



Supporting childhood sexual abuse survivors with disclosure

Lisa McNay, Glenn Marland, Sue Hampson

'Recovery is being able to live a meaningful and satisfying life as defined by each person in the presence or absence of symptoms it is about having control over, and input into, your own life' (Scottish Recovery Network, 2006: 1).

The mental health nursing BSc pre-registration programme at University of the West of Scotland (UWS) is based on a commitment to reflect principles of recovery rather than the doctrines of mental illness that inspired traditional programmes. This is in keeping with the national review of mental health nursing in Scotland (Scottish Executive, 2006) which recognises that the therapeutic relationship between service user and nurse remains the cornerstone of mental health nursing practice. Essential to this is seeing the whole person, not just the symptoms.

Although it has long been known that people with mental health problems often have histories of childhood trauma—particularly sexual abuse (Spataro et al, 2004; Dube et al, 2005; Read and Bentall, 2012)—their needs in this regard have sadly often not been assessed (Agar and Read, 2002) or poorly addressed in practice (Nelson, 2004; 2009). Some of the reasons for this include staff feeling nervous and apprehensive of making things worse and that they need to be a 'therapist' (Cosh, 2008). Survivors can have barriers too which can include shame, guilt, difficulty in trusting and stigma (Nelson and Hampson, 2008). Males can have additional barriers which can include concerns about their sexuality and concerns that they may become a perpetrator (or that others will have this view) (Nelson, 2009).

Survivors value many things in relation to disclosing to staff including:

'Help to tell'

Survivors say that being asked sensitively would help. As would say posters and leaflets about childhood sexual abuse (CSA) in the waiting areas and consulting rooms. These would give a message that it would be alright to raise such issues (Nelson and Hampson, 2008).

ABSTRACT

Childhood sexual abuse can have a profound and diverse impact on the wellbeing of adult survivors, their families and their communities. Despite being a highly significant aetiological factor in mental and physical illness, the approach of health and social care workers is often based on misunderstanding, prejudice and fear. Front line workers need to develop a confident, safe, objective and self-aware approach to responding to initial disclosure and dealing with ongoing referral if necessary. This article outlines and justifies the embedding of the 'Safe to Say' training programme into a BSc pre-registration course.

'Not looking for great experts'

Survivors first and foremost want a warm human being. If the staff member is not informed about CSA issues they must be willing to learn. In addition survivors want someone who has examined his/her own issues around CSA (Nelson and Hampson, 2008).

'Being listened to, believed and not judged'
(Chouliara et al, 2011)

It is important for staff to recognise that survivors also have strengths including knowledge and experience, resourcefulness, courage and endurance (Nelson and Hampson, 2008). In addition, it is important for staff to recognise that not all adult survivors of CSA will develop mental health difficulties.

A parallel process of neglect can be found in

Lisa McNay

Lecturer, Mental Health Nursing,
University of the West of Scotland

Glenn Marland

Senior Lecturer, Mental Health Nursing,
University of the West of Scotland

Sue Hampson

Safe to Say, National Training Coordinator,
Scottish Association for Mental Health (SAMH)

Email: lisa.mcnay@uws.ac.uk



the curriculum content of mental health nursing programmes with regards to a lack of commitment to the needs of adult survivors of childhood sexual abuse (Warne and McAndrew, 2005). As a result we decided to review our preparation of student mental health nurses in working with adult survivors of CSA in a more focused way. This was just as we had done in relation to suicide prevention by embedding SafeTALK (see: www.livingworks.net) in Year 1, Applied Suicide Intervention Skills Training (ASIST) in Year 2 and Skills Training on Risk Management (STORM) in Year 3 (Lever-Green et al, 2008). Our aim is for students—the mental health nurses of the future—to be able to respond to and provide effective care responses for survivors of CSA.

Given that some of the key reasons cited by staff in studies for not working with disclosure were lack of training, it not being part of their role, and fear (Nelson and Hampson, 2008), our aims of the training were that students would:

- Recognise the legitimacy to discuss sexual abuse and disclosure in their professional role
- Increase their competence to respond to someone who discloses CSA
- Know where to find appropriate support if complications were to arise following a disclosure of sexual abuse.

We asked each of the seven higher education institutions (HEIs) in Scotland delivering pre-registration mental health nursing programmes the following questions:

- What is contained in terms of content within your curriculum in relation to working with adult survivors of CSA?
- What is the method of delivery?
- How many hours?
- At what point(s) within the branch?

We received responses from all but two and these responses included:

'We don't look explicitly at survivors of CSA—we only generally cover the impact it can have on mental health and development, personality disorder/self-harm etc. There is a session within the child and adolescent mental health services (CAMHS) module on emotional dysregulation and the effects of abuse are explored within that.'

'We have a session at the start of the third year delivered by a specialist charitable group, which offers support to people who have survived sexual abuse, of all ages. It is presented via powerpoint and uses vignettes to outline nature, course and impact of such

abuse—leaflets are provided. It is delivered to the full cohort—on average 200 students.'

As part of our consideration of what might be appropriate we searched the literature and we were not able to find any articles detailing how working with survivors of CSA was addressed in any pre-registration mental health nursing programme.

Since then, the Department of Health (DH) as part of their Victims of Violence and Abuse Prevention Programme, in conjunction with the National Mental Health Development Unit (NMHDU), have developed a DVD training guide and resources to assist trainers in the mental health and higher education sectors, to effectively deliver the one-day sexual abuse course to mental health clinicians and students (NMHDU and DH, 2010). Last year, Walsh and Major at the University of Cumbria published an article describing an innovative virtual simulation model, Stilwell, which they developed to help engage lecturers and students to explore CSA issues (Walsh and Major, 2011).

We decided that given the focus of the training that we required not a conventional classroom approach, but rather a workshop methodology which promoted real engagement with the emotional reality of working with survivors of CSA in a safe environment. Emotion and learning are a powerful combination for personal and professional development (Warne and McAndrew, 2008). This led us to deciding to explore the feasibility of embedding Safe to Say training into the BSc pre-registration programme which no other HEI had done.

Safe to Say

Safe to Say training was developed by Sue Hampson, National Trainer at the Scottish Association for Mental Health (SAMH). Her post was developed in line with the National Strategy for Survivors of CSA in 2005, which was in turn developed in response to the then Scottish Executive's Short Life Working Group (2003) on the care needs of people who have survived CSA. This work is overseen by SurvivorScotland on behalf of the Scottish Government. Please see the the SurvivorScotland website (www.survivorscotland.org.uk) for details of this work, the national strategy, and the *Report of the Short Life Working Group*.

The training is part of the response by SurvivorScotland to the need for training in Scotland as highlighted in research undertaken by Sarah Nelson (2001; 2004). In her research she found poor care responses for survivors in mental health services and a fear by staff of 'opening the can of worms'. Nelson and Hampson (2008) were funded by the Scottish Government to produce the resource *Yes You Can!* for working with adult survivors of CSA. This booklet was endorsed by a review carried out by the Scottish



Government with advice and input from a stakeholder review group that included the voluntary sector, social work services, survivors' representatives, psychiatrists and psychologists. This resource is central to Safe to Say training.

Safe to Say is an experiential training for a maximum group size of 15 participants—low group numbers to ensure safety, as CSA is such a sensitive issue and it is delivered over two and a half consecutive days, by two trainers together. The reason for two trainers to co-facilitate recognises that it is not at all uncommon for participants to disclose within the group. This reflects the safety of the group and the ability to effectively model responses to disclosures either individually or within the group. This also reinforces that it is effective in holding survivors safely.

Research has demonstrated that survivors trusted those they disclosed to and often did not want to be referred on—the ability to engage and stay with them being essential are crucial to the ethos of the training. The way of working and where the exercises are placed is deliberate to mirror the relationship and process necessary for disclosure. Essential to this is the co-facilitator's relationship, when this works well it is clearly reflected in the group process and feedback, likewise when it does not. This starts with each member noting down their hopes and fears regarding the training on yellow 'stickies', recognising that participants particularly at the start may lack confidence and find it difficult to voice these directly and then the trainers explore these with the group. This is an important element, with the group members citing common fears including 'worried that I am going to cry in the workshop' and 'worried that I don't have enough knowledge and skills to help'. The sense of common fears and a normalising of these fears help to set the scene. This naturally leads to a discussion about 'how do we look after ourselves?' which focuses not just on during the workshop, but after each day of the course (picked up again at the end of the two and a half days). Participants are encouraged to identify their coping strategies and sources of support and the trainers, are available throughout the 2.5 days.

Trainers then move on to supporting the group to establish 'agreed ways of working' which will cover many aspects including confidentiality and its limits, respect for other group members reflected in time keeping, and allowing people their say without judgement. Participants work individually, in pairs, small groups and in the larger group throughout the workshop. Different mediums are used including drawing to explore issues, which links to different options which survivors might find useful (Everett and Gallop, 2001). The course is person centred and fits with the recovery approach which sees the survivor

Box 1. Themes covered in the training

- What is sexual abuse?
- The continuum of abuse
- Who abuses? Is abused?
- The effects of sexual abuse
- What survivors value
- Issues that get in the way for workers
- Responding sensitively to the cultural needs of black and minority ethnic (BME) survivors
- A DVD featuring three male survivors
- What do I do if?
- Looking after yourself as a worker with CSA
- Practical resources and booklist

as the expert of their own experience. To this end participants are facilitated to realise that they do have the skills and knowledge to do this work—a philosophy of demystifying CSA, as not just the province of experts. The themes covered within the training are shown in *Box 1*.

The style of the trainers mirrors respectful and effective practice and this, along with the experiential nature of the training, aims that this is not just about the giving and receiving of information. Rather, it recognises that a wealth of knowledge and experience will exist within the group, and that key learning comes from the process of the learning from the style of the training itself. Self-awareness is a significant part of the reflective nature of the training, and by only using a few exercises in each day, leaves space for the participants to fill—this is promoted.

This resulted in UWS commissioning training for mental health lecturers, to become Safe to Say trainers. Lecturers self-selected for the training which is important, recognising that not all mental health lecturers would necessarily be comfortable engaging in emotional aspects of learning—away from more traditional didactic methods (Warne and McAndrew, 2008). The need within the training to be able to stay with self reflections/hurt—which survivors need—is essential. In all, 12 lecturers have completed the training and are now Safe to Say trainers.

Safe to Say at UWS

We decided to embed Safe to Say into the second half of Year 2 of the programme, by which time students will have undertaken the four theory modules of the mental health branch and one branch placement. The first branch module is 'Becoming a Person' and is an introduction to examining how we become the person we are. This includes psychology, life sciences



and sociology. Students explore risk and resilience factors including a general overview of childhood abuse: physical, sexual and neglect. The second module is 'Knowing the Person' which has an emphasis on engagement and therapeutic relationships. Students then go on placement to any mental health area (apart from forensic) including non-statutory agencies. During this time they complete the first half of *The 10 Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland)* (NHS Education for Scotland (NES), 2011). Students then return to university for a further two modules, The first is 'Nursing for Recovery', which focuses on developing a range of skills to promote recovery-focused practice.

The final module of Year 2 is 'Professional Development 1' which has an emphasis on ethics, law and evidence-based practice. Students then go back out to practice for two consecutive placements, which as before can be any mental health area (apart from forensic) including non-statutory. All students have an older adult placement in keeping with *The National Framework for Pre-registration Mental Health Nursing Programmes in Scotland* (NES, 2008). The other two placements are either both adult, or adult and CAMHS. At least one placement is hospital-based and one placement community-based. Students complete the remaining *10 Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland)* (NES, 2011) during the third and final placement of Year 2.

It is during the second placement that students return to university to complete Safe to Say. They are informed during the preceding theory module about Safe to Say and the rationale for embedding it within the curriculum and encouragement to approach their personal lecturer and discuss any issues/concerns which they may have. We did not initially have this contained within the module handbook but rather it was only discussed. We have since written it into the module handbook. This was in case this was missed for any reason and students then found themselves in a position whereby they attended for training and did not know what to expect (Tong and Gillespie, 2011), which is clearly an unacceptable situation.

There is an expectation that all students will complete Safe to Say. However, there can be flexibility with regards to the timing, being mindful of the possibility that students may well have their own issues (not only in relation to CSA) which may need to be addressed first and are thus important to their own wellbeing. We have an important safeguarding responsibility to our students (Morrissette and Doty-Sweetnam, 2010).

We follow the standard practice of Safe to Say training. This means that we have class sizes of up to 15 students, with each group being facilitated by

two mental health nursing lecturers trained as Safe to Say trainers. We schedule the course to run on either Monday, Tuesday and Wednesday or Tuesday, Wednesday and Thursday. This avoids the final day being a Friday, to ensure that lecturing staff are available following the course completion. Lecturers who are facilitating as with any Safe to Say trainers ensure that they are available to students before, during and after each day of the training as a point of good practice. This recognises that students may require additional support.

Where are we now?

There is a Safe to Say evaluation form which each participant (in our case students) completes at the end which we routinely collect. This indicates the positive acceptance by students and there have been no significant issues from either students or lecturers perspectives. Examples of comments from a typical completed evaluation form include:

'I felt safe and supported. The lecturers were open, honest and accommodating'

'I enjoyed this, it helps to give a realistic understanding of how survivors feel.'

'I massively value this overall experience and will value the very deep conversations and more insight it has given to me. It has further reinforced my beliefs about how mental health nurses should approach their work.'

UWS were recognised as an example of good practice for our commitment to embed Safe to Say into our pre-registration mental health nursing curriculum by NES and Scottish Government (2009) in *Charting Progress*. Since then, the Nursing and Midwifery Council (NMC) have developed new standards for pre-registration nursing education and for the first time they contain a field specific competence for mental health relating to abuse and trauma:

'Mental health nurses must be sensitive to, and to take account of, the impact of abuse and trauma on people's wellbeing and the development of mental health problems. They must use interpersonal skills and make interventions that help people disclose and discuss their experiences as part of their recovery (NMC, 2010: 25).'

However, in spite of the strong rationale and recognition for embedding Safe to Say, we realise that more work is necessary. Given that our BSc pre-



registration programme is the first to embed Safe to Say, we decided to robustly review these evaluations which are qualitative in nature and in addition, to further develop this to include a quantitative element to evaluate pre, post and at three months ratings in relation to three areas.

- Legitimacy to discuss sexual abuse/disclosure in their professional role
- Competence to respond to someone who discloses CSA
- Knowing where to get support if complications were to arise following disclosure of CSA.

This evaluation for September 2008-February 2009 cohorts will form the focus of a second article (to follow). In addition, there will be recommendations for further research and practice development. It will recognise that a key aspect which needs to be further addressed—and which both educationalists and service side have a responsibility for—is to ensure that students have access to an environment that supports their ‘holding’. Without this that students and staff are being set up to fail (Warne and McAndrew, 2005). This will necessitate further dialogue and action to fully address this important aspect. This should be helped by the Scottish Government’s *CEL_41 Gender-*

KEY POINTS

- Childhood sexual abuse (CSA) is a significant aetiological factor in a wide range of illnesses and is a major threat to the wellbeing of individuals, families and communities
- There are many barriers which inhibit disclosure stemming from the individuals and from those who work with them
- When people do decide to disclose, the response they receive from mental health staff is often poor
- Appropriate support at time of disclosure can be enabled by the use of generic skills and qualities
- Although CSA can have a profound impact on adult survivors, it can be associated with the development of strength and resilience

Based Violence Guidelines For Implementation (2009) which, among many aspects, set out that mental health services should introduce routine enquiry regarding childhood sexual abuse, supported by staff training and reviewed documentation by October 2010 (Scottish Government, 2009). [BJMHN](#)

References

- Agar K, Read J (2002) What happens when people disclose sexual or physical abuse to staff at a community mental health centre? *Int J Ment Health Nurs* **11**(2): 70–9
- Chouliara Z, Karatzias T, Scott-Brien G et al (2011) Talking therapy services for adult survivors of childhood sexual abuse (CSA) in Scotland: perspectives of service users and professionals. *J Child Sex Abus* **20**(2): 128–56
- Cosh J (2008) Coming out of the shadows. *Mental Health Today* July/August: 10–2
- Dube S, Anda R, Whitfield C et al (2005) Long-term consequences of childhood sexual abuse by gender of victim. *Am J Prev Med* **28**(5): 430–8
- Everett B, Gallop R (2001) *The Link Between Childhood Trauma and Mental Illness: Effective Interventions for Mental Health Professionals*. Sage, London
- Lever-Green G, Hays R, Mukadam D (2008) *Skills Based Training on Risk Management Facilitator Handbook*. University of Manchester, Manchester
- Morrisette P, Doty-Sweetnam K (2010) Safeguarding student well-being: establishing a respectful learning environment in undergraduate psychiatric/mental health education. *J Psychiatr Ment Health Nurs* **17**(6): 519–27
- Nelson S (2001) *Beyond Trauma: Mental Health Care Needs of Women who Survived Childhood Sexual Abuse*. Edinburgh Association for Mental Health, Edinburgh
- Nelson S (2004) *Adult Male Survivors of Childhood Sexual Abuse. Needs Assessment: Lothian*. Health in Mind, Edinburgh
- Nelson S (2009) *Care and Support Needs of Men Who Survived Childhood Sexual Abuse: Report of a Qualitative Research Project*. University of Edinburgh, Edinburgh
- Nelson S, Hampson S (2008) *Yes You Can! Working with Survivors of Childhood Sexual Abuse*. 2nd edn. Scottish Government, Edinburgh
- NHS Education for Scotland (2008) *The National Framework for Pre-registration Mental Health Nursing Programmes in Scotland*. NES, Scotland
- NHS Education for Scotland (2011) *The 10 Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland): 2011 Version*. NES, Edinburgh
- NHS Education for Scotland, Scottish Government (2009) *Charting Progress: Higher Education Institutions Implementation of Actions from Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland*. Scottish Government, Edinburgh
- National Mental Health Development Unit, Department of Health (2010) *Meeting the Needs of Survivors of Child Sexual Abuse: Underpinned by Routine Enquiry in Mental Health Assessments*. NMH DU, London
- Nursing and Midwifery Council (2010) *Standards for Pre-registration Nursing Education*. NMC, London
- Read J, Bentall R (2012) Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. *Br J Psychiatry* **200**(2): 89–91
- Scottish Executive (2003) *Care Needs of People Who Have Survived Childhood Sexual Abuse*. Scottish Executive, Edinburgh
- Scottish Executive (2006) *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland*. Scottish Executive, Edinburgh
- Scottish Government (2009) *CEL_41 2008 Gender-Based Violence: Guidelines for Implementation*. Scottish Government, Edinburgh
- Scottish Recovery Network (2006) *Journeys of Recovery: Stories of Hope and Recovery from Long Term Mental Health Problems*. Scottish Recovery Network, Edinburgh
- Spataro J, Mullen PE, Burgess PM, Wells DL, Moss SA (2004) Impact of child sexual abuse on mental health. *Br J Psych* **184**: 416–21
- Tong E, Gillespie M (2011) Childhood sexual abuse: help make it ‘Safe to Say’. *Br J Nurs* **20**(9): 553–6
- Walsh M, Major J (2011) Child sexual abuse: a new approach to professional education. *Nurs Stand* **25**(37): 35–40
- Warne T, McAndrew, S. (2005) The shackles of abuse: unprepared to work at the edge of reason. *J Psychiatr Ment Health Nurs* **12**(6): 979–86
- Warne T, McAndrew S (2008) Painting the landscape of emotionality: Colouring in the emotional gaps between the theory and practice of mental health nursing. *Int J Ment Health Nurs* **17**(2): 108–15