RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

POSITION STATEMENT PS04/26

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

August 2026

Content warning:

This document discusses child sexual abuse and includes quotes from survivors.

Please consider your wellbeing before continuing and ensure you have access to support if you need it.

How to cite this publication:
Royal College of Psychiatrists (2026) Position Statement PS04/26 – Addressing the impact of non-recent child sexual abuse of adults

College reports and position statements constitute College policy and have been sanctioned by the College via the Policy and Public Affairs Committee (PPAC).

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

Foreword

Non-recent child sexual abuse has a profound impact on an individual's mental health and, without the right care and support, increases the risk of mental illness throughout the course of their adulthood. It can adversely affect a person's ability to form loving and trusting relationships, to maintain self-esteem, to realise their full potential and, ultimately, to live a flourishing life.

Many survivors of child sexual abuse will likely seek the help of psychiatrists and other mental health professionals at different times and in different ways throughout their adult lives. This support needs to be compassionate, holistic, person-centred and trauma-informed. It also needs to recognise that a person may seek help without disclosing their experience of abuse, which highlights the importance of creating an environment that facilitates this to happen.

I am sorry that too often this has not been the case, and that those with lived experience have suffered avoidable harm when seeking help from mental health services. This is demonstrated by the testimony of the survivors who informed this work, who described painful experiences of re-traumatisation when disclosing abuse, when they have received a misdiagnosis, and when there has been inappropriate treatment and care planning, and inadequate access to the help they needed. For all these reasons, we are not getting things right enough of the time.

This will feel like an uncomfortable and unfair criticism of psychiatrists and other mental health professionals who dedicate their lives to helping their patients, particularly those who do work hard to get this right. But we need to acknowledge that sometimes unintentional harm can be caused by what is considered best or normal practice, by a lack of training or awareness, or by how healthcare systems and structures can impede the delivery of holistic care. This is a shared concern for us all, as is any instance where a survivor experiences abuse perpetrated by staff in mental health settings.

Despite a significant proportion of people in contact with mental health services having experienced childhood sexual abuse, it is not well enough recognised or responded to – it is an issue hidden in plain sight. As the professional and educational body for psychiatrists in the UK, the College has a responsibility to highlight this and push for action.

That is what this position statement aims to do. It has been co-produced with patients and survivors, and its recommendations are targeted at those stakeholders who hold the levers for change – changes to the way services are funded, designed and delivered. We will engage with them directly on how this can happen and how they must directly involve those affected. We are also committed to supporting our members to better understand how to provide appropriate care for survivors of non-recent child sexual abuse.

It will be seen throughout this position statement that survivors repeatedly state that they are made to feel as though the problems they have are inherent to them rather than being caused by the abuse they have experienced. This extends to when they

are given a psychiatric diagnosis. Too often, they say it feels that they are being held responsible for the position they find themselves in. Understanding how to support a person without a diagnosis becoming the most important thing about them is fundamental to ensuring they are not re-traumatised by psychiatric care.

I realise that aspects of what the College is proposing may require a shift in the way care is delivered in some services, particularly in providing trauma-informed care. However, this is not new thinking – there is good evidence that taking a more holistic approach and valuing the development of trusting therapeutic relationships that consider how and why a person came to need support from mental health services, is better not only for patient outcomes but for staff, too.

This shift will take time and require commitment at a national and local level, but it will lead to more efficient, cost-effective services in the long run. This needs to be built into the commissioning framework that guides how services are planned and delivered in England, and into the respective structures in Northern Ireland, Wales and Scotland. Alongside other key developments that will encourage better therapeutic relationships in mental health care, my hope is that this position statement will not only underpin the change that is needed but also help build trust between clinicians, services, patients and survivors.

Finally, I want to pay tribute to and thank those with lived experience who contributed so much to this work, and to recognise the personal toll it took on them to do so. Their perseverance, commitment and desire to help others receive better care has ensured we have produced a meaningful and comprehensive case for change.

I also want to thank Dr Jo Stubley and Dr Maria Podlejska-Eyres for championing and delivering this work for the College, as well as all the members, external stakeholders and College staff who contributed to its development.

Dr Lade Smith CBE
Immediate Past President, The Royal College of Psychiatrists

Contents

Working group

This position statement was developed by the Working Group on the Impact of Non-Recent Child Sexual Abuse on the Mental Health of Adults:

- **Jane Chevous** (from November 2021), Survivor; Lived Experience Consultant; Director, Survivors Voices
- **Diane Goslar**, Patient – Lived Experience
- **Dr Oluwatosin Mayomi**, Resident Doctor, Gender-based Violence Educator and Campaigner
- **Concetta Perôt** (from November 2020 until April 2023), Psychotherapist; co-Founder and Advisory Board Lead, Survivors Voices
- **Maria Podlejska-Eyres (Co-Chair)**, Consultant Psychiatrist in Medical Psychotherapy
- **Jo Stubley (Co-Chair)**, Consultant Psychiatrist in Medical Psychotherapy, Tavistock Trauma Service clinical lead, Tavistock and Portman NHS Trust
- **Dr Caroline Thompson**, Ear Nose and Throat Specialist; Survivor.

Working group support

The working group was supported by:

- **Dr Laura-Louise Arundell**, Lead Researcher and Developer, NCCMH
- **Tom Ayers** (from July 2021), Director, NCCMH
- **Nuala Ernest** (from October 2022), Senior Editor, NCCMH
- **Matthew Faires** (until April 2021), Research Assistant, NCCMH
- **Eva Gautam-Aiken** (from September 2022), Senior Programme Manager, NCCMH
- **Joanna Popis** (until August 2022), Project Manager, NCCMH
- **George Roycroft,** Head of Policy and Campaigns, RCPsych
- **Dr Lade Smith CBE** (until July 2023), Clinical and Strategic Director of NCCMH; Visiting Senior Lecturer, Institute of Psychiatry, Psychology and Neuroscience, King's College London.

Acknowledgements

The Working Group is grateful for the valuable contributions of those College members who participated in an initial expert reference group at the outset of the project.

The Working Group is also grateful for the valuable input and feedback from stakeholders, received during the stakeholder consultation. Stakeholders included individuals and the following bodies:

- Adira, Sheffield
- British Psychological Society
- CIS'ters (Childhood Incest Survivors)
- National Association for People Abused in Childhood
- The Potato Group (Parents of Traumatised Adopted Teens Organisation)
- The Survivors Trust.

Special thanks to **Dr Alex Thompson**, Chair of the Faculty of Liaison Psychiatry, RCPsych, for his contributions.

For the literature review, we thank:

- **Victoria Barker**
- **Kate Highton**
- **Jo Stubley**.

For editorial support, we thank **Dr Clare Taylor**, Head of Quality Assurance and Business Development, NCCMH.

Apology and acknowledgement of learning on engagement with survivors

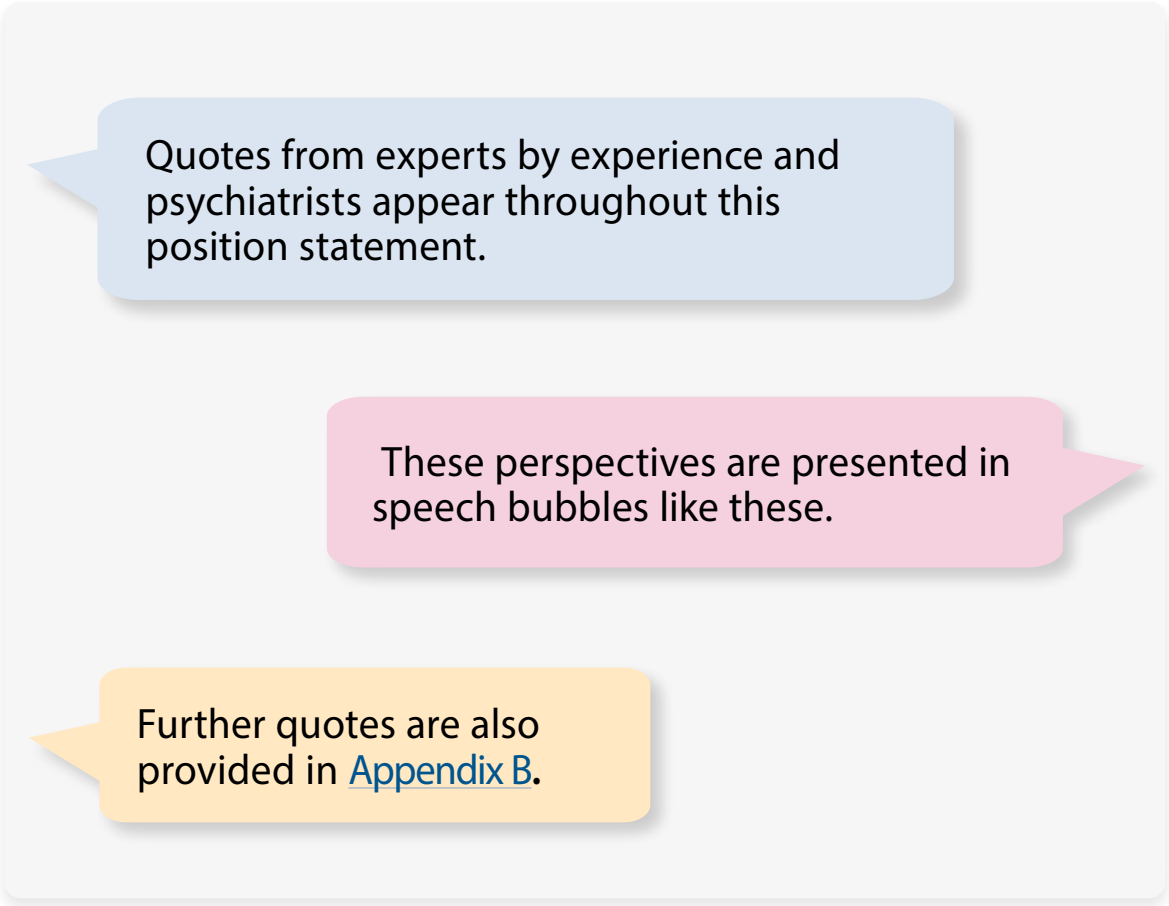
This position statement was co-produced with people who have lived experience of non-recent child sexual abuse, and views were sought from organisations who support these individuals. During the process, it became clear that the College did not directly engage with survivors and survivor organisations across all parts of the UK in a consistent way. We are sorry that this direct engagement did not happen.

The College has reflected on this as a learning opportunity and recognises the need to do better. The College commits to developing a process by which any future similar projects, for which the views of survivors and experts by experience are sought, will involve all four nations of the UK more fully. This involvement will be in a meaningful, safe and supportive way that truly recognises and values the contributions, knowledge, skills, expertise and experience essential to co-production of all those in the UK.

Dr Lade Smith CBE, Immediate Past President, Royal College of Psychiatrists

Sonia Walter, Chief Executive, Royal College of Psychiatrists

Lived experience and professional voices in this position statement



These quotes present people's personal perspectives and do not necessarily represent the views of the College.

Preface: Language matters

Terminology

Non-recent child sexual abuse

The terminology used to describe non-recent child sexual abuse varies. There is no single agreed or preferred term for it, nor for the person who has been subjected to it. Terms such as 'historical child(hood) sexual abuse' (often abbreviated to 'HCSA' or 'CSA') may be used; however, many people who have been abused are unhappy with that term.

The use of 'non-recent' is to indicate that the acts of child sexual abuse occurred in the person's past and under the age of 18, not necessarily that it was perpetrated a long time ago. However, this does not mean that the impact is historical. As this position statement demonstrates, the impact is typically current, ongoing and long-lasting. Also, non-recent does not necessarily mean that the perpetrator is no longer a risk to the survivor or to other victims.

In this position statement, the term 'non-recent child sexual abuse (NRCSA)' is used. This refers to sexual abuse that occurred in an adult's childhood (under the age of 18).

Definition of child sexual abuse

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

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

Adult survivors of child sexual abuse

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

In this position statement, the term **'survivor'** is used. To understand all terms used, please refer to the full Glossary of terms.

Language and tone used by professionals

For professionals, the language and tone used in communication with the people they are supporting should be compassionate and must reflect the person's preferences. The language and tone need to demonstrate an understanding of the impact of NRCSA and how difficult it is to seek help.

It's crucial that the terminology used avoids the potential for re-traumatisation and for preventing survivors from seeking help.

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

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

Over the years in our survivor groups, we have heard account after account of professionals using language that minimises, shames and blames. For example, writing on notes: 'had sex and regretted it' when referring to rape; referring to emotional distress of a survivor in a consultation as her 'behaving like a silly little girl'; or doubting a survivor who was describing the loyalty bond with her abusive father by asking: 'So, if he was as abusive as you say, why were you attached to him?'

If there is even a hint of denial, disbelief or blaming, we will not feel safe to open up. Language matters as does the attitude that is behind such language.

1. Introduction

1(a) Aims and scope

The overall aim of this statement is to present a clear position on the wellbeing of adults who have experienced sexual abuse during childhood or as a young person, in the context of mental health disorders and their management across mental health services. It makes recommendations in relation to NRCSA for:

- clinical care
- commissioning guidance
- the teaching and training of psychiatrists
- research and public policy.

Below, is a set of more detailed aims the College is hoping to achieve. The principles of good practice in this position statement are applicable when working with survivors of all forms of child abuse, whether they occur with or without sexual abuse.

The principles and aims are aimed at psychiatrists and mental health professionals. They will also be relevant for professionals working in the voluntary, community and social enterprise (VCSE) sector, to allied health and social care professionals, and, more broadly, to the police and the criminal justice system.

Aims

- To raise awareness of the substantial impact of NRCSA on adult mental health.
- To demonstrate that understanding the impact and providing support to people with a history of NRCSA is a core responsibility for all psychiatrists and other mental health professionals.
- To support psychiatrists and other mental health professionals to recognise the necessity and the complexity of providing appropriate trauma-informed care.
- To improve the overall response of psychiatrists and mental health professionals to people with a history of NRCSA, and improve the confidence of people seeking support in mental health services.
- To influence organisations involved in the design and delivery of mental health services to provide comprehensive and culturally appropriate trauma-informed services that meet the needs of patients with a history of NRCSA
- To influence organisations that provide and set standards in medical training and further education, to ensure high-quality care for people with a history of NRCSA across all healthcare settings.
- To encourage and support research into NRCSA, to develop an evidence base that will inform the delivery of services.
- To demonstrate the practice of co-production, and the importance of ensuring that lived experience is included in research, policy, education, and service design and review.

1(b) Introduction to the impact of NRCSA and the approach of the Working Group

Child sexual abuse is a widespread global problem[1–5] with profound repercussions for those who experience it, their families and communities, and for society as a whole. It often occurs with other experiences of abuse, such as physical, spiritual (including religious) and emotional abuse (including coercive control), neglect and domestic abuse. The Independent Inquiry into Child Sexual Abuse (IICSA) reported the prevalence of child sexual abuse in England and Wales as one in six girls and one in 20 boys.[5]

The consequences and repercussions of child sexual abuse can be profound and wide-reaching. Without the right help and support, the devastating impacts on a person's physical and mental health and wellbeing can be lifelong.[6–8]

While this position statement focuses on the impact of NRCSA on mental health, it is vital that professionals are aware of the extent of its impact on physical health[9] and provide support that addresses the needs of the whole person.

This position statement also highlights groups who are at higher risk of experiencing child sexual abuse, such as those with intellectual disabilities and children in care, and groups who may need special consideration in relation to accessing care and treatment of the impact of NRCSA, such as people who are neurodivergent.

The focus of this position statement is on survivors of NRCSA and, while it is recognised that a significant number of offenders and perpetrators of child sexual abuse are also survivors, addressing these particular groups is beyond the scope of this work. The Working Group hope that this will be addressed by other groups in the College that have expertise in working with offenders and perpetrators of child sexual abuse.

I had a doctor who took the time to listen and understood that my trauma affected every cell of my being.

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

The impact of child sexual abuse on adults

The experience of being sexually abused as a child can have profound effects. For some survivors there is immediate or early recognition that the abuse has taken place, and there will probably be consequential needs. Psychiatry is likely to have an important role in helping those in this group, but they are not the focus of this position statement. This position statement is about supporting more accurate and helpful responses to the specific needs of the many survivors who don't fully recognise (and therefore don't disclose) the abuse until much later, who we refer to as having experienced 'non-recent child sexual abuse'.

I have lived my whole life in survival mode.

[Harmful substance use] makes everything better and more manageable. It seems to make it go away so you can do things.

There is strong evidence linking a history of child sexual abuse, and other forms of child abuse and adverse childhood experiences (ACEs)[9–13] to short- and long-term adverse effects in adulthood, including severe and enduring mental illness. It can also lead to difficulties in forming intimate, trusting relationships and to sexual dysfunction.[14]

NRCSA is associated with higher rates of depression, anxiety, post-traumatic stress disorder (PTSD) and complex PTSD (C-PTSD), psychotic illness, alcohol and substance use disorders, dissociative disorders and eating disorders. People who have experienced NRCSA are also more likely to receive a diagnosis of personality disorder than those who have not been abused.

The effects of NRCSA may lead to poorer social, educational and economic outcomes, and the risk of further abuse, including sexual abuse, in adulthood[15]. NRCSA is also likely to lead to significant experiences of guilt, shame and low self-worth, which will impact on many aspects of a survivor's life.

On the other hand, for some, a history of childhood sexual abuse may be masked by pro-social coping styles and 'appeasement' survival responses, and through hyper-functioning and perfectionism.

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

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

Disclosure

Research has consistently shown that many children and young people do not disclose sexual abuse at the time the abuse is occurring. A large number of survivors report only disclosing childhood sexual abuse experiences in adulthood.[16] One study found that almost 60% of adult survivors delayed disclosing for 5 years or more, with one in five survivors reporting never having disclosed to anyone.[17]

If survivors then meet with professionals who are poorly equipped to respond in a helpful way, this may be due to significant gaps in the training of mental health professionals in relation to disclosure, safeguarding and reporting requirements. It may also be due to a lack of trauma-informed services and gaps in the evidence base of developing interventions that survivors find helpful and effective.

Disclosure may occur in physical health settings, especially when they are potentially triggering for the survivor. The survivor may need to alert professionals of their needs and concerns by disclosing their histories. This may include professionals such as dentists, those in primary care, midwives, gynaecologists and obstetricians, because the examinations and procedures may hold potential for re-traumatisation.

Many survivors will present to mental health professionals with symptoms resulting from the trauma caused by childhood sexual abuse and not with disclosure of the abuse. This is why recognising trauma and subsequently facilitating disclosure is crucial. Many survivors will have tried to disclose or seek help while the abuse was occurring, only to be disbelieved and even returned to the abuser or abusive institution. The impact of such experiences on survivors' trust and confidence in the institutions that are expected to provide protection may impact relations with mental health services in adulthood.

In addition to the risk to the patient/survivor themselves, the perpetrator may still be active and sexually abusing other children.

Disclosure is discussed in detail in Section 6. Disclosure.

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

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

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

High-risk groups for child sexual abuse

Any child is vulnerable to child sexual abuse, but those at higher risk include children with intellectual disabilities and neurodivergence[18,19] children who identify as lesbian, gay, bisexual, transgender, queer or other (LGBTQ+)[20] and children who are asylum seekers and refugees.[21] (See also Section 2(b) Intersectionality and NRCSA). Any child who has suffered other forms of abuse (ACEs) may also be at higher risk.[5,22,23]

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

Gaps in treatment and services

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

Equally, professionals can end up treating people without adequate training and support, and without fully understanding what might be behind the presentations if disclosure hasn't been supported and facilitated. They therefore may not be able to offer what is most needed or helpful. Research indicates that there are better outcomes if child sexual abuse is recognised and people are helped earlier.

Care pathways and treatment are discussed in detail in Section 8. Care pathways and treatment.

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

Economic costs

A Home Office report has estimated that the lifetime cost of all contact child sexual abuse in 1 year in England and Wales is at least £10.1bn.[24]

A recent study analysed the costs of disclosures being delayed, denied or disbelieved, and of survivors not receiving effective treatment and support. It was estimated that the delays cost nearly £3bn[25], with an average lifetime health cost per survivor of nearly £5m. This research may not have fully captured the physical and mental health impact of child sexual abuse in relation to economic cost and further research is needed.

Services that enable early disclosure and provide the right support are therefore vital, to reduce the impacts on people's safety, health and wellbeing. Investing in these services can also reduce future healthcare expenditure.

1(c) About the development of the position statement

This position statement has been co-produced as a collaboration between survivors (some being health professionals and researchers), psychiatrists, mental health policy professionals and researchers. During the development of this position statement, it became clear that the direct and comprehensive involvement of people with lived experience in such endeavours is vital to minimise re-traumatisation, and to improve services, care and treatment for adult survivors.

In 2014, the RCPsych Psychotherapy Faculty set up a working group on NRCSA, chaired by Jo Stubley and Maria Podlejska-Eyres. The group raised the issue in various College forums, with growing support to address it.

The College's Policy and Public Affairs Committee agreed at its meeting in December 2019 that an expert reference group (ERG) with wide representation from across the College should be convened.

The ERG was to focus on

- **a** the development of a position statement,
- **b** the identification of what other work the College could do beyond a policy statement,
- **c** recommendations for research to fill existing gaps in knowledge and for future work to contribute to service improvement.

When the ERG was set up in 2020, it became evident that the format needed to be amended to carry out the work required and the ERG was no longer used. A smaller working group was established with additional representation from experts by experience from the non-profit, survivor-led organisation Survivors Voices (see The Working Group).

The expertise, and personal and professional experience, of the survivors and professionals in the Working Group enabled them to appreciate together the impact and consequences of NRCSA at a deeper level, and to work towards more authentic co-production. The Working Group needed additional time to address the complex dynamics that this topic inevitably generated, including engaging with external facilitation by an organisational consultant for a short period. The impact of the COVID-19 pandemic also played a role in the complexity of this work.

In 2024, after the Working Group developed a substantive draft of the position statement, there was an extensive process to seek views from across the College, as well as engaging with some external stakeholders. The Working Group received 290 comments, which were overwhelmingly positive and constructive. The Working Group spent time considering the feedback and making further revisions before a version was submitted for sign-off and approval for publication by the College.

Literature review

This position statement was developed alongside a literature review that explored the prevalence of child sexual abuse in adults diagnosed with mental health conditions. Development started in 2020, and the literature searches spanned January 2019 to June 2021, to identify studies published after a 2019 umbrella review by Hailes HP et al.[26] A summary of the literature review findings is provided in Appendix A.[(a)]

If I could sum up what good support feels like in just three words, they would be…

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

(a) Given the time taken for this position statement to be developed, the literature review searches are consequently several years old. However, it was agreed that updating the searches was unlikely to yield significantly different results.

2. Overarching considerations

There are a number of themes relevant to NRCSA that are considered in this section because of their importance to understanding the factors that affect an individual's experience of seeking help.

2(a) Survivor-centred charter

In developing this position statement, the Working Group agreed its support for the recommendation of The Charter for Organisations Engaging Abuse Survivors in Projects, Research and Service Development:[27] that all work with people who have experienced abuse and trauma needs to be the opposite of abuse, so that it does not (inadvertently) replicate the dynamics of abuse and cause harm.

Services for survivors should follow the seven principles of the Survivors' Charter below.

Principles for safe, empowering and survivor-centred engagement

Build trust and safety
Abuse is inherently unsafe. It leaves a long legacy of fear. Many survivors remain frequently triggered into 'flight, fight, freeze or appease' responses. Some survivors will still be in situations of ongoing abuse and risk of harm. Thus, the first priority for engagement is a safe environment: this begins with providing attentive listening and connections that are warm, collaborative and relational, which recognise and minimise triggers and may include safety protocols. Dedicated time needs to be given to building trust and safety at the start.

Promote survivor empowerment
People who are abusive dominate and take away personal power. Good engagement should be collaborative and must empower survivors to have control of decisions about their own involvement. This includes the decision about their capacity to participate in services or projects, within agreed boundaries of being able to keep themselves safe and support the maintenance of safety for other participants. Services and projects may be survivor-led or co-produced with survivors and survivor organisations. Shared decision-making should be used in clinical/treatment settings.

Amplify the voices of survivors

Abuse is silencing. Engagement should help release and amplify survivors' voices, experiences and expertise. Good engagement is survivor-centred, meaning it sees things from the survivor's perspective and is led by their views, wishes and feelings. Services and projects are evaluated with survivors' voices as a key input, allowing them to be the 'experts by experience'. 'Participation' in projects should not be reduced to 'recruiting' participants or representatives 'round the table' with no attention to power dynamics that diminish true participation. Practitioners need awareness of these same dynamics in clinical/service settings, to ensure survivors are heard and have real choice in treatment decisions.

Promote self-care

Abuse is self-negating, destroys self-worth and damages wellbeing. Many who have been abused experience times of fragile mental and physical health and may find it hard to practise self-care. Engagement in co-production, shared decision-making and trauma treatments can impact coping mechanisms – thus, self-care should be promoted and normalised. This includes recognising that many survivors are both 'okay' and 'not okay' at the same time (often masking distress). Resilience and 'pathology' are intertwined (for example in self-harm, dissociation, overwork) and are often coping strategies to participate in life despite the pain. Practitioners and organisations should support and not pathologise service users and workers who are survivors, enabling them to be real about their struggles and 'not OK' days, and ensuring sufficient support, which means a holistic approach to care.

Be accountable and transparent

Abuse is hidden, and abusers often act with impunity. Engagement with survivors must have clear lines of communication and accountability, including to survivor participants and survivor communities. Processes and decision-making should be relational, honest, real, transparent, and open to feedback and dialogue. Clinical/service settings should adopt a shared decision-making approach. There should be effective and clear complaints processes, and adequate support and information to access them.

Support self-care and wellbeing

Abuse restricts and arrests healthy growth, imprisoning people in physical, mental and emotional shackles. Engagement should be a voluntary, unconditional process and easy to withdraw from at any point (without fear of permanent exclusion). Good engagement is liberating, dynamic, life-giving and helps survivors experience a sense of possibility and life beyond the aftermath of abuse. Services should include a focus on strengths and support, not just struggles and needs.

Include creative and joyful elements

Abuse is corrosive, restrictive and soul-destroying. Engagement should be a creative process. Good engagement focuses on positive experiences and strengths as well as negative ones and can increase capacity for joy, creativity and imagination. Where appropriate, services should include elements of fun and celebration of achievements and landmarks.

2(b) Intersectionality

As well as the negative mental health impact of sexual abuse in childhood, survivors with certain protected characteristics are at greater risk of mental health problems because of discrimination.[29]

It's important for mental health professionals to be aware of inequalities and intersecting characteristics and identities. When first meeting with individuals with mental health problems, assumptions must not be made about their characteristics because they could influence the person's engagement, treatment and outcome.

Multiple intersecting characteristics, as well as political and social identities, combine and overlap, leading to greater or lesser advantage or disadvantage (intersectionality).

The abuse in NRCSA oppresses and marginalises survivors. For survivors with intersecting characteristics and identities in particular, the oppressive nature of the abuse can add extra layers of intersectionality. When these oppressions and marginalisations accumulate, it can make it much more difficult to access appropriate culturally and identity-competent mental health services.

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

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

A brief look at the evidence related to protected characteristics and child sexual abuse is included below. However, the evidence around ethnicity and NRCSA is sparse, and more research in this area is needed.

First, note that people from Black, Asian and minoritised ethnic groups are more likely to experience trauma,[30] be over-represented in acute mental health services,[31] and experience more negative and potentially harmful care[32,33] than White people.

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

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

Findings of the Independent Inquiry into Child Sexual Abuse for England and Wales

In the IICSA's 2020 report on child sexual abuse in minoritised ethnic communities,[34] they found that literature for England and Wales focused more on the experiences of Asian and South Asian communities than on Black communities, and only a few studies mentioned other minoritised ethnic groups. From their research into the literature and in the form of focus groups, the IICSA concluded the following.[34]

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

As with any survivor of NRCSA, those from minoritised ethnic groups, and with other protected characteristics, may also experience shame and stigmatisation because of negative judgement from their families and communities. One of the IICSA's key research findings was that:

> ***"Shame and stigma were frequently mentioned by ethnic minority participants as leading to a code of silence.***
>
> ***While shame and stigma surround child sexual abuse across all communities, participants identified this as a specific factor influencing how child sexual abuse is responded to within ethnic minority communities.***
>
> ***Participants from a range of ethnic groups described how shame and stigma associated with child sexual abuse contribute to a code of silence on child sexual abuse within their communities. Shame and stigma can act as drivers of responses to child sexual abuse that seek to preserve honour rather than to meet the needs of the victim and survivor."*** [34]

Barriers and facilitators to disclosure are discussed in more detail later in this position statement, particularly in 6(a) Barriers that may prevent a person from disclosing and in 6(b) Facilitating disclosure which discusses best practice.

Sexuality and gender

On shame and stigma, the IICSA found that, just as for men from White majority countries, some male survivors from minoritised ethnic communities who had been abused by men feared being labelled as gay. This was particularly the case for men from cultures in which same-sex sexual activity is taboo and from countries where it is illegal.[35] The IICSA also learned that trauma and other mental health problems are "not widely accepted and understood in many ethnic minority communities".[35]

The IICSA found that while social and political attitudes to LGBTQ+ identities have improved, there are still views in society that were "built on harmful myths and stereotypes".[36] Some LGBTQ+ survivors reported to the IICSA that they were blamed for the child sexual abuse because of their sexual orientation or gender identity ('you brought it on yourself'), or that they had been told that their sexual orientation or gender identity resulted from the child sexual abuse, or that people who had been sexually abused as children would go on to abuse others. These myths severely affected LGBTQ+ survivors' self-identity and mental health, and many of those myths can affect all survivors in similar ways.

The IICSA also learned that because LGBTQ+ people are seen as 'different', it could be more difficult to disclose NRCSA. Internalised homophobic shame and stigma, and overt homophobia, particularly affecting gay and bisexual men, also constituted significant barriers to disclosure and seeking help.

Another prevailing myth is that child sexual abuse is perpetrated by heterosexual cisgender men, and that the survivors are heterosexual cisgender women and girls. This myth and the reluctance to recognise female perpetrators can be damaging for

men and boys, who could feel reluctant to disclose. It is exacerbated by male rape not having been recognised by law until 1994: until then, a male victim of rape could be subject to the same gross indecency laws as his rapist. The IICSA was told that, as a result, many male survivors have never disclosed child sexual abuse.[36]

Finally, men of all sexual orientations and ethnicities are less likely to access or engage in psychological therapy than women, as evidenced in other studies,[37,38] which reduces the opportunities for men to disclose child sexual abuse.

2(c) Iatrogenic harm in relation to NRCSA

Psychiatrists have a duty to combat iatrogenic harm, and the organisations they work in have a duty to adequately support them in this work. Iatrogenic harm has been done to survivors within mental health settings and this has been one of the driving factors for the development of this position statement.

While there is potential for harm throughout healthcare, iatrogenic harm should be thought of in terms of avoidable harm and considered separately from known complications or side-effects of a medical intervention. In relation to NRCSA, iatrogenic harm can be understood in the following ways.

Harm caused by:

- **Lack of awareness of abuse and trauma**, leading to triggering and subsequent re-traumatisation as well as misinterpretation, misdiagnosis and lack of appropriate treatment.
- **Disbelief, diminishment or turning away** from the recognition of NRCSA, which is likely to result in disclosure not occurring and subsequent failures in care.
- **Repeated assessments and history-taking** can be re-traumatising when care systems fail to share information effectively, resulting in survivors being required to repeat descriptions of the abuse.
- **Treatment** (all psychosocial interventions, including psychotherapy and medication):
  - Harm can be caused as a result of the intervention itself or through interactions with professionals and others involved in disclosure and treatment.
  - Harm may result from a lack of appropriate treatment, or from appropriate treatment that is delivered incorrectly.
  - Harm can be caused by therapy, treatment or interventions being withdrawn too early, or, in the case of brief interventions, not being sufficient for the survivor's needs.

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

- **Restrictive and potentially punitive practices** used with survivors. These practices are more likely to be seen when people are given diagnoses such as emotionally unstable personality disorder (EUPD). Restraining a survivor is likely to trigger memories and emotions associated with child sexual abuse, including helplessness and the sense of being physically overpowered. Being detained under mental health legislation or being physically forced to take treatment can also potentially trigger such memories.
- **Systemic failures** (when the structures and systems fail to provide the necessary education, training, support and appropriate intervention, including sufficient funding and resources). This links with failures of national and regional commissioning (where applicable) to support organisations and systems to adopt a trauma-informed approach. Trauma-informed care emphasises the need for a 'top-down' approach in all management policies and procedures. The harm may include the need for repeated assessments across different settings when the system or network isn't working in a collaborative and joined-up way.
- **Poor or inappropriate responses** from other professionals or services, including social care and the police. Inappropriate responses may also include failure of health professionals to recognise the physical health consequences and mental health impact of NRCSA, and thus not refer for appropriate treatment or provide adequate support to access treatment.
- **Diagnostic overshadowing**, in which adult survivors are at risk of being misdiagnosed when there is not an adequate diagnostic assessment. An incorrect diagnosis can be made even if diagnostic criteria are not met or a different mental disorder is present. Risk of misdiagnosis is increased if the person is a woman, they are not heterosexual or they have a history of self-harm. This links with the potential failure to offer survivors a care pathway appropriate to their needs.
- **Intentional harm to adult survivors** by the childhood perpetrator, by other unrelated adults, and by predatory or abusive staff in statutory, voluntary and privately provided mental health services, police and other institutions.[39]

The range of potential harms may seem daunting, but through training and better understanding, a clinician can help avoid them – and this is why we recommend iatrogenic harm as an area of training.

All types of harm may be amplified by a failure to recognise the impact on high-risk groups (as highlighted in Section 1(b) under High-risk groups for child sexual abuse) or specific needs in relation to intersectionality. It's common for survivors to experience re-traumatisation when disclosing the abuse, or when they receive misdiagnosis, inappropriate treatment and care planning and insufficient healthcare provision. It is the view of this Working Group that there is likely to be a significantly increased risk of iatrogenic harm and re-traumatisation at multiple points in contact with health services.

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

To reduce the risk of iatrogenic harm, research has shown that people seeking support emphasise the importance of mental health practitioners' adherence to therapeutic guidelines and codes of practice.[40]

Currently, there is an insufficient body of knowledge on the iatrogenic harm that some psychosocial treatments have the potential to inflict.[41] Problems associated with the adverse effects of certain aspects and types of psychotherapy are well-recognised, yet there remains work to be done to prevent them from occurring.[42] There needs to be better standardised definitions of harms, and a way of monitoring and documenting their effects. Adequately powered research trials to identify benefits and harms would help move the field forward – in particular, research that seeks views directly from survivors about what helps and what harms.[43]

The systematic research review (Appendix A) identified a lack of guidance for best practice after a survivor discloses NRCSA to a mental health professional. Guidance from the National Institute for Health and Care Excellence (NICE) for treating adults with mental health conditions and experience of NRCSA were not only limited to PTSD and EUPD[44,45] but were not considered comprehensive.

Re-traumatisation

In the context of iatrogenic harm, re-traumatisation can be an unintentional result of contact with health care services.[46] The risk of services re-traumatising survivors is lower when collaboration and trust are established as an integral part of the therapeutic relationship.[47] This leads to better outcomes and increased patient satisfaction.

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

Taking a trauma-informed approach

A trauma-informed approach to treatment seeks to prevent re-traumatisation when delivering psychiatric care. It does this by working to understand the complex and pervasive impact of trauma on a person, including their relationships, world view and ways of engaging with support services.[47,48]

It also recognises the need for professionals to attend to their own self-care. This should include recognising the impact of their own lived experience, which may include NRCSA or other adverse experiences, as these may add to the complexity of the clinical encounters.

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

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

Where professionals with such lived experience have been supported in a trauma-informed way to address the impact on them, they are likely to be more empathetic and helpful to other survivors. In contrast, not having had this support may affect their response to those they are working with, making it more difficult for them to maintain their professional stance. This highlights the need for appropriate support for staff, including reflective practice spaces.

2(d) Cultural competence and trauma-informed practice

Cultural competence relates to understanding how beliefs and values may differ between people and/or groups of people, and how those beliefs and values may at times conflict with one another. This directly influences the ability to communicate with people of different cultures effectively and appropriately.

The concept of cultural humility for professionals suggests the need for an ongoing process of self-exploration and self-critique, combined with a willingness to learn from others. It means entering a relationship with another person with the intention of honouring their beliefs, customs and values. It means acknowledging differences and inherent power imbalances.[49]

In relation to NRCSA, a lack of awareness in healthcare professionals and health systems of prejudices, stereotypes, cultural norms and beliefs may be a barrier to providing good quality support and treatment. For example, healthcare professionals must understand how cultural and community practices can be potent forces in the perpetuation of childhood abuses such as female genital mutilation or sexual abuse as punishment. It's also important to look at survivors' 'micro' culture (for example, a family of origin in which intergenerational sexual abuse has taken place).

A health professional's cultural beliefs (for example, if they have strong patriarchal views) may also affect the extent to which they can understand or provide support in a non-judgemental and compassionate way. Being culturally competent requires good understanding of how the intersections of a person's different identities (for example their race, ethnicity, sexuality, religion, and so on) can influence their access and experience of health services. See also Section 2(b) Intersectionality and NRCSA.

Cultural competence is also critical to understanding and avoiding the emotional and mental health impact of being marginalised. This includes the potential for professionals to 'other' people seeking support. The potential for 'othering' is also present in relation to individuals with mental health conditions,[50] including those who also have intellectual disabilities, are asylum seekers, or are neurodivergent and so on. As these factors can increase the risk of a child experiencing sexual abuse and its potential impact, professionals should have awareness and an understanding of how to avoid this marginalisation.

Training and supervision for healthcare professionals

It is essential that healthcare professionals are comprehensively trained in cultural competence, which should take into account trauma-informed principles[51]. Such training should, for example, help professionals understand why individuals from some cultural groups may not want their experience of child sexual abuse written in their notes, nor for this information to be passed on to other care professionals. Understanding this reduces anxiety about unwanted disclosure.

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

See also Section 9. Training and supervision and Resource 1 and 2 in Appendix C on trauma-informed talking therapy assessments and addressing inequalities in the health service in.

Cultural competence needs to be an ongoing aspect of supervision and reflective practice. Attending to this area also requires staff to have space for reflection and understanding. This is linked to cultural humility, but also reduces the potential for vicarious traumatisation in staff working with NRCSA and other forms of trauma.

I received no training on NRCSA as a medical student or a junior trainee [1997–2000]. I remember an Irish man I saw as an SHO [senior house officer] who was admitted with a suicidal crisis. He spoke about being sexually abused as a child in care of the religious institution and a court case relating to this. He was treated with suspicion, and the nursing staff spoke openly about him not to be believed as he was making things up.

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

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

3. Aspects of NRCSA

3(a) Definitions, types and contexts of child sexual abuse and NRCSA

Child sexual abuse has been defined as "developmentally inappropriate sexual activity between a child and another individual who is in a relationship of power, trust or responsibility to the child."[52] Determining when child sexual abuse becomes non-recent has not been defined, especially given that how recently the abuse took place does not determine the impact on survivors. There have been significant attempts to define child sexual abuse and exploitation that are worth reading, including in the UK Government guidance, Working Together to Safeguard Children.[5,53] Recognising the complexities of defining child sexual abuse, a conceptual approach can be helpful (see Matthews and Colin-Vezina[54]).

The accompanying literature review (Appendix A) highlights the inconsistencies in definitions of NRCSA. Also, preferences for which terms are used differ between individual survivors and between stakeholder groups. In the literature and in clinical practice, a consensus has not been reached on the definition of NRCSA.[54]

Child sexual abuse often takes place in the broader context of ACEs[55] and abuse: "All abuse involves a misuse of power within interpersonal relationships. The power may be due to age, relationship, strength, personality, profession, role or position. These experiences can occur in a variety of social settings including families, schools and communities. We understand that different forms of abuse can all have a deep and long-lasting effect on us as children and adults and this can be even more profound if it occurs in early years and within significant relationships".[27]

One also has to consider other factors, such as, to mention a few: the relationship of the abuser to the survivor, the age at which abuse occurred and the age of the abuser.

Peer-to-peer and sibling sexual abuse (often missing from definitions) must also be recognised. Peer-to-peer sexual abuse was thought to account for one-third of offences, but police data now suggests that it accounts for more than half.[56] Sibling sexual abuse may involve complex relationships that could be ongoing, and involve more than one survivor of abuse and trauma.

Often, child sexual abuse occurs alongside or as a part of other forms of abuse (such as physical, emotional, and institutional[57] or organisational abuse) and other ACEs. Child sexual abuse perpetuated by organised crime networks must also be recognised. All these are underpinned by an abuse of power on the part of the abuser, and by powerlessness on the part of the victim. This can increase even further if child sexual abuse is perpetrated by a caregiver or main attachment figure. The imbalance of power and the secrecy of the abuse leads to isolation, and can often leave the child vulnerable to further abuse in adulthood. In defining child sexual abuse, clarification of the distinction

between consent, compliance and coercion in line with the imbalance of power is vital; a child has no agency, is not able to consent and is not responsible if their behaviour is perceived by the adult to be sexualised.

As noted elsewhere in this position statement, child sexual abuse is known to frequently occur in institutions where predatory abusers seek positions that give them access to vulnerable victims. For example, the IICSA found that the locations of the abuse most frequently reported by victims and survivors (outside of the family home) included:

- schools (15%)
- religious institutions (6%)
- residential care and children's homes (6%)
- foster care (3%)
- healthcare institutions (2%)
- other institutions (5%).[58]

Thus, it is important to acknowledge that, even if rare, some adult survivors would have been sexually abused within children's mental health services. Children with mental health conditions are particularly vulnerable. In inpatient settings, they may be separated from family networks and have limited opportunity to seek help. However, in whichever setting they may be – community, home, school and so on – children with mental health conditions may have been unfairly perceived as unreliable; consequently, disclosures or requests for help at the time may not have been believed or acted upon.[39]

Sexual abuse can take many forms. It can include grooming, covert sexual abuse, verbal or written sexual abuse and non-contact sexual abuse perpetrated before any form of physical contact. Grooming (a common term for the manipulation, exploitation and control used by abusers as a tool) and other forms of non-contact abuse still constitute sexual abuse even if contact (physical) sexual abuse does not follow. Non-contact sexual abuse, including online, can be as mentally and emotionally damaging and debilitating as contact sexual abuse.

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

Definitions of child sexual abuse used in research, and across health and social care systems, should include all forms of sexual abuse, both contact and non-contact. Child sexual abuse may be understood as an invasion of the body and the mind, and this highlights that non-contact sexual abuse may be as damaging to one person as contact sexual abuse is to another.

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

Survivors should receive whatever help and support they need, regardless of the type of sexual abuse experienced. The impact of child sexual abuse can be exacerbated or mitigated by the response (or lack of response) received by the child at the time, so impact should be assessed person-to-person rather than based on any assumptions or ideas of 'hierarchy of abuse'.

It is important to consider cultural and regional differences. For example, so-called honour-based abuse can include harmful behaviours such as violence, harassment, sexual assault, coercive control, 'policing' of sexuality and sexual expression, and female genital mutilation/cutting. Sexual abuse may be understood and interpreted differently across cultures, but it remains the duty of clinicians and health and social care professionals to support people to recognise it, disclose it safely, and get the right care and support, while practising individual and cultural sensitivity within the context of UK legislation.

Although studies and information have been sparse on rates of child sexual abuse within religious institution and groups, striking evidence has been emerging both nationally[59] and globally.[60] It's important for all practitioners to explore its possibility without prejudice, whatever their own religious background.

In my culture, loyalty to the family and preserving family honour is everything and you must not bring any shame to the family name by speaking about 'family business' to anyone. On top of this, as a girl, I was taught that I had to submit to anything my brothers or father did to me. Speaking up made me a shame-bringer and shame-bearer.

Mental health services need to educate themselves about the profound shaming and silencing dynamics of honour-based cultures (which also exist in White communities like mine) so that you can sensitively ask the right questions and help us dare break the loyalty bonds that stop us from healing.

3(b) Different journeys

There are considerable differences in how each individual is affected by child sexual abuse, in the immediate aftermath and during their lifetime. Trauma can happen as a result of the failure of others to:

- protect the child from sexual abuse
- hear or respond appropriately to disclosure if it occurs, and
- support the child in the aftermath of the abuse.

As part of defining and understanding child sexual abuse, it's important to acknowledge the substantial effect that abuse can have on a person's life. A definition of child sexual abuse must also acknowledge the impact across a person's lifespan, particularly how the resulting trauma can contribute to different forms of physical, emotional and mental ill-health.

Intersectionality is of particular importance when it comes to understanding different journeys (see Section 2(b) Intersectionality and NRCSA).

4. Awareness and prevalence of child sexual abuse

4(a) Awareness

While there have been several high-profile criminal cases, police operations and social campaigns regarding this topic,[(b)] there is insufficient informative and coordinated public and media education and awareness of NRCSA. A national public awareness campaign to address this is a key recommendation of the IICSA's final report of the Inquiry Panel.[5]

The Scottish Government launched a national framework 'SurvivorScotland' in 2005, which included the aim of raising awareness of the childhood abuse and its long-term impact. This led to greater awareness of NRCSA among professionals and policymakers, although it was less visible as a public-facing campaign. It eventually evolved away from a national framework to be embedded across different funding programmes and policy areas, which reduced its sustained impact.

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

- a failure to facilitate disclosure of NRCSA in the early stages of contact with services
- a failure to identify and diagnose trauma
- misdiagnosis and the attachment of labels that stigmatise the survivor, seeming to blame them for the harm experienced rather than acknowledging that they are a victim of trauma
- inadequate provision of resources and training in services, for the recognition of NRCSA and treatment of its impact, resulting in long histories of service use without the underlying cause (trauma) being addressed.[61,62]
- not being familiar with the latest research into effective treatments for complex trauma, and little research into trauma-informed care pathways and their impact.

(b) This includes the #MeToo movement, which focuses on sexual violence to women but also includes NRCSA.

4(b) Prevalence

The high heterogeneity between studies of child sexual abuse makes it difficult to appraise the prevalence of child sexual abuse;[63] however, our understanding is improving in this area.

> ***"Child sexual abuse is not a problem consigned to the past, and the explosion in online-facilitated child sexual abuse underlines the extent to which the problem is endemic…"***
>
> — IICSA[5]

Recent research and analysis brought together a number of data sources to gain a more accurate picture: in England and Wales, 3.1 million adults aged 18–74 years experienced sexual abuse before the age of 16.[3] The Centre of Expertise on Child Sexual Abuse's 2026 review estimates that around one in six children in England and Wales are sexually abused during childhood, including at least one in five girls and one in ten boys. It also estimates that at least 500,000 children experience contact sexual abuse each year, with the true scale likely to be significantly higher; yet only a fraction of this comes to the attention of statutory agencies, meaning that the gap between the prevalence of abuse and the identification and response by public services remains far too wide.[64]

We know that child sexual abuse is vastly under-reported.[4] In England and Wales, one in seven adults who called the National Association for People Abused in Childhood (NAPAC) helpline were disclosing for the first time[3], and research suggests that child sexual abuse is 30 times higher than official reports.[2] In their 2021 report, the Centre of Expertise on Child Sexual Abuse estimated that at least 15% of girls and 5% of boys experience child sexual abuse before the age of 16 in England and Wales.[1]

Global estimates on the prevalence of sexual violence vary between studies because of differences in age range, type of violence, population and time period considered – for example, slightly more than 1 in 10 girls (less for boys) have been subjected to sexual violence in their lifetime[4]. Sexual violence is endemic in a number of particular circumstances, such as wars or conflicts, remote and marginalised communities, and religious and state institutions.[66] Many studies on NRCSA have focused on female survivors because girls are far more likely to experience sexual abuse than boys.

> ***"This is not just a national crisis, but a global one."***
>
> — IICSA[5]

The review of the literature undertaken to support this position statement (see Appendix A) explored the broad topic of prevalence of child sexual abuse in adults with mental health conditions. Estimates vary considerably, but there is consistent evidence for a link between experiences of NRCSA and the development of mental health problems later in life.[67,68]

Variation in the definition of sexual abuse and the lack of routine data collection has led to problems in understanding its prevalence in and between mental health conditions.[2] The variation seen in research also depends on whether an age difference between the people involved was taken as a defining factor (and what the upper age limit was),

whether encounters involving no physical contact were included, and whether one or more episodes were considered.[26]

Although the review undertaken for this position statement did not explore how experiences of child sexual abuse affect people by gender and sex, many studies of NRCSA focused on female survivors (as noted previously). Potential differences in the impact of child sexual abuse on people from different ethnic groups was also not explored in the review; however, we do know that people from Black, Asian and minority ethnic groups are more likely to experience trauma.[30] The complexities and variation in national, regional and local data on the prevalence of NRCSA as a contributing factor to the development of mental ill-health may cause a barrier to the provision of services that meet people's needs.

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

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

While it's challenging to give an exact prevalence of NRCSA in mental health disorders due to the lack of a research, the evidence strongly supports an association between child sexual abuse and the development of mental health conditions in adulthood.[69,70]

Moreover, research suggests that most people who use mental health services have trauma histories that are ignored[71,72] suggesting that awareness, disclosure and diagnosis are the key issues in ensuring child sexual abuse survivors are recognised and get the service that they need. A 2007 UK Government report suggested that 50–60% of inpatients and 40–60% of outpatients in mental health services had experienced sexual violence and/or child sexual abuse.[73,74]

5. NRCSA and memory

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

- grooming techniques that created confusion and uncertainty in the child's mind
- silence, shame and secrecy, which all perpetuated a sense of uncertainty and potential unreality in relation to the events
- early (preverbal) sexual abuse may mean the trauma is held as somatic experience within the body (procedural memory)[75–78]
- memory-processing during and after traumatic experiences, which is unlike memory processing of non-traumatic experiences
- dissociation during the event(s) may lead to partial or complete amnesia for the traumatic experience, which is linked to memory processing.

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

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

5(a) Dissociation and memory

Dissociation may be understood as the separation of realms of experience that would normally be connected. People may describe feeling 'cut off' from their thoughts, feelings, memories or even identity. It can be thought of as the ultimate survival defence, the escape when there is no escape. Dissociation is a psychic process that everyone experiences to some degree at some time, which may be transient or enduring. It can be used defensively, adaptively or as a form of protection.

Dissociation, as a defence against overwhelming and unbearable terror and helplessness, is part of the hypoarousal freeze-response. It is likely to occur in response to trauma, especially if a person has endured traumatic experience during childhood.

Examples of dissociation include:

- depersonalisation and derealisation
- amnesic episodes
- identity confusion
- fugue states
- freeze responses
- sleep-related disorders such as sleepwalking, night terrors and hypnopompic and hypnogogic hallucinations.

My experience of childhood rape has left me feeling like a half-formed person. I'm more often than not observing myself in the world but never fully a part of it.

As a result of what happened to me, I've spent over half of my life in psychiatric services.

I feel totally disconnected to my own trauma and to my own body.

Dissociative identity disorder (previously referred to as 'multiple personality disorder') has been widely disputed and seen as controversial in the past. This has led to a failure to diagnose the condition, and it is often misdiagnosed.[79] Neurobiological research has supported the existence of dissociative identity disorder[80] and it is important that clinicians are aware of this, especially in relation to a history of severe relational trauma. International general population epidemiological studies also suggest that dissociative identity disorder has a much greater prevalence than previously suggested, with a 1-year prevalence of 1.5% and lifetime prevalence of 3.5%.[81,82]

5(b) So-called 'false memory syndrome'

There is no significant evidence base for so-called 'false memory syndrome' and it has never been ratified by any accredited psychological diagnostic systems as a formal medical diagnosis. Recovered memories of child sexual abuse have been found to be "more likely to correspond to genuine abuse events".[83.] Despite the lack of evidence, the concept of false memory as a psychiatric syndrome has been used in legal proceedings to discredit survivors, and in areas of social work underpinning decisions about a person's care.

While there is no doubt that memory can be unreliable, and that there have been false accusations or retractions made following initial reporting, the evidence suggests that traumatic amnesia occurs in 19–38% of documented child sexual abuse cases with subsequent recovery of memories[84]. False allegations are rare,[85] and less than one quarter of respondents to the ONS crime survey[86] who had been raped in childhood

told someone at the time. Of those, only 8% told someone in an official position.[16,87] It should also be noted that a retraction does not mean that the initial allegation was incorrect; victims retract for many reasons, such as fear of the statutory process, threats from abusers, pressure or fear of consequences from family, and lack of self-belief.

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

5(c) Clinical implications

It's important that psychiatrists and other mental health professionals working with survivors are aware of the complexity of memory in relation to NRCSA, the concept of false memory and how a person seeking support can be impacted by this concept, either in their past interactions with services or by how it is sometimes portrayed in the media. It's also vital that clinicians understand the importance of listening openly and respectfully to any disclosure of abuse.

6. Disclosure

The conceptual understanding around disclosure of NRCSA has evolved from a singular or one-time event to a dialogical process that occurs over time, through reciprocated interactions with family members, spouses, other survivors, and mental and physical health professionals. There is evidence that adult survivors can safely discuss their experiences of child sexual abuse with non-specialist clinicians if safely supported, and treated with belief and dignity.[88]

Disclosure of child sexual abuse to a professional is much more likely to happen in adulthood than before. The average time to disclosure for survivors is 16–24 years after the abuse[5,89] and two-thirds of survivors don't disclose during childhood.[90,91]

It's also much more likely that people in the adult mental health system will be survivors of sexual abuse compared with the general population,[5] although only 20–25% of people accessing mental health services report being asked if they have been abused[92.]

Many survivors access and disclose to organisations in the VCSE sector. One survey[93] highlighted that over 70% of survivors felt they had been heard, believed and respected in their encounters in the VCSE sector, while less than 20% of survivors felt this in relation to statutory services. This highlights the significant issues around experiences of disclosure in the statutory sector.

Non-disclosure or delayed disclosure are the result of multiple factors (described below), but the consequences can be far-reaching and detrimental for survivors and for mental health services. If disclosure is not facilitated to occur, this may lead to misunderstanding and neglect of need, misdiagnosis, inadequate care planning and insufficient healthcare provision,[94] inappropriate psychological interventions and likely iatrogenic harm. Disclosure can be a turning point for survivors, and it's critical that mental health professionals are appropriately trained and supported to facilitate disclosure in a trauma-informed and culturally competent manner.

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

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

6(a) Barriers that may prevent a person from disclosing NRCSA

The following lists were developed by the Working Group using research evidence and expert-by-experience input.

Barriers to disclosure from a survivor's perspective

- **Being male:** males are significantly less likely to disclose than females.
- **Culture and intersectionality:** there are specific barriers for marginalised communities.[5] Fears that the professional will not understand those barriers.
- **Guilt and shame:** disclosure usually triggers the emotions that were experienced when being abused. These, together with the core after-effects of shame and stigma, and the fear of being judged negatively, are major barriers to disclosure.[95,96]

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

- **Feelings of blame, responsibility and culpability.**
- **Concerns about the consequences** of reporting abuse.
- **Uncertainty about the limits of confidentiality** within the therapeutic encounter.
- **Concerns over being required to repeatedly recount the details** of NRCSA to different agencies and/or professionals, which can lead to re-traumatisation.
- **Lack of education** about:
  - sex or sexual relationships
  - what is or isn't appropriate behaviour
  - what constitutes an abusive act.
- **Actual or perceived lack of available support** for survivors.
- **Lack of trust in institutions:** this may arise from negative experiences of mental health institutions, failures to facilitate disclosure, or lack of ongoing support and care offered in the past.
- **Safeguarding and criminal justice processes:** these can be barriers to disclosure if a person with mental health conditions has been routinely failed by the criminal justice system; 76% of people going through criminal justice process say there has been an impact on their mental health.[56,97,98]
- **Presence of dissociation:** this may mean that memories are fragmented and unclear.
- **Grooming methods:** these may create a culture of shame and secrecy.
- **Compliance:** when grooming, coercive control, power imbalance or violence have resulted in the child being compliant.
- **When the abuser is a close family member:** feelings of guilt for the survivor about exposing them, sometimes out of a sense of loyalty to or love and affection towards the perpetrator, or over how it may affect other family members.[95,96]

- **Fear of losing the support of family members or not being believed.**
- **Compounded feelings of fear, guilt and shame arising from interactions with mental health professionals** when there is an unequal power dynamic: survivors might feel that they are not worthy of respect, and therefore avoid discussing the abuse.
- **Fear of disclosing again:** if a survivor has previously felt they had a poor response to disclosure (for example, one that is negatively judgemental, disbelieving, trivialising or offhand[5]) from a care professional or someone in a position of authority.
- **Worries about the processes of safeguarding and reporting:** including, for example, previous negative experiences in health care or reporting.

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

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

Barriers to disclosure from a professional's perspective

- **Lack of training in facilitating disclosure.**
- **Fear of causing further harm** or re-traumatising.
- **Uncertainties about protocols and treatment pathways** following disclosure.
- **Lack of appropriate resources to support survivors** following disclosure.
- **Concerns that survivors may produce false memories** or obstruct legal processes (see also 5(b) So-called 'false memory syndrome').
- **Fear that the wrong timing for disclosure may bring up strong reactions** in the survivor.
- **Fear of having to manage the complexity of possible reporting and subsequent police involvement**, such as notes being subpoenaed and legal processes.
- **Lack of training and clarity around safeguarding and reporting:** confusion and uncertainty about the legal requirements can inhibit professionals.
- **Lack of training and clarity around appropriate note-keeping:** in relation to reporting and subsequent legal processes.[99]
- **Lack of cultural awareness**, and sensitivities and anxiety about this.
- **Belief that the topic of child sexual abuse should not be raised** unless the patient chooses to do so.
- **Anxieties around impact on wellbeing:** including the practitioner's own history of NRCSA or other traumas.

Other barriers are referred in the section below, 6(b) Facilitating disclosure, which describes what to do and what not to do.

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

6(b) Facilitating disclosure

The importance of mental health professionals creating a safe environment so that survivors feel able to disclose cannot be overemphasised. Disclosure should not be forced, but must move at the survivor's pace, giving them enough space and time.[100–102] A few simple prompts such as, 'Tell me your story', or, 'Would you tell me a bit about your childhood?' could be enough to elicit or prepare the ground for disclosure.[100,103]

To address any power imbalance in the therapeutic relationship, mental health professionals need to demonstrate that they are empathetic, respectful, are listening and that they believe the survivor.[27] This is enormously important, as it enables trust. Exploring and understanding why earlier attempts to disclose have been handled badly by professionals could be helpful for both survivor and professional, so that mistakes are not repeated and re-traumatisation is avoided.

It may not always be possible to create the safest spaces or the strongest therapeutic relationship but it's still necessary to create the opportunity for a survivor to disclose, in any setting.

Communicate your compassion and belief that I can heal.

Recognising and exploring any issues in relation to intersectionality and the potential impact on disclosure is a vital aspect of creating safety and trust for disclosure to occur. (See also Section 2(b) Intersectionality and NRCSA.)

A survivor must never be put under any pressure to disclose information in order to prevent the sexual abuse of others. The primary responsibility for preventing sexual abuse of others falls to the perpetrator, and secondary responsibility falls to the institutions charged with protecting us all from harm and abuse. It's important to ensure that the person disclosing retains as much agency and choice as possible about what happens next, in terms of any safeguarding or criminal justice processes. They will need time, information and informed support to explore the avenues open to them, and the impact of any formal reporting processes.

It must be recognised that while, for some survivors, formal processes have brought a measure of justice and been a helpful part of the recovery journey, for most, justice is unlikely to lead to a court case or conviction. Information about criminal and civil compensation is also important. If criminal proceedings are possible or likely, it's

important that professionals are aware of pre-trial therapy requirements and best practice.[104]

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

The Breaking Silences zine (2023) demonstrates how visual art and poetry can be used as psychoeducational tools to facilitate disclosure.

Triggers for disclosure

Certain events may trigger disclosure and/or cause re-traumatisation, such as a national news story about child abuse, or a life event such as the death of the abuser or becoming a parent. This could also include certain physical procedures or investigations such as dental treatment, cervical smear tests, childbirth and so on. For example, birth trauma is more likely to occur in survivors of child sexual abuse.[105] All professionals should be alert to such events and the possibility that they might present for disclosure. They should also be aware of the possibility that such events may increase the likelihood for disclosure by some survivors.

When survivors or family members reach certain developmental milestones they can be a trigger for first disclosure, and require exceptionally sensitive and collaborative management. Such scenarios might include (a) the child of a survivor reaching the same age as the survivor was when they were abused; and (b) the abuser having a new family, and the survivor being aware that their child or children are reaching the age they were when they were abused. These should be covered in training for mental health professionals.

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

6(c) Safeguarding (adult support and protection)

A disclosure of NRCSA may raise contemporary adult or child protection considerations. Non-recent doesn't necessarily mean that the abuse was perpetrated a long time ago; for example, a person in their early 20s may disclose sexual violence perpetrated when they were in their late teens.

Similarly, a perpetrator may still be active: if a person in their 30s discloses that they were raped in their early teens by a healthcare worker who was in their 20s at the time, the healthcare worker would be in their 40s at the time of disclosure and so may still be working, with access to child victims, for another 20 years of their career.

Continued contact with a perpetrator should also be considered: an adult survivor may remain at risk from a perpetrator, who may continue to subject them to coercive control, further sexual abuse or other threats. People who have experienced child sexual abuse may have an increased risk of experiencing sexual violence or abuse in adulthood, either through being targeted by a perpetrator who is aware of the previous history or because of barriers to seeking help in adulthood.

A disclosure should therefore prompt enquiry about a patient's current safety and risk of abuse, and a wider consideration of the risk a perpetrator may present to others. A survivor's willingness to report to police or social services may be affected by childhood experiences of disclosure or help-seeking, particularly if their reports were not believed or did not stop the abuse.

Because of this, it's important that a survivor remains in control of any actions arising from disclosure. An initial disclosure may need to be held within mental health services until appropriate support, time and consideration is given to involving other agencies. A survivor should not be pressurised into making a report.[106]

6(d) Disclosure as a journey not a single event

It's highly unlikely that everything will be disclosed by a survivor in one discussion; in fact, they might hardly scratch the surface. Mental health professionals need to bear in mind that they might not have the 'whole story', and to work on establishing trust with survivors so that they feel safe to disclose further.

A survivor might come into contact with a number of different professionals in mental health services, and therefore might disclose on several different occasions. This applies not only to mental health professionals but to other professionals that survivors may encounter, such as in the police, social care or physical health care.

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

6(e) Support and referral after disclosure

After disclosure, the survivor may feel distressed and fearful about the consequences, and the support that they are given at this time is crucial. This is a period when professional guidance is needed, which should cover the following aspects.

- Understanding the immediate support systems the survivor has in place and whether they are still at risk of abuse.
- Arranging a time to check in within a short timeframe and providing details of how to access help in the meantime, particularly given the impact disclosure can have.
- Explaining what might happen next in providing care, including discussing whether referral to expert services (such as sexual assault referral centres or independent sexual violence advisors) could be helpful. If safeguarding concerns make a referral necessary, as far as possible the survivor should be supported to self-refer if they wish to (for example, if children may be at risk). Otherwise, any exploration of formal reporting should happen when the survivor wishes to do so. (See also Section 6(c) Safeguarding (adult support and protection.)

Providing advice and information on sources of help in managing any immediate distress and other impacts associated with making a disclosure.

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

7. Psychiatric diagnosis and formulation

Within a formulation approach, the assessment of an individual's cognition, emotional regulation and behaviour, alongside a review of their history, can lead to a diagnosis of a mental health condition as part of the process to determine appropriate treatment options. If a survivor would like a companion/advocate with them, this should be supported. Diagnostic assessment also includes the evaluation of risk, and tests and investigations to determine if there are physical problems underlying the presentation. Categories of diagnosis are based on the current clinical teaching, underpinned by diagnostic tools and manuals such as the ICD-11.[107]

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

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

7(a) Survivors' experiences of diagnosis and formulation

The testimony of survivors commonly describes poor practice in terms of formulation, receiving incorrect diagnoses when seeking help from mental health services, and correspondingly, experiencing fragmented and/or inadequate care that caused them harm.

They report how their difficulties cannot be captured by diagnosis, and that their presenting symptoms reflect the coping mechanisms developed during their abusive childhood which enabled them to survive.

I am not mentally ill. I was abused – and my 'symptoms' are simply coping mechanisms.

It was very much all 'What is wrong with you' not 'What happened to you'.

The following summarises ways in which survivors' have had problematic experiences with diagnosis.

- For a survivor, a diagnostic label may be experienced as the medicalisation of distress, perpetuating the shame and stigma that is often already linked to the original trauma.

- Categorisation of diagnoses of mental health conditions is socially and culturally informed. It's influenced by an understanding of social norms and practices to which people in society are expected to adhere, and deviance from such norms has formed part of our understanding of mental ill-health. Survivors have criticised an approach that focuses on labels, categories and classes of disorder because they experience it as dehumanising and as labelling them as 'deviant'. To not consider subjective experiences of culture, oppression and trauma can cause re-traumatisation, shame and further mental distress.[108.]

- Growing evidence[5] shows that the potential harm caused by child sexual abuse may lead to a wide variety of possible presentations as an adult, which can lead to multiple diagnoses. Fragmentation of care often results in people being given multiple brief interventions that don't address the substantial impact of NRCSA, but are instead symptom-focused. (See also Section 2(c) Iatrogenic harm in relation to NRCSA).

- Undue focus on symptoms can be unhelpful and may impact on the quality of the consultation to offer a space which can facilitate disclosure of NRCSA.[109] (See also Section 6. Disclosure).

- For some survivors, referring to their experience/presentation with the term 'symptoms' may feel unacceptable or uncomfortable. This is because the way in which the person presents is a reaction to what was done to them, not having arisen from them. Certain feelings, thoughts or behaviours that can be understood in terms of symptoms by mental health professionals might have been protective for the individual, allowing them to survive in a hostile and abusive world around them in their early years.

- When care and treatment plans have focused on diagnosis, a proportion of survivors have been treated by personality disorder services within the NHS. This reflects how these services have often been the only specialised psychological services to provide long-term care for patients with complex presentations. It has also led to many of these patients obtaining a diagnosis of EUPD as the only way to access long-term treatment. This is particularly problematic for many survivors. They have described how the construct serves to confirm their worst fears about themselves, that they were abused because of something inherently wrong with them and leads to care that is re-traumatising.

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

Working in a personality disorder service, I realised that almost every patient in the service had been sexually abused as a child. I became aware how, for many of them, this experience became an organiser of their internal structure – like a nexus around which they functioned.

- While this remains a controversial area within psychiatry, the potential stigma and shame associated with the personality disorder construct, and the focus on symptoms, can fail to acknowledge the strong links to ACEs including child sexual abuse.[110] This isn't a matter of contested concepts, disputes about labelling or diagnostic models. The current situation regarding standards of diagnostic assessment for EUPD is not helped by NICE guidance in this area,[44] which states that it is acceptable to base a diagnosis on a standard clinical history or impression alone, without the use of a structured assessment or collateral history.

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

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

These survivor experiences are also recognised by many clinicians in mental health. Clinicians report hearing narratives in which iatrogenic harm has been linked to failures within the system to work in line with trauma-informed principles, and also to a lack of knowledge of the potential impact of NRCSA[112,113] Inadequate access to trauma-specific services and trauma-informed pathways may present the clinician with ethical dilemmas, or even moral injury, in relation to the prevention of re-traumatisation and iatrogenic harms.

7(b) Reflections on diagnosis, formulation and NRCSA

A trauma-informed approach in working with NRCSA survivors would require a formulation that shifts the focus away from "What is wrong with you?" to "What has happened to you?" and "What do you need now?" This holistic form of formulating difficulties is a strengths-based approach that moves away from an emphasis on symptoms. Instead, it focuses on what the survivor may have needed to do, and what coping mechanisms were required, for them to survive.

Trauma-informed care is, therefore, a necessary foundation for a psychiatric formulation, alongside awareness and training in facilitating disclosure (See also Section 6.Disclosure.) An awareness of the impact of NRCSA and of the appropriate pathways for care would also inform the formulation.

The current emphasis on diagnosis rather than a biopsychosocial formulation within the mental health setting is one aspect of failure to facilitate access and provide appropriate care. Inadequate training in trauma-informed principles, absence of widespread uptake

of facilitating disclosure trainings, and a recognition of the prevalence and impact of NRCSA, are all important contributing factors. This is reflected in the experiences detailed above, in Section 7(a) Survivors' experiences of diagnosis and formulation.

There are multifactorial causes of this drift from the comprehensive use of the biopsychosocial model.[114] Members of the College have described how modern health systems work against its principles. For example, the pressure on psychiatrists – because of factors such as burdensome administrative tasks, ever-increasing referrals and work-force vacancies – significantly limits the time for more thorough, formulation-based assessments.

There is a consequential lack of continuity of care; a tendency for patients to experience multiple assessments of their symptoms, risk assessments and tick-box engagement; and treatment plans that do not focus on addressing the underlying causes. While psychiatrists are trained to deliver psychological treatments, doing so as part of a comprehensive package of care can be difficult because services are typically coordinated so that other mental health professionals provide those treatments.

Thus, current services are commonly orientated away from best practice, leading to a lack of a holistic approach to diagnosis. This is highly problematic for survivors and patients, as clinician's will often have a limited understanding of the complexity of each person's life and presentation, and a limited ability to work with the individual according to their needs.

Conversely, a biopsychosocial formulation may capture complexity and need, and recognise the potential centrality of the traumatic experiences, but not adequately help a survivor to receive appropriate support because of the way services are designed around individual diagnostic categories and the absence of sufficient trauma-specific treatment pathways.

This highlights the importance of the recommendations in this position statement on training, guideline development and the design of services and pathways that best support clinicians in providing a holistic biopsychosocial approach, and addressing the gate-keeping of services on the basis of diagnosis.

7(c) Attitudes and knowledge of the diagnosing clinician

Since any clinical encounter may be with a survivor who has not yet disclosed NRCSA, all clinical encounters across all settings need to:

- **Be non-judgemental, open, respectful, collaborative and culturally sensitive**, with an emphasis on working alongside the survivor. This may include a discussion of how helpful a diagnosis might be for the person and what it may mean for them in their circumstances. (See also 2(d) Cultural competence and trauma-informed practice.)

- **Recognise and explicitly acknowledge the inherent power imbalances** that may interfere with the therapeutic relationship.
- **Understand, acknowledge and address intersectional issues** that may be contributing to the person's presentation. (See also Section 2(b) Intersectionality and NRCSA.)

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

If you have no trust in the person who's meant to help you, where do you go from there?

- **Recognise the potential for diagnosis to be stigmatising and re-traumatising.** (See also 2(c) Iatrogenic harm in relation to NRCSA.)

7(d) Complex PTSD

Although a psychiatric diagnosis has the potential for the difficulties described in the previous sections, many survivors require a diagnosis to access care. The addition of C-PTSD to ICD-11 acknowledges the aetiological links between childhood trauma and current presentation. Further research is needed in this area to gain accurate prevalence rates of C-PTSD within survivor populations. Research shows that 80% of service users have experienced trauma, yet only 5–20% have a diagnosis of C-PTSD.[115,116] The ICD-11 diagnosis of C-PTSD typically arises from severe and prolonged ACEs.[107]

In a meta-analysis of predictive variables for C-PTSD, the experience of child sexual abuse was identified as the main risk factor. Emotional neglect in childhood, physical abuse throughout life and being female were also significant.117 Prolonged trauma in adulthood is also an identified risk factor.118 C-PTSD's construct validity has only been examined in childhood abuse, and single-trauma exposure samples.

Thus, the extent to which C-PTSD applies to other repeatedly traumatized populations is unknown. It is hoped that the C-PTSD diagnosis will make it easier to identify survivors of NRCSA and other developmental trauma, thus improving access to appropriate mental health support119. It is also essential that people with a diagnosis of C-PTSD are offered treatments that match their needs, especially in terms of the practitioner's level of experience and the length of overall treatment.

I got no real help with the reasons for my distress – I'm being offered only medication. I have had doctor after doctor who didn't understand trauma and just said, 'Take the tablets'.

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

8. Care pathways and treatment

8(a) Current support for survivors

Many survivors report never having accessed care, despite being at a higher risk of experiencing mental health problems than people who haven't experienced abuse.[120] For those who do, it's extremely challenging to access the appropriate trauma-informed care and treatment across different settings. Not only is appropriate care likely to be difficult to find, but the person may have feelings of shame, and fear of the consequences of disclosure (such as the impact on their life, family and loved ones, and the repercussions of reporting to social services or the police).

There may also be cultural, religious, gender or sexuality-based issues that are not addressed within an appropriate, culturally competent framework to facilitate the access and engagement with a therapeutic service. All these issues can contribute to the creation of barriers to accessing care, and these barriers reflect a lack of prioritisation of mental health care for survivors in key areas of relevant guidance.

NHS mental health services

In the report of the All-Party Parliamentary Group of Adult Survivors of Childhood Sexual Abuse[121], only 16% of survivors said the NHS mental health system met their needs. This is less than half of the overall satisfaction rate in mental health services.[122]

Survivors face multiple hurdles in accessing appropriate NHS care. This may begin with NRCSA not being identified as part of the presentation because of failures within primary or secondary care to facilitate disclosure (See also Section 6. Disclosure).

When there is disclosure, a failure to understand the role that NRCSA can play in mental health presentations can lead to gate-keeping of access to care, either by being labelled 'too complex' or through not meeting eligibility criteria. If a person does meet the criteria to access treatment, subsequent care pathways and interventions may not be appropriate to their needs – survivors are likely to face repeated assessments across a number of services, and may receive multiple diagnoses for which treatment is short-term and aimed at addressing symptoms rather than tackling the underlying cause.

This can lead to a spiral of exclusion and a fragmentation of care. Interventions based on diagnosis may also offer little in terms of flexibility and choice in modality or ways of working (see also 2(c) Iatrogenic harm in relation to NRCSA and Section 7. Psychiatric diagnosis and formulation). Appropriate trauma-specific services, especially those that are low gate-keeping, are likely to have long waiting lists, which may serve as a further barrier to care.

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

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

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

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

Access to care may also be restricted due to failures within the system to recognise and adapt to the particular needs of certain groups at higher risk of NRCSA, particularly those with intellectual disabilities and neurodivergence. This may also be true for those with severe mental illness. Failures by services to recognise intersectional issues that may prevent or hinder access will also be linked to services not being culturally competent.

When survivors have been sexually abused within institutional settings, or experienced sexual assaults or abuse by mental health staff, access to statutory care is likely to be impacted and specific adjustments to care pathways and treatment are needed.

Trauma-informed care and trauma pathways in NHS services

All NHS services should provide care that is trauma-informed. The long-term lack of understanding and acknowledgement of the prevalence and impact of NRCSA has resulted in a failure of sufficient numbers of trauma-specific services, and of a coherent and accessible treatment pathway. As recognition of the impact of ACEs increases and the movement for trauma-informed care grows, there is an early period of development in which NRCSA is beginning to be addressed in mainstream psychiatric care. This is being supported by welcome initiatives such as NHS England's sexual violence and trauma pathfinder programme, which is being implemented in several regions in England.

Given that survivors often have greater complexity and comorbidity, and higher severity of psychiatric presentations[26] than those who have not experienced NRCSA, the Working Group believe it is justified to prioritise action to implement trauma-informed services and appropriate pathways of care throughout NHS mental health settings. Additionally,

it's important to note that there are calls from within the survivor community and survivor organisations, and from researchers and professionals within the mental health system, to create a specific trauma pathway to address such concerns.

Other forms of care and support

While the most commonly accessed forms of support, advice or treatment are through NHS services, many survivors turn to or prefer to access other forms of care[123]. This may be related to the lack of available and appropriate NHS services or long waiting lists. It may also be because of a lack of trust in statutory mental health services, linked to previous experiences of harm and re-traumatisation.

Survivors have reported that, across all types of care they have accessed, the most helpful support has been from VCSE specialist services. There, they typically experience enhanced knowledge of trauma and sexual abuse, as well as access to peer support groups[121,123]. Survivors accessing other VCSE services that are not specialists in sexual abuse and trauma may find them helpful, but generally not to the same extent because they provide more generalised mental health support[123].

As with NHS services, survivors can face challenges accessing VCSE services. The sector is often oversubscribed, with waiting lists then needing to be closed, while contracts and funding are often short term which can limit access to only receiving short-term interventions. Private psychiatric and psychotherapeutic services are another form of support survivors can find helpful, although these are accessed less frequently than NHS and VCSE services.[123]

While this position statement predominantly focuses on improving NHS mental services' response to NRCSA, given survivors often access different types of VCSE and private services, it is important all these are working within appropriate governance systems that support continuous improvement in quality and safety. Similarly, to reduce the risk of survivors experiencing harm and re-traumatisation when access voluntary and private services, there is a need to focus on ensuring these are only provided by qualified and accredited practitioners with specialist training in supporting individuals affected by NRCSA.

Coordination of care across services

To date, there has been a profound lack of a coherent inter-agency response between statutory and VCSE support services. This perpetuates the difficulties in accessing care and the fragmentation of the care received. While many VCSE services may work in a trauma-informed way, and patients with complex needs might be presenting there, some services may not feel sufficiently equipped to work with high-risk and multiple comorbidity presentations.; The lack of coordination between VCSE sector and NHS services hinders shared learning between these organisational structures. Multiple referrals with repeated assessments, followed by a closed door or a long waiting list to access services, is a repeated experience for many across VCSE and statutory services. VCSE short-term funding may not sufficiently support the service's training, regulation and supervision needs.

Clinical guidelines

An exercise was undertaken to explore any reference made to providing or adapting treatment following disclosure of NRCSA in mental health clinical guidelines. The Working Group found a lack of guidance for clinicians and health workers on supporting people to disclose abuse, and on providing appropriately adapted treatment when NRCSA has been disclosed. A summary of the findings of the review of guidelines is included with the literature review (Appendix A).

See also Appendix C, Resource 3, for an example of good practice in complex trauma service provision; Resource 4, for the interdependent model of apology in non-recent institutional abuse; and Resource 5, for IICSA's report on their investigation into accountability and reparations.

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

8(b) Treatment and care pathway principle

I bring at times unbearable pain and inconsolable loss, looking for someone with the strength to hold me in that suffering. I need to be held by someone who understands the pain of betrayal.

The Working Group developed the following principles for treatment and care pathways:

1. The survivor's voice and practising shared decision-making[124,125] should be at the heart of all treatment and care pathway design, production and implementation.

2. Pathways need to be designed within the principles of trauma-informed practice.

3. Following disclosure, pathways of care allow for choice and flexibility of care that align with need and complexity. This may include a general hierarchy of need, from trauma-informed to trauma-specific to trauma-specialist. This hierarchy suggests that there are likely to be different needs among survivors and not all will require specialist trauma interventions, but all interventions need to be trauma-informed.

4. While a significant number of survivors may not require specialist trauma services, some will. These need to be separate from personality disorder services.[109.]

5 Pathways need to recognise the impact of attachment trauma, and that the continuity of a therapeutic relationship is vital to engagement, the development of trust and a therapeutic alliance.

6 Collaboration and learning across the VCSE and statutory sectors need to include easier access and transfer between sectors as needed.

7 Mental health services should make sure that all adult survivors receive the care and support that they need.

8 Appropriate research needs to be conducted, to ensure the growth of evidence-based care and to support appropriate training of staff. This could also lead to the development of guidelines for care (for example, NICE guidelines).

8(c) Treatment issues

It's important for clinicians to ask about and be aware of other services being accessed by a patient, and to liaise as appropriate with private or VCSE therapists to ensure coordination and safety. Whether patients are able to access statutory services at the same time as private or VCSE sector services is often a decision taken at a local service level. Significant ethical clinical issues can arise, such as financial pressure on survivors from fees for non-NHS care, and issues of access to NHS services. Issues around confidentiality and shared care must be considered. When either facilitating a handover to statutory services or providing ongoing care, communication across these different settings is vital for good care and coordination.

Survivors may present in any physical or mental health setting within the statutory sector. From the evidence in the prevalence review undertaken for this position statement (see Appendix A), there is a significant likelihood of seeing survivors in substance misuse, eating disorder, psychosis, depression and anxiety services. The need for trauma-informed care embedded within psychiatric support and treatment required is part of the model of trauma-specific services.

Survivors' identities as a survivors of a serious violent crime must be recognised, if they wish, as part of their treatment plan. Every effort must be made to not compound this by acting in coercive ways. Coercive or restrictive practices may re-traumatise NRCSA survivors, so work being done to reduce this will help this vulnerable group. If restrictive practice cannot be avoided, then post-incident there will have to be more in-depth and careful support of the individual, to manage the almost inevitable re-traumatisation.

It's also important to be led by what the person finds helpful. This includes being culturally sensitive to any needs that arise through intersectional issues (for example, requests for a female therapist, a Black therapist, a men-only group and so on). Survivor-led requests or requirements may include a range of other approaches, such as peer-support groups, mindfulness and yoga, body/somatic work, neurofeedback, and art, music and dance/movement approaches.

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

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

Effective treatments

Examples of effective treatments for some NRCSA survivors include:

- cognitive restructuring and imaginal exposure for complex trauma, depression and anxiety[67]
- phase-based trauma-focused psychological interventions for emotional dysregulation and interpersonal problems[67]
- trauma-focused psychological therapies for symptoms of psychosis and dissociation[119,126]
- eye movement desensitisation and reprocessing (EMDR) for psychological distress for people given a personality disorder diagnosis[127] and psychosis[128]
- body movement for PTSD symptoms and related health issues[129].

There is also promising emerging research evidence for the use of neurofeedback,[130,131] psychedelic-assisted psychotherapy for PTSD,[132] and trauma-informed yoga as an adjunct therapy.[133,134]

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

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

8(d) Treatments for complex PTSD

It has been highlighted that in C-PTSD diagnosis, child sexual abuse is a strong predictive risk factor and there is evidence of high prevalence rates among survivors. There is a growing body of evidence in relation to C-PTSD that highlights the need for a phase-based, multimodal approach that needs to be both verbal and body-based (see also Appendix C, Resource 3, for an example of good practice in complex trauma service provision). Coupled with this is the trauma-informed approach of co-produced and personalised treatment plans.

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

A phase-based approach of stabilisation and safety, trauma processing and reintegration is recommended. Stabilisation work focuses on trauma psychoeducation, which includes an understanding of trauma and its potential impact. The emphasis is on the management of hyperarousal and dissociative symptoms, learning to regulate emotions and strengthening support networks. Attendance to physical health and general self-care are also integral aspects.

Trauma processing may include a variety of modalities, such as EMDR, trauma-focused CBT, adapted psychodynamic therapy, trauma-focused mentalisation-based therapy, art therapy and so on. There is also emerging evidence for the use of body-based therapies for C-PTSD as either adjuncts to talking therapies (such as trauma-sensitive yoga[135]) or stand-alone treatments (such as sensorimotor psychotherapy[136] or Somatic Experiencing.[137]

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

Two meta-analyses of treatment trials suggest that although trauma-focused treatments such as EMDR and trauma-focused CBT are likely to be effective, treatment outcomes are not optimal and not all modalities of treatment will work for everyone. Results also suggest that multicomponent interventions, including distress tolerance and emotional self-regulatory strategies, make trauma-focused interventions in C-PTSD more effective[67,138] where participants were likely to have clinically significant baseline levels of one or more C-PTSD symptom clusters (affect dysregulation, negative self-concept and/or disturbed relationships).

Two multicomponent sequential approaches have shown positive results: STAIR (Skills Training in Affect and Interpersonal Regulation) with narrative therapy[139] and dialectical behavioural therapy for PTSD.[140] However, randomised controlled trials are urgently needed, and strategies for patient engagement due to risk of high attrition rates is an important topic for further research[141].

The reintegration phase highlights the ongoing nature of recovery. It challenges the idea that trauma can be fixed and instead focuses on the ongoing nature of the work. This phase also addresses the integration of the knowledge, skills and processing work completed in the first two phases. Reintegration focuses on connection with others, and this can be enhanced by group work both therapeutically and in the community. Social prescribing can be a helpful tool to facilitate this.

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

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

8(e) Transition from children and young people's to adult services

Particular issues arise in the transition from children and young people's to adult services that can further fragment care (such as becoming lost to services, and if parents and carers are no longer involved in the person's care when they reach 18 years of age).

The impact of sexual abuse on a child often presents as emotional or behavioural challenges in childhood and may precipitate the onset of a mental illness. The child may disclose the sexual abuse, may imply but not confirm abuse or may deny abuse ever occurred.

Children and young people's mental health services are experienced at supporting young people with such presentations and often have excellent support packages; however, it's important to recognise that it's likely the support will not fully mitigate the impact of the abuse in adulthood, and/or that the treatment or support may not have been completed before the age of 18.

Transition of young people with significant levels of emotional dysregulation and disclosed or non-disclosed child sexual abuse can be particularly challenging. The young person may not meet criteria for mental health services or specific trauma pathways, but

still be presenting with significant needs. As such, it is vitally important that the impact of NRCSA on young people transitioning to adult services is taken into consideration in all transition pathways.

8(f) Delivering system change

Improving care pathways and treatment for survivors will require system change. This needs to be supported by a framework for how services should be designed and delivered differently, with the necessary resource allocation.

The way this happens varies across the UK, from nationally driven central and regional commissioning of services in England, to more regional level decision-making in Northern Ireland, Wales and Scotland. It will be important that this process is co-produced with patients and survivors, and fully takes into account the needs of those seeking help, as well as of the evidence-based guidance and service specifications.

9. Training and supervision

9(a)Types of training

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

The training outlined below can increase the likelihood of disclosure occurring, reduce the time taken to disclosure and, depending on resources, facilitate prompt access to appropriate help. This is likely to reduce the incidence and severity of mental health conditions for survivors of child sexual abuse. Therefore, the provision of effective training packages is also likely to lead to cost savings.

It's essential that NRCSA is comprehensively included in the training curriculum for doctors, nurses, midwives and psychological professional roles, and as continuing professional development (CPD) for those who have finished their training or are in non-training posts. It's also important to ensure that this training is embedded in reflective practice and through every level of leadership. Learning from other organisations who have already developed and incorporated this kind of training is vital.

All training and education efforts should incorporate intersectionality. A primary level of training should enable staff to:

- facilitate disclosure
- demonstrate understanding of:
  - confidentiality
  - safeguarding
  - note-taking protocols
  - related policies and legislation
- recognise common presenting symptoms/coping mechanisms
- be able to work to the principles of trauma-informed practice
- be confident in the use of trauma-informed language
- understand trauma and it's psychological and physical effects on survivors, including the brain and the nervous system
- respond to trauma, including strategies for co-regulation and dealing with vicarious trauma
- know where to access necessary information to signpost or refer survivors for further help, support and, if required, trauma-informed psychological therapies
- know how to support and advise a survivor who wishes to talk to the police.

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

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

Because survivors are seen as patients across the spectrum of health and social care services, a basic level of training also needs to be provided to a wide range of professionals (including paramedics, A&E staff, physiotherapists, dentists, social workers and blue light services).

9(b) Co-production of training

Survivors should be empowered and enabled to meaningfully co-produce any training provided. This includes co-design and delivery of training.

To support this, the Royal College of Psychiatrists' is already committed to developing co-produced guidance for resident doctors and trainers, as well as an eLearning module to provide CPD for more established psychiatrists.

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

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

9(c) Supervision and reflective practice

Staff working with survivors need appropriate spaces to reflect on their work, acknowledge their own emotional responses, and consider how this may impact on their capacity to engage with survivors in a trauma-informed manner. Appropriate use of reflective spaces and supervision for staff working with survivors is also likely to reduce iatrogenic harm. Embedded in these structures is cultural competence and humility, with space for recognition of intersectional issues.

The College has recently published a position statement on the importance of high-quality reflective practice in mental health care. This sets out what teams and organisations should do to provide this form of support for their staff. As such, we have not explored this aspect in detail in this document.

To ensure CPD and ongoing optimal delivery of services for survivors of NRCSA, staff need to have reflective practice sessions within their teams. Sessions need to be regular and structured. They should allow each team member to openly share their reflections on their own practice and how it might impact on other members of the team. Adequate supervision time that also recognises the potential impact in terms of vicarious traumatisation and burnout is essential. Timely access to psychological support for staff who are impacted is also vital.

At an organisational level, there needs to be leadership that develops and promotes trauma-informed organisations across all levels of care, within all policies and procedures so that it is embedded at a systemic level. This will include appropriate management structures that support trauma-informed ways of working.

10. Research

Despite a growing body of research on the prevalence of child sexual abuse, the evidence base is challenging to navigate because of the inconsistencies in definitions and methodology, and the availability of data (see Appendix A). Qualitative research into the impact of NRCSA on mental health and wellbeing in adulthood is minimal compared with quantitative research, including survivor-led and survivor-focused research. While further quantitative research is welcome, this disparity should be addressed with prioritisation of qualitative and survivor-led/focused research.

10(a) Priorities for research into NRCSA

The top 10 priorities for sexual violence and abuse research

1. From the perspective of survivors of sexual violence/abuse, what does recovery involve, what outcomes do they value and what factors can promote these outcomes?
2. How can survivors of sexual violence/abuse who identify as people of colour or as members of Black, Asian and minority ethnic groups be best supported?
3. How can access to high-quality psychological therapies for survivors of sexual violence/abuse be improved?
4. What interventions with the general public could reduce misconceptions and stigmas about sexual violence/abuse and their consequences on survivors of sexual violence/abuse?
5. How can the process of police reporting and police investigation best support survivors of sexual violence/abuse and avoid re-traumatisation, distress and victim-blaming attitudes?
6. What support is most helpful to and valued by survivors of sexual violence/abuse themselves?
7. How can mental health services and physical healthcare services that are likely to come into contact with survivors of sexual violence/abuse (for example, dental care, general practice, accident and emergency, intimate healthcare and pregnancy termination settings) become more 'trauma informed' to best support survivors and prevent re-traumatisation?
8. How does involvement in the criminal justice system impact survivors of sexual violence/abuse (for example, their emotional and psychological wellbeing), and what support do they need during and in the aftermath of criminal justice proceedings?
9. How can support be more accessible, inclusive and effective for survivors of sexual violence/abuse who identify as LGBTQ+?
10. How can survivors of sexual violence/abuse be supported to report sexual violence/abuse that happened many years ago, and what services should be offered to help them recover?

Source: Varese et al. (2022) Top 10 priorities for Sexual Violence and Abuse Research: Findings of the James Lind Alliance Sexual Violence Priority Setting Partnership[135]

Across medical research, the involvement of people with lived experience in research has been inadequate, but the situation is improving as co-production, co-development and co-design become more standardised and essential components of the research process. The importance of public and patient involvement (PPI) and its value to healthcare research is generally recognised; PPI standards[142] are a priority for the National Institute for Health and Care Research,[143] and an expected part of funded research projects.

The Violence and Mental Health Network has funded a number of projects to improve research in this field, focusing on measurement, understanding and interventions. They found that key research priorities for survivors included helping survivors to understand what happened to them as abuse, and providing professionals with tools to recognise abuse[144] survivors.

Researchers, clinicians and people with lived experience are all vital to helping shape the health research agenda on NRCSA. A joint research approach allows for the identification of unanswered questions, the prioritisation of important topic areas and the publicising of opportunities for researchers and funders.[144,145] See also Appendix C, Resource 6, for priorities in sexual violence and abuse research.

While 62.5% of the mental health primary care research reported having PPI, this was true in only 12.9% of studies about abuse survivors, with survivors tending to fill more advisory roles at isolated stages of research development.[43] Survivors have put forward ethical, epistemological and methodological reasons for more inclusion in research,[146] yet there is a pragmatic argument, too.

Survivor-led research identifies solutions to tackle key issues of disclosure, diagnosis and treatment.[109,147] There remains considerable opportunity for improved research that is driven and led by survivors, with their voices truly at the forefront. This is crucial for a better understanding of the impact of NRCSA and for continuing to improve approaches to treatment. Research by survivor-researchers can have additional benefits and impact to research with PPI (bringing deeper insight and understanding, supporting trust and rapport with participants, and so on).[27,147].

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

10(b) Conducting research in partnership with survivors

When embarking on research with survivors, creating a sense of safety and trust is vital. Joint working can be carried out in different ways (workshops, online consultations, surveys, and so on), but safety and compassion are always of utmost importance. Fortunately, there is guidance on setting principles for consultations so that approaches used are safe and don't lead to re-traumatisation[148]. Survivors should be treated as research partners, respected, listened to and offered the opportunity to provide feedback on processes. Research led by survivors is an important step towards developing, commissioning and providing appropriate services to meet their needs.

10(c) The evidence base for NRCSA and mental health

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

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

More broadly, the body of research relating to ACEs demonstrates the significant impact that they (including child sexual abuse) may have on physical and mental health, as well as on relationships, academic and occupational achievements, and wellbeing. This research has been vital to the recognition of the interplay between experiences of NRCSA and their potential impact on the body and mind.

Research on treatment interventions has tended to be diagnosis-driven rather than specifically on survivors. The addition of the diagnosis of C-PTSD may facilitate more focus on survivors of NRCSA, but further work is needed within all groups of survivors regardless of diagnosis.

10(d) Ways forward

Recent research establishes the importance of a trauma-informed approach to mental health care,[149,150] and there is growing evidence on effective treatments for C-PTSD[119,126,127,129] little is known about which treatments work best for survivors of developmental trauma with psychosis. We sought to do the first review, to our knowledge, to investigate treatments for people with psychotic and dissociative symptoms who have a history of developmental trauma.

We searched MEDLINE, PsychInfo, and Google Scholar for studies reporting psychological and pharmacological treatments of psychotic or dissociative symptoms in adult survivors of developmental trauma. We identified 24 studies, most of which investigated various modalities of psychotherapy with two case reports of pharmacological treatments. There is preliminary evidence in favour of third wave cognitive therapies. However, because of low methodological quality and reporting in most of the studies found, it remains unknown which treatments are most effective in this clinical group. Nonetheless, our findings of potential treatment targets, including emotion regulation, acceptance, interpersonal skills, trauma re-processing, and the integration of dissociated ego states, could guide future work in this area. Methodologically rigorous studies are needed to enable clinicians and patients to collaboratively form evidence-based treatment plans. Our Review is registered with PROSPERO, number CRD42018104533.

However, there is little formal evaluation of trauma treatment pathways, and issues such as diagnostic overshadowing and lack of awareness of NRCSA and its impact prevent many survivors from accessing the services they need. Our search of the guidance found that explicit treatment advice and guidance on disclosure, management or support related to traumatic experiences of sexual abuse was either minimal or absent from several mental health treatment guidelines, including NICE, SIGN and equivalent guidance internationally (see Appendix A). It's possible that challenges and inconsistencies in the evidence base have contributed to these gaps. The need for further research into effective treatment pathways and approaches is clear.[151]

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

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

11. Recommendations for action and College commitments

The recommendations[(c)] and College commitments reflect the outcomes of the research for this position statement, and the guidance and advice from the Working Group. Several areas in need of action were identified, including increasing awareness of NRCSA, trauma-informed care, professional training, clinical guidance, service provision and future research.

Only by implementing these recommendations in full will we develop a healthcare service in which survivors can feel confident to disclose NRCSA, knowing that when they do they will receive appropriate support and treatment from professionals who have had comprehensive training in this area.

11(a) Awareness, training and support

1 **The Medical Schools Council and College's Undergraduate Education Forum should encourage and support medical schools to integrate teaching on non-recent child sexual abuse in undergraduate medical curricula.**

The teaching should include the significance of non-recent child sexual abuse in the development of a wide range of mental health problems in adulthood. It should also include the importance of the biopsychosocial model in identifying possible non-recent child sexual abuse in people who use substances, have symptoms of psychosis or have other conditions, as well as the importance of establishing compassionate and relational care.

The College will work with the British Psychological Society to encourage and support education providers running their accredited undergraduate psychology degrees or postgraduate conversion courses to also integrate this teaching.

(c) Abbreviations have not been used in the recommendations, to enable each one to stand alone.

2 **The Royal College of Psychiatrists will develop supplementary guidance on non-recent child sexual abuse for resident doctors and trainers, co-produced with patients and survivors**, that supports the gaining of relevant capabilities[(d)] as set out in the psychiatric curricula. It will include training on:

- facilitating disclosure and providing appropriate practical and emotional support in a non-stigmatising way
- establishing compassionate and therapeutic relationships through relational care
- the importance of capturing the complexity of a patient's presentation and need, and the potential centrality of their traumatic experiences, when developing comprehensive biopsychosocial case formulation
- management of reporting issues, such as safeguarding, reporting to the police and advocacy
- appropriate language that will reduce stigma and avoid re-traumatisation
- understanding of trauma-informed care and the principles of this way of working to facilitate collaboration, empowerment to provide appropriate care and recognition of cultural, gender and historical issues, and to prevent re-traumatisation
- support for clinicians to facilitate therapy sessions that reflect on and allow for the incorporation of patients' intersectional identities.

The College will encourage other Medical Royal Colleges and professional organisations (including the British Psychological Society, UK Council for Psychotherapy, the British Association for Counselling and Psychotherapy and the British Psychoanalytic Council) to review these aspects where relevant in their respective curricula, and educational and training standards.

3 **NHS training organisations should ensure resident doctors and individuals in NHS-funded psychological professions training programmes have appropriate clinical exposure to recognising and responding to patients who disclose non-recent child sexual abuse in a non-stigmatising way**, in line with the Royal College of Psychiatrists' guidance on integrating patient and carer voices into educational programmes.[152]

(d) The curricula for psychiatry include the following capabilities:

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

4 **NHS training organisations and local authorities should ensure that all clinical and non-clinical staff have comprehensive mandatory training on non-recent child sexual abuse**, co-produced with patients and survivors, including on disclosure, appropriate language and immediate actions to take.

   Health and social care staff who are, or may be, in contact with survivors of non-recent child sexual abuse should receive some level of training about this form of abuse. This includes GPs, social workers, obstetricians, gynaecologists, staff in sexual and reproductive health clinics, midwives, nurses, paramedics, A&E staff, physicians, physiotherapists and dentists, as well as mental health care professionals.

5 **The Royal College of Psychiatrists will develop a CPD eLearning resource to support psychiatrists' ongoing training on and awareness of non-recent child sexual abuse.** This will be co-produced with patients and survivors and include training on:

   - facilitating disclosure and providing appropriate practical and emotional support in a non-stigmatising way
   - the importance of capturing the complexity of a patient's presentation and need, and the potential centrality of their traumatic experiences, when developing comprehensive biopsychosocial assessments
   - establishing compassionate and therapeutic relationships through relational care
   - management of reporting issues, such as safeguarding, reporting to the police and advocacy
   - appropriate language that will reduce stigma and avoid re-traumatisation.

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

7 **NHS organisations and local authorities should support routine provision of high quality reflective practice and promote personal therapeutic engagement for all clinical and non-clinical staff working with people who disclose non-recent child sexual abuse** to further develop the psychological understanding of complex presentations and to process the emotional impact of the work.

8 **The UK Government, Northern Ireland Executive, Scottish Government and Welsh Government should commission tailored awareness campaigns** aimed at the general public and professionals about non-recent child sexual abuse. They should be aligned with the development of guidelines, clinical services and pathways of care, to make sure that anyone who goes on to disclose child sexual abuse as a result of an awareness campaign receives appropriate care and support.

11(b) Guidelines, clinical services and care pathways

1 **The National Institute of Health and Care Excellence and the Scottish Intercollegiate Guidelines Network (SIGN) should develop clinical guidance on how to recognise and respond to non-recent child sexual abuse.**

This should cover:

- Principles for discussing non-recent child sexual abuse sensitively, using appropriate language that will reduce stigma and avoid re-traumatisation.
- Factors and signs that may indicate a history of child sexual abuse, and how to recognise them.
- How to facilitate disclosure (including considerations about the therapeutic setting and environmental safety), provide immediate practical and emotional support, and referral, when necessary.
- Procedures for reporting issues, such as safeguarding, reporting to the police and advocacy.
- Carrying out assessments and discussing available therapeutic interventions (including their potential advantages and disadvantages). This should take account of the different approaches that may be needed for different groups, for example:
  - whether the abuser was a family member or an attachment figure
  - institutional or organisational abuse (for example, in religious or sports settings and care homes)
  - different generational groups (for example, young adults, working-age adults or older adults)
  - different cultural and ethnic groups
  - people receiving support for specific issues (for example, perinatal mental health or disability).
- Providing a multidisciplinary response in which care and support may be provided by a range of professionals in collaboration (for example, psychiatric nurse, surgical doctor and physician).
- Coordinating a multi-agency response to providing care and support between health, social care, probation, housing, VCSE sector and other services.

2 **The UK Government, Northern Ireland Executive, Scottish Government and Welsh Government should map services, and develop, pilot and implement clinical care pathways**, for the multidisciplinary and multi-agency management of non-recent child sexual abuse.

These should:

- be co-produced with patients and survivors
- promote partnership working across health, social care, probation, housing, the VCSE sector and other services
- ensure continuity of care through integration of primary care and secondary/specialist care services

- provide appropriate and timely access to health care that meets the physical, emotional and mental health needs of the individual
- offer a holistic and trauma-informed approach to therapeutic interventions, supported by a trauma-informed multi-agency workforce.

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

11(c) Research

1 **The Medical Research Council should prioritise funding to standardise and strategically improve research into non-recent child sexual abuse**, ensuring that all commissioned research has meaningful involvement of patients and survivors who are provided with comprehensive support to be actively engaged.

This should include the following areas:

- prevalence of non-recent child sexual abuse, including consideration of protected characteristics
- impact of confounding factors (for example, other forms of abuse and the socioeconomic status of the family) and protective factors to better understand the influence these may have on the development of mental health symptoms in adulthood
- effects of non-recent child sexual abuse and its disclosure on physical health and general physical wellbeing
- efficacy of available treatments
- best practice in management of disclosure and trauma-informed pathways of care.

Glossary of terms

Unless the source is supplied, the definitions below were written by the NRCSA Working Group.

Child sexual exploitation

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

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

Co-production

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

Source: Working Well Together (NCCMH, 2019)

Contact and non-contact abuse

Contact abuse:
When the abuser makes physical contact with the child

Non-contact abuse:
When there is no physical contact between the abuser and the child, such as exposure, recording images and via the internet or messaging.

Cultural humility

A lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities.

Source: Cultural humility: Essential foundation for clinical researchers - ScienceDirect

Iatrogenic harm

Avoidable harm to patients or carers as a result of medical care or treatment, and/or the actions of healthcare professionals. The harm can be psychological as well as physical.

Intersectionality

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

Professionals in mental health services who work with survivors

These include, but are not limited to psychiatrists, psychologists and therapists, nurses, social workers, occupational therapists, support workers and independent sexual violence advisors.

Re-traumatisation

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

Trauma

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

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

Trauma-informed practice

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

The principles of a trauma-informed approach are:

- safety
- trustworthiness
- choice
- collaboration
- empowerment
- cultural consideration.

Source: Working definition of trauma-informed practice (ibid)
(You can find more information from this source in addition to the definition.)

Abbreviations

ACE	Adverse childhood experiences
CBT	Cognitive behavioural therapy
CPD	Continuing professional development
C-PTSD	Complex post-traumatic stress disorder
EMDR	Eye movement desensitisation and reprocessing
ERG	Expert reference group
EUPD	Emotionally unstable personality disorder
IICSA	Independent Inquiry into Child Sexual Abuse
LGBTQ+	Lesbian, gay, bisexual, transgender, queer or other
NAPAC	National Association for People Abused in Childhood
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
NRCSA	Non-recent child sexual abuse
PPI	Public and patient involvement
PTSD	Post-traumatic stress disorder
SIGN	Scottish Intercollegiate Guidelines Network
VCSE	Voluntary, community and social enterprise

References

1 Karsna K, Kelly PL (2021) *The Scale and Nature of Child Sexual Abuse: Review of Evidence.* England: Centre of Expertise on Child Sexual Abuse. Available from: https://www.csacentre.org.uk/research-resources/research-evidence/scale-nature-of-abuse/the-scale-and-nature-of-child-sexual-abuse/

2 Stoltenborgh M, van Ijzendoorn MH, Euser EM, Bakermans-Kranenburg MJ (2021) A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child Maltreatment.;16:79–101.*

3 Office for National Statistics. Statistical Bulletin: Child Abuse in England and Wales: March 2020. Statistics and Research on Child Abuse in England and Wales, Bringing Together a Range of Different Sources from across Government and the Voluntary Sector. London: Office for National Statistics. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/childabuseinenglandandwales/march2020

4 United Nations Children's Fund (2014) *Hidden in Plain Sight: A Statistical Analysis of Violence against Children.* New York: UNICE. Available from: https://data.unicef.org/resources/hidden-in-plain-sight-a-statistical-analysis-of-violence-against-children/

5 Independent Inquiry Into Child Sexual Abuse (2022) *The Report of the Independent Inquiry Into Child Sexual Abuse - October 2022.* London: IICSA. Available from: https://www.iicsa.org.uk/document/report-independent-inquiry-child-sexual-abuse-october-2022-0.html

6 NHS England. Improving the Physical Health of People Living with Severe Mental Illness (2024) *Guidance for Integrated Care Systems.* NHS England. Available from: https://www.england.nhs.uk/long-read/improving-the-physical-health-of-people-living-with-severe-mental-illness/

7 Fisher C, Goldsmith A, Hurcombe R, Soares C (2017) *The Impacts of Child Sexual Abuse: A Rapid Evidence Assessment.* UK: Independent Inquiry Into Child Sexual Abuse. Available from: https://www.iicsa.org.uk/reports-recommendations/publications/research/impacts-csa.html

8 Child and Woman Abuse Studies Unit. Violence, Abuse and Mental Health in England. Population Patterns. Responding Effectively to Violence and Abuse (REVA) *Briefing 1.* UK: NatCenAvailable from: https://www.londonmet.ac.uk/research/centres-groups-and-units/child-and-woman-abuse-studies-unit/projects-and-partners/reva-project/

9 Adverse Childhood Experiences [ACEs] (2021) *Research: Implications for practitioners.* Research Practice Focus #3. London, UK. Available from: https://uktraumacouncil.org/research_practice/aces-research?cn-reloaded=1&cn-reloaded=1

10 Nelson CA, Bhutta ZA, Harris NB, Danese A, Samara M (2020) *Adversity in childhood is linked to mental and physical health throughout life.* BMJ:371:m3048.

11 Selwyn J, Wijedasa D, Meakings S (2014) *Beyond the Adoption Order: Challenges, Interventions and Adoption Disruption.* Research Report. England: Department for Education. Available from: https://assets.publishing.service.gov.uk/media/5a74b507e5274a3f93b4825b/Final_Report_-_3rd_April_2014v2.pdf

12 Saul H, Gursul D. What support do young people affected by adverse childhood experiences need? BMJ. 2021;375:n2608.

13 Lester S, Khatwa M, Sutcliffe K. (2020) *Service needs of young people affected by adverse childhood experiences (ACEs): A systematic review of UK qualitative evidence.* Children and Youth Services Review; 118:105429.

14 Pulverman CS, Kilimnik CD, Meston CM (2018) *The Impact of Childhood Sexual Abuse on Women's Sexual Health: A Comprehensive Review.* Sexual Medicine Reviews, **6:** 188–200.

15 Office for National Statistics (2017) *People Who Were Abused as Children Are More Likely to Be Abused as an Adult.* England: Office for National Statistics. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/peoplewhowereabusedaschildrenaremorelikelytobeabusedasanadult/2017-09-27

16 London K, Bruck M, Wright DB, Ceci SJ (2008) Review of the contemporary literature on how children report sexual abuse to others: findings, methodological issues, and implications for forensic interviewers. *Memory (Hove – England)***, 16:**29–47.

17 Hébert M, Tourigny M, Cyr M, McDuff P, Joly J (2009) Prevalence of childhood sexual abuse and timing of disclosure in a representative sample of adults from Quebec. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, **54:**631–6.

18 Helton JJ, Gochez-Kerr T, Gruber E (2018) Sexual Abuse of Children With Learning Disabilities. *Child Maltreatment*, **23**:157–65.

19 Independent Inquiry Into Child Sexual Abuse (2022) *Child Sexual Exploitation by Organised Networks*. Investigation Report. London: His Majesty's Stationery Office. Available from: https://www.iicsa.org.uk/reports-recommendations/publications/investigation/cs-organised-networks.html

20 Capaldi M, Schatz J, Kavenagh M. Child sexual abuse/exploitation and LGBTQI+ children (2024) *Context, links, vulnerabilities, gaps, challenges and priorities*. Child Protection and Practice: 1:100001.

21 Wood S, Ford K, Hardcastle K, Hopkins J, Hughes K, Bellis MA (2020) *Adverse Childhood Experiences in Child Refugee and Asylum Seeking Populations*. Wales: Public Health Wales. Available from: https://phwwhocc.co.uk/wp-content/uploads/2020/07/ACEs-in-Child-Refugee-and-Asylum-Seekers-Report-English-final.pdf

22 Assink M, van der Put CE, Meeuwsen MWCM, de Jong NM, Oort FJ, Stams GJJM, et al (2019). *Risk factors for child sexual abuse victimization: A meta-analytic review*, *Psychological Bulletin*, **145**:459–89.

23 Sedlak AJ, Mettenburg J, Basena M, Green A, Li S. Fourth National Incidence Study of Child Abuse and Neglect [NIS-4] (2009–10). US Department of Health and Human Services; Administration for Children and Families; Office of Planning, Research, and Evaluation; Children's Bureau; 2015. Available from: https://cap.law.harvard.edu/wp-content/uploads/2015/07/sedlaknis.pdf Accessed: 12 June 2024.

24 Radakin F, Scholes A, Soloman K, Thomas-Lacroix C, Davies A (2021) *The Economic and Social Cost of the Impact of Child Sexual Abuse*. UK: Her Majesty's Government. Available from: https://www.gov.uk/government/publications/the-economic-and-social-cost-of-contact-child-sexual-abuse/the-economic-and-social-cost-of-contact-child-sexual-abuse

25 Adisa O, Hermolle M, Ellis F (2023) *Denial, Disbelief and Delays Examining the Costs on the NHS of Delayed Child Sexual Abuse Disclosures in England and Wales*. Project Report. Ipswich, Suffolk: Survivors in Transition; 2023. Available from: https://oars.uos.ac.uk/2970/

26 Hailes HP, Yu R, Fazel S, Danese A (2019) Long-term outcomes of childhood sexual abuse: an umbrella review. *The Lancet Psychiatry*, **6**:830–9.

27 Chevous J, Perot C, BRAVE survivors group (2018) *Turning Pain into Power: Survivors' Charter*. Available from: https://www.academia.edu/58872942/Turning_Pain_into_Power_Survivors_Charter Accessed: 7 Nov 2022.

28 Her Majesty's Stationery Office. Equality Act. London: The Stationery Office; 2010.

29 National Collaborating Centre for Mental Health (2019) *Advancing Mental Health Equality: Steps and Guidance on Commissioning and Delivering Equality in Mental Health Care*. UK: National Collaborating Centre for Mental Health. Available from: https://www.rcpsych.ac.uk/improving-care/nccmh/service-design-and-development/advancing-mental-health-equality

30 Hatch SL, Dohrenwend BP (2007) Distribution of traumatic and other stressful life events by race/ethnicity, gender, SES and age: a review of the research. *American Journal of Community Psychology*,**40**:313–32.

31 Halvorsrud K, Nazroo J, Otis M, Brown Hajdukova E, Bhui K. *Ethnic inequalities and pathways to care in psychosis in England: a systematic review and meta-analysis (2018) BMC Medicine*, **16**:223.

32 Morgan C, Mallett R, Hutchinson G, Leff J (2004) Negative pathways to psychiatric care and ethnicity: the bridge between social science and psychiatry. *Social Science & Medicine*; 58:739–52.

33 Mohan R, McCrone P, Szmukler G, Micali N, Afuwape S, Thornicroft G (2006) Ethnic differences in mental health service use among patients with psychotic disorders. *Social Psychiatry and Psychiatric Epidemiology;* 41:771–6.

34 Independent Inquiry into Child Sexual Abuse. "People Don't Talk about It": Child Sexual Abuse in Ethnic Minority Communities. UK (2020) Available from: https://www.iicsa.org.uk/reports-recommendations/publications/research/child-sexual-abuse-ethnic-minority-communities Accessed: 8 Nov 2022.

35 Independent Inquiry into Child Sexual Abuse. Engagement Report Ethnic Minority Communities. UK (2021) Available from: https://www.iicsa.org.uk/document/engagement-report-ethnic-minority-communities-29-april-2021 Accessed: 8 Nov 2022.

36 Independent Inquiry into Child Sexual Abuse (2022) *Engagement with Lesbian, Gay, Bisexual, Transgender and Queer/ Questioning + Victims and Survivors*. 2022. Available from: https://www.iicsa.org.uk/document/engagement-lesbian-gay-bisexual-transgender-and-queer-questioning-victims-and-survivors Accessed: 8 Nov 2022.

37 Smith DT, Mouzon DM, Elliott M (2018) Reviewing the Assumptions About Men's Mental Health: An Exploration of the Gender Binary. *American Journal of Men's Health*, **12**:78–89.

38 Sagar-Ouriaghli I, Godfrey E, Bridge L, Meade L, Brown JSL (2019) Improving Mental Health Service Utilization Among Men: A Systematic Review and Synthesis of Behavior Change Techniques Within Interventions Targeting Help-Seeking. *American Journal of Men's Health*,**13**:1557988319857009.

39 Zammit J, Brown S, Mooney J-L, King S. Truth Project Thematic Report (2020) *Child Sexual Abuse in Healthcare Contexts*. Independent Inquiry Into Child Sexual Abuse Research Team, Available from: https://webarchive.nationalarchives.gov.uk/ukgwa/20221215044946/https://www.iicsa.org.uk/key-documents/24199/view/truth-project-thematic-report-child-sexual-abuse-healthcare-contexts-.pdf

40 Itzen C, Taket A, Barter-Godfrey S. Domestic and Sexual Violence and Abuse (2010) *Findings from a Delphi Expert Consultation on Therapeutic and Treatment Interventions with Victims, Survivors and Abusers, Children Adolescents, and Adults*. Melbourne, Australia: Deakin University. Available from: https://dro.deakin.edu.au/articles/book/Domestic_and_sexual_violence_and_abuse_findings_from_a_Delphi_expert_consultation_on_therapeutic_and_treatment_interventions_with_victims_survivors_and_abusers_children_adolescents_and_adults/21018232

41 Fava GA, Rafanelli C (2019) Iatrogenic Factors in Psychopathology. *Psychotherapy and Psychosomatics*, **88**:129–40.

42 Parry GD, Crawford MJ, Duggan C (2016) Iatrogenic harm from psychological therapies – time to move on. *The British Journal of Psychiatry*, **208**:210–2.

43 Kennedy S, Bewley S, Chevous J, Perot C, Vigneri M, Bacchus LJ (2022)A systematic review that evaluates the extent and quality of involving childhood abuse survivors in shaping, conducting and disseminating research in the UK. *Research for All.* doi:10.14324/RFA.06.1.03.

44 National Institute for Health and Care Excellence. Borderline Personality Disorder (2009) *Recognition and Management Clinical Guideline [CG78]*. UK: NICE. Available from: https://www.nice.org.uk/guidance/cg78

45 National Institute for Health and Care Excellence. Post-Traumatic Stress Disorder (2018) *NICE Guideline [NG116]*. UK: NICE. Available from: https://www.nice.org.uk/guidance/ng116

46 Grossman S, Cooper Z, Buxton H, Hendrickson S, Lewis-O'Connor A, Stevens J, et al. *Trauma-informed care: recognizing and resisting re-traumatization in health care (2016)Trauma Surgery & Acute Care Open*, **6**:e000815.

47 Sweeney A, Filson B, Kennedy A, Collinson L, Gillard S (2018) A paradigm shift: relationships in trauma-informed mental health services. *BJPsych Advances*. 24:319–33.

48 Sweeney A, Clement S, Filson B, Kennedy A. Trauma-informed mental healthcare in the UK: what is it and how can we further its development? Mental Health Review Journal. 2016;21:174–92.

49 Yeager KA, Bauer-Wu S. Cultural humility: Essential foundation for clinical researchers. Applied Nursing Research. 2013;26:251–6.

50 Voldby KG, Hellström LC, Berg ME, Eplov LF (2022) Structural discrimination against people with mental illness; a scoping review. *SSM - Mental Health*, **2**:100–17.

51 Sweeney A, Taggart D (2018) [Mis]understanding trauma-informed approaches in mental health. *Journal of Mental Health*, **27**:383–7.

52 Wosu AC, Gelaye B, Williams MA (2015) Childhood sexual abuse and posttraumatic stress disorder among pregnant and postpartum women: Review of the literature. *Archives of Women's Mental Health*, **18**:61–72.

53 Savage-Brookes K. Working Together to Safeguard Children (2023) *UK: HM Government; 2023*

54 Matthews B, Collin-Vézina D (2019) Child Sexual Abuse: Toward a Conceptual Model and Definition. *Trauma*, **Violence, & Abuse, 20**:131–48.

55 Asmussen K, Fischer F, Drayton E, McBride T (2020) *Adverse Childhood Experiences: What We Know, What We Don't Know, and What Should Happen Next*. UK: Early Intervention Foundation, Available from: https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

56 National Police Chief's Council (2024) *Child Sexual Abuse and Exploitation Analysis Launched.* NPCC Communications Office. Available from: https://news.npcc.police.uk/releases/vkpp-launch-national-analysis-of-police-recorded-child-sexual-abuse-and-exploitation-csae-crimes-report-2022

57 Hurcombe R, Darling A, Mooney B, Ablett G, Soares C, King S, et al. (2019) *Truth Project Thematic Report: Child Sexual Abuse in the Context of Religious Institutions*. IICSA Research Team. Available from: https://uobrep.openrepository.com/bitstream/handle/10547/624856/truth-project-thematic-report_-child-sexual-abuse-context-religious-institutions-full-report.pdf?sequence=2&isAllowed=y

58 Truth Project, Independent Inquiry into Child Sexual Abuse. Dashboard June 2016 – October 2021. London: Truth Project and IICSA; 2022. Available from: https://webarchive.nationalarchives.gov.uk/ukgwa/20230103112937/https://www.iicsa.org.uk/key-documents/31164/view/truth-project-dashboard-final-2022.pdf

59 Independent Inquiry into Child Sexual Abuse (2021) *Child Protection in Religious Organisations and Settings*. Investigation Report, September 2021. London: His Majesty's Stationery Office. Available from: https://www.iicsa.org.uk/reports-recommendations/publications/investigation/cs-organised-networks.html Accessed: 14 June 2024.

60 Denney AS (2022) Child sex abusers in protestant Christian churches: An offender typology. *Journal of Qualitative Criminal Justice & Criminology*, **12**:doi:10.21428/88de04a1.000ff84d.

61 Kilcommons AM, Morrison AP. *Relationships between trauma and psychosis: an exploration of cognitive and dissociative factors (2005) Acta Psychiatrica Scandinavica*,**112**:351–9.

62 Rutigliano G, Merlino S, Minichino A, Patel R, Davies C, Oliver D, et al (2018) Long term outcomes of acute and transient psychotic disorders: The missed opportunity of preventive interventions. *European Psychiatry*, **52**:126–33.

63 Barth J, Bermetz L, Heim E, Trelle S, Tonia T (2013) The current prevalence of child sexual abuse worldwide: a systematic review and meta-analysis. *International Journal of Public Health*, **58**:469–83.

64 Karsna K, Cain S. The Scale and Nature of Child Sexual Abuse: Review of Evidence. Incorporating Trends in Official Data from 2024/25. Ilford: CSA Centre; 2026. Available from: https://www.csacentre.org.uk/research-resources/research-evidence/scale-nature-of-abuse/the-scale-and-nature-of-child-sexual-abuse/

65 World Health Organization Newsroom. Violence against women. Fact Sheet. World Health Organ. 2024. Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women Accessed: 4 Apr 2025.

66 Rayment-McHugh SN, Smallbone S, Tilley N (2015) Endemic Sexual Violence and Abuse: Contexts and Dispositions. *International Journal for Crime; Justice and Social Democracy*, **4**:111–24.

67 Coventry PA, Meader N, Melton H, Temple M, Dale H, Wright K, et al (2020) Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis. *PLOS Medicine*, **17**:e1003262.

68 de Aquino Ferreira LF, Queiroz Pereira FH, Neri Benevides AML, Aguiar Melo MC (2018) Borderline personality disorder and sexual abuse: A systematic review. *Psychiatry Research*, **262**:70–7.

69 Shevlin M, Houston JE, Dorahy MJ, Adamson G (2008) Cumulative Traumas and Psychosis: an Analysis of the National Comorbidity Survey and the British Psychiatric Morbidity Survey. *Schizophrenia Bulletin*, **34**:193–9.

70 Dillon J, Johnstone L, Longden E (2012)Trauma, dissociation, attachment and neuroscience: A new paradigm for understanding severe mental distress. *Journal of Critical Psychology; Counselling and Psychotherapy*, **12**:145–55.

71 Mauritz MW, Goossens PJJ, Draijer N, van Achterberg T (2013) Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*, **4. doi**:10.3402/ejpt.v4i0.19985.

72 Filson B (2016) The haunting can end: trauma-informed approaches in healing from abuse and adversity. *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies* (Eds Russo J and Sweeney A). Monmouth, Wales: PCCS Books, pp. 20–4.

73 Hughes E, Lucock M, Brooker C (2019) Sexual violence and mental health services: a call to action. *Epidemiology and Psychiatric Sciences*, **28**:594–7.

74 Her Majesty's Government (2007) *Cross Government Action Plan on Sexual Violence and Abuse*. HM Government. Available from: https://equation.org.uk/product/cross-government-action-plan-on-sexual-violence-and-abuse/

75 Damis LF (2022) The role of implicit memory in the development and recovery from trauma-related disorders. *NeuroSci*, **3**:63–88.

76 Brewin CR (2014) Episodic memory, perceptual memory, and their interaction: foundations for a theory of posttraumatic stress disorder. *Psychological Bulletin*, **140**:69–97.

77 van der Kolk B (2015) *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. London: Penguin. Available from: https://www.penguin.co.uk/books/259420/the-body-keeps-the-score-by-kolk-bessel-van-der/9780141978611 *Accessed: 14 Oct 2024*.

78 Gallese V, Lakoff G (2005) The Brain's concepts: the role of the Sensory-motor system in conceptual knowledge. *Cognitive Neuropsychology*, **22**:455–79.

79 Reinders AATS, Marquand AF, Schlumpf YR, Chalavi S, Vissia EM, Nijenhuis ERS, et al (2019) Aiding the diagnosis of dissociative identity disorder: pattern recognition study of brain biomarkers. *The British Journal of Psychiatry: The Journal of Mental Science*, **215**:536–44.

80 Reinders A, Veltman D (2021) Dissociative identity disorder: Out of the shadows at last? *The British Journal of Psychiatry*, 219:413–4.

81 Loewenstein RJ (2018) Dissociation debates: everything you know is wrong. *Dialogues in Clinical Neuroscience*, **20**:229–42.

82 Ireton R, Hughes A, Klabunde M (2024) A functional magnetic resonance imaging meta-analysis of childhood trauma. *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging*, **9**:561–70.

83 Geraerts E, Raymaekers L, Merckelbach H (2008) Recovered memories of childhood sexual abuse: Current findings and their legal implications. *Legal and Criminological Psychology*, **13**:165–76.

84 Sinason V, Conway A (2022) *Trauma and Memory: The Science and the Silenced*. Available from: https://www.routledge.com/Trauma-and-Memory-The-Science-and-the-Silenced/Sinason-Conway/p/book/9781032044293 Accessed: 8 Feb 2024.

85 Brewin CR, Andrews B (2017) Creating Memories for False Autobiographical Events in Childhood: A Systematic Review. *Applied Cognitive Psychology*, **31**:2–23.

86 Office for National Statistics (2020) *Child Sexual Abuse in England and Wales: Year Ending March 2019*. London: Office for National Statistics. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childsexualabuseinenglandandwales/yearendingmarch2019 Accessed: 2 June 2026.

87 O'Donohue W, Cummings C, Willis B (2018) The Frequency of False Allegations of Child Sexual Abuse: A Critical Review. *Journal of Child Sexual Abuse*, **27**:459–75.

88 Barker C, Ford S, Eglinton R, Quail S, Taggart D (2023)The truth project paper one—how did victims and survivors experience participation? Addressing epistemic relational inequality in the field of child sexual abuse. *Frontiers in Psychiatry*, **14**:1128451.

89 Independent Inquiry Into Child Sexual Abuse (2019) *Children in the Care of the Nottinghamshire Councils Investigation Report*. UK: His Majesty's Stationery Office, Available from: https://www.iicsa.org.uk/reports-recommendations/publications/investigation/nottinghamshire-councils/part-f-cross-cutting-themes/f1-barriers-disclosure.html

90 Ullman SE (2007) *Relationship to Perpetrator, Disclosure, Social Reactions, and PTSD Symptoms in Child Sexual Abuse Survivors*. Journal of Child Sexual Abuse, 16:19–36.

91 London K, Bruck M, Ceci SJ, Shuman DW (2005) Disclosure of Child Sexual Abuse: What Does the Research Tell Us About the Ways That Children Tell? *Psychology, Public Policy, and Law*, **11**:194–226.

92 Reid J, Sampson M, Critchley C (2016) Are mental health services getting better at responding to abuse, assault and neglect? *Acta Psychiatrica Scandinavica*, **134**:287–94.

93 Smith N, Dogaru C, Ellis F (2015) *Hear me. believe me. respect me. a survey of adult survivors of child sexual abuse and their experience of support services*, Available from: http://oars.uos.ac.uk/2622/ Accessed: 7 June 2024.

94 Hepworth I, McGowan L (2013) Do mental health professionals enquire about childhood sexual abuse during routine mental health assessment in acute mental health settings? A substantive literature review. *Journal of Psychiatric and Mental Health Nursing*, **20**:473–83.

95 Office of the Children's Commissioner for England (2015) *Protecting Children from Harm: A Critical Assessment of Child Sexual Abuse in the Family Network in England and Priorities for Action*. UK: Children's Commissioner. Available from: https://www.childrenscommissioner.gov.uk/report/protecting-children-from-harm/ Accessed: 8 Nov 2022.

96 Office of the Children's Commissioner for England (2017) *Making Noise: Children's Voices for Positive Change after Sexual Abuse*. UK: Children's Commissioner. Available from: https://www.beds.ac.uk/media/86813/makingnoise-20042017.pdf Accessed: 8 Nov 2022.

97 Jacques P (2023) *Rape and sexual assault survivors say mental health worsened by police response, report finds*. Police Professional. Available from: https://policeprofessional.com/news/rape-and-sexual-assault-survivors-say-mental-health-worsened-by-police-response-report-finds/

98 Criminal Justice Joint Inspection (2021) *Criminal justice system failing people with mental health issues – with not enough progress over the past 12 years.* Press release. https://cjji.justiceinspectorates.gov.uk/press-release/criminal-justice-system-failing-people-with-mental-health-issues-with-not-enough-progress-over-the-past-12-years/ Accessed: 7 June 2024.

99 Critchley QPM I (2024) *The Hydrant Programme*. Why Belief Matters - Blog. Available from: https://www.hydrantprogramme.co.uk/latest-news/why-belief-matters/ Accessed: 12 June 2024.

100 Ferentz L (2017) *Trauma Informed Assessments: A Clinician's Guide to Safely Identifying and Exploring Connections between Clients' Current Struggles and Prior Histories of Trauma, Abuse, and Neglect.* The Ferentz Institute. Available from: https://cdn.prod.website-files.com/660d86f906c043e1e9a274fa/66615b1fab89dd2d6f766405_Ebook-Trauma-Informed-Assessments_2017_Final_vs.4_4.19.18.pdf Accessed: 8 Nov 2022.

101 Read J, Hammersley P, Rudegeair T (2007) *Why, when and how to ask about childhood abuse.* Advances in Psychiatric Treatment, 13:101–10.

102 Rouf K, Waites B (2023) *Guidance on Responding to Disclosures of Non-Recent (Historic) Child Sexual Abuse: Safeguarding and Support Implications.* UK: British Psychological Society. Available from: https://explore.bps.org.uk/content/report-guideline/bpsrep.2023.inf258b

103 Barker C, Taggart D, Gonzalez M, Quail S, Eglinton R, Ford S, et al (2023) *The truth project - paper two - using staff training and consultation to inculcate a testimonial sensibility in non-specialist staff teams working with survivors of child sexual abuse.* Frontiers in Psychiatry. 14. doi:10.3389/fpsyt.2023.1177622.

104 The Crown Prosecution Service (2022) *Pre-Trial Therapy | The Crown Prosecution Service*. Available from: https://www.cps.gov.uk/legal-guidance/pre-trial-therapy Accessed: 3 June 2024.

105 Lev-Wiesel R, Daphna-Tekoah S, Hallak M (2009) Childhood sexual abuse as a predictor of birth-related posttraumatic stress and postpartum posttraumatic stress. *Child Abuse & Neglect*, **33**:877–87.

106 Thomson A, Nyein C, Clarke M (2023) *Protection and Safeguarding of Vulnerable Adults and Children Exposed to Violence.* In: Khwaja M, Tyrer P, eds. The Prevention and Management of Violence. Cambridge University Press, pp. 25–51.

107 World Health Organization [WHO] (2022) *International Classification of Diseases 11th Revision (ICD-11).* 2022. Available from: https://www.who.int/standards/classifications/classification-of-diseases Accessed: 10 Nov 2022.

108 Boardman J, Dave S (2020) *Person-centred care and psychiatry: some key perspectives.* BJPsych International;17:65–8.

109 Lomani J, Alyce S, Aves W, Chevous J, Clayton E, Conway D (2022) New Ways of Supporting Child Abuse and Sexual Violence Survivors: A Social Justice Call for an Innovative Commissioning Pathway. *UK: Collabora8 Research and Survivors Voices*

110 Watts J (2024)The epistemic injustice of borderline personality disorder. *BJPsych International*, **1–5.**

111 Swales MA (2022) Personality disorder diagnoses in ICD-11: Transforming conceptualisations and practice. *Clinical Psychology in Europe*, **4**:1–18.

112 Sweeney A, Edwards B, Graterol Munoz C, Rowe C, Michaels E, Rohricht F, et al (2025) *Pathway Participant Report: Care Pathways for Complex Trauma.* Programme Development Grant. London: National Institute for Health Research.

113 Lomani J, Alyce S, Aves W, Chevous J, Clayton E, Conway D (2022)*New Ways of Supporting Child Abuse and Sexual Violence Survivors: A Social Justice Call for an Innovative Commissioning Pathway.* UK: Collabora8 Research and Survivors Voices.

114 O'Reilly J, Gibbons R, Heyland S, Yakeley J (2023) Parity of esteem within the biopsychosocial model: is psychiatry still a psychological profession? *BJPsych Bulletin*, **47**:311–5.

115 Cusack KJ, Frueh BC, Brady KT (2004) Trauma history screening in a community mental health center. *Psychiatric Services (Washington DC)*, **55**:157–62.

116 Hyland P, Vallières F, Cloitre M, Ben-Ezra M, Karatzias T, Olff M, et al (2021) Trauma, PTSD, and complex PTSD in the Republic of Ireland: prevalence, service use, comorbidity, and risk factors. *Social Psychiatry and Psychiatric Epidemiology*, **56**:649–58.

117 Leiva-Bianchi M, Nvo-Fernandez M, Villacura-Herrera C, Miño-Reyes V, Parra Varela N (2023) What are the predictive variables that increase the risk of developing a complex trauma? A meta-analysis. *Journal of Affective Disorders*, **343**:153–65.

118 Palic S, Zerach G, Shevlin M, Zeligman Z, Elklit A, Solomon Z (2016) Evidence of complex posttraumatic stress disorder (CPTSD) across populations with prolonged trauma of varying interpersonal intensity and ages of exposure. *Psychiatry Research*, **246**:692–9.

119 Bloomfield MAP, Yusuf FNIB, Srinivasan R, Kelleher I, Bell V, Pitman A (2020) Trauma-informed care for adult survivors of developmental trauma with psychotic and dissociative symptoms: a systematic review of intervention studies. *The Lancet. Psychiatry*, **7**:449–62.

120 Nelson S, Baldwin N, Taylor J (2012)Mental health problems and medically unexplained physical symptoms in adult survivors of childhood sexual abuse: an integrative literature review. *Journal of Psychiatric and Mental Health Nursing*, **19**:211–20.

121 Adult Survivors of Childhood Sexual Abuse (2019) *Can Adult Survivors of Childhood Sexual Abuse Access Justice and Support? Part One: Achieving Quality Information and Support for Survivors*. UK: Adult Survivors of Childhood Sexual Abuse.

122 Kirkham EJ, Fletcher-Watson S, Beange I, Chan SWY, Lawrie SM (2022) Patient satisfaction with mental and physical health services: Findings from a UK-wide online survey. *Wellcome Open Research*, **7**: doi:10.12688/wellcomeopenres.17973.1.

123 Gekoski A, McSweeney T, Broome S, Adler JR, Jenkins S, Georgiou (2020) *Support Services for Victims and Survivors of Child Sexual Abuse*. London: The Independent Inquiry into Child Sexual Abuse

124 Castillo H, Ramon S (2017) "Work with me": service users' perspectives on shared decision making in mental health. *Mental Health Review Journal*, **22**:166–78.

125 Ramon S, Brooks H, Rae S, O'Sullivan M-J (2017) Key issues in the process of implementing shared decision making (DM) in mental health practice. *Mental Health Review Journal*, **22**:257–74.

126 Sin J, Spain D, Furuta M, Murrells T, Norman I (2017) *Psychological interventions for post-traumatic stress disorder (PTSD) in people with severe mental illness*. The Cochrane Database of Systematic Reviews, 1:CD011464.

127 Hafkemeijer L, de Jongh A, van der Palen J, Starrenburg A (2020) *Eye movement desensitization and reprocessing (EMDR) in patients with a personality disorder.* European Journal of Psychotraumatology, 11:1838777.

128 Varese F, Sellwood W, Pulford D, Awenat Y, Bird L, Bhutani G, et al. *(2024) Trauma-focused therapy in early psychosis: results of a feasibility randomized controlled trial of EMDR for psychosis (EMDRp) in early intervention settings. Psychological Medicine*, **54**:874–85.

129 van de Kamp MM, Scheffers M, Hatzmann J, Emck C, Cuijpers P, Beek PJ (2019) Body- and Movement-Oriented Interventions for Posttraumatic Stress Disorder: A Systematic Review and Meta-Analysis. *Journal of Traumatic Stress*, **32**:967–76.

130 Askovic M, Soh N, Elhindi J, Harris AWF. Neurofeedback for post-traumatic stress disorder: systematic review and meta-analysis of clinical and neurophysiological outcomes. European Journal of Psychotraumatology. 2023;14:2257435.

131 Steingrimsson S, Bilonic G, Ekelund A-C, Larson T, Stadig I, Svensson M, et al (2020) Electroencephalography-based neurofeedback as treatment for post-traumatic stress disorder: A systematic review and meta-analysis. *European Psychiatry*, **63**:e7.

132 Henner RL, Keshavan MS, Hill KP (2020) Review of potential psychedelic treatments for PTSD. *Journal of the Neurological Sciences*, **439**:120302.

133 English A, McKibben E, Sivaramakrishnan D, Hart N, Richards J, Kelly P (2022) A Rapid Review Exploring the Role of Yoga in Healing Psychological Trauma. *International Journal of Environmental Research and Public Health*, **19**:16180.

134 Taylor J, McLean L, Korner A, Stratton E, Glozier N (2020) Mindfulness and yoga for psychological trauma: systematic review and meta-analysis. *Journal of Trauma & Dissociation: The Official Journal of the International Society for the Study of Dissociation (ISSD)*, **21**:536–73.

135 Price M, Spinazzola J, Musicaro R, Turner J, Suvak M, Emerson D, et al (2017) Effectiveness of an Extended Yoga Treatment for Women with Chronic Posttraumatic Stress Disorder. *The Journal of Alternative and Complementary Medicine*, **23**:300–9.

136 Classen CC, Hughes L, Clark C, Hill Mohammed B, Woods P, Beckett B (2021) A Pilot RCT of A Body-Oriented Group Therapy For Complex Trauma Survivors: An Adaptation of Sensorimotor Psychotherapy. *Journal of Trauma & Dissociation*, **22**:52–68.

137 Payne P, Levine PA, Crane-Godreau MA (2015) Somatic experiencing: using interoception and proprioception as core elements of trauma therapy. *Frontiers in Psychology*, **6**: doi:10.3389/fpsyg.2015.00093.

138 Karatzias T, Murphy P, Cloitre M, Bisson J, Roberts N, Shevlin M, et al (2019) Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis. *Psychological Medicine*, **49**:1761–75.

139 Cloitre M, Koenen KC, Cohen LR, Han H (2002) Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology*, **70**:1067–74.

140 Bohus M, Schmahl C, Fydrich T, Steil R, Müller-Engelmann M, Herzog J, et al (2019) A research programme to evaluate DBT-PTSD, a modular treatment approach for Complex PTSD after childhood abuse. *Borderline Personality Disorder and Emotion Dysregulation*, **6**:7.

141 Maercker A, Cloitre M, Bachem R, Schlumpf YR, Khoury B, Hitchcock C, et al (2022) Complex post-traumatic stress disorder. *The Lancet*, **400**:60–72.

142 UK Standards for Public Involvement. UK Standards for Public Involvement (2021) *UK Stand. Public Involv.* Available from: https://sites.google.com/nihr.ac.uk/pi-standards/home Accessed: 8 Feb 2024.

143 National Institute for Health Research (2021) *Next steps for partnership working with patients and the public: Engagement report*. UK: National Institute for Health and Care Research. Available from: https://www.nihr.ac.uk/next-steps-partnership-working-patients-and-public-engagement-report [Accessed: 8 Feb 2024].

144 Varese F, White C, Longden E, Charalambous C, Meehan K, Partington I, et al (2023) Top 10 priorities for Sexual Violence and Abuse Research: Findings of the James Lind Alliance Sexual Violence Priority Setting Partnership. *BMJ Open*, **13**:e062961.

145 The James Lind Alliance Sexual Violence Priority Setting Partnership (2022) *The Top 10 Priorities for Sexual Violence and Abuse Research*. Available from: https://www.jla.nihr.ac.uk/priority-setting-partnerships/sexual-violence/downloads/Sexual-Violence-PSP-Top-10-Webinar-Slides.pdf

146 Sweeney A, Beresford P (2020) Who gets to study whom: survivor research and peer review processes. *Disability & Society*, **35**:1189–94.

147 Chevous J, Fischer L, Perôt C, Sweeney A (2021) *Safe, Seen, Supported: How to Help and Reach Children and Young People Experiencing Abuse in Their Households during the COVID-19 Pandemic and Beyond*. Survivors Voices, McPin Foundation, KCL and the Violence, Abuse and Mental Health Network.

148 Violence, Abuse and Mental Health Network (2019) *Survivors' Priority Themes and Questions for Research: Consultation Report 2019*. UK: UK Research and Innovation. Available from: https://www.vamhn.co.uk/uploads/1/2/2/7/122741688/consultation_report_on_website.pdf

149 Elliott DE, Bjelajac P, Fallot RD, Markoff LS. *and Reed BG (2005) Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. Journal of Community Psychology*, **33(4)**:461–77. https://doi.org/10.1002/jcop.20063 Accessed: 8 Feb 2024.

150 Bloom S (2006) *Human Service Systems and Organizational Stress: Thinking & Feeling Our Way Out of Existing Organizational Dilemmas*.

151 Sweeney A, Gillard S, Jones-Nielsen J, Sin J, Chevous J, Röhricht F, et al (2024) *The PATHWAY Study: Developing and evaluating a new care pathway to improve outcomes for people with complex trauma*. Kings Coll. Lond. Available from: https://www.kcl.ac.uk/research/the-pathway-study Accessed: 26 June 2024.

152 Richards V, Rose S (2021) Learning from Experience: Working in Collaboration with People with Lived Experience to Deliver Psychiatric Education. London: Royal College of Psychiatrists. Available from: https://www.rcpsych.ac.uk/docs/default-source/training/letb/pcitguidance-(002).pdf Accessed: 14 June 2024.

Appendix A: Literature review summary

(A1) Sexual abuse in childhood: prevalence in common psychiatric conditions, and recommendations for adult mental health treatment

Introduction

This review is an umbrella review of recently conducted systematic reviews, with the aim of contributing to (a) the literature on prevalence of NRCSA and (b) the association between NRCSA and adult mental health conditions.

The review summarises the literature on NRCSA across different mental health diagnoses and symptoms, as reported in systematic reviews and meta-analyses conducted since the umbrella review by Hailes HP et al. (2019). Their paper also discusses the inclusion of recommendations in NICE mental health treatment guidelines for treatment of survivors after disclosure of NRCSA.

For the review, the following research questions were posed:

1. Does the evidence support an association between experiences of sexual abuse in childhood and mental health problems in adulthood?

2. What is the prevalence of sexual abuse in childhood for different common psychiatric diagnoses and symptoms in adulthood?

3. What is recommended across UK NICE guidelines for treatment of adults with psychiatric conditions following disclosure of sexual abuse in childhood?

Method

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

To answer the third question, an exploratory search of NICE guidelines was conducted to examine recommendations for the mental health treatment for adults with mental

health conditions following a disclosure of NRCSA. To achieve this, we searched NICE guidelines for mental health disorders using the following terms: *sex*, abuse, childhood, adapt*, disclos*, trauma*.

Findings

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

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

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

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

Study ID (first author/year)	Study design	Year range of review	Abuse types included	Mental health conditions/ symptoms
Armoon 2020	Systematic review and meta-analysis	1995–2020	Child sexual abuse	Suicidal behaviours
Barbosa 2020	Systematic review	1995–2019	ACEs/traumatic events in childhood (including sexual abuse, physical aggression/violence, negligence/ neglect)	Psychopathy; ASPD; substance use
Cavallo 2021	Systematic review	NR	Childhood abuse (including neglect, childhood loss events and sexual abuse)	Anxiety symptoms: worry, rumination and negative thinking
Chang 2021	Systematic review and meta-analysis	2011–2020	Childhood trauma/developmental trauma	Psychosis symptoms and experiences (hallucinations, delusions, paranoia)
Cividanes 2019	Systematic review and qualitative analysis	Until 2016	Child sexual abuse and ASA (re-victimisation of people who had experienced child sexual abuse and ASA)	PTSD symptoms or diagnosis
Cobb 2020	Systematic review	1976–2018	ACEs (including sexual abuse, physical abuse, sexual assault, emotional abuse)	Eating disorders
Duarte 2020	Systematic review and meta-analysis	Until February 2019	Childhood maltreatment	Suicidal behaviours (in people with diagnosed bipolar disorder)
Favaro 2020	Umbrella review of meta-analyses	Until December 2019	Childhood abuse (including sexual abuse and other types of child victimisation)	Eating disorders
Fletcher 2021	Systematic review	2009–2019	Child sexual abuse	Substance-use disorders
Gardner 2019	Systematic review and meta-analysis	NR	Child maltreatment including physical abuse, sexual abuse, emotional abuse, neglect and exposure to IPV	Depression and anxiety disorders; PTSD
Goddard 2019	Systematic review and narrative synthesis	2006–2016	Child abuse (including neglect, abuse, maltreatment and victimisation)	Substance-use disorders; depression, psychopathic features, anxiety

Study ID (first author/year)	Study design	Year range of review	Abuse types included	Mental health conditions/ symptoms
Grose 2019	Review of reviews	2000–2016	Gender-based violence (including contact and non-contact child sexual abuse)	Mood disorders; Substance use disorders; eating disorders; anxiety disorders (including stress)
Humphreys 2020	Meta-analysis	NR	Childhood trauma	Depression diagnosis or symptoms
Karlsson 2020	Systematic literature review	Until August 2017	Sexual victimisation (including childhood and adulthood sexual abuse, rape and unwanted touching)	Mental illness (any diagnosed)
Kuzminskaite 2021	Integrated review	2009–2020	Childhood trauma (including sexual abuse, neglect, emotional abuse, physical abuse)	Depression and anxiety disorders
Li 2020	Systematic review and meta-analysis (2 meta-analyses conducted)	Up to December 2016	Child sexual abuse	Depression
Mainali 2020	Review	NR	Child abuse (including sexual abuse, physical abuse and maltreatment)	Emotionally unstable (borderline) personality disorder
McKay 2021	Systematic review and meta-analysis	Until August 2019	Childhood trauma (including physical neglect, bullying, emotional abuse, physical abuse and sexual abuse)	Depression; anxiety; psychosis; bipolar disorder
Ou 2020	Meta-analysis	Until April 2020	Childhood maltreatment (5 types included: sexual abuse, emotional abuse, emotional neglect, physical abuse, physical neglect)	Obsessive-compulsive disorder
Peh 2019	Systematic review and meta-analysis	1990–2019	Childhood adversities (including trauma exposure, bullying, victimisation, parental separation, parental loss)	Psychosis (risk)
Porter 2020	Systematic review and meta-analysis	1980–2019	ACEs (including child abuse, physical abuse, sexual abuse, psychological abuse, emotional abuse, neglect, trauma, maltreatment, bullying, loss of parent)	Emotionally unstable (borderline) personality disorder

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

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

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

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

Discussion

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

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

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

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

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

Many studies failed to differentiate between the different levels of abuse, such as non-contact sexual abuse (for example, exhibitionism, indecent exposure, sexual harassment or voyeurism); contact sexual abuse without penetration (for example,

non-genital fondling, kissing or genital touching); and contact sexual abuse with penetration (for example, oral, anal or vaginal intercourse).

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

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

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

(A2) References for Appendix A

Armoon B, SoleimanvandiAzar N, Fleury M-J, Noroozi A, Bayat A-H, Mohammadi R, et al (2021) Prevalence, sociodemographic variables, mental health condition, and type of drug use associated with suicide behaviors among people with substance use disorders: A systematic review and meta-analysis. *Journal of Addictive Diseases*,**39**:550-69.

Barbosa F, Moreira D, Moreira DS, Oliveira S, Ribeiro FN, Favero M, et al (2020) Relationship between adverse childhood experiences and psychopathy: A systematic review. *Aggression and Violent Behavior*, **53**:101452.

Cavallo C, Mansueto G, Palmieri S, Ruggiero GM, Sassaroli S, Caselli G (2021) Adverse childhood experiences and repetitive negative thinking in adulthood: A systematic review. *Clinical Psychology & Psychotherapy*, **28**:557-68.

Chang T, Cheng Z, Bracke S, Woodl MJ, Lyons LM, Bloomfield MAP, et al (2021) Psychological processes mediating the association between developmental trauma and specific psychotic symptoms in adults: A systematic review and meta-analysis. *World Psychiatry*, **20**:107–23.

Cividanes GC, Mello AF, Mello MF (2019) Revictimization as a high-risk factor for development of post-traumatic stress disorder: A systematic review of the literature. *Revista Brasileira de Psiquiatria*, **41**:82–9.

Cobb EL, Lamson AL, Steffey C, Schoemann AM, Didericksen KW (2020) Disordered eating and military populations: Understanding the role of adverse childhood experiences. *Journal of Military, Veteran and Family Health,* **6**:70–82.

Duarte D, Belzeaux R, Etain B, Greenway KT, Rancourt E, Correa H, et al (2020)Childhood-maltreatment subtypes in bipolar patients with suicidal behavior: Systematic review and meta-analysis. *Brazilian Journal of Psychiatry*, **42**:558–67.

Favaro A, Solmi M, Radua J, Stubbs B, Ricca V, Moretti D, et al (2020) *Risk factors for eating disorders: An umbrella review of published meta-analyses.* Revista Brasileira de Psiquiatria

Fletcher K. *A (2021) systematic review of the relationship between child sexual abuse and substance use issues. Journal of Child Sexual Abuse*, **30**:258–77.

Gardner MJ, Thomas HJ, Erskine HE (2019) The association between five forms of child maltreatment and depressive and anxiety disorders: A systematic review and meta-analysis. *Child Abuse & Neglect*,**96**:104082.

Hailes HP, Yu R, Danese A, Fazel S (2019) Long-term outcomes of childhood sexual abuse: An umbrella review. *The Lancet Psychiatr*, **6**:830–9.

Humphreys KL, Piersiak HA, LeMoult J, Wear JG, Lee A, Gotlib IH (2020) Child maltreatment and depression: A meta-analysis of studies using the childhood trauma questionnaire. *Child Abuse and Neglect*, **102**:104361.

Karlsson ME, Zielinski MJA-K Marie E (2020) Sexual victimization and mental illness prevalence rates among incarcerated women: A literature review. *Trauma, Violence & Abuse,* **21**:326–49.

Kuzminskaite E, Penninx BWJH, van Harmelen A-L, Elzinga BM, Hovens JGFM, Vinkers CH (2021) Childhood trauma in adult depressive and anxiety disorders: An integrated review on psychological and biological mechanisms in the NESDA cohort. *Journal of Affective Disorders*, **283**:179–91.

Li D, Chu CM, Lai V. *A (2020) developmental perspective on the relationship between child sexual abuse and depression: A systematic and meta-analytic review. Child Abuse Review*, **29**:27–47.

Mainali P, Sangroula D (2020)Exploring the neuro-morphological and epigenetic pathway for adverse childhood experiences and borderline personality disorder: A review. *Journal of the American Academy of Child and Adolescent Psychiatry*, **59**:S246–7.

McKay MT, Cannon M, Chambers D, Conroy RM, Coughlan H, Dodd P, et al (2021) Childhood trauma and adult mental disorder: A systematic review and meta-analysis of longitudinal cohort studies. *Acta Psychiatrica Scandinavica*, **143**:189-205.

Ou W, Li Z, Chen W, Liu J, Liu B, Zhang Y, et al (2020) Association between childhood maltreatment and symptoms of obsessive-compulsive disorder: A meta-analysis. *Frontiers in Psychiatry*, **11**:612586.

Peh OH, Rapisarda A, Lee J. Childhood adversities in people at ultra-high risk (UHR) *for psychosis: A systematic review and meta-analysis.* Psychological Medicine. 2019;49:1089–101.

Porter C, Palmier-Claus J, Branitsky A, Mansell W, Warwick H, Varese F (2020) Childhood adversity and borderline personality disorder: A meta-analysis. *Acta Psychiatrica Scandinavica*, **141**:6–20.

Santo T Jr, Campbell G, Gisev N, Tran LT, Colledge S, Di Tanna GL, et al (2021) Prevalence of childhood maltreatment among people with opioid use disorder: A systematic review and meta-analysis. *Drug and Alcohol Dependence*, **219**:108459.

Prangnell A, Imtiaz S, Karamouzian M, Hayashi K (2020) Childhood abuse as a risk factor for injection drug use: A systematic review of observational studies. *Drug and Alcohol Review. 2020;39:71–82.*

Schorr MT, Tietbohl-Santos B, de Oliveira LM, Terra L, de Borba Telles LE, Hauck S (2020) Association between different types of childhood trauma and parental bonding with antisocial traits in adulthood: A systematic review. *Child Abuse & Neglect*, **107.**

Shamblaw AL, Harkness KL, Cardy RE, Prost EA-S Amanda L (2019) Abuse as a risk factor for prenatal depressive symptoms: A meta-analysis. *Archives of Women's Mental Health*, **22**:199–213.

Tschoeke S, Borbe R, Steinert T, Bichescu-Burian D (2019) A systematic review of dissociation in female sex workers. *Journal of Trauma and Dissociation*, **20**:242–57.

Thomas S, Höfler M, Schäfer I, Trautmann S (2019) Childhood maltreatment and treatment outcome in psychotic disorders: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, **140**:295–312.

Zhang S, Lin X, Pan Y, Zeng X, Chen F, Wu J, et al (2020) Prevalence of childhood trauma measured by the short form of the childhood trauma questionnaire in people with substance use disorder: A meta-analysis. *Psychiatry Research*, **294**:113524.

Zhang S, Lin X, Yang T, Zhang S, Pan Y, Lu J, et al (2020) Prevalence of childhood trauma among adults with affective disorder using the childhood trauma questionnaire: A meta-analysis. *Journal of Affective Disorders*, **276**:546–54.

Appendix B: Quotes from survivors and psychiatrists

Survivors of NRCSA who coproduced this position statement and its recommendations were invited to share their experiences of mental health care. The quotes throughout this position statement, and those below, are drawn from these testimonials and are reproduced with the survivors' permission. Also included are reflections from psychiatrists on their experiences of supporting people who have lived through NRCSA.

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

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

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

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

The psychiatrist dismissed the severe childhood sexual abuse my husband disclosed to him and the jealousy-driven violence my husband was now threatening to do to me as a result of his rage, which included threats to stab me. The psychiatrist said there was not really anything wrong, just the stress of my husband adjusting to living in a new country.

As soon as we left the consulting room, my husband was emboldened. It wasn't the psychiatrist who had to go back and sleep in a bed with him, wondering what's going on in his head and what he'll get me to do. A few days after that, I had to run from my house in my pyjamas with my three young children.

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

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

Appendix C: Resources

Resource 1: Principles for trauma-informed talking therapy assessments

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

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

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

Resource 2: Addressing inequalities in the health service

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

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

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

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

Resource 3: Example of good practice in complex trauma service provision

This research report explores the causes and impacts of complex trauma, and understandings of trauma-informed care. It presents policy and practice, recommendations, identifies models of best practice and indicates future research work.

Source: "A deep wound under my heart": Constructions of complex trauma and implications for women's wellbeing and safety from violence. – Research report (Salter et al., 2020)

Resource 4: The interdependent model of apology in the context of non-recent institutional abuse

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

It looks at "the multi-layered relational dimensions of shame" surrounding historical abuse and "presents apology as a potential means of invoking:

1. truth for victims
2. accountability of offenders
3. leadership of institutions
4. the re-imagination of national identity."

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

Resource 5: The Accountability and Reparations Investigation Report

The Accountability and Reparations Investigation Report* from the IICSA defines key elements of what accountability and reparations mean to survivors, making a clear case for acknowledgement and apology. The report's focus is on the justice system, but there are valuable messages that are relevant across services. Its messages lay a foundation that services should build on to address the needs of people who have experienced child sexual abuse.

Apologies from institutions must be genuine and sincere, never watered down or ambiguous.

* (Report number CCS0719581022; September 2019)

Resource 6: The Top 10 priorities for sexual violence and abuse research

The James Lind Alliance, a non-profit making initiative bringing patients, carers and clinicians together, established a Priority Setting Partnership focused on supporting survivors of sexual violence. The top 10 priorities were co-produced with a range of stakeholder representatives, especially survivors, and are as follows:

1. From the perspective of survivors, what does recovery involve and what outcomes do they value?
2. How can survivors from Black, Asian and Minority Ethnic (BAME) communicates be best supported?
3. How can access to high-quality psychological therapies be improved?
4. What interventions could reduce the stigma and its consequences of survivors?
5. How can contact with the police avoid re-traumatisation, distress and victim-blaming attitudes?
6. What support is most helpful to and valued by survivors?
7. How can health services become more trauma-involved?
8. What support do survivors need during and in the aftermath of criminal justice proceedings?
9. How can support be more accessible, inclusive and effective for LGBTQ+ survivors?
10. How can survivors of historical abuse be best supported?

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