A Response to 'Beyond Trauma':
Appropriate Mental Health Responses to Survivors of Sexual Abuse

Presented by *Linda Regan* at the *Beyond Trauma* Conference, Edinburgh, June 2001.

My colleague Liz Kelly and I have done a range of research and evaluation which addresses sexual violence, specifically child sexual abuse, sexual exploitation of children, that is pornography, prostitution, sexual abuse rings and trafficking of children for the purposes of sexual exploitation and rape, sexual assault and trafficking of adult women. We also welcome the final report summary of 'Beyond Trauma' - although it has to be said that it makes profoundly depressing reading. So many of the findings reflect those from our previous work and the work of others.

I want to tell you a story as a way of picking up on some of the key findings in 'Beyond Trauma'. Some of you might recognise this story. It begins with a child who migrates from the UK to Canada with her mother and siblings. In Canada her household is dominated by the violent rages of her stepfather and her mothers' descent into alcohol and despair. The family spent short periods of time in a number of shelters/refuges but none seemed to be able to deal with the damage the family had already sustained and they always returned home. As she grew older, but was still a child she began running away from home. On the streets she fell prey to men who sexually abused her, often they gave her food, some gave her money. The response of the state child protection agencies was to view our young woman as 'out of control' and take her into care; she had 11 placements in 18 months. She continued to run away and continued to be sexually exploited. Like many who become entrapped in the sex industry, drugs - legal and illegal - became her survival tool and refuge. Self-harm in the form of cutting and anorexia soon followed. No one managed to reach this troubled young woman, and many of the professionals were all too happy just to label her as a young prostitute, delinquent, impossible.

She returned to the UK to find her remaining family but, to feed her now addiction to drugs, returned to prostitution. She met a punter - an older man - who convinced her he would love her and wanted to look after her, instead he became her pimp. Shortly after this she was gang raped. At this point she has reached the age of 16 and the cumulative abuse she has sustained, and survived, begin to overwhelm her. She is close to suicide and her levels of self-harm have become more dangerous. One evening she uses the knife that she had used previously to cut her wrists to defend herself from what she perceived as an attempted rape by her 'pimp'/partner. She is convicted of murder at the age of 17 and spends the next 10 yeas in prison where she becomes addicted to legally prescribed drugs, drugs prescribed as she saw it, to keep her quiet and under control, and it is these drugs which will eventually kill her. Very little attempt was made whilst she was under the care of the prison system to explore what lay underneath her 'out of control' behaviour.

The response of the mental health service to her on her release from prison was hardly any better - she was quickly labelled 'borderline personality disorder' - a label, reflected in the findings of Beyond Trauma, which some, though not all, mental health professionals, seem to use as a way of saying 'we have no idea what to do with this person' or 'untreatable' and pass them on to yet another service which responds in a similar way.

This is Emma Humphreys' story - and it is her life that makes clear the connections between a range of forms of violence. Whilst we may separate them in law, in the categories we use in research and, importantly, how we organise institutional responses - in the state and voluntary sectors - they were not separate in her experience. It is impossible to understand her life, still less imagine how it might have been different, if we fail to see that it involved repeated victimisation by the same and different men, that her attempts to cope with/escape one form of abuse made her vulnerable to others. What Emma needed, and did not encounter until too late, were people and responses that could see the connections, cross-bureaucratic and analytic borders, because she and her life were complex. The tragic irony here - and Emma is not an exception - is that women who have been most damaged are those for whom the least support and services exist. They, and their lives, are too complicated, too difficult, too disruptive, do not fit into the ways services have developed. And yet, what we know is that there are many Emma's out there:

- a substantial proportion of women in prison, and from a recent MA dissertation by Caroline Rowsell, women on probation, have histories of victimisation, and in many cases there are direct and indirect links between this and their offending;

- a substantial proportion of women in-patients and outpatients in the mental health system have histories of child sexual abuse, and often assaults as adults too. The proportions appear to be even higher in secure units;

- a substantial proportion of women in prostitution have histories of sexual abuse, and this is extremely high for those who enter before age 16. Once in the sex industry the levels of violence women experience within it are horrific, and the mortality rate vastly greater than other forms of employment. Alongside the fact that women in prostitution are targeted for lethal violence by our most rabid misogynists, many die from drug overdoses, drugs they take initially to cope with sex work and which then become the reason why it is so difficult for them to imagine leaving prostitution.

Emma's experience reflects all of this and these are more than correlations, they are routes or trajectories that are connected to repeated abuse in childhood, absence of appropriate intervention and support, and deep and debilitating self blame and in some cases, self hatred.

'Beyond Trauma' addresses many of the aspects of the response of services and professionals to Emma, both as an adolescent and as an adult. I cannot pick up on all of them but want to highlight two areas in particular - telling about sexual violence and diagnostic labelling.

Reflected in 'Beyond Trauma' is the continuing unwillingness of professionals, whether in the statutory sector, including mental health agencies or the voluntary sector, to hear the stories of survivors. Although responses have improved in the last 25 years, it has been piecemeal and inconsistent, and every research project which asks about telling and help-seeking confirms that many women want to tell, but professionals fail to ask them. It is also the case that when women do tell the responses they encounter often speak to a profound ignorance of the realities and complexities of their experience. This acts as a form of re-silencing, returning women to the isolation and self-blame, that is so destructive.

Judith Herman's work on traumatic life events (1994) argues that trauma is only resolved where there is a route to understanding and sense making (p41). Without this, individuals continue to

restrict their life in order to protect themselves from dangerous knowledge, disturbing reminders, and contexts in which they have limited control. This process can only begin when those who have experienced trauma are enabled to speak. This too was Emma's experience - no one, either when she was an adolescent or when she was in prison, wanted to hear what had happened to her, and this was compounded by the response of some of the mental health professionals she encountered on her release.

Being labelled ' borderline personality disorder' was also Emma's experience - and she too was 'bounced' between one service and another. Again, I want to refer to Judith Herman here. She states in reference to a diagnosis of borderline personality disorder that "This term is frequently used within the mental health professions as little more than a sophisticated insult. "(pg. 123) and that in the US as here, the tendency is to simply move those with this diagnosis on to yet another service. Investigation of the backgrounds of patients labelled 'borderline personality disorder' reveals that large numbers of them have histories of sexual violence. Herman goes on to argue that those who display the characteristics of survivors of sexual violence, within the mental health system and requiring psychiatric treatment, should be given a diagnosis of complex post-traumatic stress disorder. For those of you who have not come across this, it is outlined in detail on page 121 of her book 'Trauma and Recovery'. We support this, particularly as it is clear that the diagnosis given directly affects the response of the professionals.

Moving on to how we address sexual violence - we would concur with and support the conclusions in 'Beyond Trauma' and support any moves made to ensure that appropriate and responsive mental health services are available when women need them. The recommendations reflect what we have consistently argued for over the past 15 years and interestingly they also reflect the discussions amongst participants at the first ever national conference of women sexual abuse survivors held in London in 1989 - 12 years ago now. Women, and children for that matter, want and need access to a range of resources at different points in their struggles to escape from or deal with the consequences of sexual violence. All the research work done with adult survivors, and some undertaken with children, demonstrates that initially what they want most is someone to talk to, to explore their issues, to be validated. They may then want to take up medium and longer-term support - the most used of which is some form of counselling, therapy, individual and/or group work. The irony is that services developed in the voluntary sector precisely to respond to these identified needs of survivors of sexual violence have decreased rather than increased in number over the last 10 years and for many there is still no core or secure funding. One of the longest and, we would argue best, centres responding to the needs of survivors has to, each year, argue the case yet again that there is no other provision locally for adult survivors of child sexual abuse. Our point here is that services to adult survivors of sexual abuse have always, and continue to be, not seen as central to provision - and we would argue too, that they have been marginalised within statutory mental health services.

When we discuss action in relation to sexual violence we often use the concepts of 'Sanctions and Sanctuary'. Sanctuary covers responses to survivors, adults and children, which creates some form of safety - it is far more than providing refuge/shelter to those in immediate physical danger - it includes appropriate service provision. To provide sanctuary you need services which:

- begin from a climate of belief, rather than one of scepticism;
- ask explicitly about abuse - this gives women both the permission and opportunity to talk;

- create a safe welcoming environment in which some privacy is possible;
- do not question or judge her behaviour - she may interpret this as blame - and reassure her that she was right to tell, that what happened was not her fault and encourage her not to blame herself;
- check her current safety - do not assume that because she has talked about abuse in the past that there are no current safety issues;
- offer a combination of emotional and practical support;
- provide information on options - do not assume she only needs your service;
- are prepared to move at her pace - just beginning to talk can be a huge step;
- where possible and appropriate, encourage contact with support groups in the community;
- help restore a sense of control - abuse involves having your control taken away - so support should always endeavour to restore it;
- provide a short, medium and long term service - it is extremely difficult to 'time limit' the amount of support any particular woman might need and services need to be able to tailor what they provide to the needs of the woman as they emerge over time;
- are available 24 hours a day, 7 days a week, 52 weeks a year;
- are easily accessible - can be contacted by telephone, walk in, well advertised and immediately available. Asking for some form of service is a huge step for some women and they should not then be told that they are going to have to wait weeks or longer for that service;
- provide community and institution based support - importantly this should include specialist residential provision both crisis, short term and longer term;
- work in partnership with other agencies in both the voluntary and statutory sectors from a position of mutual respect for each other's skills, understanding and knowledge.

In order to take action we also have to think about sanctions: Sanctions apply to perpetrators and are actions which communicate the unacceptability of their behaviour and exact some kind of cost for it. For centuries we have seen a world-wide climate of toleration, which has resulted in a culture of impunity. Very few perpetrators are prosecuted, and few attempts are made to make them accountable for their behaviour. This has to be addressed by removing barriers to prosecution and introducing education programmes for offenders - both those who have been convicted and those who are prepared to participate voluntary. The programmes which have the most chance of success are those which see this work as a long-term project and where it is part of a wider strategy aimed at ending sexual violence. It also needs to be said that those who have experienced sexual violence need and deserve some form of justice, holding perpetrators to account is the only way of providing it.

A short word about prevention. Sanctions and Sanctuary both occur after the fact of sexual violence. We all of us need to move beyond responding to sexual violence to preventing it occurring in the first place. All agencies, whether they are in the voluntary or statutory sector and whatever they see as their primary role must engage in prevention work in their community. In our view the most effective and challenging attempts at prevention are integrated models which combine public and professional education. Prevention has to include a number of elements:

(1) public education campaigns which carry uncompromising messages which are challenging and provoke debate. The zero tolerance campaign here was an example of this.
(2) Ongoing, integrated and effective programmes in schools
(3) Training for workers, in the voluntary and statutory sector which is both in-agency and inter-agency

Finally we argue for an integrated strategy overall, in which national and local government can and should take a leading role in the elimination of sexual violence through the adoption and rigorous application of a zero tolerance policy that:

- stresses that no amount of sexual violence is acceptable;
- recognises that all forms of sexual violence are connected and that they have the same underlying causes and are implicated in the continuation of women's inequality and that they are not simply individual experiences of victimisation but have a gendered pattern which needs to be addressed;
- acknowledges that victims must not be blamed for the violence they suffer and that their responses and coping strategies should be seen as reasonable in the light of what has been done to them;
- ensures that perpetrators are held accountable for the violence they inflict.

Taking on board the recommendations in 'Beyond Trauma' and acting on them by all the responsible agencies here would go a long way towards fulfilling an integrated strategy tackling sexual violence.