

# SurvivorScotland

a survivor-centred strategic approach  
for survivors of childhood sexual abuse

Conference Report  
2007



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**Conference Report  
SurvivorScotland Conference  
Airth Castle  
28 February 2007**

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## Introduction

Scotland is the first country within the UK to have a national strategy for adult survivors of childhood sexual abuse and this report summarises **SurvivorScotland**, the first national conference on the subject.

The day had a dual purpose. It was an opportunity for people from all over Scotland to hear at first hand about national initiatives that are already under way. It also gave participants the opportunity to sign up to becoming part of a national network that would roll out the strategy in local areas. In particular, the conference placed a strong emphasis on partnership working and on the importance of identifying and addressing the wide range of support needs that survivors have.

The turnout was remarkable. The conference was intended for 150 participants but, due to demand, was extended to 330. Delegates came from a diverse range of backgrounds, and presenters and facilitators, many with vast experience in the field, put in considerable effort to make the event a success. They were joined by many survivors who all talked openly and honestly about their own experiences and about their enthusiasm for the strategy as a gateway to the recovery process. Lewis Macdonald, Deputy Minister for Health and Community Care and Marilyn Livingstone, MSP, Chair of the Parliamentary Cross Party Group on Survivors of Childhood Sexual Abuse also gave their support. Survivors have since expressed how positive the media coverage has been in terms of their recoveries. This shows that we are reaching out to people who otherwise would not have chosen to be part of official support systems.

The SurvivorScotland website which was demonstrated at the conference is in the final stages of development and will further help to take this flagship policy forward. It will become the conduit for exchanging and developing good practice. This conference report will be one of the first items to be posted there.

The report itself is not extensively edited and replicates the key points speakers made. It was heartening to see there are so many people who are willing to work with us to make the strategy a reality. We now all need to keep up the momentum and to ensure that everyone does something locally to make a difference. As you read the report please consider what difference you can make and how you might go about it.

## Welcome

**Jean MacLellan**, Head of the Scottish Executive's Adult Care and Support Change Team, and **Marilyn Livingstone MSP**, of the Scottish Parliament Cross Party Group on Survivors of Childhood Sexual Abuse, opened the conference and welcomed everyone. They detailed the journey that had brought us to this important day, and thanked participants for the overwhelming response which showed their willingness to participate and make the difference.

**Lewis MacDonald, the Deputy Minister** for Health and Community Care sent the following message:

"Due to Parliamentary commitments, I cannot be with you today for this milestone event in the progress of the National Strategy for Adult Survivors of Childhood Sexual Abuse, but I am delighted to know that the SurvivorScotland conference has had such an overwhelming response. This first conference on the National Strategy is a major opportunity to build on networking, exchanging knowledge and raising awareness.

The strategy was developed to improve the quality of, and access to services for adult survivors in Scotland. The measures that I outlined when I launched it in September 2005, demonstrated the Scottish Executive's commitment to ensuring that the needs of survivors of sexual abuse are recognised and met. I am pleased that this continued commitment on behalf of the National Reference Group has meant that we have seen real progress in a number of key areas. In addition to inviting organisations to apply to our Fund to develop services, we are also working on an independent website which will help underpin the strategy, develop networks and provide a help mechanism on personal and professional levels. Public awareness raising has been a real priority – and the very fact that there are so many of you here today will I'm sure encourage survivors to feel that they are being listened to and will give the general public an opportunity to understand what is for many people a very difficult issue.

The Cross Party Group in the Scottish Parliament achieved real success in breaking the silence that has existed so long on this issue. I am confident that by working together adult survivors, professionals, voluntary organisations, social work, health and other agencies can continue that process, with continuing support from Scottish Ministers and MSPs.

I wish you every success in what promises to be an exciting and interesting event today. I hope that we can take forward the benefit of experience and what people can learn from each other, to help us forge stronger networks which will make a real and lasting difference for adult survivors in Scotland."

# **National Strategy for Survivors of Childhood Sexual Abuse: Progress so far**

*Presentation: Anne Macdonald and Sarah Nelson , Lead Professionals, National Strategy for Survivors of Childhood Sexual Abuse, Scottish Executive Health Department  
Parallel Session – Anne MacDonald and Jeannie Hunter*

Anne and Sarah gave a brief history of the strategy and its origins within the Cross Party Group and Short Life Working Group, of which they have both been members. They set out the survivor-centred vision for the future as one which recognised the wide range of abuse suffered, and acknowledged the professional difficulties encountered by staff in addressing survivors' needs and in attempting to 'mainstream' services for survivors.

Jeannie and Anne's session went into further detail about the strategy which is co-led by officials in the Scottish Executive Adult Care and Support – Change Team, two Lead Professionals and a National Reference Group.

The first year has focussed on five areas:

## **1. Development of a website and increased networking**

The website will be a tool for communication, and will increase networking between survivors and those working with survivors. It will be a space for survivors to tell their stories and seek information on getting help, as well as giving the latest news about survivor-related events. There will also be a section on the latest research and policy.

## **2. Data collection**

This refers to the way survivors needs are identified within a wide range of service settings. For instance, only 1% of Child Sexual Abuse histories are currently documented in health records. It is hoped that some pilot projects which are in the process of being developed will add to the data currently available.

## **3. Sexual Abuse Service Development Fund (SASDF)**

The SASDF is an important strand of the overall strategy, which not only seeks to pump prime new developments, but also to ascertain what gaps in service provision exist across Scotland. The eligibility guidelines for the SASDF are broad to encourage a wide range of innovative applications for

this fund, involving partnerships between the statutory and voluntary sectors.

#### **4. Prevention of sexual offending**

The Strategy is committed to contributing towards preventing sexual offending as stipulated by Recommendation 26 of the Cosgrove Report (Reducing the Risk: Improving the Response to Sex Offending. Report of the Expert Panel on Sex Offending, 2001). This will be through education programmes targeted at changing the behaviour of perpetrators and potential perpetrators as well as by looking into other behaviours that can be linked to abuse. Work on this area will have an emphasis on young offenders.

#### **5. Public awareness raising and PR campaign**

Its primary aim is to focus on reducing stigma and increase understanding of the scale of the problem. The website will be a key element in awareness raising, and will be aided by the distribution of a public information leaflet. Media publicity also surrounded the conference, which included pieces in The Scotsman and Scotland Today.

The presenters emphasised throughout the need for sustaining and continuing progress on key priorities, widening the membership of people wishing to be involved, and the importance of more seminars & events across Scotland.

Discussion among those attending the parallel session stressed the need to raise public awareness of the strategy through the media, and to inform survivors of the services available and the need for improved development and coordination of all services for survivors, especially those abused in care.

### **Myths and Realities**

*Dr Alistair Wilson, Consultant Psychiatrist, Gartnavel Hospital, Glasgow*

Alistair made clear that there are widely different prevalence rates noted by researchers on childhood sexual abuse (CSA) as well as varying prevalence between different populations. The effects of CSA vary from person to person and he examined how trauma affects the brain's interaction, especially that of the hippocampus, with the body, to produce bodily sensations instead of explicit narrative memory.

The research evidence presented by Alistair indicated that if self-care and preventative services were developed for this under-diagnosed group the benefits to the individuals concerned would be considerable.

He took 13 robust studies of seriously ill men and women and found that the rates of childhood sexual abuse were conservatively upwards of 30%. Much of this abuse takes place in families and the subsequent trauma is manifested in a range of behaviours from treatment resistant depression, somatic symptoms such as chronic pain, alcohol and drug dependency (to blot out the experience) through to full blown psychosis. Alistair's presentation made clear the consequent extensive demands that are placed on primary and psychiatric care services.

Finally, he stressed the need for education, training, research, improved treatment techniques and support for survivors.

### **Parallel Session: Mindfulness-based approach to trauma**

In his workshop Alistair detailed his work with the Mindfulness Based Cognitive Therapy (MBCT)

This centres on:

- An individual's internal experiences (body sensations, thoughts and moods);
- An individual's external experiences (interactions with others, actions in the world); and
- The interplay between the two.

The aim of the programme is to allow participants to step out of the mental reactions that create difficulties and to equip them to deal with stress and factors that hurt them.

MBCT when geared towards depression, is an 8 week long programme. A number who have attended his groups in the past have suffered abuse, although the programme he runs has been developed for individuals suffering from depression. The MBCT programme is a group work model, and groups for those suffering from depression have approximately 8-12 members at a time.

Discussion following the presentation centred on how this course could be adapted for survivors of trauma and whether this might have a different effect on the participants than when the participants are suffering from depression. Alistair suggested that a programme which addressed abuse and trauma may have to run for perhaps 6 months rather than 8 weeks and the group size would need to be reduced to about 6 members. It

would be important not to have less than 6 as this could make the group work too intense. The length of each session would also need to be extended for a trauma course from the 2 – 2 ½ hours that each session centred on depression usually lasts.

## **Working with Homeless Young Women with Complex Needs**

*Rosina McCrae, Director, SAY Women, Glasgow*

“The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery is based upon the empowerment of the survivors and the creation of new connections”.\*\*\* (Herman, 1992)

Rosina opened by describing the work of SAY Women. The organisation offers safe, supported accommodation and related services for single young women, aged 16-25, who are homeless or threatened with homelessness and who have disclosed childhood sexual abuse, rape or sexual assault.

Young women can stay in the accommodation for up to 18 months. After this time service users are offered a follow on service of housing and resettlement support. This is crucial as the young women are particularly vulnerable during resettlement and open to targeting by those who had previously abused them. SAY Women also offers support to both young men and young women living in other housing projects as well as consultancy to staff, thus ensuring that those working alongside individuals in housing projects are sufficiently trained and can offer consistent support.

Rosina spoke of the many issues that the accommodation tenants and resource service users are dealing with. These include high percentages suffering from addiction problems, self injury and suicidal thoughts. It is never just one issue that these women have to deal with, but many layers. SAY Women base their work and understanding of the needs of the young women around Dr Judith Herman’s model of the 3 stages of healing. These stages are

1. Establishing safety;
2. Remembering and mourning;
3. Reconnection

Rosina stressed the importance for the women they look after of feeling safe before they can begin to deal with their past experiences. The accommodation and support services that SAY Women provide offer such safety.

Two service users, Lorna and Jenna, shared their stories. Their early lives had both led to them staying in accommodation provided by SAY Women. Both stressed the important role SAY Women's services provided, in particular the manner in which the services were delivered and tailored closely to each person's needs and ways of communicating.

Rosina concluded her presentation by emphasising that although sexual abuse affected both men and women, that both nationally and internationally, girls and women still suffered more heavily from many forms of gender violence.

\*\*\* Herman, J. 1992 Trauma & Recovery

# **Emerging Issues for Male Survivors of Sexual Abuse**

*Martin Henry, Executive Officer, Lothian & Borders Child Protection Office*

Martin challenged the mythologies surrounding male survivors of childhood sexual abuse. In particular, the following:

- The under representation in prevalence figures of male sexual victimisation
- The idea that male victims become sexual abusers
- The belief that same sex abuse makes male victims become gay
- The notion that gay men present a risk to children

## **Problems with prevalence**

Martin cautioned against blind acceptance of the differences suggested by prevalence figures between the incidence of sex abuse among males as opposed to females. The studies, he believes, are confounded by factors which lead to under-reporting and the questions asked frequently do not lead to disclosures from survivors, due to the nature of the question and how/when/where it is asked.

## **Male victims become sexual abusers**

There is no doubt that some abusers have been abused themselves. However, this does not imply the reverse; that survivors of CSA will go on to abuse others.

## **Same sex abuse makes male victims become gay**

Martin discussed:

- Society confusing the abusive experience with gay sexuality
- Arousal and the myth of complicity
- Masculinity and homophobia

The arousal and complicity myth implies that if the victim is aroused during abuse then this could not have constituted abuse. Instead, such arousal indicates complicity in the abusive act and therefore indicates homosexuality. This myth is exacerbated by perpetrators, who tell their victims that their arousal indicates their willingness and consent to the sexual act. This explanation lives on with the survivors into their adult lives.

## **Gay men present a risk to children**

If sexually abused boys become abusers and also become gay, then the next myth proposed is that gay men present a risk to children.

Martin believes that these myths largely stem from society's conception of masculinity. He analysed how masculinity has been constructed to ensure conformity to a code of values and behaviours which not only suppresses survivors' ability to disclose abuse, but also perpetuates society's attitude towards survivors and increases the difficulties survivors have in dealing with their abuse. He also looked at the particular issues presented for those men who had been abused whilst in institutions.

Martin concluded by arguing that we all need to reclaim masculine values and reconstruct the male identity and reinstate positive male values. Thus endurance could be replaced by steadfastness, forbearance by fortitude, aggression by courage, betrayal by honour, arrogance by determination, secrecy by loyalty and insecurity by self-assuredness.

## **Parallel Sessions**

### **Initiatives to prevent sex offending**

*Tink Palmer, Director, Stop it Now! UK*

Tink opened her presentation by explaining the aims and work of Stop it Now! It is an organisation that raises community awareness of childhood sexual abuse, and offers a telephone helpline for those concerned about their own or another's sexual behaviour. The organisation is currently active in England, Wales, Northern Ireland and the Republic of Ireland, and looking to set up in Scotland. It aims to target abuse and potential abusers, either directly, or through concerned family and friends of abused children and parents of young people with sexually worrying behaviour.

Stop it Now! aims to prevent childhood sexual abuse, Tink adapted Finkelhor's model of the motivation of an abuser (taken from D. Finkelhor (1985) Child Sexual Abuse: New Theory and Research). Stop it Now! aims to intervene before perpetrators shift from having the motivation to abuse, to actually abusing a child.

From June 2002 to May 2005 the helpline received 4013 calls. 45% of these have been from abusers and potential abusers concerned about themselves, 30% have been from family, friends and other adults concerned about another adult and 5% from parents, carers and adults

concerned about a young person. The remaining 20% were from callers outside the organisation's target groups.

There are a substantial number of pilot projects running in England, Wales and Northern Ireland. After 2.5 years of these projects, it is clear from evaluations that there is an increase in awareness of child sexual abuse issues in the local populations. It was important that local groups had close contact with local media in order to get their message out to the public.

Attendees at the parallel session discussed working with perpetrators, the introduction of Multi-Agency Public Protection Arrangements (MAPPAs) in Scotland and the importance of partnership working in preventing sexual abuse including safeguarding, public protection and criminal justice and the difficulties of 'outing' someone close to you as an abuser.

Tink stressed in conclusion that we all need to consider what we ourselves can do to make a difference.

## **Early trauma histories and mental health: survey of in-patients**

*Dr Linda Treliving, Consultant Psychiatrist in Psychotherapy & Alison Lowit, Researcher, Royal Cornhill Hospital, Aberdeen*

### **Introduction**

Research indicates that prevalence rates for Early Trauma among psychiatric patients are significantly higher than in the general population. There is a high association between early trauma and personality disorders. The primary research aims of this study were to determine an accurate estimate of the rate of childhood sexual, physical and emotional abuse (early trauma) amongst clients in contact with mental health services in Aberdeen, and to determine the range of psychological distress likely to be associated with early trauma in this population. The secondary research aims were to estimate the prevalence of personality disorder amongst clients in Aberdeen, and correlate this with early trauma. Also to determine the rate of recording by health care professionals in Aberdeen of early trauma as a possible factor in adult mental illness.

### **Method**

A consecutive recruitment/assessment cross-sectional study was carried out on adults within the Aberdeen mental health services. Three validated questionnaires were used:

*The Childhood Trauma Questionnaire (CTQ); The Symptom Checklist 90 Revised (SCL-90-R); The Personality Disorder Questionnaire (PDQ-4).*

Due to the participants' preference, rather than filling out the questionnaires themselves, they completed the forms via a structured interview.

## **Results**

- 90 of the 136 psychiatric inpatients had experienced moderate/severe early trauma (66%), this included 48 out of 74 males (64%) and 42 out of 62 females (67%). 60 of the 90 participants who had experienced early trauma had this recorded in their psychiatric medical records (66%).
- 95 of the 136 participants had significant personality disturbance (70%), this included 58 out of 74 males (78%) and 37 out of 62 females (60%). 20 of the 95 participants who have significant personality disturbance have a recorded diagnosis of it (21%).
- 70 of the 95 participants with significant personality disturbance had experienced moderate/severe early trauma (74%), this included 43 out of 58 males (74%) and 27 out of 37 females (73%).

These results showed no significant differences between genders. They cannot however be taken on face value, as epidemiologically men and women in the overall population report different symptoms and severity of symptoms. Such differences may distort interpretation of the results. Therefore, the scores were adjusted to reflect that. They were then compared and significant differences between the genders became apparent.

## **Conclusions**

There are very high rates of early trauma amongst mental health inpatients in Aberdeen. A high percentage have significant personality disturbance. Early trauma is associated with significant personality disturbance. Male inpatients with early trauma report higher symptom levels than similar female inpatients when gender differences in reporting of symptoms are taken into account. Female inpatients regardless of presence or absence of early trauma report similar symptom levels. Males with early trauma reported significantly higher symptom levels for all symptoms measured by the SCL-90-R than males without early trauma.

## **The clinical implications of this study**

- A diagnosis of personality disorder is known to complicate treatment regimes. However, this complication could have its origins in an unrecognised history of early trauma.
- It is likely there is under-recognition of comorbid diagnoses involving personality disorder.
- If a patient presents with symptoms of personality disorder it is crucial to check for a history of early trauma – a treatment regime may be more effective if it also tackles problems directly attributable to early trauma.

Discussion with Dr Treliving and Alison after their presentation included :

- The methodology of the research;
- Explanations for the difference in results between males and females;
- Patients'/clients' frustration at not being asked about early trauma;
- The need for more research on mental health, yet the difficulty of getting mental health studies approved by ethics committees;
- Suggestions for further research included doing comparable work with suicidality; looking at the effect on symptoms of the type of abuse and age at which is abuse is experienced; and doing similar work among the prison population.

## **Self-harm, abuse and the psychotic experience**

*Ron Coleman, Working to Recovery, Fife*

Ron described the aims and background of the Hearing Voices Network which was established in 1991.

Many people he works with who hear voices have been abused. To illustrate the role of heard voices, Ron drew a voice diagram where the voices are represented by concentric circles, with the voice of the abuser at the centre. Through his work, Ron aims to make the voice of the abuser less important, less central.

Ron pointed out that survivors can find it hard to believe that the abuse is not their fault. This disbelief occurs because children are groomed by their abusers to feel complicit.

It is important that people have a choice about going on the journey of recovery and also to recognise that doing this may involve them in more pain for a while. Many people believe psychosis is not suited to "talking treatments". Ron however believes that these can help, especially where pharmaceutical treatments are not working. This may be because the

psychosis is not rooted in issues to do with genes nor dopamine receptors, but is a response to the abuse, and the person experiencing psychosis is hearing the voice of the abuser.

Ron described simple coping strategies and the importance of thinking of imaginative responses. For example, he talks to the voices that people hear and gets the voices to talk to each other. These voices can be not only that of the abuser but also of supportive people, or a "younger self" of the client. One of the supporters may be able to speak to the voice of the client's younger self, and help that self, where that voice cannot or will not listen to Ron.

Attendees at the parallel session discussed treatment, services and the current problems with both. One participant made the point that a client may not wish to disclose to everyone, or a psychiatrist may choose not to write down the history of CSA, because case notes are available to all within the service, and thus not confidential. While Ron does keep notes, he hands these over to the client at the end of their time with him. He always sees himself as the facilitator, rather than the therapist, in order that the client really owns the process.

## **Findings from the National Awareness Training Project**

*Sue Hampson, Person Centred Counselling and Training Consultant*

Sue began by noting that research carried out by Sarah Nelson in 2001 into the mental health care needs of adult survivors established that there was a pattern of poor care responses and a fear by staff to openly discuss patients' experiences with them. These concerns prompted the beginning of a national awareness training project in which both front line staff and managers were targeted.

The training programme was devised to address concerns through building self confidence for front line staff, enabling staff to develop safe, sensitive ways of exploring a sexual abuse history, encouraging safe and helpful responses to disclosure and enabling managers to effectively support staff working with adult disclosures. The training ran from 2005 to 2006 in 8 locations throughout Scotland. Overall, 300 people received training.

The main feedback received from all of the training courses was that work with survivors is a huge part of frontline workers' roles and this is not acknowledged, or if it is, is underplayed by organisations throughout Scotland. Staff felt that they were unsupported in dealing with CSA and that it was important that the issues surrounding disclosures of abuse and the issues surrounding CSA for frontline workers were acknowledged.

Time and support need to be given to front line staff so that they can carry out their work.

Those who attended the training also expressed a need for access to support and counselling for staff, feedback and understanding from colleagues, organisational policy for CSA work, regular support and supervision and training throughout their organisation starting from the top.

Sue explained that staff disclosures were high from participants on the course and it was therefore important for organisations to recognise the prevalence of survivors within the workforce, establish a safe working environment, actively promote work cultures where staff are able to identify themselves without fear of discrimination and to put in place clear and accessible support systems that become a meaningful part of the work environment.

There were particular issues for men in training on CSA. Only 11% of front line staff and 20% of managers that attended the course were men. There were also men who left the course as they were having difficulty with its content. There were a number of re-occurring themes from men who attended the training. These were firstly that it was difficult for men to talk to other men about being abused and secondly that it was very difficult to show their vulnerability. Such issues are important to take into account when considering how male survivors may present symptoms. There is a need to consider male workers' fear of vulnerability and how that may make them stop short of addressing male clients' vulnerability.

Following the training, staff were contacted 6 months later to evaluate how the training had benefited them. The feedback was extremely positive and paradoxically staff now stated they were more confident in the knowledge that there is no magic solution to working with disclosures.

Discussion among attendees included concern that staff are sometimes advised to immediately refer clients to experts when more spontaneous, humane, responses could be of equal value. It was also noted that fewer men than women disclose and that the establishment of male specific counselling is important.

# Medically Unexplained Symptoms in Childhood Sexual Abuse(CSA) Survivors

*Dr Sarah Nelson, Professor Julie Taylor and Professor Norma Baldwin,  
University of Dundee*

Sarah presented research conducted by herself and Professors Julie Taylor and Norma Baldwin of Dundee University. They carried out a review of the research literature on medically unexplained symptoms (MUS) in people with sexual abuse histories and mental health symptoms:

The main types of Medically Unexplained Symptom (MUS) include:

- Irritable bowel syndrome & other gastro-intestinal complaints
- Chronic pelvic pain/severe premenstrual pain
- Fibromyalgia & other chronic pain
- Respiratory conditions, wheezing, throat problems
- Non-epileptic seizures

*The study aimed to find out how "survivors with MUS and mental health issues have been identified and sampled; the key findings of research literature; theories used to explain inter-connections; any interventions and treatments for the CSA group; gaps in knowledge or understanding which require further research...and to make recommendations."*

96 studies were analysed plus 27 reviews or discussion papers and was largely a medical literature. CSA survivors were the main focus in only 9 studies. Instead, the symptoms that people were presenting with were usually the focus. There were only three qualitative studies and three on males. Most researchers were medical specialists rather than experts in CSA, with few collaborations with CSA support agencies.

Most studies confirmed that people with CSA are at higher risk for MUS, especially for GI and chronic pain. The more serious the abuse, the more serious the impact on MUS, disability, sick days and healthcare use. Childhood physical abuse and adult physical assaults were also significant influences on MUS. Recommendations stressed general good practice including detailed history-taking, respectful listening, referral for psychological therapy.

Theories which try to explain the links between MUS and CSA include

- somatisation: where emotional stress translates into bodily symptoms;
- severe trauma causes changes in the central nervous system increasing vulnerability to pain and infections;
- depression and anxiety lead people to amplify their physical symptoms;

- injury and infection through assaults directly influence symptoms, especially chronic pain.

The main problem with existing research was found to be *“An overriding concern with testing which risk factors contribute to which outcomes (this) has produced a repetitive (and competitive) body of case control studies, which have failed to identify helpful interventions for sexually abused people with MUS”*.

Studies often used variables which do not match survivors’ experience, there was little collaboration with specialists in CSA, the voices of survivors were rarely heard and a lack of ethical safeguards or support for the survivors involved. “Somatisation” concept was problematic, prejudicial and ill defined.

The study made the following recommendations for future research

- CSA survivors must be the primary focus of research.

Research needs to be:

- Geared to exploring causes and relieving suffering;
- Open minded, free of value judgments re. “somatisation”;
- Collaborative between medical specialists and CSA specialists for design and interpretation of studies.

There is a need for:

- Qualitative research with adult survivors with MUS, to explore health history, abuse history, experiences of health system, and interconnections;
- Studies of male survivors with MUS;
- Case histories, exploring medical records and attitudes of clinicians;
- Research into direct physical effects of violence and injury, and into “body memories”, including collaboration with torture research experts;
- Collaborative research with voluntary sector support agencies;
- Prospective studies with children & young people

These recommendations could result in the design of good-practice interview schedules for MUS patients and an increase in respect and dignity of CSA survivors. They could inform design of therapeutic interventions which could be piloted and evaluated, increasing informed knowledge, understanding of causes, and long-term research collaboration.

Discussion among attendees at this parallel session centred on how survivors carry the ‘shame’ of abuse in a variety of ways. They also

discussed the danger of medical professionals dismissing too readily symptoms with which survivors present and the need for GPs to give more time to addressing survivors' needs holistically. Advocacy and support for survivors also needed to be improved.

## **Closing remarks**

Jean MacLellan thanked all the speakers and presenters, the conference organisers and indeed everyone who had attended in whatever capacity for making the day so successful in taking forward a strategy that would shed light in dark places.

The first sessions from Marilyn, Anne and Sarah had been interesting, because of the clear evidence of progress in circumstances that all acknowledged have not been easy. There was considerable goodwill to keep going on the journey, but it was important to recognise that there is a long road to travel.

The most challenging aspect of Alistair's presentation for her personally, had been his question: why is major research not undertaken in this area?

Rosina's contribution and the personal testimonies from survivors made it clear that intervention is a long-term necessity, but this can be based on a few relatively simple principles like believing and listening, and sticking with someone through 'thick and thin'.

Martin had said a very great deal on masculinity, 'identity theft' and potential loss of spiritual values.

Jean said that everyone would take their own memories of the workshops, but that for her, attending Tinks' workshop, Stop It Now, reminded her that Scotland is the only country within the UK that has a Strategy. That means it is incumbent on us to be generous to our colleagues in other parts of the UK in sharing the challenges we have faced, and to building up a joint agenda.

She closed the conference with contributions from her colleague, Jeannie, and Carol, who is a survivor. What they hoped to do for everyone was to help them to focus on what their own personal contribution to the Strategy might be.

*Jeannie Hunter works in the Scottish Executive as a Policy Officer on the National Strategy and Carol is a service user representative on the Cross Party Group and National Reference Group*

Carol and Jeannie used the following image to illustrate the quote from a survivor describing the effects of abuse:

“The thorn is planted as a vulnerable child and you know no better.

Then it grows and twists inside, and as an adult when you attempt to live your life it rips you apart from inside.”



Jeannie and Carol shared their personal experiences of becoming involved in the strategy and the challenges involved. Jeannie said that above everything else, what she had come to understand was that all of us, whether we are aware of it or not, will know someone who has been abused, therefore the need to address this issue and to raise awareness is paramount.

Setting the remit for the Reference Group had been no easy task. Although everyone had been aware of the need to improve services, it had been difficult at times to recognise that other aspects were vitally important, such as the need to consider prevention, and those who had perpetrated the crimes. Members of the Reference Group come from a variety of backgrounds and priorities. However despite these differences, what has been apparent throughout is that they all have the same overriding desire - to make things better for survivors and to address the effects of abuse of all kinds.

Survivors are crucial in informing the strategy. For it to develop effectively we must ensure that their experiences are taken into account. Jeannie said that for her it had not been about sitting at a desk, but it had been about speaking and listening to people - hearing the experiences of others and making them count. This could be challenging, but we had a real chance with this strategy to show we care. She never ceased to be humbled by the experiences that survivors shared with her and despite

the fact that many of them have gone through a lifetime of pain, they have the courage to help to make a better future for others.

Carol is one such person who has put her all into raising awareness and making sure that others can learn from her experiences and is helping shape the strategy. Jeannie passed the last words of the day to her.

Carol reflected on the years of abuse she had suffered within the family, but thanks to support from many organisations her life was now for the first time beginning to gain some stability. This did not however help the hurt, pain and the memories. The everyday struggle she faced as she tried to get on with her life was too much at times. She had been frustrated not only with her situation, but because abuse of children appeared to be continuing to happen and was ruining more and more lives with nothing being done to stop it. Carol then found out about the work being done by the Cross Party Group and became involved.

One of the biggest hindrances to the healing process and recovery is the lack of acknowledgement that abuse of children is wrong. Carol stressed the importance of the survivor's words in the poem. Children do not always know that abuse is wrong, it isn't until they try to live their adult life that it seriously affects them and this is the hardest struggle. She said that although nothing could be done to change what had already happened to survivors, with the support of everyone we can change it for future children, by creating awareness, prevention and having the appropriate justice. Just knowing that work on this area is now being done, has played a major part in her recovery.

## Frequently Asked Questions

We have put together some frequently asked questions about the strategy. For any more specific questions, please could you contact Jeannie Hunter on [jeannie.hunter@scotland.gsi.gov.uk](mailto:jeannie.hunter@scotland.gsi.gov.uk) who will be happy to direct as appropriate.

### ***Q What do you hope to achieve with the National Strategy?***

The aim of this work is to effect a culture change in service responses to survivors of childhood sexual abuse across Scotland and to mainstream health and support services, listen to survivors and provide them with choices in how they access help and support when they need it. This will not only lead to recovery from their early trauma, but make more efficient use of existing public sector resources. We are also keen to increase public awareness and society's response to childhood sexual abuse, with the hope that girls and boys will feel more confident to disclose their abuse at an earlier stage, and be protected from further abuse.

### ***Q Long overdue - Why has it taken so long for any action to be taken?***

This is a long term project which will take time to fully deliver. Sexual abuse is a complicated issue which requires careful consideration and a reasoned approach for us to do it justice. But the initial steps and progress to date are positive proof that we are determined that survivors receive the most appropriate and sensitive care and support relevant to their needs.

### ***Q What's happening to the £2m which goes with the strategy?***

In respect of the Development Fund, we have had an overwhelming response from projects seeking funding to develop existing projects and to create new and innovative services. An independent panel has been working on this and we hope to be able to announce the results soon. We appreciate that many will be disappointed, but we hope to use this exercise to help inform policy development and to signpost applicants to other areas where funding may be available if appropriate.

### ***Q £2 million is not likely to go very far is it?***

It is the commitment to policy change and development that is important, for the long term. The funding is only one aspect of the whole strategic approach to address all aspects of childhood sexual abuse and thereby achieve lasting progress. £2m is a means to boost the areas the Reference Group consider to be most in need. More than anything we need to develop our Awareness Raising Campaign to raise the profile of

the issue, and to ensure current services are 'survivor aware'. The forthcoming website will be vital in helping survivors, their families, friends, as well as those who work in the field of CSA to be able to communicate more effectively. The strategy is also geared towards identifying areas for local authorities and health boards to consider taking forward, by re-provisioning existing services and resources to better meet the needs of survivors.

***Q Will any of the funding be given to perpetrators ?***

Some funding will be spent on education and prevention programmes targeted at changing the behaviour of perpetrators and potential perpetrators, as well as looking at behaviours that are linked to child abuse.

***Q Why?***

We have a commitment to give consideration to identifying and securing funding for risk assessment and personal change programmes for:

- individuals who have admitted sexually offending behaviour but without providing sufficient information to secure a conviction; and
- individuals who admit concerns that they may be at risk of sexual offending and convicted sex offenders who remain at risk but are not subject to statutory supervision and who require ongoing support/intervention to reduce the risk they present to the public.

***Q How do you know this will be worth doing?***

Evidence from child protection and domestic violence work suggests that investment in such approaches leads to altered behaviours in the longer term. Potential solutions lie not only with improved access to more proactive and responsive psychiatric/counselling services, but changing attitudes to children, strengthening vulnerable families capacity to parent safely, and providing access to change programmes both within the justice system and outside for potential abusers not yet convicted.

***Q. What support are you currently giving survivors?***

The Executive directly supports a range of survivor and victim support services in Scotland under various funding routes. There are many good and valued services available, and more are developing all the time e.g. within Children's services, for those with mental health problems, and from implementing our Domestic Abuse and Victims' Support strategies across Scotland. At a strategic level, we continue to work with stakeholders in the NHS, local authorities and the voluntary sector to be more responsive to identified needs. The key emphasis for our



