feeling good enough, and you're constantly comparing yourself to all the holier than thou [laughs] Christians around you. I'm never going to be like that. I'm bad. I'm going to hell. It became obsessive, and I think it was definitely one of the main triggers of things that caused the breakdown.’

The effect of shame is key to Alice’s struggle. The perpetrator may have ensured her compliance by creating a sense of complicity and shame. For a child brought up with a religious household, this creates a conflict between wanting to confess and feeling compelled to do so by the Church, but not doing so because of the abuser’s manipulation of their value system. As Alice explained, this feeling of shame caused a great deal of anxiety and stress.

Ritual has the potential to be an important part of religion for the abused child. Ruth wanted help to deal with her feelings of being dirty, both physically and in her soul:

> *'when I was 13, the abuse had been going on for a year, and I was absolutely convinced that I was completely tarnished, filthy and lost forever…I went to talk to my main Sunday school teacher and I went to see my Minister as well and I asked them whether there was any possibility of me being baptised…So I asked I said 'look I've done some things I've not proud of, there are things about myself I'm not happy with but I'm trying and I want God to love me. I want him to know that I am doing my best and I want to get myself into his hands and say, 'I know I am not perfect but can you at least love me as I am?'' They talked to me about it and in the end they said, 'I can see that you are serious about it, so yes, if that's you want'*
>
> *So we worked through the whole thing and I picked out the verse of the hymn where I wanted the baptism to take place. For me it was something very, very special. It was a very important moment for me. I remember I was shaking and I think he thought I was cold but I'm wearing the baptismal robe and I'm standing in the font and I'm shaking because I'm convinced that the water will start boiling and a voice from above will say 'get that thing out' but when he dipped me and I came back up I actually felt clean.*
>
> *I felt that it's a fresh start. I felt like I could start again and it meant something to me and then, a year later, my father who was still doing those things to me and wasn't remotely sorry for it, didn't have any remorse, went and talked to the minister and he was baptised the year after I was and when that font water didn't turn black and there wasn't a crack of thunder and a flash of lightning and there wasn't a...he wasn't struck down on the spot. He came up and everyone was congratulating him and patting him on the back and welcoming him to the family - that killed my faith.'*

Here Ruth was hoping that undergoing a ritual cleansing at her church would help her in her nascent recovery from the abuse her father was inflicting. Within these parameters it did work, for a time, but the fact that there was no response to her father's blessing left her questioning her fundamental beliefs. As Ruth illustrated, a child can feel rejected by his/her religion and, more fundamentally for the psyche, by God.

Furthermore, the institution of the Church can negatively respond to disclosure. There were descriptions of negative reactions from religious leaders when participants did try to disclose abuse. Amelia reported the perpetrator to the police because he was just about to be married

to a woman with children. She was horrified, after this came to light, to learn that her Church were still willing to perform the ceremony. Previously they had been aware of the abuse, as she explained:

> *'I was confronted about my abuse by church officials. On being told that I might be removed from my parents' care and never see them again I told them I had lied. I was then forced to apologise to my abuser. He was automatically viewed as the wrong party and as a more credible source of information as an adult male than an adolescent girl…*
>
> *They publicly shamed me to the congregation as a liar, ostracized me from my peers and confronted me aggressively about the 'relationship', while making the abuser out to be a victim of a sexually deviant teenager. They called me a sinner and told me they would pray for me. The self-harm scars on my body were seen and ignored. They destroyed any paperwork, denied the details of what they did to the police and didn't follow safeguarding procedures. They didn't report anything to my parents or the police at the time. They let me ride in the abuser's car alone, continue one on one music lessons with him and allowed him to continue as our youth leader.'*

This defensive responsive enabled the abuser to further assault her. Furthermore, it meant that there was no record of this disclosure and clearly no adherence to any kind of safeguarding procedure. Similar negligence was reported by other participants. Nobody reported a good response to childhood disclosure from a church. Instead they spoke of poor support from church leaders (5), pressure to forgive (4), struggles with sexuality (3) and problems dealing with shame (6).

The tenets underpinning religion can also affect recovering as Helen, who was abused by her father, demonstrated:

> *'Up until I was around 27, I was a Christian and I'm not sure that that helped my recovery. I think framing mental illness, abuse, and trauma within a theological model can be problematic and I felt for many, many years that I wasn't 'trying hard enough' to recover or that I didn't 'have enough faith' to 'be healed'. I stopped being a Christian around the time I started becoming aware of the abuse because I just felt that I couldn't reconcile what was happening (and what had happened) with the idea of a loving god - particularly one that is usually conceptualized as 'father', as that is who abused me.'*

Helen described in her interview how she was told that she would be healed if she 'surrendered my life to Jesus', leading to more self-blame when that did not occur. Furthermore, as discussed, abuse is often perpetrated within the family, by a father or father figure, making the focus upon a male God with male religious leaders problematic. Theology itself can compound the problem. George expanded upon this:

> *'I think the other problem is, certainly in Christian churches, where they talk about confession, repentance and absolution...well that might all be very well on a spiritual basis but if a crime has been committed the secular authorities have to deal with that and I think it is absolutely wrong if the church is looking at the sinner and only dealing with that person and not the victims of that sinners offences, you know? I point very much to the Catholic and Anglo-Catholic traditions in that respect but it's not just them. I think the Christian culture of forgiveness of sins is all very well but if it's a sin against a person there's also 'well what you going to do about the victim?''*

There have been many cases where the first instinct of Church leaders is to minister to the sinner not their victims (Gardner, 2012; BBC, 2019; Stack, 2019). Palmer and Feldman (2017) argue that the Christian concept of CSA, as a sin, means that it is seen as forgivable, which engenders a culture that deals with perpetrators internally rather than contacting police.

Part of the issue here is the powerful position Church abusers are in and the respect in which they are held. Participants were very clear that religious organisations need to adopt rigorous child protection policies alongside an acknowledgment that anyone can be an abuser and that no-one is above the law. They also clearly need to engage with external processes of law enforcement.

Thus, religion can be used to facilitate abuse, silence abused children and create a negative climate for the recovering individual by employing the same kind of institutional deviance described in the Sandusky case (Klein and Tolson, 2015). However, religious institutions are not mere organisations. They also create moral landscapes and define existence. One can differentiate between the organisation and the religion itself. There is harm inherent within a poor institutional response to CSA but there is a more extensive harm caused by damaging a child's world view, sense of belonging and safety. In fact, in reference to Shengold's (2012) concept of 'soul murder', described above, he extends the definition as created by a rejection by both family *and* God. Thus, a feeling of rejection by important people and institutions can be a fundamental existential harm.

An unsafe world

'I haven't really felt safe to be open about what happened to me very much.'

Giddens (2013) argues that our 'ontological security' is based upon a basic trust in the world combined with the reinforcement of day-to-day activities and experiences. He theorises that families are essential to create this security. A positive relationship with caregivers, as a child, is an 'emotional inoculation' against existential anxieties throughout life. Children who have been abused have that trust destroyed, and their distrust can be reinforced by the response of agencies and institutions, as described above. It could be argued that this ontological insecurity is the opposite of Antonovsky's (1979) idea of coherence: that they conceptualise the world as incoherent, confusing and unsafe. This concept of the world, as fundamentally dangerous, appears to persist even when the abuse was many years before. This may be precisely because is it maintained and confirmed by later experiences.

Participants outlined situations where professionals and even close family members reproduced or enforced the same techniques of neutralisation employed by the offender. For example, perpetrators justify their actions by denying the victim's humanity, denying any harm and blaming the victim for seducing them. The families discussed above appear to deny or ignore any signs of abuse and minimise those that are revealed. The child, later the adult, can be encouraged to be loyal to the family and not to disclose the abuse. There are further examples that suggest that institutions, can struggle to respond any better, with actions described that range from wilfully ignoring evidence of abuse, victim blaming, enabling abuse and protecting perpetrators.

Participants were asked if society assists recovering and many felt that it does not, as this anonymous survey respondent stated:

> '*Society hinders recovery in SO many ways…We're supposed to sit there with a shit-eating grin through rape scenes on tv & in movies that are just thrown in there for an extra bit of entertainment. The ubiquity of porn, the degradation of women in all types of media, make it clear that society is on our rapist's side - just as my family was on my father's side when I was being raped as a child. It feels the same, but on a bigger scale.'*

Here a clear line is drawn between the reaction of family to abuse and wider discourses around abuse and rape. There is evidence in support this point of view. CSA is covered in the media in a titillating and sensationalist way focussed upon the most extreme cases (Bingham and August, 2015). Daro (2002) argues that most people get their information about CSA from the media, which compounds this distorted view of the reality of abuse.

Although UK conviction rates for CSA cases that make it to court are high, at 74.8%, the actual number of offenders prosecuted is low, with only 5374 people convicted in 2016-17 (Crown Prosecution Service, 2016). The National Crime Survey for England and Wales reported a figure of 7% of the population were sexually abused in childhood suggesting that, even with this low estimate, there are approximately 4 million victims in the UK and correspondingly thousands or even millions of offenders (Office for National Statistics, 2018). It is clear that the conviction rate does not reflect the rate of offences and offenders. Therefore, the dominant discourses and actions of society can be argued to reflect or reinforce the neutralising messages from the perpetrator(s).

A fundamental consequence of this neutralisation from the macro to the micro level is demonstrated by respondents who describe not feeling safe. Altogether there were 89 mentions of 'safe' or safety' in the survey and interviews. As discussed in the previous chapter, individuals may either exaggerate or downplay their gender in order to feel safer. This feeling of danger can then affect their ability to recover. Herman (1992) asserts that before any counselling begins, the individual must feel safe because only then can positive changes be made. Van der Kolk (2014) explains this further: a feeling of being unsafe evokes a panicked state where the individual retreats to previous and potentially negative coping mechanisms. Thus, an individual literally cannot apply techniques learnt in therapy until they feel safe and calm.

Ruth, discussed in the previous chapter, mentioned 'safety' 21 times, more than anyone else. She grew up in a situation that was extremely dangerous for her, physically, emotionally and sexually, with no safe place or person. Her requirement for safety has endured, as hypothesised by Herman (1992) and Van Der Kolk (2014). Melissa also grew up in a similarly dangerous environment. She described the feeling of being unsafe as being 'bait:'

> *'I think that being raised that way you really do give off an energy of being more vulnerable and in cases where the opportunity presents itself someone who wants to take advantage of it, that vulnerability, steps right in because they've been primed to do that in some way. You know, so I think that's why so many people who have had childhood sexual abuse wind up being abused again because it just kind of even intensifies that energy around you. You know, I'm vulnerable and that's just like bait to those other types.'*

Fear was the second most mentioned emotion in this research. Considering the evidence given above, it is understandable that people who have experienced abuse feel fear. Their family may not protect them even when they do disclose the abuse. Indeed, the abuse may

be within the family. They may internalise this by seeing themselves as immutably ‘bait’ as Melissa explained above.

It is self-evident but vital to state that child abuse occurs to children, with a child’s world view and a child’s ability to comprehend what is happening. They also have a child’s ability to question the messages they receive from society about that abuse. The processes of socialisation reinforce the idea of a fair and just society, however the child learns through the fact of abuse that there is something wrong with this ideal. As they mature, they may conclude that society fails to deal with abuse effectively. Therefore, respondents describe what appears to be a deviant society as it perpetuates, through discourse and action, the neutralisation techniques utilised by perpetrators.

This mismatch between an individual’s requirements and societal messages seems to reinforce a feeling of danger. The idea of a safe, just world is destroyed by CSA and remains in rubble. It is torn down by the act itself and then by subsequent neutralising responses to disclosure and societal discourses. The individual is left to rebuild their idea of the world and their place within it, sometimes with little or no support. Thus, this chapter outlines a third form of harm caused by abuse, following on from physical and mental health: abuse causes existential harm. This fundamental and enduring harm may well feed the development of mental and physical health issues. Recovering, therefore, can be conceptualised as a struggle, swimming against the tide of societal discourses and actions.

Chapter Seven - Connected

'Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare'

Audre Lorde, (2017, p.130)

CSA creates intense emotions in the people who have experienced it and those around them. As demonstrated in the previous chapter, the overwhelming message from society, at every level, appears to be towards ensuring the victim's silence. Adults who have experienced CSA can be conceptualised as awkward reminders to families, institutions and society itself of actions not taken, of unheard children who were left unprotected. They are literally walking crime scenes: crimes that, in all likelihood, have not been addressed. Silence on their part, therefore, appears to be both expected and encouraged. Within this atmosphere, disclosure is, in and of itself, an act of defiance. It could be argued that recovering is also. Although self-care has been criticised as being co-opted by neo-liberalism, as an austerity-driven alternative to properly funded health and social care, it was originally conceptualised as an act of defiance, as in the quote that begins this chapter (Lorde, 2017; Michaeli, 2017).

In response to what the previous chapter argued to be societal deviancy, people who have experienced abuse search for, and sometimes find, paths to recovering. Recovering is an active process created through the interplay of individual and environment. Such human interactions are the defining events of sociology at both the macro and micro level. As such, there are differing interpretations of their influences or meanings. Goffman (1959) asserts that we cannot truly know another person. We can become familiar with their curated presentation of their internal self, but never with the reality of it. Thus, we interact as players in a drama, manipulating others impression of us to maintain status. As Chapter Five suggested, this does not appear to be the motivation for the participants in this research, who reported that their 'act' is carried out to preserve their safety, rather than to increase their status.

In contrast to Goffman, social interactionists such as Blumer (1969) argue that we invest objects and people with meaning which then defines our interactions. Indeed, this meaning is created during our interactions with others, as was demonstrated in the previous chapter. People who have experienced CSA are stigmatised and silenced because they, as representations of a victim of CSA, have been invested with meaning by society. Thus, meanings are social products constructed through numerous interactions (Blumer, 1969). This particular construct, that of 'victim', is one which people who have experienced CSA struggle with, as discussed in Chapter Five.

This chapter will explain how people who have experienced abuse surmount such hostile terrain to achieve better health and well-being. Survey participants were asked firstly what most contributed to their recovering. Following on from that, questions in the survey and interviews explored each significant area. The factors that contribute to recovering appear to be characterised by a reversal of the neutralisation techniques outlined in the previous chapter. For example, being heard is valued as the direct opposite of being silenced. This chapter will explore the different ways an individual can reach for recovery through social interactions and relationship, spirituality, good healthcare, challenging society and increasing their self-esteem. As Herman (1992) asserts, safety is key, but human connections, finding oneself enmeshed within society rather than rejected by it, is another fundamental facet of recovering.

Healthcare

Survey participants described what most helped their recovering.

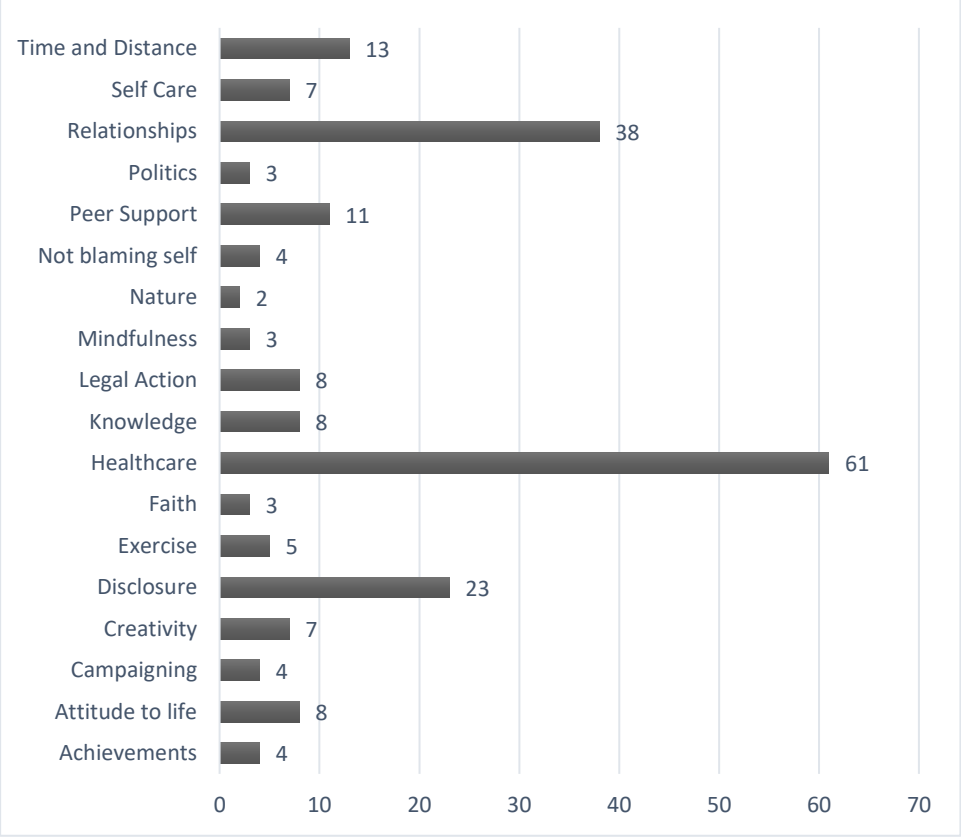


Figure 7.1 What Most Helps Recovering? N:135

NB: This question allowed multiple answers. There were 219 comments in total.

There are many different routes towards better health and well-being. Some survey responses were specific. For example, 61 people felt that healthcare was one of the most important factors and 38 people reported that relationships were vital. 23 said disclosing the abuse and

being believed helped them. Others raised internal attitudinal changes including attitude to life (n=8) and stopping self-blame (n=4). Following on from those items, further significant factors were being an adult, time and distance from being an abused child (n=13), as well as peer support (n=11) from other people who have experienced CSA (Figure 7.1).

For nearly half of the survey respondents, healthcare was the most important factor in recovering and the reasons for this are discussed in this section. Medical intervention can be the point at which the victim and the harm caused by the abuse are acknowledged. A good institutional response is clearly vital, particularly at the point of disclosure. Some participants gave examples of good reactions to disclosure by a medical professional. Ruth, who in the previous chapter recounted how her previous GP had told her as a child to stop being selfish, had a very different experience with another GP when she was older:

> *'she was amazing...I…ended up having a meltdown in the surgery. I'm just blurting everything out and she did something which I've never had a GP do before which was she got up from behind her desk and she knelt on the floor with me and she held my hand, talked to me and calmed me down and told me exactly what she was going to do. 'I am going to get you help. You need someone to talk to about this.''*

For Ruth, this connection with the GP was vital in her recovering. The description above of the nature of a good disclosure experience underlines the importance of the reaction of the listener. The GP indicated, by her actions, both belief and compassion. This is echoed by other respondents. Alice described her experience as a long-term inpatient where she was hospitalised for four years. She described the support she received as 'very good' and non-judgemental. Alice experienced multiple disclosure events on those wards, and her description expands upon the characteristics of a good disclosure experience.

Counselling and therapy were *an* important factor in recovering for nearly three quarters of survey respondents (n-97) and was *the* most important for 59. Different types of therapies were reported, from CBT, EMDR, AXSIS, psychotherapy, psychoanalysis, group therapy and specific CSA therapy from NAPAC. It appears that the type may be less important than the interpersonal experience itself. Charlotte describes the positive environment that counselling has created for her:

> *'It's just an empowering circumstance it's really safe, so the counselling has really helped me. The counselling is just one of the most extraordinary experiences of my life. It's opened hope and so many doors for me.'*

Therefore, counselling is, when carried out effectively, a safe space for the individual to explore their feelings. Hochschild (1979) argues that emotions are expressed where it is socially and culturally acceptable. Considering participants described a life lived in a deviant society, one that tries to enforce silence, a situation where the expression of emotions is allowed and encouraged is very likely to be viewed in a positive way.

Beyond that benefit, counselling/therapy can lead to explanations for behaviours that have frustrated the individual, which includes the coping behaviours explored in the literature chapter. For Michael, who has been searching for an answer, a diagnosis has been key:

> *'I really do have PTSD and when I accepted that...knowledge of course is power and you can attach a meaning into what you've got going on, you know. We talked about that and that helped me accept what I have, you know, although I'm not totally there yet. I'm trying'*

Therapy can provide tools for managing the anxiety and fear inherent in c-PTSD, leading to a reduction in coping strategies with more negative outcomes. It can also, by defining the issue, provide meaning to actions, reactions, experiences and emotions.

Furthermore, therapy and counselling can help individuals to challenge the family narratives that denied or even enabled abuse, as Agata explained:

> *'Therapy is invaluable. I am in therapy for over four years now...It changed my image of my childhood and my family. I cut ties with my father after that. Therapy also helped me deal with my family's reactions. My grandmother (his mother) still asks me almost every time I see her: 'why don't you speak to your father? How can you not love him, care how he is? Why don't you help him?' Therapy helps me feel less responsible for what happened. In the beginning I thought I didn't feel responsible, but I must have, because this has improved. I see that my grandmother's comments bother me less and less.'*

A family's first instinct when abuse is disclosed appears to be to deny, because to accept and hear is a seismic explosion in familial relationships, as discussed in the previous chapter. A therapist is independent of this, not enmeshed in the family dynamics or as emotionally invested. Therefore, a good therapist can create a less emotive venue to process feelings.

Considering the above, it is clear why good counselling and therapy is rated so highly when recovering from trauma. Penia described the effects of trauma-focussed counselling on his life:

'I am now all here. I am all here in this conversation. I am all here with my wife. I am all here with my children. I am all here with my grandchildren. But unless I had actually got the right treatment, the right trauma treatment, I doubt that would have ever occurred.'

Therapy can change the focus from the past, still experienced through cPTSD, to the present. It can begin a transformation in the individual, encouraging them to look to the present and the future, after dealing with the past. Finally, by creating hope that there is a possibility of being heard, respected and safe, it can engender an atmosphere where the individual can develop positive relationships outside the therapist's office.

Healthcare is a traditional venue to explore one's emotions and feelings around CSA. It may well be one of the first places someone discloses the abuse they have experienced or are still experiencing. A good response means looking beyond the discourses around 'victims' of CSA, alongside of a rejection of the meanings invested in them. Instead it involves connecting in a compassionate, humane way, as Ruth's GP did when she stepped away from her desk and took her hand.

Social Interactions and Relationships

As stated in the introduction to this chapter, human interactions are at the core of sociology. An important aspect of recovering involves those interactions: reaching out to connect with others and that being reciprocated. Masten (2001) asserts that just one connection with a trusted, safe adult can be the catalyst for childhood resilience. Many resilience studies identify relationships as vital for adult recovering (see Collishaw *et al.*, 2007; DuMont, Widom and Czaja, 2007; Singh, Garnett and Williams, 2013; Domhardt *et al.*, 2015). Such connections can be with family, friends, lovers, acquaintances or groups. Relationships and interpersonal connections can be the arena where the neutralising messages, described in the previous chapter, can be challenged and the wounds healed. Within close relationships, a person can feel valued and heard. This section explores how this can be achieved in partnerships, friendships, parenting and peer support.

Just over a quarter of the survey respondents (n-38) valued relationships as *the* most important factor for healing. Alice explained how her relationship has helped her recovering:

'I met my husband. I was 17 engaged by 18. I think I was so blessed to have this marriage. 26 years this year. He's just amazing, he's gentle, he's sensitive, he listens, he understands, there's never any pressure and never has been over the years that we've been together. That really, really helps. I don't know how I would've survived the shame of sexuality and being in an intimate relationship if

he'd been any different. I think because of who I married; it made my own personal processing that issue a lot easier.'

For Alice a sexual relationship initially felt shameful but her husband has helped her overcome this. Her supportive and, significantly, safe relationship is a platform from which she has then taken further steps to recovering. Charlotte also described a similar relationship:

'*My partner is the best thing that has ever happened to me. We knew each other when I was 17 so it is a good point of reference for me. He has been tantamount to my slow, steady recovery. He believes in me, trusts me and has my absolute welfare always in mind. He is mindful and is so selfless with no agenda. I am lucky and eternally grateful. He is someone I do not want to let down. He gives me faith in humankind.'*

Thus, springing from this healing, safe relationship, the individual can develop more confidence in other people. Furthermore, these relationships create an arena where emotions can be expressed and responded to in a loving way. A strong, healthy, loving relationship belies the messages from childhood and is, of itself, healing, as it re-establishes trust and reverses the ontological, existential harm described in the previous chapter.

As another close relationship, parenting was also described as a significant factor in recovery by eight survey respondents. Indeed, one respondent described her children as inspiring her to 'keep going'. Children can, therefore, be an inspiration and a driver towards recovering. However, they can also bring up memories of the past. For example, Lynne said:

'You scrutinize every person that you meet at nursery, at school ...when kids go 'Oh, I'm going to so and so's for tea' you are like 'who is that?' (laughs) because you know it happens in…all walks of life, all groups it occurs, and people don't get that, they only think it occurs in low income families, on an estate. They don't see that it happens everywhere. It could happen anywhere.'

Lynne characterises parenting as a positive experience but is clear that her experiences of CSA have created a wariness that other parents may not have. This may, of course, be a positive or negative factor, depending upon its extent and effects. It could be argued that the average parent is not concerned enough about the risks of CSA.

Experiencing CSA did, however, leave other participants worrying about their ability to parent effectively. In interviews, two people who have not yet had children stated a fear that they would inadvertently harm their child. For example, Agata said:

'I am a little scared what will happen if I have kids. I don't think that I had the healthiest... I don't think that I was able to learn certain things and I will be afraid of hurting them or not seeing that somebody else is hurting them (pause) or somehow subconsciously making them believe that the world is bad and everyone is going to hurt them.'

People who have experienced CSA can be concerned that they will reproduce the unhealthy elements of their parenting or indeed pass on their fear of the world. However, participants, who were parents, explained that they consciously tried to not let their experience of CSA or poor parenting affect their parenting. George explained:

'I have consciously tried to be a good parent. I have consciously not tried to parent like my parents did (laughs) It's pretty obvious isn't it that they weren't a good example?'

He did state that he found it 'emotionally exhausting' but that he became more skilled as the children grew older. However, parents identified some advantages to having experienced a difficult childhood, as Melissa said:

'I never once hit my children…I definitely had a concern becoming a parent that I would be abusive to my children but I just don't have that instinct. The only person I take things out on is me. In so far as anybody, I mean everyone has a bad day - they yell at their kids, they are short with their spouse but I would say specifically with this issue it was helpful with them in their own transition to young adulthood.'

The fear of repeated negative cycles is clearly there and, for those participants who were parents, it made them more conscious and thus more careful in their parenting. Parenting can be an opportunity to heal by modelling the parenting behaviour that the individual did not receive. There are difficulties reconciling the anxiety around the safety of one's children but, on the whole, parenting was viewed as a positive experience. Although this study did not interview children of people who had experienced CSA, this appears to be in contrast to the wider literature where the experience of CSA is seen as a negative influence on parenting (Buist and Janson, 2001; Wright, Fopma-Loy and Fischer, 2005; Zvara *et al.*, 2015).

Extra-familial relationships were also valued, with both friendships and peer support being valued. Over a quarter of survey participants (n-38) valued friendships as important in recovering. Their descriptions of their friendships are characterised by experiences of support, love and laughter. For example, one anonymous respondent described how humour has helped her recovering:

'Laughing with my male friend & my sister about the black comedy evident to me in my abuse experiences (my abuser and his wife have rhyming names, his name doubles as a slang word for penis, etc.). I know this does not sound funny, nor is it really, but it helps me and my sister & my male friend get that. Their witty nature and the relationships we share make it possible. I would not dare share that with anyone else.'

This typifies the idea of a safe relationship, one where 'black comedy' is acceptable and the person is clearly accepted.

Further to this, in contrast to the descriptions of familial responses, many people rated friendships as a significant arena for healthy disclosure experiences. For example, Grace spoke about an experience with friends where they all shared experiences of sexual assault:

'*all of us in that room were like talking about it and crying and that was really powerful.'*

The benefit Grace is highlighting is not simply in the act of disclosure but of being heard and having a shared experience in a relationship of trust. Friends who believe the individual and support them can be very significant, particularly when familial relationships might be strained because a disclosure of CSA often means split loyalties in the family. A supportive response to disclosure is a reversal of the neutralising denial of the previous chapter, as the individual is heard, believed and their suffering is acknowledged. Thus, friendships are another arena, like love relationships, to re-learn one's ideas about the world and about whether one can trust (Giddens, 2013). Participants valued them extremely highly.

An overlap from friendship is found in peer support and this was valued too. Eleven survey respondents named peer support as the most important factor in recovering. One advantage is that through peer support one can learn from other's experiences. This can help people move forward faster by learning from what has and has not worked for others. Having role models for recovering can also be helpful and empowering. That is also the inspiration for this research: to share this knowledge and learning more widely.

Participants described another benefit of gaining a more general perspective about abuse:

'talking to other survivors helps reflect on how much, much worse it could have been/was for others'

As the reality of CSA, its extent, affects and specifics of abuse, is not discussed in society, peer support can help fill that gap in knowledge within a supportive friendship. The discourses within society can drown out the facts, meaning many people, including people who have

experienced CSA, can be ignorant of different aspects and experiences.

Peer support can also be provided in partnerships. Three participants mentioned being in a relationship with someone who had also experienced CSA. Helen's wife has also experienced CSA. She feels that this has advantages and disadvantages:

> '*she "gets it" a lot easier than some other people might. Although one thing that surprised me, is that I kind of assumed she really would "get" all of it, because our experiences were similar, but actually I realised that the experiences are different enough that there are some things that still need explaining.'*

As Helen stated the diversity of experience, for example, differences in family situation, effects and aftermath can make direct comparisons difficult. However, it is clear to see that the lack of a stigmatised response to disclosure from a person who has also experienced it is a benefit.

As shown in the previous chapter, close relationships for the abused child are often not healthy or supportive. Even if the abuse is not within the family, there may well be other issues ongoing in the family unit that may affect the child's mental and/or physical health and well-being. However, as Edward *et al.* (2017) suggest, the presence of these ACEs need not determine the individual's outcome in adult life. Many participants have found ways to heal some of the issues clouding their past, away from their birth family. They have formed positive close personal relationships which they value strongly. These help the individual rebuild or even create the ontological security that was missing in their childhood and begin to heal the soul, as discussed in the next section (Shengold, 2012; Giddens, 2013).

Healing the Soul

Jenkins (2000) argues that who we are and who we are not is vital for identity formation. This is particularly important after abuse, as explored in Chapter Five. We consider ourselves members of particular groups or categories, and one significant group mentioned by participants was religion. Whether people were abused by church leaders or not, religion, as an important part of life, often played a part in recovering. There is, however, a marked difference drawn by respondents between religion as an institution and spirituality as an emotion or experience. Nineteen people described religion as being a positive influence upon their recovering, while twenty-seven described themselves as spiritual but not religious. This section explores those two facets and the differences between them

Some participants relied upon their faith and the Church to help them in their healing process. Three people described their faith as the most important factor in their recovering. This survey respondent said:

'God has helped me through. There have been many times though where I've really struggled with my faith, being angry with God and turning my back on Him, questioning how He could let it happen. Though I don't have that answer, I couldn't live without my faith.'

Thus faith, and the benefits of that, do not preclude anger at God for not preventing CSA but can provide support in recovering. In fact, two male survey participants felt that their faith in God saved them from drug addiction and suicide. For example, one man, who was abused at age seven by a stranger, said:

'In January of 1998…I entered Detox from the hospital where the police had taken me a few days prior. I had attempted to overdose on cocaine in a hotel that I had pre-booked for three days…Long story short, while in the hotel room I had a near death experience and was actually dead for a very short time. After what I saw, my faith did a 180 and I am proud to say that I serve Christ today and I will never ever apologize for it.'

For him, God literally saved his life and his faith continues to keep him safe. He now raises awareness through his media role to support men who have experienced abuse. The second respondent was abused by a religious leader and found his faith again in later life:

'To go through what I have been through as a child and be in such a dark place and then to become a Christian and really embrace the fact that God is Love and God will always Love me is so overwhelming. To go from being a dangerous psychopathic criminal to be the pacifist and loving caring individual I have become makes me proud and at peace.'

He too campaigns to help other people who have experienced abuse. So, for some, religion is a fundamental part of recovering and can impel people into working to benefit others.

However, other participants have had a more complex relationship with religion. For example, Michael explained:

'I did religion for a long time…I had gone to a born-again Christian meeting the day after I had been out drinking heavily, and you know accepted the Lord and became a Christian and my whole life changed, I can't even explain it, I just became not a drinker...it was like I went from drinking and being totally involved in that then flipped instantly and became totally a changed man. It was an amazing transition, I mean AA didn't have nothing on this change. I mean it was amazing but I come

to realise over time and I don't know I haven't put my finger on it except that it was a miracle but that also, you know, if you want to look at it, you know, psychologically I was able to take one and, in an instant, replace it exactly with another.'

Here Michael is talking about his search for better coping mechanisms and switching from one less healthy (alcohol) to more physically healthy (religion), although he does not now describe himself as religious. Neither option delivered long-term relief from anxiety for him or a lasting recovery.

People who were brought up in a religious family can yearn for spirituality as an adult, as Amelia explained:

'Having attended church for most of my childhood and adolescence, religion has the power to comfort and terrify me. Much of the abuse was conducted in a religious setting. I no longer really have any faith but often miss it. I have tried to recapture it as an adult'

Both Michael and Amelia here talk about the capacity for religion to provide answers and, as Michael notes, religion can be a substitute for a more harmful coping mechanism. Religion can have a positive part to play in supporting individuals attempting to recover from trauma if it empowers those searching for answers.

For some participants (n-24), the institution of religion was not one they could take part in but their enduring desire for a spiritual aspect to life led them to develop their own philosophy. This choice can be a reaction to not being able to believe in the Christian god after experiencing abuse, as this anonymous survey participant explained:

'I began questioning religion and God in 2011 when life just kept getting harder for me. This is where I lost faith in religion and God…I have slowly developed within secular spirituality which has helped hugely because instead of relying on someone or something to make things happen, I have grown an attitude of - if you want something, go and get it.'

An appealing factor in non-institutional spirituality is autonomy, something denied to the abused child and underlined by the concept of a judgemental, male God. Indeed, as Helen stated in the previous chapter, the fact that the Christian God is described as a father was very alienating for her.

Instead, people described a spirituality connected with nature and the earth. Two people saw a connection with nature as the most important factor in recovering as this survey respondent described.

> *'Not organised religion (which I see as contributing to the oppression and exploitation of children); but a sense of awe in nature and cosmology.'*

Thus, in many ways, organised religions' failure to address abusive behaviour within its institutions, the institutional deviancy, has contributed to this exodus. People have looked elsewhere to fulfil their spiritual needs.

A personal spirituality, rather than a defined belief, can be built from different philosophies as Steven explained:

> *'I would describe my Paganism as being Pantheist with Wiccan leanings. Part of this is a belief that the deity is part of everything and everything is part of the deity. This helps with a sense of self-worth and self-belief. That no matter how I am feeling, how down or self-destructive that I am a part of the universe and have as much right to be here as anybody or anything else.'*

Thus, his spirituality is centred upon the value of the self and this enables him to withstand the negative influences of his past. This is particularly important for Steven because, as covered in the previous chapter, as he currently cannot access counselling or therapy.

The final factors described as important in a spiritual practice are yoga and meditation. Helen explained:

> *'I have started practicing yoga and the spiritual elements to that 'sit right' with me and seem to resonate with my experience much more. I feel it is a more authentic spirituality for me.'*

Research suggests that yoga and meditation activates the parasympathetic nervous system to calm anxiety (Kim *et al.*, 2013; Scotland-Coogan and Davis, 2016). Thus, it has a physical benefit for people who have experienced trauma and may well have cPTSD. Baldwin *et al.* (2016) found a similar effect with prayer. Therefore, both religion and a personalised spirituality can have benefits to the individual in terms of self-identity and a sense of autonomy. Furthermore, they can have physical benefits for people suffering from cPTSD. It is through our connections with others and the divine that people who have been abused can re-establish or at least start to hope for a world they can trust and feel safe in. These connections

acknowledge the individual, as a person not an object, and begin to re-establish ontological security.

Work

Another important area for social interaction is work and it has the potential to have a positive effect on mental health. This can be specifically related to cPTSD. For example, Precin (2011) described a case where work, specifically, as a musician, was therapeutic for a woman with PTSD from childhood trauma. She identifies benefits from raised self-esteem, self-expression, being heard and forming human connections (Precin, 2011).

The majority of the survey participants who discussed work (n-66 out of 85) described it as a positive influence on their recovering, with eleven viewing it as negative. Work is described as a place where people can raise their self-esteem and it can also be a way to suppress, express or manage emotions. What became clear during the analysis of my data, was how often participants' career choices seem to have been affected by their experiences, and this will be explored in this section.

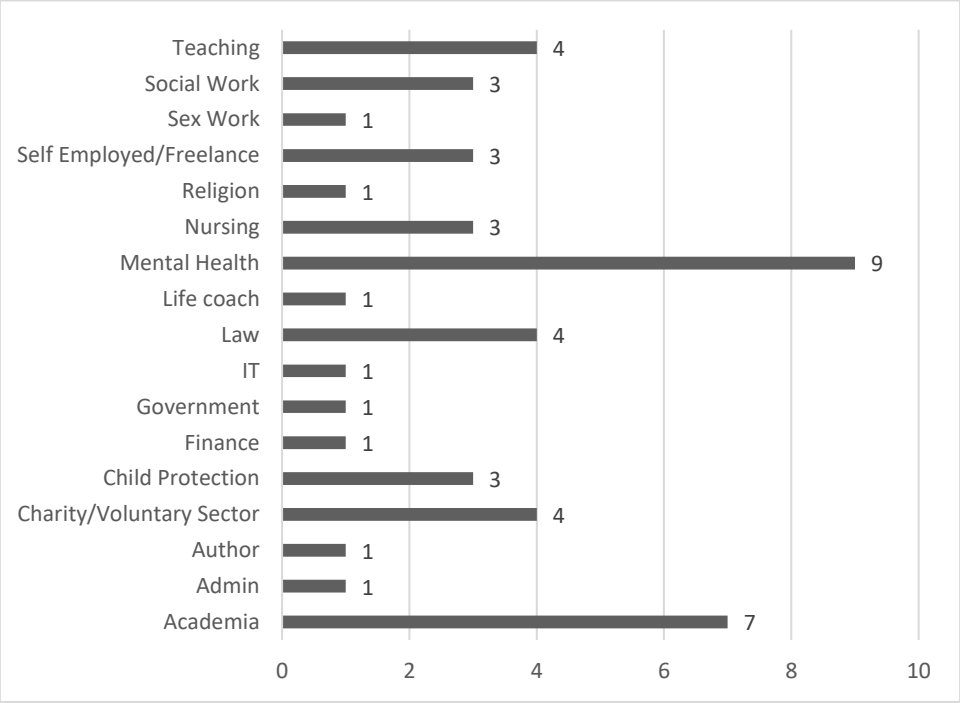


Figure 7.2 Career Choices. N=48

Although this was not a specific question, 48 people mentioned their career sector. The occupations were working in the mental health sector (n=9), academia (n=7) many researching trauma), charities (n=4), the legal sector (n=4), teaching (n=4), social work (n=3), nursing (n=3), unspecified role in child protection (n=3), self employed (n=3) and one person worked in each of the following fields: sex work, religion, life coach, IT, Government, finance,

writer and administration (Figure 7.2). Many of these careers could be influenced by participants' experiences of trauma.

Respondents did, in some cases, directly relate their careers choices to their experiences, for example Sarah, an academic, is clear about the impact:

> *'it's fair to say it's had a pretty impressive impact, it's not all that I teach but a huge chunk of what I teach is around sexual violence. The issue about how it has affected my recovery and things...clearly it has impacted on the journey I have taken, just because of the research I ended up doing and similarly doing that research has impacted me then kind of back (laughs)'*

Sarah is describing a circular effect of work: it can be influenced by one's childhood experiences and, in turn, influence one's perception of those experiences, which could be in a positive or negative way. Sarah's comments echo the research carried out by Precin (2011) regarding work as part trauma therapy.

Some participants saw their experiences as being a positive influence in their career, as it has granted them knowledge others do not have. For example, two survey respondents explained:

> *'I work with vulnerable children in my job now. I believe that I may of never have done this job if it wasn't for my own childhood experiences. I'm just passionate about making sure children, adults who have experienced abuse are listened to.'*

> *'I choose to work with child sexual abuse victims and share my strength and advice, I wouldn't of been able to do this if I wasn't a victim myself that has recovered'*

Therefore, working in these fields enables people to utilise wisdom, gained through lived experience, to benefit others. This parallels the statements above about the positive effects of religions in inspiring people to support others. Thus, there is an identified benefit in turning the focus outwards.

Such work can also have therapeutic effects for the individual themselves, as this survey respondent wrote:

> *'Working for the police I was able to see how some people got justice for the abuse they went through and it helped.'*

Work, particularly helping others, can in some way redress experiences the individual had as a child. In a similar way to campaigning, discussed below, work in related areas can be healing

because it enables the individual to vicariously feel satisfaction in resolving those issues for others. Participants described a further benefit of work as raising self-esteem through creating a sense of achievement, as this example demonstrated:

> *'I loved working: and in each job I took on, was told that I was very good at what I did. That is probably one of the achievements I'm most proud of'*

Therefore, for individuals who have experienced abuse, work can be an opportunity to improve self-esteem.

Work can also be utilised as a distraction from negative thoughts, as Judith, an academic, stated:

> *'in itself (it) was a diversion of energy and focus from thinking about other things so having that as something I would do well at in itself was a protection.'*

Work can be an important way to manage emotions, distracting from them and also enabling the individual to express them positively by helping others. It can also raise self-esteem, help in the development of a sense of autonomy and raise the individuals' value to society. Work is clearly valued by the majority for these factors. However, as stated in the previous chapter work, like religion, can also exacerbate issues. Thus, like many factors raised in this thesis, it has the potential to be a negative or a positive influence upon recovering. One positive facet identified in both arenas was where individuals felt that their actions were benefitting others. Another area where an individual can feel that they are making changes to society is through campaigning or politics and this is covered in the next section.

Challenging Society

As a discipline, sociology concerns itself with humanity at the micro and macro levels. The areas above mainly concern the micro levels of individual human interactions, although work can, depending upon its scope, have a far wider impact. However, as the structure of society itself appears to deny or enable abuse, many participants described their efforts to challenge this. Interviewees were asked what they wanted to change, and many structural issues were raised. These included challenging harmful discourses, belief, improved services, better funding and systemic change. Furthermore, a number of participants had already been inspired to take part in campaigning or politics and this is also covered in this section.

The twenty-one interview participants were asked what policy makers should prioritise to help people who have experienced CSA. People could choose multiple areas for improvement and various themes emerged.

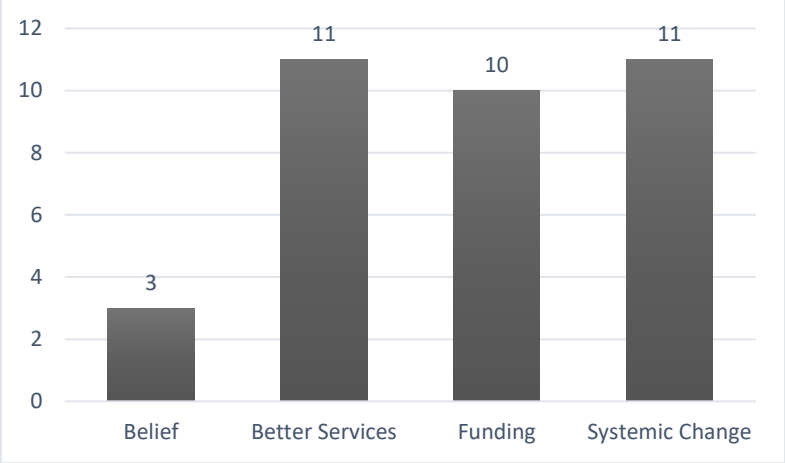


Figure 7.3 Improvements Needed. N=21

Eleven people wanted better services, ten people expanded upon this by specifically mentioning more funding both for charities and long-term counselling. Eleven wanted a more fundamental systemic change and three wanted a culture of belief for people who disclose abuse. Their explanations of these improvements are expanded upon below.

Firstly, people wanted a change to what they experienced as a denial culture. Lorraine, whose physical and sexual abuse was ignored, stated:

> *'I would want them to commit to listening to and believing children and creating safe spaces for children to speak out. I couldn't speak out about the violence that was being done to me because I'd have to return home where I just got more of it.'*

This highlights the need for early intervention, which has not been reported as occurring in this research. Sarah feels that this attitude of disbelief and denial goes further than the professionals who come into contact with vulnerable children:

> *'As a society we...our default presumption is 'well this doesn't happen' so it is incredibly difficult to breech that in any meaningful way...If you are in that position where you have remarkable and undeniable evidence like a video and yet the perpetrator is still found not guilty then there is something broken in the system.'*

Sarah outlined how deep the culture of denial goes, even rejecting guilt when there is clear evidence. She highlights the need to challenge the prevailing discourses in society because those ideas have real-life consequences. One way to achieve this is through dialogue with people who have experienced CSA, as Ruth started:

> *'You need to listen to the children, you need to listen to people, you need to listen to the adult survivors because until you hear them you are not going to understand, you are not going to learn. You can have all the training you want, you can have all the psychologists, all the psychiatrists, all the experts you want tell you 'This can*

happen in this situation' but until you speak to the people who have lived through it you are really not going to understand how insidious it is.'

Ruth highlights the value of lived experience, particularly when it comes to preventing abuse. It is a flaw in the wider literature that information about perpetrators, as regards the number of children they abuse or grooming methods, comes from the abusers themselves, from legal statistics or from the people who treat them (see Abel *et al.*, 1987; Riggs, 2010; Schulz *et al.*, 2016). Adults who were abused as children may be best placed to give information regarding these matters and are more likely to be truthful than abusers.

Another area where people who have experienced CSA can contribute is by describing how they fell through the gaps in social care as a child and, therefore, highlighting where services can be improved. Michael argued for:

'early intervention, totally, early intervention. I mean, and I would say government needs to support the family to the best of their ability and, without erm...I mean, face it,…all of us CSA survivors are the product of people that we trusted because we might not have gotten to that point, we might have screamed loudly but we didn't because we trusted what they said, you know 'shhhh, don't tell anybody' and so we trusted that 'ok I won't tell anybody.' Otherwise there would have been 'NO, THIS IS MY BODY!' and somebody would have heard and they would have been saved.'

Michael believes that if he had spoken up, someone would have reacted. Unfortunately, as discussed in the previous chapter, even if there are clear signs that a child is being abused, these can be ignored. This illustrates the need for change. It is to be hoped that child protection services have improved since Michael, now in his 50s, was a child. It does indicate a real potential benefit in the concept of ACEs. Rather than being conceptualised as a curse colouring a child's entire life, other ACEs could be used instead to raise the possibility that there is a need for social services intervention, as other issues may be occurring within the home concomitantly.

Once a child or adult has disclosed CSA, participants wanted better support and much of this related to resources. Eleven interviewees wanted better funding for mental health services. Seven interviewees mentioned paying privately for therapy, as the government-provided service either was not available, depending upon their country's healthcare system, or had limited sessions. Respondents felt that recovering should not be dependent upon the availability of personal financial resources. Steven argued that CSA should be acknowledged to be a significant health issue, and this should translate into more resources.

Two participants were involved in charities providing support to adults recovering from CSA and talked about their struggles to access funding. Alice said:

> *'I've been working for two years without a wage...We are continually evidencing the work we're doing and the outcome but why do we have to beg and plead for funding? Surely, we're helping them. I think it's 3.2 billion it costs the government to support this sector…We're working for nothing to help these victims, survivors that are dealing with immense issues of mental health, physical health, their emotional or mental well-being...Yet, we have to beg and plead. That's what's it feels like [chuckles] for funding. It would be nice to work for a wage.'*

Smith *et al.* (2015) reported that service users preferred services provided by the voluntary and community sector. The APPG for Adults Survivors of Child Sexual Abuse (2019) has recently recommended that the government create a strategic fund for core services, highlighting the quality services provided by the voluntary sector. Better funding for therapy and the charity sector that supports people who have experienced abuse is vital.

Finally, interviewees discussed more systemic changes to institutions and society. Eleven interview participants said that they wanted a more in-depth change to the discourses around child sexual abuse and the institutions that maintain them. Agata described the discourses as she experienced them:

> *'Our lives are pictured as shells, trash, a cloth that can never be washed clean. It is unrealistic and hurtful. It creates a kind of a new fantastic beast – a ghost of a woman, who has been abused. The reality is there are millions of us and we talk to, work with, help, study with "non-abused" people every day.'*

There is an awareness here of the stereotyping of people who have experienced CSA as dirty, less than human and eternally ruined. There is also a sense that people who have experienced CSA are rare and separate, not enmeshed within society.

As part of challenging these discourses, Judith wanted an acceptance of the scale and impact of CSA:

> *'The other thing I would like to say to policymakers is that it is just there, it is endemic. There is almost no way of saying this... you can't say 'just accept it as normal.' I would want to say, 'this happens.' If you treat it as something that is exceptional - that's ridiculous you can't do it but you can't normalise it and say that it's ok...I don't know how to put that into acceptable words…Ordinary but extreme, ordinary and devastating. Very ordinary things can be devastating. They are such*

small moments of pleasure that then can have such long effects. I mean I assume it is some kind of pleasure for the perpetrators.'

Judith is arguing that society's inability to accept the scale of abuse affects their willingness to take the steps necessary to deal with it. The discourse of moral panic enables this dismissal by asserting that the extent of CSA is exaggerated, when evidence indicates that it is actually minimised (Stoltenborgh *et al.*, 2011). Therefore, participants are clear that challenging the erroneous discourses around the scale and impact of CSA would improve their lives by creating a society where victims are believed. From that point of belief there should be well funded services, information and support (The APPG for Adult Survivors of Childhood Sexual Abuse, 2019a)

Even more fundamentally than this, other interviewees argued that the structure of society itself needs to change. Mary wanted the government to demonstrate their commitment to change by properly funding investigations into institutional corruption, such as the Independent Inquiry into Child Sexual Abuse:

'I'd go down to this institutional inquiry. They have put resources into it and put their money where their vote catching mouths are.'

Two people taking part in the research mentioned engaging with other research, including the Independent Inquiry into Child Sexual Abuse (IICSA), and viewed it as their way to contribute.

Penia argued that politicians need to examine their own structures and processes:

'Have a look at their own structures and how they duplicate the emotional and psychological abuse within their own structures because I think empathy and genuine compassion comes from understanding the excesses that are within yourself and I would say that is very true of most governments and most people in power…I don't think people realise the impact that having structures that are excessively power dominated or authoritarian in terms of how much that trigger's and limits the capacity of your abuse survivors'

The structure of society itself, by having powerful, dominant decision-makers, often men, limits the capacity of people who have experienced CSA to reach their potential. It mirrors too closely the relationship between adult and child, particularly when exacerbated by the infantilising of people who have experienced abuse.

Many people were sceptical about government and society changing. This is reflected by Carly, who does not believe that people in power want to change the status quo:

'Honestly, I'm not optimistic that these powers can change themselves. There's too much self-interest, too much compromise, too much power-mongering…But I do believe that change comes from the outside and there's where I put my faith, my hope, and my energies. Grassroots campaigning. Electing honest, hard-working people to be our local and national representatives. Fighting against patriarchy at every turn. Fighting rape culture, victim blaming in media, on campuses, on the streets. Then we can tell them what they should've changed as we're booting them out the door.'

Carly returns to the idea of individuals resisting the abuse of power as, in some way, mirroring the resistance of the initial abuse. This ties into Penia's argument about the dominating structures of society and right back to the child resisting the abuser.

As Carly suggested, many participants preferred direct action. 54 survey participants were involved in campaigning or politics and described it as having a positive effect on recovering. Others are moving towards such action as they find their voice. Charlotte described this feeling of wanting to speak out:

'I am new to the whole world of 'one's own voice', and 'speaking for what you believe in'. One way or another someone else has always spoken for me...and eventually I hid behind that. I don't want to hide anymore.'

As described in the previous chapter, people who have experienced abuse can feel silenced and unheard, therefore campaigning or simply speaking up can be therapeutic in itself.

Participants who reported being involved in campaigning described either a wider theme such as feminism or specifically speaking out against CSA/CSE. Fred, who works for a charity supporting adults who have been abused, described his job as:

'a constructive part of the healing process. There's all sorts of people in the survivor's movement and in others, many other campaigning movements who are driven by an experience of trauma and it's not right and it's unfair and entirely justified to shout about it and it's also a way of directing anger that might otherwise be misdirected into the people around you.'

Thus, there is also a personal benefit to campaigning in expressing emotions and channelling anger in a more positive way.

Campaigning and politics can also create a sense of belonging and community, as Fred suggests when he mentions the 'survivor's movement'. Penia agreed with this and stated:

'If you don't engage with the broader context you are still going to feel isolated and alone.'

A silenced or unheard child can feel very alone. As highlighted above, peer support can be very beneficial, and it is clearly important to be heard. Campaigning with others combines both of these factors.

Campaigning can also, through the sharing of stories and information, lead to greater knowledge around the issues leading to abuse. Eleven people specifically highlighted feminism as helping in their recovering as this survey respondent illustrated:

'I am involved in various general feminist activist things. This gave me a context for understanding issues of power imbalances and so on that are relevant to CSA.'

Feminism provides a framework for understanding male violence, placing it within its structural context (Brownmiller, 1975). Thus, through campaigning, it also provides the means to address and challenge it, which are active ways to engender recovering.

Some participants reported that they trained others around CSA. Ruth has been involved in raising awareness about CSA both in the media and training police officers. She views her experiences as valuable in informing this:

'I guess for me it's another step from me being a survivor from a victim being able to speak up, to be a little bit feisty, a little bit pushy and tell it like it is. It is something I get very passionate about.'

Many of the academics who contributed to this research reported that they too used their lived experience to train others to protect and support individuals today.

Therefore, campaigning provides active routes to challenge the harmful discourses and stereotypes that affect recovering. It is also a chance to disclose and be heard. By helping others, through campaigning, disclosure, religion, parenting or work participants are turning their energies outwards, challenging the deviant society, and not just hoping for a better future but trying to create it.

Existential Healing

The main factors influencing these examples of positive human interactions are expressing emotions and being heard. Such simple actions, yet transgressive within what can be argued to be a deviant society. Participants reported finding connections with lovers, friends, peers and professionals, who saw the person not the stereotype. These people were not connected

to the past, not enmeshed within the mire of guilt, defensiveness and regrets that characterises many familial relationships.

In the same way that society reproduces and entrenches the neutralisation techniques carried out by the abuser, research participants resisted and challenged them. This mirrored the way that they resisted the abuser. Recovering is led by the individual actively taking the chance to disclose, seeking out close relationships and even daring to be a parent: rejecting the trope that they are forever damned by their experiences. Some adopted a spirituality that aimed to heal the existential harm caused by abuse. Others gave examples of engaging with and challenging a dysfunctional society, working and forging loving partnerships.

Relationships are key to recovering, as they are also the fundamental factor in many abusive incidents. Positive relationships reignited hope in the participants and rebuilt the foundations of ontological security. They created safe places to release long-denied emotion. This confirms the evidence raised in the wider literature, that recovering is a social phenomenon. We exist within social networks and these relationships affect our health (Berkman *et al.*, 2000).

Van der Kolk and Najavits (2013) argue that treatment cannot ignore the interaction with others and that we 'do things because we are a part of tribes, communities and groups' (p.519). Within well-being research, respect and having one's social needs met were the strongest predictors of positive feelings (Tay and Diener, 2011). This is clearly reflected amongst people who have experienced CSA. Their social needs include being heard, respected and loved.

However, our health and well-being are also affected by wider structural issues, again raised in this chapter, such as the funding of services or the discourses around conditions. Dahlgren and Whitehead (2006) proposed a 'rainbow model' to illustrate the varied influences upon an individual's health, moving from the individual's health choices, community influences, social conditions and wider societal factors. Such a social model could be utilised to map out the individual circumstances for a person who has experienced abuse.

The salutogenic approach, alongside of the evidence given by participants, suggests that a focus upon the strengths and capabilities of people who have experienced CSA is beneficial. Indeed, another characteristic of these relationships described by participants is that as an individual they are appreciated and respected for what they can achieve, rather than there being a focus on what they cannot do. Therefore, a strengths-based, social model of recovering is suggested by the evidence and this will be discussed in the following chapters.

Chapter Eight - The Body as a Battleground

This chapter explores how abuse, its effects and recovering are embodied. The body can be conceptualised as a social object (Waskul and Vannini, 2006). Indeed, Butler (1993) argues that the body is only given meaning through its interaction with society. It can also be a vehicle through which power is renegotiated and discourses challenged (Foucault, 1977). The body is, therefore, a site of communication (Goffman, 1959; Hlavka, 2010). The individual communicates their conceptualisation of their identity, their relationship to their body and to society through their body.

This is particularly relevant to the experience of CSA. Abuse is literally embodied. In the most basic and visceral way, abuse is carried out upon the body, piercing the individual's physical boundaries and bodily integrity. Talmon and Ginzburg (2018) argue that the boundary of the body is the place where the self and the 'not self' meet. Therefore, it is unsurprising that there is a correlation between CSA and disrupted bodily boundaries (Talmon and Ginzburg, 2018a).

A child's body is normally one over which someone else has dominion, usually their caregivers, but this is normally within a situation of trust. Sexual abuse disrupts that trust and Hvalka (2010) argues that through this invasion of the 'self', the child becomes conscious of their body, questioning its meaning. The objectification inherent in abuse, as discussed previously, can be internalised by the child who then views their body as existing for others' pleasure. Therefore, the body can express that distorted identity.

Within this chapter, there is an examination of how abuse initially affects the body by causing a severance in the connection between the body and the mind. This can then endure in the longer term. Secondly, embodied recovering is addressed. Participants listed many enjoyable activities involving physical activity or creativity. Their descriptions of these benefits are then analysed to identify themes, which are outlined below. Finally, these factors are drawn together in a discussion concerning the benefits of a flow state upon the mind and the body.

Embodied Harm

As stated above, in most cases, the body is the site of abuse, which can have long term effects upon the body. Dissociation is common in victims of CSA, especially in younger children, and this can lead to issues around the individual's sense of ownership of the body. Dissociation and, in the longer term cPTSD, can result in the adoption of coping strategies which may have positive or negative impacts upon the body. Firstly, before considering embodied recovering, it is vital to clarify how the trauma of abuse is experienced by the body.

Young (1992) argues that the violation of abuse, particularly if it is penetrative and/or violent affects the child's relationship to their body. The dangerous outside world has literally invaded

and figuratively infected the safe inside. The body becomes foreign (Young, 1992). To deal with this, the child retreats into the mind as a protection against further assaults and unwanted bodily sensations. This dissociation is initially involuntary but later, if the abuse continues, can become a voluntary state that the child enters at will (Young, 1992; Van der Kolk, 2014). It can also be a state that persists more permanently. De-personalisation occurs when the individual experiences an ongoing sense of disconnection between the mind and the body (Sierra and Berrios, 1997).

Dissociation and de-personalisation appear to affect identity. Young (1992) argues that for a person who has not experienced trauma, the physical environment is divided into 'me' and 'not me.' The physical boundary between 'me' and the outside world (not me) is conceptualised as being at the site of the skin. Therefore, 'me' is embodied by the sensations and experiences in the body as well as the mind. However, Young (1992) explains that for someone who has experienced CSA 'me' withdraws to the mind, as they have learnt to expect little control over what occurs to the body. 'Not me' then extends to include the body as a foreign, alien object.

This dissociation between the mind and the body was clearly outlined by the participants. Lynne described the effects of trauma upon her awareness during the abuse that she endured:

> *'I remember the incidents, the things that happened, and who they were, but I don't remember feeling anything. I remember looking at patterns on wood chip wallpaper, you know that sort of thing, those little things and bristles and smells'*

Lynne and many other participants recall dissociating as a protective measure. This may also be a form of escape and resistance when physically fleeing is not possible.

To further compound the concept of the body as alien sometimes, during abuse, a child might feel pleasurable sensations as Ruth explained:

> *'one of the hardest things for an abuse survivor to talk about at times is that, people imagine that when you are abused it is painful and it's scary and it is but sometimes your body lets you down and there is a degree of pleasure involved and I hated my body for that. I felt betrayed by it. I had no control over that it wasn't something that I...I hated that there had been any degree of that. I felt completely betrayed and I couldn't trust my body. It didn't belong to me anyway because that had been taken away from me.'*

Pleasure that the child has not and cannot consent to entrenches their separation from the body. The body 'lets you down' leaving the mind 'betrayed.' This idea of an alien enemy body continues to influence the adult who has experienced abuse. Carly also used the word

'betrayal' about her body:

> *'Rape and sexual abuse is done via the body and it leaves its marks – my flashbacks are more often than not triggered by particular touch and sensation and those trigger points are potentially always there. In a way it feels like your body has betrayed you – it carries the memory of the trauma in such a visceral way that keeps you in a high state of feeling bodily unsafe because our brains have been unable to process that trauma and allocate it firmly in the past.*'

Therefore, dissociation, as a method of avoiding feeling the sensations of abuse, can linger into adulthood. Although initially protective to a child being traumatised, in the longer term it can have negative consequences, as Charlotte described how she relates to her body as an adult:

> *'I feel in one way numb from the neck down, I don't feel as if my body belongs to me or my mind. I'm having to read just to find out that it does, so to speak. I don't like my own body. I find making decisions about the things I have to buy for it so to speak, clothes for it or feed it -[chuckles] breakfast etc, very difficult. Anytime I have to make a choice about something to do with my body, it's just very difficult. It's very difficult to explain. It sounds mad, doesn't it? How can you not live well within your own body? But I don't…There's no connection there.'*

From this state, where the body is separate, one's identity resides purely in the mind, as Ruth explained:

> *'it was the body; it wasn't my body. It was **the** body. It was like a house that I lived in or a vehicle I used to get from place to place…It wasn't me. Me was behind my eyes. Me was in my head.'*

Ruth is using 'the' rather than 'my' to highlight this severance, this denial of a relationship, in the same way she did when describing her parents as *the* parents. Thus, her separation from her body is similar conceptually to her figuratively pushing her parents away through language. As she explained above both 'betrayed' her.

For some participants this dissociation can have physical effects on the child, as Penia stated:

> *'I was actually tested for autism back in primary school. That was because I actually stopped talking, stopped reading...I was there but not there…In my late teens and early 20s was when it really hit, where there was a lot of dissociation…the use of drugs …added to the feeling of not being connected to my own body …I always felt that I had a mask on and that people only were seeing part of me.'*

This silencing and in this case actual loss of speech is key to understanding the embodiment of abuse. Silenced people express emotions without words, through their bodies, as Foucault (1977) argued. Resulting from that dissociation, care for the body is not a priority, as the body in itself is not a priority or even viewed as part of the self.

The result of this is that the body is seen as an actor, separate from the self, which responds when the self does not choose to, as Ruth outlined above (Hlavka, 2010). Even the act of freezing, another natural response to trauma, can be seen as a betrayal by the body, which did not try to escape (Möller, Söndergaard and Helström, 2017). It is also a response that can lead to longer term trauma effects (Möller, Söndergaard and Helström, 2017). Thus, the response of the body to trauma can reinforce the initial divisions between the 'me' and 'not me.' 'Me' firmly resides only in the mind.

Leading on from there is the question, previously raised in the 'Disconnected' chapter, of who then 'owns' the body. Often the answer appears to be the family, as Grace explained, and this can be communicated by non-abusive family members:

> *'when I was about 13, I wanted to get my ears pierced and wanted to shave my legs…but [my stepmother] said 'you are not allowed to do any of these things. Your body is mine until you are 18.' …My body belonged to my family. I remember feeling 'no this is my body!''*

The quote above from Grace echoes a previous comment from Carly regarding ownership of their own body. What can seem a trivial event can lead to a belief that the child does not have any bodily autonomy and indeed that their body was merely an object to service someone else's requirements whether they were sexual or not. This is reflected in the literature, where a child who was sexually exploited in Thailand stated ''it's only my body, but this is my family' to justify familial encouragement of her abuse (Montgomery, 2014, p.177). The importance of her body and her physical choices are diminished in importance to her family's needs.

This state, where one has a body but does not possess it, is directly tied to familial abuse where the parental physical dominance over the child is exploited. However, even acquaintance abuse can be facilitated by this message given to the child by the family, as the child might not even realise that they can say no. Children are told in various areas, such as school, sports clubs etc, what to do with their bodies: when to dress or undress, use the toilet, eat, drink or sleep. Their rote compliance with this can be exploited by perpetrators.

However, despite these familial messages, children do recognise that their body has been violated as Ruth explained:

'for most people the body is the safest place you can be, you live there. You live in your house and if somebody burgles your house you feel violated and you can't go into certain rooms but this is your body there isn't anywhere else you can go. You can't move to a new body and if somebody violates that they take away not just your control of it but they take away your ownership, so your body does not belong to you.'

The abuse then confirms what may have been the previous familial message regarding lack of bodily ownership. This severance may also be reinforced by the physical nature of de-personalisation, where the mind withdraws from the body. Indeed the American Psychiatric Association (2013) definition of de-personalisation is:

'persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body'

This directly relates to the idea of a divorce between the body and the mind. This expands upon the previous section where the traumatised person defined the body as 'not me'. In this case, the body is not even owned by the self - 'not mine'.

The second area where the body is impacted by abuse is in sensations. Cartesian logic argues that the body cannot think, however, there is evidence that the body remembers what the mind cannot (Hlavka, 2010; Van der Kolk, 2014). Therefore, the body becomes the site of communication by and for the body (Hlavka, 2010; Van der Kolk, 2014). Sensations are felt during abuse and the immediate consequences of abuse are also communicated by the body. For example, the child may regress to bedwetting or have stomach and headaches (Hlavka, 2010). Kolk (2014) asserts that trauma is then encoded within the body rather than the mind, so the memories of trauma are physically felt rather than recalled. These embodied memories can be very debilitating, as Charlotte described:

'I always have these very strange flooding…I think its cortisol or maybe adrenaline that just floods through my legs and body it's like rippling, it's like a tsunami of chemicals and emotions that run through me. I have to navigate through. It's very difficult.'

Charlotte's body appears to be producing hormonal reactions to a trauma experienced long before. Thus, embodied memories produce very real reactions from the body, regardless of the individual's temporal or physical distance from the trauma event/s.

Michael also experiences similar effects and described his confusion around them:

'I get inside myself and I can't...I feel anxious, I can't breathe...it's almost like (pause) well it's almost like anxiety attack or something and I'm like 'what the hell' I'm dropping expletives left and right, I almost felt like I've got Tourette's or something. I just didn't know what to do. Sometimes it's like I just fall on the bed and say 'Urgh, I just don't know what to do.' That's my form of rending myself, that's my form of abusing myself'

There is a sense here that the body is not under the individual's control, either as a child during the abusive incidents, or as an adult when traumatic sensations can be overwhelming. It can entrench negative feelings towards the body. For example, seven participants stated that they 'hated' their body. To manage the symptoms described above, people appear to site the blame for them within their body. An alien body, 'not me or mine', has taken over and is disrupting the mind, negatively affecting 'me and mine.'

Such embodied memories, experiences and sensations are clearly difficult to cope with. To reduce, numb or express these symptoms, participants described various coping mechanisms. These coping mechanisms also impact upon the body. All coping mechanisms can have negative consequences if carried out to extremes, for example, overworking. However, participants described utlising coping mechanisms that are traditionally viewed as having negative consequences.

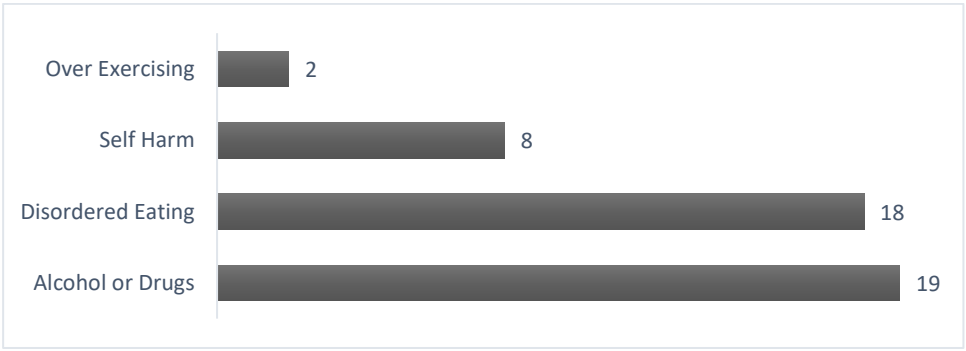


Figure 8.1 Coping Mechanisms with some Negative Effects. N=36

Nineteen survey respondents reported issues, either now or in the past, with alcohol and/or drugs. Eighteen described disordered eating, eight had self-harmed and two had over-exercised. Respondents were aware of the parallels between these coping mechanisms, as Michael explained:

'Whether I cut myself or whether I hook up and then end the marriage early, you know, it's all the same. Whether I go into alcoholism, which I did, I did alcohol for a long time and I liked it because it allowed a totally different person.'

He acknowledges the self-harming aspect of these actions, but highlights that there are

benefits in them. Both facets are explored below. He is also suggesting that both had an element of escape from himself and, presumably, his history.

Alcohol or drugs are acknowledged to be harmful for the individual but, despite knowing that, many people struggled to resist them as Fred told me:

> *'I drink too much alcohol, I'm overweight, I don't know why I do that. I've had talks about it in my counselling and say, "Well don't buy the booze." and I'm in the supermarket trying not to reach out for a bottle of gin and I put a bottle of gin in my bag, in the trolley. It's still there very much, very much so.'*

This may be because such substances are utilised to permit or enable the participants to act and feel differently. Participants discussed how they were used to manage emotions and sensations that were otherwise overwhelming. Grace used them to deny or avoid negative thoughts:

> *'I definitely used drink and drugs in a way to cope with things, to shut out things for a long time, since I being a teenager til...er I haven't taken drugs for 10 years but you know drink can be a real problem for me still, I have to really be careful erm, and I use drink to sort of have these conversations (about abuse), you know like with this new boyfriend. There is no doubt that I will probably get some beers or some wine in and I will need to have a drink before I sort of say anything because I am too scared of having that conversation. So yes, I definitely still use, abuse drink to cope with this'*

So, drink is utilised to dull emotion and to give Grace 'Dutch courage' to enable her to disclose her history of abuse, such is the extent of her fear of rejection.

Eating disorders are another way to manage emotions, particularly anger and fear, as Rachel described:

> *'I am underweight and I hate my body. I feel like I can't give myself the nutrients I need to live, I am only allowed to 'exist' with as little as possible. It's safer to hate myself and be angry at myself than to be angry with the abuse/abuser. I have been like this for years.'*

There is an element here of punishing the body and asserting control over it. Secondly, the rage engendered by the abuse is literally internalised and this is seen as 'safer.' This concept of safety is echoed by Helen:

'Around the time that I started experiencing flashbacks I also developed quite severe bulimia. Partly that was a way of making myself feel safe and in control but also it was a way of taking up less space, which is something that I think I have always felt is important to a greater or lesser extent. I've always hated my body.'

It appears that Helen is describing attempts to hide her body to feel safer. This survey response reinforced this:

'Unfortunately, I still self-harm a lot and don't look after my body at all. I need to lose weight for medical reasons but think I have a psychological 'block' to losing weight and more attractive. Best be fat and ugly.'

Thus, as stated previously, this sense of being in danger still persists and is compounded by flashbacks to the abuse, where the emotions and feelings are felt as if they are occurring contemporaneously (Van der Kolk, 2014). Body modification, either being fatter or thinner, appears to be an attempt to create a sense of a safety within a dangerous environment and this is reflected by other research (Felitti *et al.*, 2010).

Eating disorders can also be a rebellion, about demonstrating control and ownership of the body, as Carly explained:

'Controlling what you eat and how much you exercise was an easy way to regain some control over all of those things – suddenly you have this secret thing about your body that is just for you and you alone, that's very intoxicating.'

Thus, there is pleasure in this rebellion. Carly also described a process of changing her mood through food (or restricting it) and exercise. The feeling of control and secrecy is empowering.

Therefore, the body and one's treatment of it offers a way to express, create and manage emotions. It may be that such coping mechanisms developed in childhood, during or shortly after the abuse, when many respondents were too young to have easy access to other, more traditionally psychoactive substances, such as alcohol or drugs. Indeed, out of the eighteen people who disclosed disordered eating, fifteen were under age twelve at the time the abuse commenced and may have had restricted access to alcohol or drugs.

As can be seen in the case of disordered eating, the body is the site where dynamics of power and powerlessness are explored (Reavey and Brown, 2007). This can also affect an individual's later sex life. Referring back to the idea that the role of the body is to service other's needs, Amelia stated:

'I am married and we have been together for over 10 years, but my attitudes to my own sexual pleasure have mostly been that I don't deserve it, and I am here to serve my partner. I sometimes feel guilt for allowing myself to feel pleasure and reach orgasm. I know logically that is not healthy to feel this way, and I have been working on this for the last couple of years with some success in changing my attitudes.'

Amelia is not the only participant who has struggled with the idea that she deserves to have sexual pleasure. One impediment to this is when cPTSD is triggered during sex. Lynne found this difficult to talk about with partners:

'I don't want that person to feel that I connect them with an abuser but you can't help what comes up into your mind…because of that you don't want to tell them the reason why you've gone off it or why you want them to stop because that's a horrible thing for them to think, you know, be connected with...'

Lynne tried to protect her partner from the knowledge that she has been triggered, at the detriment of her own enjoyment. However, Nielsen *et al.* (2018) found that couples that communicated about intimacy issues affected by CSA were happier than those that did not.

The risk of triggers can be reduced if the individual does not have sex with someone who is the same gender as the abuser. Carly explained her experience of this:

'as a bisexual woman, I often find intimacy with women easier. I have never had a 'triggering' episode during intimacy with women but often do with men.'

Other respondents reported avoiding sexual contact completely because of being triggered by the experience. Three people described themselves as asexual and this can be a protective measure. For example, this survey respondent reported:

'I identify as asexual. I have little interest in sex and only sexually engaged in previous abusive relationships'

Thus, sex become associated with abuse and is therefore avoided. Furthermore, the physical experience of sex can also be negative. Judith said that she sometimes found sexual sensations or urges unpleasant:

'I think some experiences of desire or arousal that I think retrospectively I would think 'well that's not very nice' (laughs) Now it makes a lot of sense so I think that obviously has a long term effect on the body'

She has found that an understanding of the consequences of abuse, explored through counselling, can mean a greater understanding of the effects on the body.

Other participants talked about promiscuity. George connected this to low self-esteem:

> *'I prostituted my body for zero, for free, you know, because my self-esteem was so low...even now …I can't believe that somebody likes me for being me and that is the most devastating effect I think.'*

Thus, promiscuity for George is not about being confident about his body, but the opposite. Sexual risk taking and low body confidence are associated in previous research to the experience of CSA (Wenninger and Heiman, 1998; Nielsen *et al.*, 2018). For example, Wenninger and Heiman (1998) found, in their study of 104 women, that the 57 women who reported experiencing CSA rated their attractiveness lower than those who did not.

As well as low self-esteem, promiscuity can also be influenced by an early knowledge and experience of sexual activity, albeit not consensually, as Grace explained:

> *'I think I was like a lot more kind of promiscuous at like a young age, so in that way had quite a few partners and things like that so I think in that way, to do with my body, I felt probably older than I was, so doing things that I shouldn't have even at 13. And that's to do with what happened when I was five so yeah, I think that definitely comes into it.'*

Therefore, CSA can influence sexual choices and also affect the embodied experience of sexual relationships. The choices described above typify the idea of the body as being 'not mine,' an alien, not valued object, where emotions and sensations are denied, minimised and unrecognised.

An area where coping mechanisms can have both positive and negative affects is self-harm, as a survey participant reported:

> *'I feel better when I self-harm, but then feel bad.'*

They are describing both positive and negative effects. Self-harm can be a method to release emotions but also creates guilty and regretful feelings. This reflects the research covered in the literature review regarding 'maladjusted coping mechanisms', where such actions may, and often do, have some positive short-term effects. In some ways, self-harm can also be an attempt to communicate distress, as Amelia stated:

> *'The self-harm scars on my body were seen and ignored.'*

Thus, there was an intent for that to be a form of communication when her voice was not heard. Self-harm, through cutting, eating disorders or addictions can be conceptualised as internalised violence (Parkkila and Heikkinen, 2018). It is a way to punish the alien body that is 'not me' and 'not mine'. However, it can also be a form of resistance, a rebellion and it can produce temporary relief from distress.

For some, this 'hatred' of the body that is 'not me' and 'not mine' is expressed by punishing it through addictions or exercise. Melissa has utilised exercise in both positive and negative ways*:*

> *'my body has always been the number one thing people comment on my entire life…It was something my mother put an extreme value on as I was growing up. It has always been reinforced in many ways...I have definitely have punished my body with brutal exercise…it's always been a push me, pull you. It's a helpful thing. I feel much better. You get those endorphins going. I definitely almost only experience like a mental relaxation when I'm doing something physical…So yeah, it's a daily struggle. It really is…You know you feel obligated to present yourself a certain way, at least, maybe other people don't, but I do. I feel most of the time a lot of pressure to appear in clothes that display my shape in a very feminine way that people respond positively too. So, I definitely feel like I'm a prisoner of my own body.'*

Melissa describes not feeling in control of her body and, further, that her physical identity was defined by others. She feels defined by people's comment on it and rebels against that by 'punishing' her body through exercise, although she also gains some physical and emotional satisfaction in this rebellion. She describes a process of mixed outcomes from this, which echoes the information given by the people who disclosed self-harm. There is immediate relief but longer-term consequences, in Melissa's case she is re-enforcing her relationship with her body, which she feels incarcerates 'her'.

The embodied effects of trauma and the multiplicity of coping mechanisms can cause long term damage to the body. Some respondents outlined what they saw as a direct relationship between their physical health and CSA. For example, Lynne has gynaecological problems:

> *'I think it's to do with that. I absolutely believe that physically it's gynae problems and emotionally connecting my head to my sexual organs doesn't always work. When I was younger it wasn't so bad but as I've got older, and even before kids actually, I had started to get flashbacks…I definitely think physically it had a gynae*

effect on me and my hormones. I started my periods really early and things like that.'

Research has demonstrated a strong association between experience of CSA and gynaecological issues. For example, Latthe *et al.* (2006) carried out a meta-analysis of 122 studies and identified child sexual abuse was strongly associated as a risk factor for chronic pelvic pain.

Furthermore, there is a growing body of evidence connecting CSA and other ACEs with the development of chronic conditions, particularly auto-immune disease where the immune system attacks healthy cells in the body (Dube *et al.*, 2009; Shields *et al.*, 2019). Miller *et al.* (2011) theorise that the maintenance of threat vigilance throughout life causes autonomic reactions that can foster chronic diseases. Mary is aware of this research and explained how this has affected her:

'I've had to cope with arthritis for over 40 years. Just in the last 11 years I've had seven major operations…I know the BPS research into arthritis showed a threefold increase in people with childhood sexual abuse. So yeah, I just think, I don't like my body and I just put up with the bloody thing.'

She described a sense of anger and disconnection from her 'alien' body. It has let her down again by developing an illness. This can be compounded by ageing, as Mary continued:

'I think I live in my mind, I would agree with that because…it's (my body) not done me much good. As my body deteriorates, as I go as I'm now a pensioner…I'm still working but obviously...I'm in this last part of my life, the last quarter of my life. I don't have much of my body to thank for it. It's just that it keeps me going for now…I can't say I like it'

Mary's body has aged but her anger at and detachment from her body has remained from childhood. It is separate from 'her' and she has just endured rather than loved it.

In conclusion to this section the effects of trauma are embodied, participants describe the reality of dissociation and the motivations behind it. Behind the wall between the body and the mind are embodied memories of sensations and emotions, which sometimes leak out, creating the need to express or numb them. These leaking memories are often not understood or even recognised as such, thus the body's reactions can make it seem like a separate entity, an alien: 'not me' or 'mine.'

The use of coping mechanisms can enable the individual to ignore or deny these memories.

However, this denial compounds the initial disconnection from the body because ignoring memories reduces communication of any sort between the body and the mind (Young, 1992). Consequences include not receiving signals when the body is being harmed, such as by coping mechanisms, and also not always feeling pleasurable sensations.

The key motivation for this separation between body and mind is the desire for safety. The body is abused, not the mind, thus the body must be punished, altered, hidden and destroyed in a futile attempt to create a sense of safety in the individual. Residing in the body is not safe as the body is in the dangerous world. Thus, Young (1992) describes this dilemma as:

> *'To survive, I must destroy my body. But if I destroy my body, I can't survive'* (p.96).

People who have been abused resolve this paradox by denying a relationship to the body, which becomes not 'me' or 'mine.' This severance and resulting lack of self-care, as the body is not even part of the self, is a fundamental effect of CSA and one that does not appear to be addressed by traditional therapies. However, participants did independently find ways to achieve embodied recovering. The next section will examine how this détente is negotiated and achieved.

Embodied Recovering

In direct contrast with the above outline of the embodiment of harm, participants described the body as integral to recovering. Recovering is likely to feature an altered relationship with the body, either healing the rift from the mind or, at the very least, reaching some sort of truce with it. Ruth described this compromise:

> *'I don't like my body. I live in it. I don't trust it. (pause) I am actually coming to some sort of a compromise with it now. I am treating it like you would treat a car. If I don't fuel it, maintain it, you know, keep it running smoothly - it is not going to get me anywhere. So, if I can at least look at it that way and know that it needs to be cared for, even if I don't feel connected to it, I am making progress.'*

Ruth's recovering has included the recognition of her body as something that deserves care. It is still not 'me', part of her sense of self, but is 'mine': something she is responsible for caring for. This is a significant step forward for her.

As stated above, the issue of body ownership is a basic question raised by the experience of CSA. Feeling safe is fundamental to re-establishing a sense of ownership. If the alien body feels in danger, then ownership will be rejected (as per Young, 1992). Some participants talked about using body modification and decoration to reclaim ownership of the body. For example, this survey respondent said:

'my identity is very clouded by my eating disorder. I want to find ways to reclaim my body beyond the very maladaptive ways my ED offers me but I worry what others will think about this. Even really small things like getting a tattoo. I think this is a really important area and one I am still working out.'

A tattoo may be an effective way of demonstrating autonomy. Maxwell *et al.* (2019) also found that tattoos are valued by survivors of sexual trauma to embody their ownership of their body.

Thus, the body is integral, for many, to the experience of CSA and recovering. Carly elaborates upon this:

'I've been coming to understand that trauma gets written in the body in a way that's intimately connected with our mental and emotional state – it would be impossible to talk about the mental health of victims/survivors without also talking about the body…That trauma always has the potential to feel present and so we carry it around with us daily.'

Carly relates the effects of cPTSD, specifically the way in which memories and sensations of abuse are recalled in the present, as if they are occurring in the present (Van der Kolk, 1998). She recognised that 'she' (her mind) can work to support her body:

'I can help my body not react violently when sensations arise'

There is a recognition here that the mind can work in tandem with the body to reduce the effects of cPTSD. Thus, respondents had in their own ways realised that a partnership needed to be forged with their rejected body. Participants described myriad ways they had discovered to assist in their recovering, which can be divided into the themes of physical activity and creativity. This section will report their explanations of what the benefits are in each area beginning with physical activity.

Physical Activity

The survey included a question about whether care for the body plays a part in recovering, and nearly half the respondents reported that good body care was significant in their recovering.

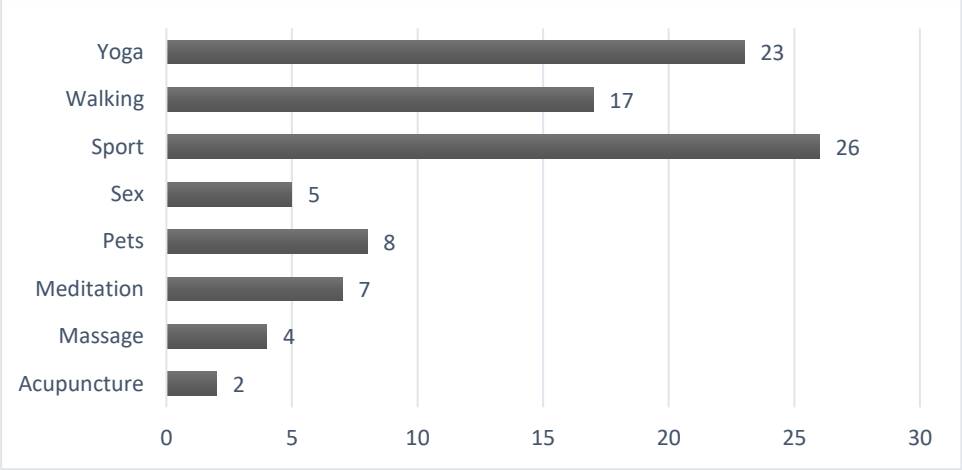


Figure 8.2 What Physical Movements and Sensations Help Recovering? N=89

Out of 89 participants, the activities listed were sport (n=26), yoga (n=23) and walking (n=17), pets (n=8) meditation or mindfulness (n=7), sex (n=5), massage (n=4) and acupuncture (n=2) (Figure 8.2). Participants described physical activity as helping them feel stronger and increasing their self-esteem and sense of safety through a sense of mastery over their environment. They also highlighted the benefits in expressing emotions through activity and managing their mental health. These factors are explored further in this section.

A significant factor motivating physical activity is developing strength, as this survey respondent explained:

> *'Sport, any sport, has helped me. Feeling stronger has helped me feel safer in my body. Also running, it's nice to know I can run away if needed. I'm not a kid anymore but I can still feel as helpless.'*

As previously stated, a heightened sense of danger can persist long after the immediate threat has gone, and this survey-respondent has clearly described this. Being fitter and stronger helps this woman, who was subject to multiple abusers in childhood, feel safer in adulthood.

Adulthood itself and a mature body can also increase confidence and safety, as George described:

> *'I did go through a period when I lived in Switzerland of working out, going to the gym, learning to ski and enjoying doing that. I have sort of grown into my body. I probably do look better looking now at the age of 58 than I did at 28, erm, because I don't look so gawky. I look like I have grown up. I used to look terribly young. I was 20, 22 I looked like I was only 14 or 15. So I have sort of matured better now, I feel a bit more comfortable'*

Here he is talking about a dual benefit of becoming stronger and ageing. Thus age, becoming further away in time from the abuse as well, as a having changing body from child to adult can be of benefit.

Exercise can also be useful for expressing emotions because it is a physical outlet for them, as this respondent explained:

> *'I practiced martial arts for quite a long time and really liked it as an outlet for my anger.'*

The release of emotions through the body may be especially important. Van der Kolk (1998) suggests that, in part, cPTSD is formed by the actions denied during trauma, i.e. the inability to run away or fight. Thus, Kolk argues that completing movements that were impossible can be healing. It can also help an individual feel safer. This combination of motivations matches with the statement above regarding running, a movement obviously denied to this person as a child. Physical activities such as aerobic exercise, resistance training and strength exercises such as yoga have been shown to be beneficial in reducing the symptoms of PTSD, although they are more commonly used in the treatment of combat induced PTSD (Ley *et al.*, 2017).

As discussed above, sex is one of the fundamental areas where cPTSD can be triggered. Alice described how she overcame the triggering nature of sex with her husband:

> *'Straight away the memories are there. We are human beings, you can't erase our minds, they're there. It gets-- The empowerment and being restored is being able to- you know when you brush your shoulder, brush it off, brush it off. I think that's what you have to do. Brush it off. Brush it off. You acknowledge it. "Okay, that's a trigger but I'm okay." You acknowledge it. Don't try to ignore it. That's what I did, that moment with my husband and it's never been a problem since.'*

Alice is describing a process of mindfulness here, acknowledging a feeling in order to minimise its effects. This has been shown to decrease PTSD symptoms (Kim *et al.*, 2013; Scotland-Coogan and Davis, 2016).

Another positive aspect of exercise is a reduction of depressive symptoms, as this example demonstrates.

> *'I strive to maintain a minimum level of physical activity and to eat healthily because that is one of the main pieces of advice given on alleviating depression/anxiety and I start to feel shit if I don't'*

This respondent recognises that exercise has a positive effect on mood and can help lift depression. This also reflects previous research (Ley *et al.*, 2017; Ley, Rato Barrio and Koch,

2018). Thus, exercise can provide similar effects to the more negative coping-mechanisms in terms of emotional release and management.

Exercise can also be enjoyable. The physicality of the experience, with the body and the mind in sync, is described evocatively by Charlotte:

> *'Exercise is really important. I feel that it has a very calming effect on me, on my mind, on my body, it feels I love the movement, the motion of it. It gives me a different kind of focus. It feels nice, I love the rhythm of it, and I find myself when I'm doing exercise, if I'm going for my walk by the water. I usually speak out loud at one point, I look and notice the birds and the trees and I stop, I listen to the wind and walk again and just looking at things. The movement feel nice, the left rightness of it all. You feel your arms moving and I haven't thought about it until now but I feel un-judged, I suppose, somehow doing something like that. It's just really nice movement. You can begin to feel like you're in control of something as well because usually I don't feel like I have control over much of my life.'*

Here Charlotte's body is moving in rhythm whilst her mind is observing and enjoying the sensations. This sense of oneness, for her, evokes a feeling of being in control and is one that she clearly treasures.

Exercise can also challenge the individual and test their abilities as Sarah explained:

> *'I guess in some ways it's about seeing how far I can push (pause) but I also have to be aware when I'm doing yoga that I am very hyper mobile so I sprain at the drop of a hat, erm, so even things that seem nice and sedate to other people are a risky sport to me...I guess it's about mastery, having that control of being able to push that little bit harder…I think it is about being in control and taking charge and seeing how far I can push things before I injure myself and I sometimes get that wrong.'*

This sense of challenge and, if it is met, of mastery is very important to Sarah. This is echoed by this response from a man abused by his mother:

> *'when I was younger I learned the value and honest pride that comes from hard work and the exertion required do it.'*

He is now a nurse and views his job as similarly providing that physical challenge as well as caring for others.

Through exercise, individuals identified ways to reconnect with their body in an enjoyable and challenging way. Charlotte is clear that exercise is vital for her recovering:

> *'Movement is important. In any form, dancing, laughing walking, bicycling, and fresh air and daylight. I have a kayak too. I have a good 1hr walk in the morning most days. It is important to be 'in contact with your own body'. I know this can be difficult…to try to like yourself…to try to love yourself…to try to touch yourself. 'You are worth the try'. Make time to spend by yourself…even with a hot water bottle... it's lovely!'*

Charlotte is combining the many benefits of exercise here and highlighting its ability to reconnect the body and the mind. Therefore, when carried out in an appropriate way, exercise and physical movement can be extremely beneficial for recovering, by releasing emotions, changing mental states, engendering a feeling of safety and inducing pride in mastery. Through physical movements, respondents are relearning how to see their body as 'mine', how to work in unity with it and, vitally, why this is a positive phenomenon. The body is no longer a betrayer, but a partner.

Creativity

'Creativity is vital. Creativity is life itself.'

Charlotte

Creativity was also identified by respondents as a positive method to express and process trauma. Some rated it extremely highly, as Charlotte states above. Within the survey, there was a question about whether creativity helped in recovering.

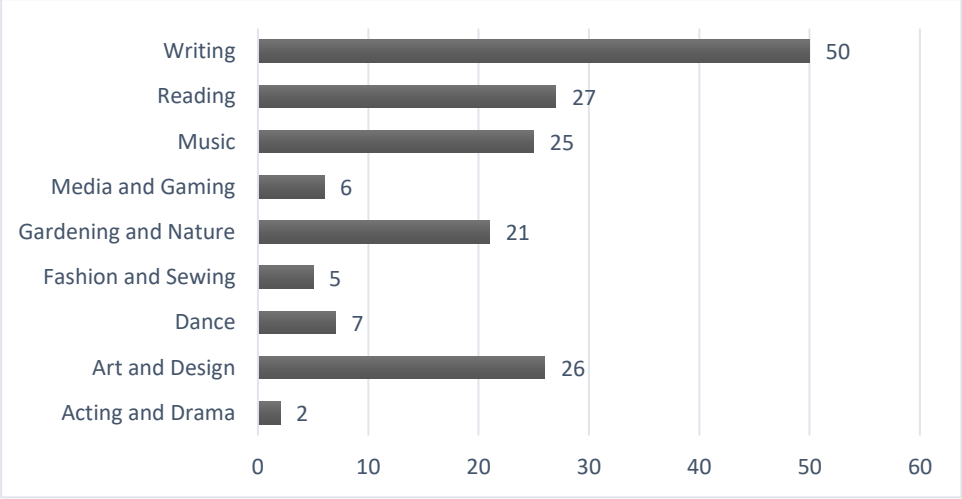


Figure 8.3 Creativity

Altogether, 82 survey respondents found creative activities beneficial for recovering. The largest number of those (n=50) cited writing, prose and poetry, as helpful. This include fiction

and non-fiction, writing for pleasure and also for work. Following on from this was reading (n=27), art/design (n=26), music (n=25), gardening (n=21), dance (n=7), media and gaming (n=6), fashion and sewing (n=5) and acting or drama (n=2) (Figure 8.3). It should be noted that there is an overlap with the exercise section above, as some topics, such as gardening or dance, can fit in both. As will be demonstrated below, the themes emerging from comments about these creative pursuits echo the statements about exercise. Themes include safety, expressing feelings and raising self-esteem. Participants also described an enjoyable feeling of absorption in a task, having fun, connecting with others and communicating with them.

The first and, it appears, most fundamentally important of these is safety, reflecting Herman's (1992) ideas about the first stage of recovery. Participants did describe safety being found through strength-building activities, as above, but it can also be less corporeal. Participants describe the process of being creative as a safe place they would retreat to away from the reality of abuse. For example, Mary stated:

> '*I have always played the piano and remember playing directly after abuse incidents. I also sing in a classical choir. Music helps me connect feeling, thought and action'*

Thus, creating music can be a way to reconnect the body and the mind by having them work in tandem. Creativity was described as a safe place, as these survey comments demonstrate:

> *'Creativity has been a huge part of recovery for me. Reading was my escape when things were too bad and too much'*
>
> *'I can hide away in books and writing.'*

Reading and writing can be a valued escape from reality. Judith credits writing with creating a safe mental environment:

> '*I work as an academic, and I find both teaching and writing helpful. Writing, in particular, gives me a safe retreat, a place where I can get satisfaction and distraction in complex ideas and language.'*

What is also interesting here is the idea of a safe area being created in the mind as opposed to safety for the body. Therefore, even a person who is not safe physically can create a safe area mentally. Lynne credits her imagination with saving her:

> *'I used to dream of escape and freedom and daydream about being a grown up and out of all of this and that is how I think I always stuck with it - I used to think 'there is better than this, there is better than this' and that is what kind of got me*

through'

Thus, creativity and the imagination serve to create an idea of a world that the adults around them may not be showing them, literally inspiring the child not to give up.

Creativity also assists with expressing feelings. Malchiodi (2008) argues that non-verbal arts are vital to express trauma and argues that 'when an experience is extremely painful to recall, the brain protects the individual by literally making it impossible to talk about it' (p.10). However, it can be expressed in creative non-verbal ways. Rachel described the process of self-expression that begins once within a creative safe place:

> *'It gives me a way to express feelings and thoughts that I cannot find words for, as well as subconscious thoughts emotions and feelings. Art and creativity is also a way to safely release emotion, rather than using more self-destructive methods such as self-harm. It can also be a distraction from negative thoughts.'*

Through art, Rachel can express feelings that she cannot find words for. Art has been noted as beneficial to mental health for many years, and art therapy was originally developed to assist people in their emotional expression. Art therapy enables trauma survivors to express, process and reinterpret trauma in a less challenging way that verbal therapies like counselling (Green, 2011). Art therapy encourages the journey through the three stages of recovery described by Herman (1992) which are: establishing safety, remembering and mourning and finally reconnecting with society.

The act of creating a physical expression of feelings, thoughts or emotions can also reify them as Agata explained:

> *'I think creativity can help you make it feel more real and make your feelings feel real'*

Creating a piece of art helps Agata value and acknowledge her feelings. She then described a particular example where a piece of artwork she created that was displayed in an exhibition:

> '*this says 'our fathers taught us how to love people we are afraid of' and I found that when I was in a relationship with someone it was really controlling and abusive and it kind of reminded me how I felt with my father, as if it is like preparing you for other people'*

Through her art she expressed a feeling of her father's dominance affecting her adult relationships. By that creation, this thought was solidified, displayed, communicated and processed. Remembering and mourning reflects Herman's (1992) second stage of recovery. Malchiodi (2008) suggests that the reification of the past through creativity can be seen as a

fundamental human motivation to produce art throughout human history.

As with exercise, art and creativity can increase self-respect, as this example demonstrates:

> *'During my breakdown I discovered I could sketch. Sketching helped to boost my confidence and self-belief. It also worked as a distraction from my mental torment.'*

Here there are multiple benefits listed, including raised self-esteem and confidence. These abilities can be utilised in a working environment which requires writing skills, as this survey participant explained:

> *'I guess in terms of my career this has made me feel proud. So creative in terms of my work (which is not especially creative i.e. art but creative with writing)'*

Thus, artistic and creative skills can give the person who has been abused greater self-respect and pride. It can also, through showcasing their talents, potentially benefit their working life. One respondent was an author, clearly demonstrating the benefits of creativity. This reflects Precin's (2011) research, where a woman processed her trauma through music, and this benefitted her career.

Another commonly mentioned factor influencing people's enjoyment of creativity was the process of becoming absorbed into a task as Judith stated:

> *'even now I find when I start doing a piece of writing or when I start preparing a lesson that can just give me a sense of relief, I enjoy that and it absorbs me, it's a very absorbing, intricate and creative activity. It can just make me... if I have got other stuff on my mind. If I have got the right kind of piece of work like that to do I will just feel fine and I feel like myself again…It's just that the process of being absorbed in that sort of thinking is pleasurable and safe.'*

That state of absorption is again a safe space. Participants described losing 'hours' in art and 'disappearing' in it, as this example illustrates:

> *'My best friend has got me into her passion of art. This certainly helps and I can pass many hours without 'thinking' which is amazing for me.'*

This absorption is a fundamental facet of a flow state and can assist recovering by blocking out other sensations (Csikszentmihalyi, 2002). This is discussed further in the conclusion to this chapter.

Fun is an embodied experience perhaps missing, or reduced, in the childhood of a person suffering trauma. Participants saw creativity and art as a method by which to recapture or even

create that sense of play, as this example, from a woman abused from 6 months old, demonstrated:

> *'I learned to get in touch with my happy inner child and nourish her through laughter, song, dance, love and silliness'*

There is a sense then that the child is hidden inside the body, waiting for a chance to play. Ruth also described finding a way to enjoy life through play and adventure:

> *'I did a lot of things that were fun and exciting and the fact that I was saying yes to things, you know, if somebody suggested 'why don't you try this' instead of cringing and running away and thinking I'd never tried that in a million years I was like 'yeah, let's try that, let's see.' I was a performance poet for a while. I got up and sang in front of people. I worked in a stables for a while. I did a cross-country jumping course on a shire horse...I've had a few golden years being brave and being out there and doing things I never thought I'd be able to do and that for me helps hugely that I could be...I could be a part of things and not have everybody feel sorry for me. I wanted to be me. I wanted to be Ruth not the girl who had that happen to her.'*

Such activities and choices can be a way to redefine the self, to widen the definition from merely a passive, abused person. So, for some participants creativity and physicality were an important a way to find pleasure in life and, through this, redefine their identity.

Research participants shared examples of ways in which they communicated and connected via creativity. For example, Ruth shared her poetry, as demonstrated in the 'Defined' chapter and explained its benefits:

> *'my only expressive outlets were art and writing. I wrote poetry: short stories. Started a journal when I left the parents' house. Drew cartoons, and scenes from inside my head: allowed my inner pain and mess and whatever out onto the page in whatever format was easiest at the time. If I hadn't been able to write, I would not have survived as I have, and while I'm currently in the grip of a vicious writer's block, I still journal and draw. Ink is my lifeline, and one of the few things that connects me to the world outside – Reaching out to others, grounding, not disappearing'*

Therefore, art and creativity can be a significant way to connect with other people, and to express one's emotions and thoughts in an understandable format. Carly uses poetry in this way:

'I am a spoken word poet who regularly performs in public and I often speak about issues of sexual assault and abuse. Writing was an important first step in being able to articulate what had happened to me in a way that felt safer than simply having a 'normal' conversation. Now is it important to me as performing is a good platform to use to talk about difficult things in an accessible way.'

Creativity can, therefore, be an acceptable way to describe or express trauma. Such art can feed into campaigning or challenging the dominant discourses, as in the previous chapter. The third and final stage of Herman's (1992) recovery journey is reconnecting with society and this is reflected in these examples. Creativity is utilised to break through the walls of denial and communicate truths.

Art and creativity were so highly valued that some participants described them as a fundamental part of their identity, as this survey respondent expressed:

'It's my lifeblood. I'm an artist, musician and writer. It's literally how I cope, survive and engage with others.'

For this participant, creativity is the outlet for emotions and a method for interpersonal connections. As with the subject of exercise, many respondents credited creativity with contributing to their recovering. Creativity has become the means by which they continue to exist.

The benefits of creativity are multiple. Artistic ability can lead to raised confidence as well as expressing emotions and distracting from difficult feelings. It may also raise an individual's status in society if others recognise their skills. What is vital to note is that these activities are carried out by the body, connected once more to the mind. This experience of mind and body working in tandem to produce, express or feel something of value demonstrates to the individual the benefits provided by their body and why they may want to accept it as 'mine'. Thus, creativity offers a real opportunity for individuals who are dissociated or depersonalised. It is valued by them and can be a route back to connecting with the body once more.

Reconnected

The examples given above, of physical activity and creativity have many parallels in their effects upon and benefits to individuals. For example, art and creativity can assist recovering by establishing a feeling of safety by relaxing the participant and reducing anxiety (Green, 2011). Physical activities create safety through the development of strength and agility, as well as clearly demonstrating that the individual is no longer a child. Both take place in or, indeed, create a safe space which, as Herman (1992) and Van der Kolk (2014) argue, is the bedrock from which positive change can grow for traumatised people. People reported positive effects

from exercise, painting, singing, gardening, dance, music, work, yoga, meditation, writing – indeed anything that was challenging and resulted in an absorbed attention to the task. Furthermore, the individual discovers and chooses their own activity, an example of their will being embodied. This autonomy is an important reversal of abuse. The body has been treated as object when being abused and becomes an actor in recovering. Therefore, for a person who has experienced abuse, the body becomes a conduit through which that abuse is denied, felt, worked through and expressed.

Janoff-Bulman (2004) views trauma as an earth-shattering event/s that requires a subsequent rebuilding of the self. Roepke and Seligman (2015) found that engagement with new possibilities had a positive effect on trauma recovery. These included engaging with new philosophies, actions, interactions and inspiration. This is reflected by the research participants.

The themes and examples given by participants illustrate a state known as flow, first described by Csikszentmihalyi (1991). Flow is defined as a state created through carrying out a task that is intrinsically rewarding, challenging but possible and gives immediate feedback. The immediacy inherent in these tasks enables a deep involvement and concentration as well as, significantly, engendering a sense of control over the body. During the task, the individual becomes less conscious of the self and less aware of the passing of time. The task then leads to personal growth and learning (Csikszentmihalyi, 2002).

Csikszentmihalyi (2002) argues that happiness is not found in relaxation but instead in challenge and achievement. The brain is only capable of processing a number of factors at one time and, therefore, flow activities, as absorbing events, create a state where there is less room for negative thoughts. Thus, a flow state may be beneficial for recovering from CSA, as it reduces the impact of trauma as well as re-establishing autonomy. This reflects Young's (1992) argument that recovering can be facilitated by the re-establishing of the mind/body connection and allowing the self to feel pleasurable bodily sensations. Flow activities can induce these feelings of pleasure and happiness. Thus, flow does appear to be important for recovering and is clearly valued by participants (Csikszentmihalyi, 1991).

However, creativity does not remove PTSD. Schouten *et al.* (2015) studied 154 Holocaust survivors and found that engagement in art did not affect the incidence of PTSD but did relate significantly to resilience, which was defined in this research as 'the ability to thrive despite adversity'. The creation of a flow state seems to assist with the processing of somatic memories and their effects. However, it does not remove those effects. It encourages a better connection between the mind and the body but a feeling of being unsafe can be created by the environment as well as the individual (Ley *et al.*, 2017).

As important as individual actions can be in recovering, there are other factors to consider as Carly stated:

> *'I don't believe we should let narratives of self-care, resilience etc overwhelm the actual critical narratives we should be pushing. Headspace is not a replacement for NHS funded therapy. Yoga cannot replace medication if that's what you need. Lifting weights does not replace properly funded Rape and Sexual Abuse centres. You can only help yourself so much and then it's the job of society to step up and provide support, which is almost absent at the moment.'*

This is a fundamental point. Actions an individual can, and clearly does, take to ameliorate the effects of trauma do not replace the assistance needed from the society and institutions that failed them. There is a responsibility upon society to assist people who have experienced CSA, and this responsibility is clearly not fully met. Therefore, there should also be structural change to engender recovering.

The body and mind connection is threatened by abuse. The resulting emotions, sensations and memories can be extremely distressing for the child, and later the adult. Participants described their confusion over their memories, compounded by the false memory discourse. There were also descriptions of the physical effects of those memories, of a flooding of emotions and hormones. The individual's inability to understand and cope with this encourages a conceptual separation between the body and mind. The body is rejected as 'not me or mine'.

This dissociation affects how individuals cope with the effects of CSA. As a child, it appears they are often unheard and experience their distress in secret, so they reach for whatever numbs their unwanted, uncomfortable emotions. This can centre around food, as a mood-altering substance a young child can access or deny. It is one of the few things they can control. As they grow older, they may continue utilising food and add others. Treatments should promote and encourage a re-establishing of a relationship between the mind and the body, whilst understanding the mechanics and effects of a fundamental rending between the two. Concentrating on the mind risks reinforces the division from the body. Treatment of just the mind will not resolve issues with the body. Thus, the evidence provided by the respondents suggests that the body needs to be treated as carefully as the mind and in tandem with it. Ignoring the reactions and expressions of the body, reducing them merely to symptoms of a mind's distress, risks entrenching the separation between the two (Hlavka, 2010; Talmon and Ginzburg, 2018b).

Creating a flow state, which is an intrinsically individualistic endeavour, engenders a temporary fusing of mind and body – a trust that could lead towards a more permanent sense of cohesion.

In fact, Lutz (2009) draws parallels between a flow state and the salutogenic state of coherence. He argues that flow is coherence ‘made visible’ in the present: that coherence is built and created by moments of flow. The actions that lead to flow are inherently physical, they are carried out by the body. In turn, a flow state has an embodied impact. Therefore, creating frequent states of flow may enable the individual to (re)-create a sense of coherence and ontological security.

Chapter Nine - Discussion and Conclusion

My PhD has sought to understand the lived experience of recovering by exploring what helps or hinders that process. It has aimed to understand how people who have experienced CSA define recovering as well as whether it was facilitated or obstructed by interpersonal relationships and interactions. By utilising my knowledge as someone who has experienced CSA, combined with my interpersonal and research skills, I wanted to produce useful research for people who have also experienced CSA. Thus, I wanted to take the worst thing that ever happened to me and use it to create one of the best. However, I was keen that whilst my experiences were used to inform the methodology, they would not constrain the data or my interpretation of it.

The literature review highlighted the centrality of both cPTSD and the enduring nature of discourses around CSA. An awareness of the socially constructed nature of CSA and the effects of those constructs is central to this thesis. My theoretical approach began with salutogenics which was critically evaluated, combined with an interpretivist epistemology and a qualitative methodology. The key drivers in the development of my research methods were utilising my experiences in a strategic way as well as a truly ethical approach which was embedded within the research.

When considering the participants in this research, it should be noted that they are not people who necessarily experienced 'milder' forms of CSA. Many participants described long term, penetrative and/or violent CSA, which are usually conceptualised as being more severe (see Johnson, Pike and Chard, 2001; Lacelle *et al.*, 2012; Lonergan, 2014). Furthermore, there is some evidence that many of the participants have cPTSD, although this would need to be confirmed by a medical professional. The respondents may not be representative of people who have been affected by CSA because they are self-selecting as being further along with their recovery. This may mean that they are a disproportionate sample with more social capital and/or more social or financial resources which have enabled them to support their own recovering.

The resulting data identified important themes. Recovering is not a binary process: none of the research participants were broken or fixed, but instead moving each day backwards and forwards along a continuum of health and illness. Child abuse reverberates down the life-course but that shadow does not mean that people cannot have periods of happiness and well-being. People who have experienced abuse may be determined to recover and find a happy life, but this can be a struggle, partly because of the ongoing effects of abuse but also, and at least as significantly, societal attitudes towards people who have experienced abuse.

One influential factor is the need for ongoing, repeated disclosure of that abuse and each disclosure is a critical point as it is in our relationships with others that we make our most important connections. Those connections are vital for recovery.

CSA is a trauma experienced by a child who is yet to solidly establish their ontological and emotional security. It is likely to be carried out by someone, or multiple people, that the child knows, may trust or even love. It may be their primary caregiver, or it may occur with the knowledge or consent of their caregivers. The child may be too young to understand or even verbalise what is happening. They may not know that it is criminal or even that it is sexual for the perpetrator.

Furthermore, sexual abuse is carried out upon the child's body. Before they may have learnt to clean their own teeth or catch a ball, their body is subject to experiences and sensations that may be painful or pleasurable: experiences that they are unable to comprehend enough to consent to. As George stated, CSA may not always be violent, but it is always a violation of the child's bodily integrity and right to autonomy.

This abuse is tangled within the family, the core unit of security for the child and society itself. Even if the abuse is not carried out by a family member, any disclosure of it will drop an emotional grenade into their family. The child is fully aware of this, their fear of the loss of that security is exploited by perpetrators and appears to be enforced by the dominant discourses of society.

But the child, and later the adult, is not passive. They are not, as the perpetrator believes, mere objects to be acted upon. They are active embodied agents in the world who make choices and carry out actions. They struggle to be happy and fight to be heard. Recovering from CSA involves, in some ways, reversing out of spaces that the abuse drove them into, particularly those created by neutralisation techniques. Thus, to understand recovering one must understand the harm caused by abuse.

Therefore, in this chapter I will first examine the different facets of the negative effects of CSA and its aftermath. Next, I summarise and discuss the evidence gathered regarding recovering, particularly in terms of therapy, relationships and flow. I then elucidate the contribution of the results and acknowledge their limitations.

Harm

Harm is caused initially by the act/s of abuse but then can be exacerbated by poor reactions to disclosure of that abuse. This section will examine whether different aspects of harm are caused by either the act/s itself or by the subsequent neutralising societal reactions. The data delineates three aspects to the harm caused by CSA, which are physical, mental and

existential. These factors interrelate and influence each other. They are not necessarily all present in each person who has experienced CSA, but there do seem to be many commonalities in the experience.

In the context of CSA, existential harm can be defined as meaning that the individual has felt that their existence was physically threatened or their right to exist as an autonomous being was challenged or denied. Abuse can be enforced through threats, entreaties, persuasion and manipulation. Sometimes, however, it is violent and may result in injury or even death. As a protective measure, in any type of CSA, children may freeze and/or dissociate to escape from an unbearable situation. Participants described being left feeling unsafe. This existential harm and concomitant fear may be at the base of the effects of CSA: a feeling of being unsafe and in danger, formed through the invasion of the body and one's personal space (Herman, 1992a; Young, 1992; Van der Kolk, 2014).

This research indicates that for many people who have experienced CSA, a sense of trust in existence is either not formed or is destroyed at an early stage. Participants remain in Giddens's (2013) state of ontological insecurity, or incoherence, compounded by ongoing experiences of rejection or denial, which engender lifelong anxiety and fear. This can trigger cPTSD, which then amplifies danger signals. This sense of danger demonstrates why an individual rejects ownership of the body to remain 'safe' (Young, 1992). This may result in attempts to numb the fear through psychogenic substances and to reduce risk through body modification or clothing. The existential harm caused by abuse, the responses to disclosure and societal discourses fundamentally affect recovering.

One factor which has emerged from the data is how little time alters the effects of abuse. Due to the experience of cPTSD, the individual is temporally stuck: their feelings, sensations and emotions around the abuse are experienced in the present but from a child's perspective. This is not to say that they are inherently childish, more that the immediacy of cPTSD inhibits the processing of abuse to relegate the trauma of CSA to the past. cPTSD is a fundamental issue for people who have experienced CSA. The experience of cPTSD evokes the feelings and memories of abuse, particularly in the body, rather than the mind. Therefore, logical dismissal by the mind does not reduce symptoms. Also, the body can be neglected to avoid the trauma. Treatment for cPTSD may increase health and well-being, increasing the individual's day to day functioning.

It is no wonder that participants talked about developing long-term mental health conditions. Some appeared to be a result of the abuse itself or the situation the child was in, such as Ruth's dissociative identity disorder. Other conditions could have developed as a reaction to the long-term effects of cPTSD, such as depression or anxiety. Individuals dealt with this fear

and anxiety however they could, either through positive or harmful coping mechanisms. More frequently, they appeared to adopt a mixture of both. Therefore, it is not only the abuse itself, but also the resulting dissociation and consequent cPTSD for some, that impacts upon their mental health.

There are also physical health concerns. In the immediate experience of CSA, children can suffer physical damage, in terms of STDs, wounds or bruising. In the longer-term, participants discussed physical conditions developing as a result of enduring anxiety, fear and the negative effects of coping strategies. Firstly, poor body care is influenced by the separation of mind and body. A sense of the mind being 'me and mine' and the body being 'not me or mine' can result in choices that move the individual further away from good health and well-being. Often these choices involve psychoactive substances to manage mood and emotions, as well as body modification to increase a sense of safety and ownership.

Secondly, evidence from these participants suggests that long-term conditions can develop as a result of maintaining a permanent state of threat awareness. Finally, the individual may also experience further abuse or violence, damaging the body and further embedding the idea of the world as an unsafe place. Thus, the existential and mental health harm above is embodied in alterations to the body and its effects on physical health.

CSA also appears to have a substantial impact on the individual's identity. Firstly, there is the question of how to encompass the experience of CSA within one's life narrative. This was demonstrated by the choices people made in terms of a label for their experience. Secondly, it affected people's willingness to disclose abuse, as it could very well mean stigmatisation and disruption to significant family relationships. Externally, the effects of CSA can be visible on the skin and in the composition of the body. Clothing choices can also be affected by the desire for safety, over and above the more usual attempts to raise social status. Finally, the actual concept of the 'self' appears to be fundamentally affected by residing purely in the mind, enabling poor treatment of the body. The original instigator for this harm is the abuser (s) but the manifestation of them are formed through culture and society.

The different aspects of the harm caused by CSA appear to create a harm matrix that is individually composed. Not every participant described every type of harm. Some people did not see the abuse as life threatening. Others cared well for their body. Thus, these potential harms are not applicable in every circumstance. There are, however, many commonalities. There does also appear to *be* harm to the individual, in some form, caused by CSA.

Recovering and Resistance

Although abused people can be viewed as passive, there is, as Liz Kelly (1988b) asserts, 'another side' where individuals resist and cope with abuse. This is demonstrated in this research. None of the actions described in this thesis imply complicity or consent to abuse. Being able to act is not the same as actively choosing. Attempting to limit damage or abusive incidents, acquiescing to abuse or even feeling pleasure is not informed consent. The agency illustrated herein is of a child trying to manage a situation that is beyond their understanding or control.

Even as children, some participants tried to speak out and end their abuse or to manage the abusive events and limit them. Dissociation is, in and of itself, can be a form of resistance as the individual is denying the perpetrator their conscious awareness of the abuse. As further examples, Lynne was disruptive in foster care to avoid further abuse and Ruth split identities so 'she' was not hurt. Participants were active agents in avoiding further harm as children, however, it is important to note that this was restricted by their individual circumstances.

In adulthood, individuals also tried to manage a situation that, again, they were not usually fully informed about. Their lack of knowledge about CSA, specifically memory and cPTSD, has affected people's ability to manage their own condition, leaving them to flounder in unwarranted self-blame nourished by the victim-blaming discourses discussed above. Participants talked of attempting to manage their anxiety and fear through alcohol, drugs, eating disorders and regretted sexual encounters.

There are positive and negative coping strategies as well as actions that may be both, according to the level of engagement with them. For example, both work and exercise are named in the data as factors that can improve mental health and also illustrate a deterioration in it. This echoes the literature on flow, where it can be a negative state if it affects the individual's ability to engage with their life (Csikszentmihalyi, 1991).

A binary approach to recovery where people are viewed as either ill or well is problematic when applied to people who have experienced trauma. Salutogenics does seem to be a more useful way to conceptualise recovering from CSA: as a general movement towards better mental health, happiness and well-being, involving more good days than bad. It does not, unlike the concept of resilience, demand a lack of symptoms or perfect mental health. Instead is takes a more inclusive, strength-based approach.

Participants described a more mixed experience, with success in some areas of life and issues in others. For example, some people were doing well in their careers which does not imply that the abuse they experienced did not have debilitating effects. Indeed, many felt that their

concentration on intellectual pursuits was in itself a way of mitigating or avoiding the effects of trauma. Thus, although they were 'functioning' in society they were not unaffected by their experiences. This points to a fundamental issue with the idea of 'functioning': that it ignores the individual's perspective and experience.

Participants were realistic about their recovering and practical in their many attempts to promote it. What is clear is the agency required. They talked about the actions they had taken in recovering and this reflects the approach described by Antonovsky's (1979) theory of a 'sense of coherence', where life is seen as comprehensible, manageable and meaningful. Participants managed the effects of abuse, accessed treatment, moved towards positive coping mechanisms, and found ways to have meaningful connections and creative expressions.

Recovery is viewed by participants as an ongoing process, a permanent state of recovering. Part of defining recovering also involves defining the self. This can include choosing between the terms victim and survivor or rejecting them. There is a process by which individuals define themselves internally first before choosing whether to be open with society. The initial choice of term, or choice to reject any terms, is as much about the individual's own stance as regards the significance of the trauma in their life as it is about societal reactions. Thus, choosing terminology to describe the self is not necessarily about membership of a group, as the group is too nebulous and does not congregate. Whatever the reason for the decision they are clearly choosing socially constructed terms.

The idea of recovering as a never-ending state conflicts with the medical model which views recovery as a binary process aiming to make people 'well' with treatment effectiveness measured by a permanent reduction of symptoms (Van der Kolk and Najavits, 2013). This approach is problematic according to the definitions given by people who have experienced CSA. In their descriptions, the effects of CSA, particularly cPTSD, can fluctuate but may well be ongoing and permanent, although the well-being and happiness of the individual can improve. Therefore, the salutogenic approach, with a strength-based focus can reflect people's lived experience of CSA recovering.

One promising way to promote recovering is through the creation of flow states which may offer a path to longer-term cohesion. Lutz (2009) argues that there is a fundamental relationship between flow and Antonovsky's salutogenic 'sense of coherence'. He argued that:

> *'flow is sense of coherence made visible in the present, while sense of coherence is a product of flow over time'* (p.66).

Thus, flow could, in itself, be an indication of recovering, as well as factor in it: flow being the

individual's creation and expression of that sense of coherence in the present (Lutz, 2009). Flow states were indeed described by participants as very important in recovering, meeting many different needs from escape to expression. Respondents reported many ways in which they created a sense of flow in their lives.

This may be a key to recovering: finding a way to induce flow despite the circumstances. For example, Lynne ascribes her remarkable resilience to her ability to dream '*of a better future'*, literally using a flow state to change her mood and approach to life. The importance of flow, as defined and delivered by the individual, should not be underestimated for its influence on recovering. By creating flow, the individual is recovering and, presumably, breaking through depersonalisation by putting the body in sync with the mind and healing the conceptual divorce between the two.

Fundamentally, to heal the individual who has experienced CSA needs to reside in a safe place. This might be within their own mind, body, their home, working life, spirituality or society. Flow states are safe absorbing places, little worlds where the individual is safe and can trust, thus the more an individual has of these, the more their existential wounds heal.

Despite these failings and discourses, adult participants found ways to speak and be heard through disclosure, research, campaigning and art. Positive reactions encouraged further disclosure, enabling perpetrators to be prosecuted and people who have experienced abuse to access support. Thus, the research participants were active in creating their own lives, if hampered by lack of knowledge and poorly funded healthcare. What was remarkable in the research was how much people who have experienced CSA continued to fight for recovering. Responses from others could inhibit attempts for long periods of time but each participant kept trying and reaching for a better, more enjoyable, happier life.

Participants valued social interactions where they were treated as individuals. They credited love and friendship as being vital for recovering. They also talked about good, positive responses to disclosure. Social interactions can help recovering if they include recognition of the individual because they break down messages of objectification and societal ownership of the body. Participants described how a good response from medical professionals and law enforcement made them feel heard and, presumably, safer. Friends and partners were reported as, more often, giving better support than family members. Adults who have experienced abuse search out caring individuals, moving away from what appears to be, in the main, a negative familial situation. These connections are formed with friends, lovers and professionals re-creating or even creating for the first time a sense of trust and hope (Giddens, 2013).

Time can also provide distance from CSA. Adults can leave home, move away and reduce the number of triggers by doing so. They can create safe, loving, warm environments in which to flourish. They can report the crime and, in doing so, aim to regain a sense of fairness and justice. They can control more of their world and have more power than a child. None of this takes away the experience of trauma or the effects of it but it creates an individual with more support and resources to deal with it.

Social Challenges and Constraints

Maslow's (1943) hierarchy of needs argues that our second most fundamental requirement, after food and water, is safety. Once that need is met, an individual can move onto social requirements such as increasing status. Well-being research echoes the importance of this factor with basic needs, respect and autonomy needs relating strongly to negative feelings (Tay and Diener, 2011). This research demonstrates that for many people who have experienced CSA, safety requirements are not met. Furthermore, this feeling of ontological insecurity is maintained by society and the people around them (Giddens, 2013).

There is a tension between the pressure not to discuss CSA socially and the desire of the individual to speak about it. People who have experienced CSA reported being stigmatised and stereotyped. By disclosing abuse, participants attempted to create a safe and coherent environment but there are significant barriers to achieving this, not least a poor response to that disclosure. Unfortunately, there were many descriptions of poor responses to and neutralisation of disclosure from professionals. There are also many examples of people both being and feeling shamed. Therefore, beyond the harm caused by the act(s) of abuse there is ensuing social damage. This may be caused by interpersonal interactions or the general milieu of discourse and counter-discourse. It is worth noting that this can be avoided.

Many participants feared disclosure because of these discourses. They worried that they would be viewed as tainted or stereotyped as non-functioning and permanently incapacitated members of society. This stigma and shame affected their willingness to report the crime and, the data suggests, makes their family reluctant to support them. The harm caused by neutralising, inattentive, enabling or abusive families can be a core barrier experienced by the individual.

Further barriers are erected by professionals' reaction to disclosure, inattention or even complicity. Professionals are clearly affected by the neutralising discourses around CSA. The responses to disclosure described a failure to respond effectively. They may even be complicit with abuser/s. Furthermore, there are significant gaps where professionals should have been involved. There was a remarkable lack of involvement by social services, despite clear examples of mental, physical and sexual abuse, noted by other agencies, as well as parents

with other debilitating problems. There does not seem to have been a safety net to catch these families. It is to be hoped that this has improved over time and that today's children experiencing CSA are more likely to have social services involvement.

The examination of how society uses the same neutralisation techniques, in chapter six, has suggested that society itself, perhaps formed by these religious and later scientific constructions, is a deviant society, one that, hopefully unwittingly, enables perpetrators. This has been argued before, by Kincaid in his book 'Erotic Innocence' (Kincaid, 1998). However, Kincaid (1998) asserts that society facilitates CSA because 'most adults in our culture feel some measure of erotic attraction to children' (p.25). This is absolutely not the conclusion drawn here.

Instead, this research suggests a requirement to indict society for failing to protect children, failing to identify and prosecute perpetrators and blaming victims. Individuals and institutions are reluctant to address the issue of CSA because it involves challenging the fundamental discourse of the family and respect for authority. However, this reluctance results in perpetrators not being dealt with and ongoing negative effects for their victims. The very fact of it being committed by humans, not monsters, enmeshed within society appears to increase the extent of the harm as well as our reluctance to deal with it.

Limitations

There are three main limitations to this thesis. Firstly, the generalizability of this data is limited by the number of participants and their demographic characteristics. As a small-scale sample, respondents cannot represent all people globally who have experienced CSA and this was not the intention. The qualitative methodological choices made mean that the research aimed for richness of data, which was achieved, but not large volumes of responses. However, as previously stated, this research aimed for Payne and Williams (2005) concept of 'moderatum generalisation' independent of statistical generalisation. Participants have provided detailed evidence of their experiences following CSA, with remarkable consistency in the experiences described, particularly in terms of the negative reactions to disclosure. Therefore, they do raise issues which deserve further study.

Secondly, as the participants are adults, their experiences in childhood of personal and professional interactions relate, in some cases, to many decades ago. This is a limitation as it is not building up a picture of the experience of CSA today. This choice was ethically necessary, as the aim was to reduce the risk of harm by recruiting participants who were at an acute stage of recovering, which children would be likely to be. Also, interviewing children would involve getting consent from their parents, who may themselves be abusive, raising the risk of harm to the child. Thus, while this choice was ethically and methodologically sound, it

does mean that it is not a picture of a child's experience of current society and culture. As a consequence, one aspect not covered is the effect of austerity upon today's children who have experienced CSA. However, participants themselves draw a line from their childhood experiences and their current perceptions. They describe a sense of continuity in terms of relationships, professional services and discourses. As covered in the literature review, many discourses are extremely long-lived and enduring, repackaged for each generation, but with the same underlining messages.

Finally, it should also be noted that participants were self-selecting. This means that there is no secondary corroboration for the experiences or events they discuss, however, belief was a fundamental basis for this research. It does also indicate that as self-selecting participants they agreed, in the main with the premise of the survey: that CSA is abusive and causes harm. Thus, they do not reflect alternate opinions on that subject.

Implications

These results agree with and extend previous research in the following ways. Firstly, it has extended research methods by employing a strategic insider-research approach. This approach was particularly valuable when recruiting people who feared stigmatisation and has gathered extremely rich, in-depth data. This, combined with the salutogenic approach, has led to information around people's definitions of recovering as well as contributing to the victim/survivor debate.

It extends the salutogenic approach to recovering (Sandford, 1990; Dube and Rishi, 2017). As a strength-based approach, salutogenics is useful to conceptualise both CSA research and recovering. Recovering is an ongoing, repeated process, that is affected by the discourses of society and the individuals in it. People who have experienced abuse are remarkably resourceful in identifying factors that assist in this recovering and moving away, where possible, from factors that inhibit it. Good treatment, a flow state and significant relationships appear to be key to recovering as is resistance.

Following on from this, the embodied lived experience of recovering bears little resemblance to the medicalised measurement of it. Present measures of recovery are focussed upon symptoms, not the individual's assessment of their own current experience of living. This suggests that the individual should be involved in defining their recovering and assisted to identify the actions that will help them to move towards that healthier life. While there is obviously a need for counselling and therapy to assist with managing PTSD, there is also a significant requirement for clinicians to measure happiness to assess the progress of recovering. People who have experienced CSA seem to be capable of being happy, even if not in perfect mental health, and as a society there is a duty to assist them to achieve this.

Treatments could be assessed to establish if they reflect the salutogenic approach of assisting the individual moving towards their own definition of well-being and better self-care.

The choice participants made in nomenclature is important information for organisations that provide services for people who have experienced CSA, as mislabelling them might be a barrier to accessing services. It may also indicate how people approach recovering and what method will be effective. For example, 'survivors' may respond better to a strength-based intervention that encourages self-reliance. 'Individuals' may prefer interventions that do not focus upon the traumatic experiences, or do so within a wider narrative. Further research is required to examine if this is the case.

In terms of demographics, the data agrees with wider research, in that most CSA is carried out by people known by the child and their family (see Finkelhor, 1994; Hussey, Chang and Kotch, 2006; Stoltenborgh *et al.*, 2011). However, there are questions raised regarding the prevalence of CSE, specifically in boys, among younger children and where it is facilitated by parents. A large proportion of participants were abused before the age of 4, which differs from previous research. Perpetration of CSA is reported by participants to have been carried out by adults and children, male and female. One under-researched area highlighted is the extent and characteristics of maternal perpetration of CSA.

The research raises questions regarding the experience of CSA in the non-white ethnic groups in the UK. It also suggests a need for comparative research by country, especially the global south, to establish if there are any cultural difference in the discourses around CSA, and also how funding or health service structures affect recovering.

The data validates a trauma-based approach to recovering and centres the body as a vital site of recovering (Herman, 1992; Van der Kolk, 1998). An important issue raised is about how people who have experienced CSA define the self in totality, specifically whether the self includes their body (Young, 1992). To many respondents it did not. This raises the question of how to relate Goffman's (1959) ideas about performance to the many issues people report about their bodies. For the participants, body-modification, addiction and clothing choices are not about the body being used to reflect or increase status. Instead the body is the primary battleground for recovering and trying to create a sense of safety (Young, 1992). Thus, the data reflects more the approach of Butler (1993) and Foucault (1977).

Treating issues around poor self-care, eating disorders and addictions require a deeper investigating of the underlying cause for people who have experienced CSA, which may well be cPTSD. At the moment, cPTSD is viewed as a potentially permanent condition but there are treatments proven to ameliorate it. However, adults reporting CSA to their primary healthcare practitioner are not automatically assessed for cPTSD. In fact, there are no NICE

guidelines specifically for adults reporting CSA (NICE, 2019)), but this thesis suggests that assessment for cPTSD ought to be a first step in their treatment and support. Clear guidelines provided by NICE would significantly improve the lives of people abused in childhood as well as reduce the negative impacts on healthcare or other institutions. They would also provide essential guidance to healthcare professionals who may not have been trained to deal with these patients and/or may have their own unresolved issues surrounding CSA.

Giddens (2013) idea of ontological insecurity is upheld by the data, and I argue that it is the opposite of Antonovsky's (1979) sense of coherence. As regards flow, the participants report the benefits of mindfulness and yoga, but a flow state is not limited to these activities. Therefore, other activities could be equally beneficial. The importance respondents afforded to flow-creating activities suggests that it can indeed be seen as creating long-term cohesion to recovering from CSA, as Csikszentmihalyi (1991) and Lutz (2009) argue, however, this would need further research to measure it over the longer term.

Safety is vital for recovering, as Finkelhor and Browne (1985), Herman (1992) and Van der Kolk (1998) argue, however, this requirement extends far beyond the therapist's room into the individual's life. The extent of the existential harm has been underestimated previously, and this research highlights its significance. Indeed, it could be argued to have fundamental and causative effects upon the other factors. The thesis extends Goffman's (1959) idea of the presentation of self as status improvement, as it indicates that a need for safety may be a primary motivation for people who have experienced CSA.

This research also raises the importance of time. cPTSD, in some ways, links the past too closely to the present and, conversely, some respondents really valued the passing of time as it gave them temporal and physical distance from the abuse events. The data also highlights how vital people are in recovering, echoing Kolk and Najavits' (2013) argument about the importance of interpersonal relationships. Each disclosure event matters, as does each response.

Finally, Klein and Tolson's (2015) concept of a deviant institution is expanded to a deviant society. This research indicates that we have a deviant society that, unwittingly in the main, reinforces the neutralisation techniques of the perpetrator. Respondents gave examples of family, professionals and wider society all trying to neutralise disclosures and silence them. This may be because CSA is tangled within families, therefore, rooting it out can involve an existential threat to families. It is of no wonder that society is reluctant to address CSA as it involves questioning the basic unit of society itself.

Conclusion

This research has built a picture of a society that, through action and discourse, neutralises

disclosures about CSA. It suggests that there is a need for change, and there is a need for further research into this conclusion. However, there are clear contributions that individuals who have experienced CSA could make to challenging these discourses. There is little in terms of a narrative created and curated by people who have experienced CSA, both within academia and wider society. By telling different stories, there is an opportunity for education about CSA/CSE, perhaps as a public-health campaign, aimed at professionals, people who have experienced CSA and wider society. There are people who have experienced CSA who want to speak and to carry out research. There should be more platforms available for them to do so.

As constructions of CSA are not usually created by the people who have experienced it, they are not embedded in lived experienced and individual truth/s. There are people who have experienced CSA who campaign and/or publish their stories (see Woodhouse, 2008; Anonymous, 2013; Ruston, 2016). However, these are not valued as evidential. There is also a dearth of academic researchers who admit to having experienced CSA. The current climate can be related to attitudes towards disabled people who were described as:

> *'objects about whose existence someone else is to be given greater knowledge and competence'*
>
> (Hunt, 1981, p.41)

Hunt (1981) argued that disability experts were more concerned with maintaining their status than questioning the status quo, and there are clear equivalents here. Therefore, the argument that society should examine how it accommodates and supports disabled people can also be applicable here. Challenging such a deviant society requires a social model, driven and informed by people who have experienced abuse.

However, individuals who have experienced CSA remain resistant. They are constantly trying to move towards better health and well-being. Furthermore, there are clear pathways to better health and well-being, including relationships of trust, counselling or therapy as well as individual creations of flow. However, I would argue that effective recovering involves a recognition of the social factors impeding it. These include neutralisation, poor funding for services, a lack of social support, labelling and stigma. Therefore, recovering from CSA demands a trauma-focussed, individualistic and social approach.

This research, by focussing on the individual in a holistic way, has identified myriad ways in which the problem of recovering can be approached. Therefore, treatment could be designed to be unique to the individuals, dependent on their harm matrix, circumstances, motivations and desires. For example, this could involve identifying how to improve the person's personal

sense of safety. Physicality and creativity can be encouraged to reconnecting the mind and the body by turning thought into action. From that sense of safety and personal power, therapy can explore the abuse itself and assign it to the past, where it belongs. The law can deal with perpetrators, ensuring that justice is not only done but is also seen to be done, deterring the next generation of abusers. All of these actions can take place contemporaneously or in a linear fashion. There are many ways to reach a place where the individual feels that they are successfully recovering, sliding closer to the happiness and well-being pole. Fundamentally, however, the message from participants is that their own needs, wants and desires should be central to recovering.

The findings in this thesis demonstrate that adults who have experienced CSA/CSE want to be actively involved in their recovering. The notion of 'being heard' is a key factor in recovering and this leads to feelings of well-being and resilience. Denying people the chance to contribute to their own recovering risks infantilising them. Separate from a medicalised recovery, participants had developed their own ways of increasing coherence, through flow and challenging the deviant society. They have a great deal to contribute to this debate. Society too, must play its part by challenging harmful discourses and fully resourcing recovering.

CSA thrives in a complicated situation, often the family. The effects of CSA are also numerous. Recovering is also not a simplistic or linear process. For example, many of the coping strategies utilised produced both positive and negative effects. More positive actions can have a multiplicity of benefits. High status work increases knowledge and, therefore, a sense of safety and control whilst also inducing flow. Campaigners speak out, support others and consequently assist in their own recovering. Many people find satisfaction and release in flow activities, which engender a sense of challenge and achievement. Thus, while recovering is complex, this research identifies many ways and opportunities for an individual to choose a more positive path. However, it is in the interplay of mind, body and society that recovering can be more effectively facilitated.

There are challenges raised within this research that are directly relevant to dealing with the ongoing abuse of children today. More action is required to notice abuse, step in and stop it. Ignoring or enabling abuse should be punished, whether this is by an individual or an institution. The focus should be on eradicating abuse wherever it is, not just whether it is a current issue or acceptable victim.

This all needs funding and commitment from politicians and policymakers. It requires challenging the prevailing discourses to illustrate stories that have not been heard. There must be action to challenge and reject stigma, to remove that ancient taint from victims. There

should be further research into resolving cPTSD. The consequence of not performing these actions is another generation of neglected and abused children.

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Appendices

Appendix One – Consent Form and Survey Questions

Adults Recovering from Childhood Sexual Abuse

About Me
This survey is being carried out by Claire Cunnington, Wellcome Trust funded PhD student at the University of Sheffield, Department of Sociological Studies and Child Sexual Abuse (CSA) survivor. You can find information about me and videos about the survey here: www.clairecunnington.com. You can also contact me at: claire.cunnington@sheffield.ac.uk

Data Protection and Confidentiality
Your responses will be kept private, confidential and will stored securely. They will be treated with care and, if quoted in any resulting publication, I will ensure that you are not identifiable in any way.

Recovering
I think that recovering is about more than just counselling or therapy (although that can be useful) so I am looking at what helps us feel better in a more general way. You might see recovery as a journey, finding a way to live with trauma, involving ups and downs or you might see it differently. I'd like to hear your views.

I am asking other CSA survivors for their opinions as we are the experts in our own lives. It's important that I state that whatever you say, I will believe you and respect your experience and opinions. As victims and survivors, we come from very different backgrounds. We have different genders, ethnicities, ages and experiences so your opinions are very important, as no-one else has the knowledge that you have. I hope that you are happy to share it.

About the Survey
The survey has two aims:
1) to understand how people deal with their experience(s) of childhood sexual abuse
2) to explore the role of society in the recovery process

The survey will take some time to complete (estimate 30 minutes) so please find time when you can do this in an appropriate environment for you. You can stop filling in the survey at any time and come back later, if you wish. There are text boxes and you can write as much as you like. Ignore the questions that do not seem relevant to you or that you do not want to answer. At the very end there is an opportunity for you to give me your contact details if you would be willing to take part in further research, which might be a more in depth interview either online or face to face.

The survey concentrates on adults recovering from childhood sexual abuse and, as such, you don't need to give me any details about the assault (s) you experienced if you don't want to. It is not necessary for my research, unless it adds context to your other responses.

The survey lay out is as follows:
a) A bit of general information about you - gender, ethnicity, age, age when (first) abused, relationship to perpetrator(s)
b) What you knew/know about childhood sexual abuse as a child and as an adult
c) What actions in different areas of your life have helped or hindered you in your recovery

Support
If you feel you want support or someone to talk to about CSA you can visit the following websites to find help in your area;

The UK
http://thesurvivorstrust.org/

International
http://www.ibiblio.org/rcip/internl.html
http://www.hotpeachpages.net/a/countries.html

Specifically for male survivors
https://www.survivorsuk.org/
http://www.pandys.org/malesurvivors.html

*Required

1. **I am happy to continue with the survey and consent to my responses being included in the research** *
   Mark only one oval.
   - ◯ Yes

2. **Due to the nature of this research it is likely that other researchers may find the data collected to be useful in answering future research questions. Any data we share would be untraceable back to you. Are you happy that your data might be shared in this way?** *
   Mark only one oval.
   - ◯ Yes

General Information about you

I am asking these questions because I want to understand if recovery is affected by differences in gender, ethnicity, ability or disability and age. You can skip this section if you choose.

3. **What is your gender?**
   Mark only one oval.
   - ◯ Female
   - ◯ Male
   - ◯ Trans or non-binary, please add your preferred term below

4. _____

5. **What is your ethnicity?**
   Mark only one oval.
   - ◯ White
   - ◯ Multiple/Mixed ethnic groups
   - ◯ Asian/Asian British
   - ◯ Black/African/Caribbean/Black British
   - ◯ Other Ethnic group

6. **How old are you?**
   Mark only one oval.
   - ◯ 18-29
   - ◯ 30-39
   - ◯ 40-49
   - ◯ 50-59
   - ◯ 60-69
   - ◯ 70-79
   - ◯ 80-89
   - ◯ 90+

7. **Do you live in the UK?**
Mark only one oval.

- ◯ Yes
- ◯ No

8. **If no, where do you live?**

_____

9. **Are you disabled?**
Mark only one oval.

- ◯ Yes
- ◯ No

10. **Did you have a disability as a child?**
Mark only one oval.

- ◯ Yes
- ◯ No

General Information about the abuse you experienced

I am asking these questions to understand if recovery is different depending on the age you experienced it and how you knew (if you did know) your abuser (s). You can skip this section if you choose.

11. **How old were you when you were first abused? If you are not sure of the exact age choose the response that seems appropriate**

_____

12. **Was your abuser(s)..?**
Tick all that apply.

- ☐ a child
- ☐ a teenager
- ☐ an adult

General Information about the abuse you experienced

You can skip this section if you choose.

13. **How did you know your abuser (s)? In the case of multiple abusers please tick all that apply**
Tick all that apply.

- ☐ Acquaintance or family friend
- ☐ Family member (including step family)
- ☐ Friend
- ☐ Partner (boyfriend or girlfriend)
- ☐ Stranger
- ☐ Other: _____

14. **If you responded 'Acquaintance or family friend' did you meet this person/people through... (tick as many boxes that are relevant)**
Tick all that apply.

- [ ] Education
- [ ] Family
- [ ] Medical /NHS
- [ ] Neighbour
- [ ] Online
- [ ] Religion
- [ ] Residential care
- [ ] Specific disability services
- [ ] Sport/outside school activities
- [ ] Support services (social care)
- [ ] Other: _____

15. **Did the abuse involve child sexual exploitation? The UK government's definition of this is 'where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator.'**
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ Other: _____

Recovering from Abuse

You can skip this section if you choose.

16. **What does recovery mean to you?**

_____

_____

_____

_____

_____

17. **What do you think has most helped your recovery?**

_____

_____

_____

_____

_____

18. **What do you think has most hindered your recovery?**

Recovering from Abuse - What Helps or Hinders Recovery?

This section asks questions about all areas of your life, to see what things helped you and also what didn't help. These actions might not directly relate to your experience (s) of abuse but have affected it anyway. If an area doesn't apply don't fill in the box. You can skip this section if you choose.

19. **Have relationships with family, friends and others influenced your recovery? If so, how?**

20. **Have legal actions, such as reporting the crime to the police, influenced your recovery? If so, how?**

21. **Has counselling or other health related actions influence your recovery? If so, how?**

22. **Has your personal philosophy, spirituality or religion play a role in your recovery? If so, how?**

23. **Has your care of your body, for example through sport, healthy eating or massage, influenced your recovery? If so, how?**

24. **Has creativity play a role in your recovery? If so, how?**

Recovering from Abuse - What Helps or Hinders Recovery?

25. **Has campaigning or politics affected your recovery? If so, how?**

26. **Has your expression of who you are, including your gender or sexuality, influenced your recovery? If so, how?**

27. **Have your career choices influenced your recovery? If so, how?**

28. **Have any hobbies or interests played a role in your recovery? If so, how?**

29. **Is there anything you haven't tried yet that you think might help your recovery?**

What you knew/know about childhood sexual abuse as a child and as an adult

With these questions I want to understand how society affects survivors, as children and as adults. You can skip this section if you choose.

30. **As a child what were you told, in general, about child sexual abuse?**

31. **Now as an adult do you think society helps or hinders recovery? Please explain why**

Anything else

I may have missed something out that matters to you. Please tell me here. You can skip this section if you choose.

32. **Anything else that has helped you?**

33. **Anything else that has hindered you?**

34. **Anything else you want to say about the survey?**

Thank you!

Thank you so much for taking the time to fill in this survey. I am going to analyse the responses and see whether there are any patterns or themes that can be used to help people just starting on their recovery journey.

The results will be published on my website: www.clairecunnington.com and in open access academic articles.

I will also try to lobby policymakers, such as the government and NHS, if we have identified any actions that they can help with.

35. **If you are happy to take part in further research, which might be an interview, please enter your email address here. I may not be able to interview everyone who volunteers.**

Appendix Two –Tweets, Emails and Organisation Information Sheet

Tweets

General

Are you an adult recovering from child sexual abuse? Please share what you have learned http://bit.ly/recoveringcsa and retweet #CSA #CSE #csasurvivors

Does society help or hinder your recovery from child sexual abuse? What do you think? Please tell me http://bit.ly/recoveringcsa and retweet #CSA #CSE #csasurvivors

Is recovery from child sexual abuse possible? What do you think? Please tell me http://bit.ly/recoveringcsa and retweet #CSA #CSE #csasurvivors

Men

How do men experience recovering from child sexual abuse? Please tell me http://bit.ly/recoveringcsa #CSA #CSE #MEN

Is it harder for men to recover from child sexual abuse? Please tell me http://bit.ly/recoveringcsa #CSA #CSE #MEN

Older People

What were attitudes towards child sexual abuse like in the 1940's, '50's or '60's? How did it affect your experience of abuse? Please tell me http://bit.ly/recoveringcsa #CSA #CSE

Emails

I also drafted generic emails and altered the first paragraph for specific agencies. Again examples are below:

General Email (with attached Research Information Sheet)

Hello

I'm emailing to ask you to publicise my survey into recovery from childhood sexual abuse. Often research into recovery either looks at specific treatments or unchangeable personality characteristics. There is very little research into recovery in a holistic sense and often engagement with people who have experienced abuse is rather limited. I am a survivor myself and have decided to fill these gaps in the research by doing it myself.

In my Wellcome Trust funded PhD I am aiming to learn from other people who have experienced abuse to create freely available resources for professionals and individuals. I have attached my survey (subject to revision after piloting) and research information sheet. There are videos explaining the research at the following website:

https://clairecunnington.com/recovery-from-childhood-sexual-abuse-survey/

The survey is not live yet, but when it is, will you help me by publicising it on your website or social media? Also, if you are aware of anyone who would be willing to pilot the survey I would be happy to hear from them. I will, of course, share the results with you and credit your involvement in my PhD as well as any resulting academic publications.

Thank you

Men

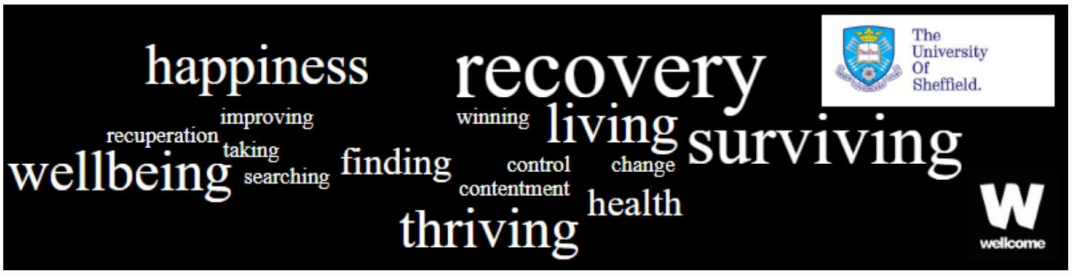
Hello

I'm emailing to ask you to publicise my survey into recovery from childhood sexual abuse. Often research into recovery either looks at specific treatments or unchangeable personality characteristics. There is very little research into recovery in a holistic sense and often engagement with people who have experienced abuse is rather limited. There is a particular gap in research with men who have experienced abuse. I am a survivor myself and have decided to fill these gaps in the research by doing it myself.

Older People

Dear

I'm emailing to ask you to publicise my University of Sheffield survey into adult recovery from childhood sexual abuse. Often research into recovery evaluates specific treatments. There is very little research into recovery in an holistic sense and often engagement with people who have experienced abuse is rather limited. In my Wellcome Trust funded PhD I am aiming to learn from people who have experienced abuse to create freely available resources for professionals and individuals. My research initially involves a qualitative survey followed by targeted in-depth interviews. The focus is on recovery in general but I also have a specific interest in male and older people's experiences of recovery. There is a particular gap in research with older people who have experienced abuse; specifically in their understanding of their experiences and their concept of recovery. Therefore, I am asking agencies involved with these groups for help.



Recovering from Childhood Sexual Abuse

About the Project

This is a Wellcome Trust funded PhD project at the University of Sheffield that aims to consult people who have experience abuse to create resources for other survivors. The research takes a salutogenic approach, looking at what moves a person towards wellness, rather than illness.

Significance of the Research

There is no similar research. This research is survivor led and focusses upon the recovery knowledge gained by the survivor of abuse. It has received support from the Wellcome Trust, University of Sheffield and MPs, including Sarah Champion and Tom Watson. It has undergone a rigorous ethical approval process at the University of Sheffield.

Participants

The project aims to recruit adult participants from different groups; both genders and diverse ages to ensure the results are applicable to survivors at whatever point in life they decide to deal with an abusive past.

Research Methods and Results

Initially an online survey will be utilised to identify themes with interviews following to expand the data.

The results will be shared with professionals, reported in academic journals and the media as well as being freely available for survivors.

Contact Details: claire.cunnington@sheffield.ac.uk

Videos and link to the Survey: http://bit.ly/recoveringcsa

Appendix Three – Interview Information Sheet and Consent Form

Participant Information Sheet
From Victim to Survivor: How do people negotiate and manage their identity when recovering from Child Sexual Abuse?

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

About the Research
There is lots of research into the negative effects of child sexual abuse (CSA) or evaluating specific treatments and this is useful but my research takes a different approach. I am looking at what helps us recover in a more general way because I think that recovery is about more than just counselling or therapy (although that can be useful). I want to ask other CSA survivors for their opinions as we are the experts in our own lives.

This research has two aims:
1) to understand how people deal with their experience(s) of childhood sexual abuse
2) to explore the role of society in the recovery process

Why have you been chosen?
You were chosen because you filled in my online survey about recovery from CSA and said that you might be happy to contribute further. I am aiming to interview no more than 20 people, all recruited from the survey.

Taking part
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form) and you can still withdraw at any time. You do not have to give a reason.

What will happen if you take part?
You will take part in an interview where questions will be asked to explore your experiences of recovery from CSA. This will be audio or video recorded with your permission. The interview will last approximately an hour and can be either face to face or online. You will not need to discuss any specific details about the abuse you experienced as the focus is on recovery. However, you can talk about whatever you feel is relevant to the subject.

Will you be recorded, and how will the recorded media be used?
The audio and/or video recordings of your interview will be used only for analysis and audio only for illustration in conference presentations and lectures. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

What are the possible disadvantages and risks of taking part?
Considering the subject matter the interview might be upsetting and if you want to you can stop the interview at any time.

What are the possible benefits of taking part?
Whilst there are no immediate benefits for those people participating in the project, it is hoped that this research will identify actions that could help others recovering from CSA and, if applicable, feed into appropriate organisations.

What happens if the research study stops earlier than expected?
In this unlikely event I will inform you and explain why.

What if something goes wrong?
If you want to complain you can contact me (Claire.cunnington@sheffield.ac.uk) and I will investigate for you. Alternatively you can contact my academic supervisor Dr Tom Clark (t.clark@sheffield.ac.uk).

If you are unhappy with the response to your complaint you can contact my Head of Department, Professor Kate Morris (kate.morris@sheffield.ac.uk) who will then escalate the complaint through the appropriate channels.

Confidentiality
All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any reports or publications.

What will happen to the results of the research project?
It is hoped that the results of the research will be published in an academic journal and it will also be available on the following website: www.clairecunnington.com

You will not be identified in any report or publication.

Due to the nature of this research it is very likely that other researchers may find the data collected to be useful in answering future research questions. We will ask for your explicit consent for your data to be shared in this way and if you agree, we will ensure that the data collected about you is untraceable back to you before allowing others to use it.

Who is funding the research?
My PhD and this research is funded by the Wellcome Trust (https://wellcome.ac.uk/).

Who has ethically reviewed the project?
This project has been ethically reviewed by my department, Sociological Studies and has gone through the University's Ethics Review Procedure.

Contact for further information

Claire Cunnington
c/o Department of Sociological Studies
Elmfield, Northumberland Road
Sheffield, S10 2TU
Claire.cunnington@sheffield.ac.uk
Tel: 07890 686 126

Dr Tom Clark
Department of Sociological Studies
Elmfield, Northumberland Road
Sheffield, S10 2TU
t.clark@sheffield.ac.uk
Tel: 0114 222 6446

You will be given a copy of the information sheet and a signed consent form to keep. Thank you for taking part in this research.

Date: 1/9/17

Participant Consent Form

From Victim to Survivor: How do people negotiate and manage their identity when recovering from Child Sexual Abuse?

Name of Researcher: Claire Cunnington

Participant Identification Number for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated 1st September 2017 explaining the above research project and I have had the opportunity to ask questions about the project. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.
   Tel: 07890686126 or email Claire.cunnington@sheffield.ac.uk ☐

3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. ☐

4. I agree for the anonymised data collected from me to be used in future research ☐

5. I agree to take part in the above research project. ☐

_____	_____	_____
Name of Participant (*or legal representative*)	Date	Signature
_____	_____	_____
Lead Researcher	Date	Signature

Appendix Four – Interview Questions

Recovery (for people who thought it was not possible)

Why do you think recovery is not possible?

Is there anything that could be done to change your mind?

Society

Do you think anything should change about the way we talk about abuse?

Do you think anything should change about the way we treat abuse victims?

Do you think anything should change about the way we treat male abuse victims?

What do you think children should be told about abuse, if anything?

Medicine (including counselling)

What's been good about the medical help you've had?

What could be improved?

Is there anything you wish they'd said or done?

Is there anything missing from medical treatment?

Legal - didn't report

Is there anything that could be changed to encourage you to report the crime?

Legal - did report

What did you want to achieve when you told the police?

What was good about the legal process?

What could be improved?

Is there anything missing from the legal process?

Career

How do you think your working life has affected your recovery process?

Is there anything employers or the government could do to help victims and survivors in the workplace?

Campaigning

Why do you think campaigning is so important to you?

Religion - Positive Experiences (NOT including people abused by priest etc)

How has religion been involved in your recovery journey?

Have you ever doubted your faith because of your experiences?

What should religious organizations do in response to the growing awareness of CSA?

Religion - Negative Experiences (NOT including people abused by priest etc)

Why do you think you couldn't find your answers in organized religion?

What should religious organizations do in response to the growing awareness of CSA?

Creativity

Would you be willing to share some of your writing/art and tell me about it?

How does it benefit you?

Body

Do you feel that the abuse you experienced has affected your relationship with your own body? If so, how?

Tell me about how *(specific)* exercise helps you?

Is there anything that could be done to help you care for yourself better?

Identity/Sexuality

Tell me more about….

Relationships and Friendships

Do you think your experiences have affected your relationship and friendship choices?

Family

Is there anything you wish your (non-offending) family had done or said when you were a child?

Is there anything you wish your (non-offending) family could do now?

Finally

Imagine someone just starting to face their past experiences of abuse. What do you want them to know about recovering?

Imagine you are sat in front of people in power. What one thing do you want them to change?

In any report or article about this research I will not be using your real name. Would you like to choose your pseudonym? If, so please tell me what name you'd like me to refer to you by in the anonymised report?