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THE PROCESS OF DISCLOSURE OF CHILDHOOD SEXUAL ABUSE: OLDER ADULT WOMEN: A PILOT STUDY

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by

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ABSTRACT

THE PROCESS OF DISCLOSURE OF CHILDHOOD SEXUAL ABUSE; OLDER ADULT WOMEN: A PILOT STUDY

KATRINA LAYDON-WALTERS

A pilot study was conducted in response to the paucity of research describing the disclosure of childhood sexual trauma for older adult women. This research sought to provide a tentative base for an understanding of the process of disclosure of childhood sexual abuse for older adult women through a descriptive, client centred approach.

In-depth interviews were carried out with ten participants. These included an older adult survivor of childhood sexual abuse, six health and social service practitioners who had received disclosures, and three who strongly suspected their clients had been sexually abused as children.

Qualitative analysis of verbatim transcripts of the interviews revealed elements, themes and core categories of factors relating to the process of disclosure for older women. Measures of internal consistency and intercoder reliability of the analysis of the data revealed moderate reliability.

The main findings of this study suggest the process of disclosure of childhood sexual abuse for older adult women, when in receipt of health or social service care, is a function of her context(s) and life experiences. The practitioner with whom she comes into contact was found to represent an essential aspect of the current context and practitioner variables associated with the process of disclosure of childhood sexual abuse for older adult women are described. The findings of this study are presented in a descriptive format supported by summary tables. A context model of the process of disclosure of for older adult survivors of childhood sexual abuse is presented in the discussion.

This pilot study appears to be the first research which has focussed specifically on the process of disclosure of childhood sexual abuse for older women. Through the words of an older adult survivor of childhood sexual trauma, and practitioners who have worked with older women who have disclosed sexual abuse during childhood, a unique contribution to an understanding of what influences older women to begin to tell of their experiences has been possible. The findings of this pilot study are tentatively informative for practitioners and researchers interested in the needs of survivors of sexual abuse during childhood, and older adult women.

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AUTHOR'S DECLARATION

At no time during the registration for the degree of Doctor of Clinical Psychology has the author been registered for any other University award.

The contents of this bound volume are identical to the volume submitted for examination in temporary binding except for the amendments requested at the examination.

This study was conducted while the author was a Trainee Clinical Psychologist in the South West Region based with Exeter Community Health Services Trust.

Signed. Katrina Layton-Watts

Date 17th June 1995

CHAPTER ONE

INTRODUCTION

INTRODUCTION: Interest and research into the prevalence and impact of childhood sexual abuse (CSA) is relatively recent, with a surge of papers over the last 20 years (the last 10 in particular). Increasing sophistication in research methodology, with the use of standardised instruments and comparative statistical analyses, has provided greater depth of knowledge and understanding about the meaningfulness of CSA in the victim's lives, and on their mental health status.

The sexual abuse of children is purposeful. It is forced, or coerced sexual act(s), perpetrated by physically and developmentally mature persons upon physically and developmentally immature children and adolescents, to gratify the perpetrators own sexual desires 'disregarding the child' Steele (1986). In a landmark review of the nature and impact of CSA, Kempe and Kempe (1978, c Kilpatric, 1987) describe the sexual exploitation of children as robbing them of 'their developmentally determined control over their bodies, and of their own preference, with increasing maturity, for sexual partners on an equal basis' (p175). Sexual abuse of any nature, is an abhorrent act, and an emotive subject. Reading, talking and writing about acts of, and the impact of sexual abuse can trigger a multitude of affective responses, from shock, horror and numbness, to extreme sadness and rage. These feelings mirror (albeit in much diluted form) some of the effects abuse has upon the victim.

However, in taking an 'objective' view of the research, it is important not to become 'lost' in the morality of abhorrent acts, conversely neither should we ignore the gross degradation and injustice. Survivors accounts comprise an invaluable contribution to our existing literature, and knowledge of abuse These are the

accounts upon which a clinical and scientific research base into sexual abuse began, and continues. They also help to 'ground' us with the 'reality' of abuse. As Williams and Watson (1994) meaningfully state, 'We have much to learn from those who use our mental health services, and it is essential that clinical psychology theory and practice is shaped by this knowledge' (p7).

The memory does not come easy
It comes with screams that will not stop
It comes with tears and terror
It comes with shame that I felt this
Shame that I feel this

(Yarrow Morgan whose earliest memory of ongoing abuse was as an infant, c. Bass and Thornton 1983))

PREVALENCE OF CHILD SEXUAL ABUSE: Many studies looking at the effects of sexual abuse have identified prevalence rates within these samples. These include clinical and non clinical population comparisons and purely clinical samples. Considered alongside community and general population studies, the findings have identified a wide prevalence range, some of which indicate as many as one in three female adults have a history of CSA (Anderson, Martin, Mullen, Romano and Herbison 1993).

The first large scale estimate of prevalence in a nationally representative sample in Great Britain was conducted as part of a MORI survey. In this study of 2019 adults, 12% of women and 8% of men

reported being sexually abused before 16 years of age. 51% of those with a history of CSA said they felt 'harmed' by the experience, and of those abused by a parental figure, 74% thought the abuse was damaging. Upon this evidence, the authors estimate that in GB alone there are over 4.5 million adult survivors of CSA (Baker and Duncan 1986). This estimate leads to the conclusion that at least 2.25 million adults are currently feeling harmed and damaged as a consequence of CSA. The implications for mental health are enormous.

Findings with community samples of women evidence prevalence rates of 66% (Anderson et al 1993), 62% (Wyatt 1985), 34.4% (Martin, Anderson, Romans, Mullen and O'Shea 1993), 26% (Lechner 1993), 20% (Moeller and Bachmann 1993) and in a mixed gender sample, 5.3% (Scott 1992). Clinical samples have also identified a range of findings. Williams (1993, c Williams and Watson 1994) reviewed research concerned with abuse and found 49% of women using community and hospital based mental health services had been sexually abused. Other researchers have identified prevalence rates from clinical populations ranging from 18% (Brown and Anderson 1991) to 64% (Walker, Katon, Harrop-Griffiths, Holm, Russo and Hickok 1988).

Interestingly, a comparison of the Kinsey Report (first published 1953) and 19 prevalence studies between 1981 and 1991 indicated similar findings, that 10%-12% of all female children less than 14 years of age had been sexually abused (Feldman, Feldman, Goodman, McGrath, Pless, Corsini, and Bennett 1991) It is also noted that in spite of the evidence at the time, the incidence of CSA was 'de-emphasised' (Kilpatrick 1987).

Professor Jean La Fontaine (1988) points to problems defining

prevalence, and suggests processes such as denial (eg where abuse has been denied in postal questionnaires, but not upon interview) adds to the complexity of CSA research and will inevitably lead to prevalence underestimates. Differing methodology, particularly with regard to research definitions of abuse may account for the wide variation in prevalence study findings. However, it is clear that a substantial minority of the population has been abused, and the majority of those abused experience distress and damage as a consequence.

THE IMPACT AND LONG TERM EFFECTS OF CHILDHOOD SEXUAL ABUSE A plethora of studies describe the impact of childhood sexual abuse on the victim, and the long term effects for males and females, as children and adults have been extensively examined. The researchers have utilised clinical diagnostic tools and criteria to identify and describe mental health, distress and level of pathology. Briere and Runtz (1993) found the few studies which have looked at sex differences suggest that male victims often externalise their distress with extrapunitive aggression, whilst female victims appear mostly to internalise distress with intrapunitive aggression and depressive states.

The long term effects of CSA include somatoform disorders (eg sexual dysfunctions), eating disorders, substance misuse and dependence, multiple personality disorder, major depression, anxiety disorder, borderline personality disorder, obsessive-compulsive disorders, (Kinzle and Biebl, 1992; Brown and Finkelhor, 1986; Shearer, Peters, Quaytman and Ogden, 1990; Pribor and Dinwiddie, 1992), PTSD, (Rowan and Foy 1993), and suicidality (Brown and

Anderson, 1991). Long term effects are also directly associated with abuse specific variables, with the most damaging associated with penetration and force (Pribor and Dindwiddie, 1992) long term duration of abuse, the abuser being a father-figure, genital contact, aggression, unsupported reaction to disclosure (Brown and Finkelhor 1986), younger age at onset, and number of abusive incidents (Baker and Duncan, 1986; Hartman and Finn, 1987; Herman and Schatzow 1987, c Briere and Conte, 1993; Lechner, Vogel, Garcia-Shelton, Leichter and Steibel, 1993).

The identification of links between abuse variables and symptoms provides important information when considered alongside abuse history data. In a recent study, it was found that CSA survivor's histories revealed that for 50% of those abused, the abuse included intercourse, and 85% report some type of genital contact. The abuser was a family member in 63% of cases, with 15% reporting multiple abuser of both family and non-family members. The abuse continued on average in this sample for 2.1 years (Yama, Tovey and Fogas, 1993). In another recent study, Anderson et al (1993) found 10% of the women in their research reported having been abused for 3 or more years, with the age of greatest risk for onset being between 8 and 12 years. 65% of the victims were pre-menstrual at onset of abuse, 13% in their menarcheal year, and 22% post-menarcheal. Considered together, the data describing symptoms, the links with abuse variables, and the incidence of those variables causing most harm suggests that a high proportion of those victimised have been rendered vulnerable to the most serious long-term sequelae. Clark, (1990) suggests that it is essential that 'all health care workers' recognise that 'intense symptoms are

indicative of underlying vulnerability' (p.95). Perhaps, for the substantial minority, that vulnerability is the direct, and long term consequence of childhood sexual trauma.

SEXUAL ABUSE IN CHILDHOOD: RESEARCH AND OLDER ADULTS Older adults in particular appear to have been grossly neglected in this domain of knowledge. Up until the time of writing this report, only one paper could be found which directly addressed CSA and older adults. This paper explored and described issues and outcomes associated with sexual abuse of childhood, as they relate to, and impact upon, older adult women. In this brief (N=3) study, the most commonly observed residual effects of CSA upon older adult women were: chronic depression; revictimisation as adults (including elder abuse) and the misdiagnosis of residual effects as dementia or mental illness. The authors also point out that these effects 'continue to plague older adults and disrupt their ability to function independently' (Allers et al 1992 p.17).

The absence of our older adult population in the research literature is at a minimum intriguing; and maximally alarming. In one study, the authors had literally removed the data obtained from older women from the study findings (eg Anderson et al 1993, excluded data from 259 women who responded to an investigation into the prevalence of childhood sexual abuse in a community sample of women, because they were 65 and over). The silence is deafening, the invisibility annihilating of their experiences.

Research evidence has demonstrated the importance of being aware

of CSA as a possible contributory factor in the emergence or continuance of mental health problems. There is consistency of findings across studies, that for many victims, CSA can have life-long, pervasive and seriously detrimental effects on mental health and psychosocial functioning (Allers, Benjack, and Allers, 1992; Baker and Duncan, 1986; Brown and Finkelhor, 1986; Jennings and Armsworth, 1992). Considered to be 'at the core of much that is diagnosed as severe mental illness' CSA is also 'strongly associated with high service use' (Williams and Watson, 1994 p.7) and has been identified as a 'significant long-term health hazard' (Briere and Runtz, 1993, p.312).

But how many 'older women' have been sexually abused in childhood? Given that there appears to be no research describing prevalence across the 'third generation' how do we begin to find out or even estimate?

A national population projection, prepared in 1989 by the Government Actuary in consultation with the Registrars General suggested that the national population of women over 60 years of age in the UK in 1991 would be 6,848,000 rising to 6,898,000 by the year 2001 (c. Women's National Commission, 1992). If these projections are taken to be accurate, in 1995 there will be approximately 6,873,000 older women in our population. If we take a conservative view of the estimates of the prevalence of CSA of females in this country as based on the prevalence studies previously quoted in this Introduction, it would appear that this would represent 10-12% of the researched population, but given the lack of research with older women it is inappropriate to state categorically that these statistics are

representative of their experience. However, from the information that is currently available we can do a bit of research detective work with some of the historical data and make hypotheses. One way of doing this is to consider the findings of the Kinsey Report c. This report was published in 1953, however the collection of data took place during the late 1940,'s. The prevalence rate of CSA at that time was 10-12% of female children under 14. These data would include children born in the mid to late 1930's and those born at that time are now just qualifying to be classified as part of our estimated 'older adult' female population of 6,873,000. If the data from the Kinsey Report is accurate, and the Government population projections are accurate, it could be hypothesised that in the UK, at this time, there are approximately 687,300 - 824,760 women entering or just in their 60's who were sexually abused before 14 years of age

It is essential that as clinicians and researchers we identify older women as existing within the context of survivorship of sexual trauma of childhood. The statistics inform us that they are already there, with or without our recognition. Our lives are a continuum. Women who have been sexually abused in childhood do not suddenly become asymptomatic, or the meaning of symptoms suddenly change simply because one day we are 59 and the next 60. I believe we can begin to attain inclusivity of older women in this domain of knowledge more readily when we challenge ageist assumptions and decide to see and understand 'older women' as 'women who are older'. Furnish (1994) states that 'Ageist beliefs are known to be associated with discrimination in services' (p2), and if women who are older are also survivors of CSA, they are, by definition likely to have experienced

long term problems for a very long time. With our current emphasis on age (old woman) rather than personhood (woman who is old) it is too easy to focus on symptoms as a function of old age rather than a consequence of younger life experiences.

'DIS-CLOSURE': A PARADOXICAL TERM ?: Within academic psychology, the term 'closure' can be found in Gestalt theory. Here, it describes a phenomenon of perception. The 'principle of closure' suggests that psychological and perceptual processes facilitate making sense of the perceived world. Automatic information processes, utilising existing knowledge gained through previous experiences, eliminate the perception of fragmentation of experience, by 'filling in the gaps' and creating a meaningful 'whole'. Paradoxically, from this perspective, the process of dis-closure would suggest a shift away from 'completion' and 'wholeness' and a return to disjuncture.

Where closure appears to occur in connection with sexual victimisation, it would seem to be in defence of the integrity of the ego in the course of egodystonic events. One study which explored the recollection of events associated with sexual victimisation found that people who repressed details (as measured on free recall following hearing an account of victimisation), 'filled in' the missing details with 'positive reconstructions, designed to reduce the overall negative quality associated with the victimisation' (Guenther and Frey, 1990., p. 207). From this perspective, disclosure (as the 'lifting' of repression of abuse details) will entail the client challenging (re-constructing) some of the positive reconstructions which appeared functional in the maintenance of that very repression.

Such reconstructions would have served as an appropriate defence against the reality of the trauma (as psychological closure) and their deconstruction holds the potential for being psychologically painful. When undertaken alongside a professional helper, the professional should be sensitive to the function of active defences.

The style of psychological defence mechanisms documented as associated with sexual trauma of childhood include 'forgetting, distancing, minimising and dissociation (Sorensen and Snow, 1991). Hall and LLoyd (1989) provide an example of what Guenther and Frey (1990) termed 'positive reconstructions' when they describe how an adult woman 'remembers the sexual abuse but transfers the memories to a safer place (eg outside the home) and to a less threatening abuser (eg a stranger rather than father)... The abuse is recalled but without any emotional reactions: denial or minimisation of feelings is common, and may reflect the methods the woman used to cope with the abuse when she was a child' (p89). One way in which professionals and survivors of abuse have begun to address the vacuum which might be experienced during the deconstruction of defences is to reconstruct or reframe the notion of 'victimhood' to that of 'survivorship'. Survivorship emphasises strengths and has positive, empowering implications whilst utilising the term victimhood can imply continuing disempowerment or powerlessness. Whilst a woman survivor of CSA may still <u>feel</u> powerless, the transition into a sense of self as a survivor (of being a child victim) may help begin to 'empower' her.

'Closure' (as the antithesis of dis-closure), can also be experienced as a sense of being 'closed off' and silenced. This silence is often a consequence of fear (of re-abuse, blame,

punishment, rejection), and can create intense feelings of isolation, self-blame, self-hatred and psychological fragmentation (Sanders and Giolas, 1991; Elliot and Briere, 1993). Feeling unable to share their distress about the abuse as a consequence of imposed secrecy, the potential for dis-closure can represent a possible means of making sense of the world. Although the desire for validation, support, self-worth and a sense of 'wholeness' is a basic need, these ego supportive structures are often elusive for survivors of abuse, and the distress associated with their non-attainment is understandably intense.

DISCLOSURE OF CHILDHOOD SEXUAL ABUSE: A futher comprehensive investigation of available literature was undertaken to identify any book chapters, theoretical or research papers which alluded to, or described in any detail the disclosure of sexual abuse for older adult women. None were found. Our silence reflects (or is reflected in) the silence of our older population, therefore, this review of the literature on the disclosure of sexual abuse of childhood is dependent upon and will focus on what is available.

The disclosure of sexually abusive experiences of childhood appears to be an extremely complex process which can take many decades to work through, if at all. The process of disclosure begins the moment the first act of abuse takes place. From that time on, to tell or not to tell can become a constant source of anxiety. Perhaps in contradiction to the commonly held view that to disclose having been a victim of sexual abuse is a positive and healing process, the process of disclosure may not only fail to alleviate distress, but directly

create it. Research exploring the psychological consequences of children's disclosure and non-disclosure of sexual abuse points out that 'children are understandably reluctant to say what adults are reluctant to hear' (Sauzier, 1989, p.455). In this study, all of the (156) children showed fear and ambivalence in relation to disclosure, and those with the highest fear scores were children who had not disclosed. The elevated fear was related to 'the negative consequences of telling, and retribution'. In some cases living with further abuse was seen as less traumatic than facing the consequences of disclosing. The feelings associated with thoughts of, or actual disclosure during childhood are often vividly remembered during adulthood. Sauzier (1989) quotes the words of an adult survivor who explains:

> "I would have killed myself rather than heap shame on my good mother" (survivor of father-daughter incest)

and another who described how:

> "I told my mother, and she said I was a liar"

It would appear that sexual abuse is such a taboo subject, that survivors face very powerful societal barriers to disclosure.

> 'It is as if the mere mention of sexual abuse is as taboo as the sexual acts themselves' (Fontes, 1993, p32)

Religion has been identified as an important factor in maintaining taboos and silence, with the mere mention of abuse being a sin, and resulting in exclusion from heaven, and where sexual abuse resulted in loss of virginity, this was seen as the fault of the victim. The high value placed on virginity leads to perceptions of, and reactions to the victim of abuse as 'ruined'. In one moving account, a twelve year old girl who had been raped, became pregnant. Her pregnancy was aborted, but she was held responsible for the consequences of this violent crime against her:

> 'All her life from then on they would tell her that she could not wear white to her wedding because she was no longer a virgin' (Fontes 1993, p.31)

The denial or minimisation of the reality of sexual abuse and its consequences is validated by subscription to various cultural/societal myths about abuse. The degree to which an individual is influenced by her or his social milieu will influence readiness to disclose, or receive disclosures. Hall and LLoyd (1989) suggest 'These beliefs have enabled professionals and society at large to fail to acknowledge the prevalence of sexual abuse, its resulting pain and the damage it carries for children and adult survivors' (p.19). Driver (1989) argues, denial of and myths about sexual abuse are purposeful for silencing the survivor; protecting the perpetrator and comforting the community member or professional worker. Myths appear to 'explain' sexual abuse and take the emphasis away from the act of abuse itself, and the responsibility of the perpetrator. Commonly held beliefs

suggest that sexual abuse is:

(a) a myth (sexual abuse never happens, women and children lie)

(b) the victims fault (children are sexually provocative, children do nothing to stop the abuse)

(c) the non abusing parent's fault (mothers collude, mothers fail to protect; mother did not provide partner with sexual satisfaction)

(d) inevitable (men cannot control their sexual impulses)

(e) not harmful (children are resilient)

(f) class/culture specific (predominantly working class, ethnic minority based)

These powerful beliefs can support confidants in failing to think or hear about the reality of abuse. Victims of abuse are also exposed to these myths and where survivors of sexual abuse felt reluctant to disclose and/or were silenced as children, can as adults, find the 'unthinkable' unsayable, and the sayable disbelieved, minimised, and invalidated.

The listener's reaction to disclosure is extremely important to the survivor of sexual abuse. For many survivors, negative reactions will have been anticipated, making the decision to disclose a difficult one. In addition, the ability to trust is eroded by 'violation and betrayal during child sexual abuse', and the 'failure to validate sexual abuse contributes to difficulties with trust'. (Browne, 1991; Timmons-Mitchell and Gardner, 1991; Wyatt and Mickey, 1988.) With these points in mind, research findings indicating that a substantial proportion of responses to disclosure are negative are particularly alarming. Moeller (1993) found that where sexual abuse

victims had attempted to disclose to relatives, 33% minimised the abuse; 14% disbelieved abuse had taken place; 11% blamed the victim and 7% told the victim she was crazy. It is also concerning to note that therapists were found to disbelieve reported histories of abuse, (5.5% of victims had to find an alternative therapist), and of the 9% of survivors in the Moeller study who had been attempted to disclose to their GP's, a massive 97% experienced dismissive or unhelpful responses. These included shock with no other reaction (29%); doubting the history of abuse (10%); and doubt about the mental stability of the victim (10%). Almost half the physicians (47%) felt that the abuse was irrelevant to medical care. These responses are more alarming given the body of evidence which shows that women who have a history of CSA experience significantly more medical complaints (particularly pelvic and gynaecological problems) and have more contact with mental health services than women who have not been abused ($p<0.001$) (Walker et al 1988). In addition, associations between multiple medical complaints (and possibly psychological difficulties) and CSA are rarely understood by the client herself (Lechner et al 1993).

Blaming responses are noted to be potentially harmful for victims of abuse, and particularly so where self esteem is already damaged (Testa, Miller, Downs and Panek, 1992, p.174). Childhood sexual abuse is ranked one of the worst stigmatising conditions, which leads to feelings of shame, and disclosure may exacerbate associated shameful feelings (Limandri 1989). Fontes (1993) suggests that 'many victims hide disclosures to escape the stigma of abuse' (p31) and enquiry into the reasons that prevent disclosure, described by survivors of sexual

abuse, included: the expectation of blame; embarrassment; fear of upsetting important others; expected disbelief; wanting to protect the abuser; fear of the abuser; and wanting to obey adults (Anderson et al, 1993). A realistic view, given cultural myths about abuse, and the documented dismissive and punitive responses experienced by many survivors.

Although the common denominator in disclosure is a desire for help and relief, that 'even where circumstances are desperate, if disclosure seems to lead nowhere, victims stop talking' (Browne, 1991, p.150). As one survivor describes the experience:

> "If they come across as indifferent and uncaring, you just shut down" (Limandri, 1989., P.75)

When the attempt to tell of abuse is discounted or disbelieved, this in itself can become a 'secondary trauma', which can lead to intense psychological distress. Bryer et al (1987) argue that where disclosure is silenced, the abuse survivor is 'simultaneously forced to deal with overwhelming emotions and to deny a large part of reality' and suggest 'professionals not initiating discussion of the topic can transmit a message confirming survivor belief in the need to deny the reality of their experience' (p1430). Contrastingly, where supportive reactions were received, these are experienced as validating and minimise self blame (Wyatt and Mickey, 1988). In addition, and importantly for future health, victims who were supported, evidence fewer psychological symptoms and higher self

esteem that those who felt unsupported (Testa, Miller, Downs and Panek, 1992).

AN ECOLOGICAL MODEL OF DISCLOSURE: A model of the factors which make disclosure difficult is provided by Fontes (1993). The factors were identified through interviews with adult survivors of CSA. A hierarchical model of influence and potential for silencing, it is suggested that the characteristics of wider society (widely accepted taboos and myths); the characteristic of ethnic culture (specific cultural taboos and myths); the characteristics of the victims' family (family dynamics and the degree to which the above have been internalised); the characteristics of the abusive situation (eg threats re: disclosure) and the characteristics of the victim (age-developmental level and personality factors) have a 'top down' flow of influence and can act as 'muffling blankets' layered one on top of another. This is a useful model for beginning to draw together existing knowledge and understand the multifacted nature of the process of disclosure, however, for a contextual model, it fails to address two very important factors. The first factor is particularly relevant to older adults, in that 'time' (as in historical time) is also a context (eg does the broader contextual influence change as a function of time?). With specific reference to the sexual abuse of children our 'place' within its 'public' and adacemic research history is relatively recent. Gordon (1990) points out that child abuse was originally 'discovered' through the capitalist industrial work in the 1870's and defined as 'cruelty to children' she suggests that what 'constitutes unacceptable violence towards children has changed

according to political moods and movements over the last century.' This 'politicising' of abuse led in the 1960's to a 'rediscovery of the widespread incidence of child abuse' and has 'led to new public programmes aimed at helping victims and abusers' (pxv). Certainly in the last decade there has been an increase in media coverage (part of our technological context) of programmes focussing on child sexual abuse. In late 1994 'Forbidden Britain' a documentary on the experience and impact of child sexual abuse on older women was broadcast, and over the last few years Childline (a telephone helpline for victims/survivors of CSA) has been publicised through the media. The power of the media to impact upon people who have been abused is evident when we consider the Childline annual report for 1993-4 (published December 1994) where it was reported that 81,543 children were counselled by the helpline in that year, and of those 10,600 were children who had been sexually abused (Context, 1995, p.3). For our older population as children, and young adults, no such 'public' acknowledgment of the harm sexual abuse can cause was available. Thus, our place in historical 'time' has an impact on us, it is part of our context.

My second criticism of the ecological model is focussed on the lack of inclusion in this model of the 'disclosed to' as part of the disclosure dynamics. 'Disclosure' is by definition an interaction between discloser and confidant, and as it stands the ecological model fails to describe (although it could be adapted to do so) the effect of contextual variables upon the confidant. Where the confidant is in a professional role, then agencies (as groups of

people coming together for a common purpose) are also subject to the influence of historical, social and personal contextual factors.

ACKNOWLEDGING OUR FAILINGS: In consideration of the complexities of disclosure, the evidence from empirical enquiry strongly emphasises the importance of a milieu of acceptance for the process of disclosure to unfold. It is also anticipated that with the recent surge of interest into the possibility of therapist suggested or implanted memories (false memory syndrome), that this field will be well researched over the coming months and years. However, this detailed investigation of papers describing the disclosure of childhood sexual abuse is found to be consistent with those describing the prevalence and impact of CSA, where women who are old are notable by their absence. Whilst acknowledging the scientific value of carefully controlled and representative samples to obtain meaningful and generalisable findings (thus studies focussing on children and younger adult women are invaluable to our knowledge about these populations), the paucity of studies and research exploring variables associated with sexual abuse of childhood and older adult women is particularly noteworthy.

We can assume that older women have similar experiences of attempting to dislose as younger adults, we can also assume that of the potential three quarters of a million older women who have been sexually abused as children (see page 8) some will have disclosed as children or younger adults, and many will not. We can make many assumptions, but we do not know. We need to ask. It is hoped that this pilot study will go some way towards redressing this imbalance.

RATIONALE FOR THIS STUDY: The impetus for this study arose from the exploration of current literature and the identification of a 'gap' in existing research. However, the decision to explore the process of disclosure for older adult women gradually evolved. The original study had proposed to investigate the prevalence of childhood sexual abuse relating to older women. Information gathered by questionnaire with quantitative analysis of the obtained data was to be sought pertaining to a large number of 'abusive experiences'. However, at the proposal stage, it became increasingly apparent that this work was 'clinically unviable', by practitioners working within older adult specialty services, and the medical ethics committee. In agreement with this evolution of events, I wished to remain focussed on the needs of older women who had experienced sexual trauma in childhood, as my reading led me to be clinically concerned for the (potentially) large number of older women who are in receipt of mental health services being treated for mental health problems which may have been strongly associated with the long-term impact of CSA. As I continued to 'hold' older women in mind, I realised that by its exclusion of older adults, psychological research relating to childhood sexual abuse was only tentatively generalisable to this population. There was no definitive research base on this topic with older adults. This realisation led me to detailed discussions with a senior clinical psychologist (older adult specialty), and through these conversations emerged a series of questions which felt essential to answer if older women were to begin to be central to our thinking relating to sexual trauma. The questions began with 'why the silence?' both within clinical settings and across academic fields. Clinically, older women

were either not being heard, or not talking of these things frequently, why? what silences them? us? (current research omissions are discussed in detail in the Introduction). As these questions became articulated and an awareness of the lack of knowledge with which to answer them arose, the need for a new base of knowledge became increasingly apparent. These matters required exploration from the perspective of 'not knowing'. One way of beginning to know however, arose from the hypothesis 'If some older women have disclosed, their personal accounts of their previous silence would help us begin to understand.' From a clinical perspective it would be important to know 'what helps older women come through the silence to speak out', and from an academic viewpoint, a model, or models which might begin to help explain these phenomena felt imperative. What emerged was, a need to know about the process of disclosure of childhood sexual abuse for older women, and suddenly, this study was born.

RATIONALE FOR QUALITATIVE METHODOLOGY:

Why qualitative? Having defined the area of the 'need to know' as one where very little research base appeared to exist (with the single exception of the Allers et al. 1992, paper) it became clear this area of clinical concern required definition and some kind of structure. If this were attained, a tentative model, or models might begin to emerge which could then be examined for evidence of links with any existing psychological theory and research. It appeared that qualitative methodology provided the most appropriate research rationale to meet the needs of the research question given the

parameters within which it was set. Using qualitative methods, the researcher has the opportunity to 'open up' previously unknown areas of interest through thorough, rigorous, systematic enquiry, data collection and analysis of the data. In depth interviewing with open ended questions where the participant 'frames and structures the responses' (Marshall and Rossman, 1989 p.82) was considered essential for the maximum breadth and depth of information gathering within the limited time available. In addition, field researchers focussing on sexual abuse argue for the usefulness of qualitative method in this area,

> 'Detailed qualitative research into the ways specific groups define and experience sexual abuse, how they express their pain, where they turn for help and how they make use of the treatment currently available would have immediate implications for clinicians' (Fontes, 1993, p.34)

Grounded Theory: It feels essential to make reference to 'grounded theory', as much qualitative methodology is associated with this philosophy of method and data generation formalised by Glaser and Strauss (1967) for 'its application in daily situations by sociologists and laymen' (p237). Since that time psychologists interested in the generation of theory and sympathetic to qualitative method have suggested that 'grounded theory is one useful approach to the systematic generation of theory from qualitative data..' (Henwood and Pidgeon, 1992). In its original form, grounded theory is inductive, being data driven. Ideally the participants in grounded

theory research are invited to comment upon the interpretations of the data by the researcher to increase validity and reliability of the data as a true representation of the participants' meanings. At the outset, the researcher should be atheoretical, the purpose of the research being theory generation. However, recent criticisms of this method of enquiry include those of Henwood and Pidgeon (1995), who now argue that 'Theory cannot simply 'emerge' from data, because all observation is pre-interpreted in terms set by existing concepts and theory.' (p117). Describing the usefulness of a constructivist revision of grounded theory (after Charmaz 1990 c. Henwood and Pidgeon) these authors suggest that researchers using qualitative methods should be aware that they are actively building their analyses from a perspective and avoid 'merely applying it to new data, problems and contexts' (117).

As the generation of new information which could be used to extend the area of information, and linked with existing knowledge was the hope for and purpose of this study, (rather than theory generation per se) 'pure' grounded theory did not feel entirely suitable, however, the methodology did offer important guidelines for a scientific approach to 'open' research questions, including the 'quality' of informants, data gathering, coding and analysis, reliability (which is bound with the appropriateness of the sample) and generalizability which were considered essential for any sound piece of qualitative data collection.

Following discussion with research supervisors relating to the methodology most appropriate to the research question, the decision to utilise qualitative methods was taken.

AIMS OF THE PROPOSED STUDY:

1) To explore the existence of identifiable and consistent elements in the process of disclosure of CSA during therapeutic contact, in a clinical population of older adult women.

Contingent upon having identified specific elements and themes within participant data:

2) Between participant data will be examined to identify consistencies of themes across participants.

Subsidiary aims and expectations:

1) To provide an initial, tentative understanding of the process of disclosure from a descriptive, client centred, exploratory perspective. It is anticipated that this aim will be realised through in depth, semi-structured interviews, using open ended questions (eg Can you tell me in your own words what you think made it possible for you [or, your client] to begin to tell of your [her] experiences of childhood sexual abuse?), conducted with older women who have disclosed sexual abuse of childhood, and practitioners who have worked with women who have disclosed CSA. Is is further anticipated that the resulting accounts provided by the participants will reveal information relating to the process of disclosure for older women, from which it will be possible to conceptualise, map and describe this process.

2) To provide new leads and the beginnings of a basis for an under-researched area of clinical and psychological importance. From the emerging concepts and descriptions of the process of disclosure of CSA for older women anticipated with aim one, it is hoped the findings of

this research will identify factors specific to the process of disclosure for older women which can be used to begin to derive a representative model of this process.

3) To provide meaningful information derived from the research evidence to enrich and enhance clinical knowledge and practice. It is anticipated that the emergence of relevant conceptualisations, descriptions and factors specific to the disclosure of CSA for older women will be directly relevant for future research and existing practice relating to older adult survivors of CSA and it is hoped the findings will be informative to researchers and practitioners in the field.

RESEARCH HYPOTHESES:

1) Older adult women who have disclosed having been sexually abused during childhood to their practitioner, will reveal specific themes relating to the process of disclosure.

2) Within participant qualitative data analysis will identify key factors (elements) of influence relating to the disclosure.

3) Between participant qualitative data analysis will identify a consistency of themes and elements across participants.

CHAPTER TWO

METHOD

METHOD

RESEARCH PROTOCOL: The proposal for this study was submitted to the University of Plymouth clinical teaching team and the Exeter Medical Ethics Committee for approval. In addition the study was presented to the older adult psychological services at the Department of Community and Clinical Psychology, Exeter for support and comments.

Following course team approval, the Medical Ethics committee requested a personal meeting to discuss their concerns relating to the research. These focussed primarily on the potential for interviews to create a re-surfacing of difficult or painful affect, and a guarantee of total anonymity given that the participant's own words were to be used as research evidence. In response to these concerns, it was possible to inform the ethics committee that members of the older adult team had agreed to provide a safety net system of support/counselling should this have been required. As a measure of control over confidentiality, all names and any identifying information would be omitted. Following these reassurances, ethics committee approval was awarded (appendix 1)

RESEARCH DESIGN AND METHODOLOGY: This study was planned to proceed through four main stages:

1. Pilot study and preparatory sampling
2. Semi-structured interviews with a representative sample
3. Qualitative analysis of the data
4. Bias control

Stage 1: Initial contact and sampling: The focus of this stage was to contact and enlist the co-operation of health and social care workers with four objectives:

1) To inform health and social care workers of the intended research

2) To request worker participation through semi-structured interview with the intent to obtain a 'sample survey' and pilot study from which worker impressions of the process of disclosure could be utilised to inform future interviews with clients who had disclosed.

3) To request worker assistance with access to a representative population sample (eg women with whom they had worked who had disclosed CSA).

4) Following initial interviews with (a minimum of two) field workers, interview notes and taped transcripts would be inspected in detail to identify elements and themes relating to the disclosure of CSA from their perspective. This information would be used to guide and inform the researcher and for the generation of emerging hypotheses. This fourth objective of stage 1 was also intended to provide the researcher with more detailed knowledge of disclosure dynamics, with the intention of increasing and improving researcher sensitivity to these issues; help guide and influence research practice towards maximum sensitivity and ethical concern for the main research sample of older women who had disclosed CSA.

Stage 2: Representative sample, contact and research interviews:

i) Following advice and permission from a named worker, older adult women who had disclosed CSA would be contacted to inform them of the study and request their participation.

ii) Upon affirmative response, the women would be interviewed using a semi-structured, open ended interview. It was hoped that participants would agree to the interview being audio taped.

Stage 3: Inspection and coding of the data:

i) Interview data analysis: Detailed inspection of the interview data was anticipated to reveal elements and themes from which the process of disclosure could be described. Throughout the text, codes would be entered alongside identified themes and elements.

ii) Internal consistency: To ensure scientific rigour the data would be read at least twice. The second reading of the transcripts would take place at a minimum of two weeks after the first and coded separately. Inspection of the time-lapsed coding of the data would identify a % reliability score relating to consistency of reader coding over time.

Stage 4: External readership and inter-coder reliability: A randomly selected sample of the interview transcripts were to be read and coded by external readers to provide a measure of subjectivity bias control and provide an inter-coder reliability score pertaining to themes and elements.

RESEARCH SAMPLE:

Sample 'representativeness': Accessing the planned research sample (older adult women who had disclosed sexual abuse of childhood) was limited to a single respondent. The information gathered during the course of this interview was invaluable and has been utilised to support obtained evidence or raise questions in relation to the greater quantity of research data obtained for this study. This has been drawn from a 'convenience' sample of ten professionals all of whom were working in older adult specialties. Of these, six were employed by social services and four by local health trusts.

Disclosure experience: Across the professional sample, five had experienced disclosure of CSA from older adults, three suspected abuse but had not experienced disclosure, and one who had worked with a client who had been referred following disclosure of CSA to her GP. A tenth professional who agreed to be interviewed was working in older adult services, and had experienced disclosure of CSA from younger adults during previous employment.

Exclusion of unrepresentative data from the results: The data relating to younger adults was analysed but excluded from the findings as it was inconsistent with the research criteria of women over 60.

Practitioner agency: final research sample: Five of the interviewees were employed by social services, (three social workers, one 'befriender' scheme worker, one occupational therapist) the remaining

four interviewees were health service employed community psychiatric nurses.

Table 1 (below), describes and summarises the final research participant sample.

STATUS	SEX	AGENCY	DISCLOSURE	AGE OF CLIENT(S)
CPN	M	HEALTH	YES	73
BSM	F	SOCIAL SERVICES	YES	Late 60's
SW	F	SOCIAL SERVICES	YES	62
CPN	F	HEALTH	YES	>60
OT	F	SOCIAL SERVICES	YES	Late 70's
CPN	F	HEALTH	NO	75
SW	F	SOCIAL SERVICES	NO	80
SW	M	SOCIAL SERVICES	NO	70
CPN	F	HEALTH	After GP	69
MOP	F	-	YES	69

TABLE 1. Summary of the final research participant sample.

CPN - community psychiatric nurse; BSM - befriender scheme manager; SW - social worker; OT - occupational therapist; MOP - member of the public.

PROCEDURE:

Initial contact: Letters were sent to older adult specialist health and social service practitioners in Exeter and East Devon informing them of the research, inviting them to participate and requesting their assistance in contacting older women who had disclosed CSA (appendix 2). In three instances the proposed research was presented to teams or groups of practitioners. From this initial canvassing, 10 practitioners agreed to be interviewed (eight women and two men). Of these five had experienced older adult client disclosure of CSA, one had experience with disclosures during previous employment in younger adult services, one had worked with a client referred by her GP immediately following disclosure and three suspected CSA but had not experienced disclosure. Only one practitioner felt it appropriate to initiate contact with an ex-client.

Pilot study: As a pilot study, the first two practitioners who agreed to participate were interviewed. Both participants were women, employed as community psychiatric nurses (older adult services) and were based in a local in-patient unit with out-patient facilities. The interview commenced with a recapitulation of the purpose of the research and informed consent sought. Semi-structured, the interviews were guided by interview 'theme prompts' (appendix 3) adapted for use with this research sample. These were intended for guidance and prompts and to provide a measure of consistency across interviews. The data from the pilot interviews were gathered by note taking during the course of the interview. At the end of that time, interviewees were invited to read the notes to control for researcher mis-

interpretation during note taking, and to remove any information they felt unsuitable. As soon as possible following interview, the notes were typed and transcripts examined for evidence of elements and themes.

Research interviews:

Sample one, practitioners: As a consequence of the positive response from practitioners to being interviewed contrasting sharply with the minimal possible interviews with older women who had disclosed, the remaining practitioners (seven women and two men) were subsequently interviewed. Whilst this was inconsistent with a 'representative sample' within the parameters of the original intention of the study, it was felt that practitioners had valuable insights into the process of disclosure for older women and would stand as a 'representative' sample from a practitioner perspective. Morse and Johnson (1991) suggest that 'hearing the entire story from beginning to end from several participants, common patterns or critical incidents will become evident to the investigator' (p6).

Pilot study influence on data collection: Based on the researcher's experience of conducting the pilot studies, it was decided that note taking was an inefficient method of data collection as interview protocol required sufficient attention from the researcher to the interviewee as a person, to the detriment of writing notes. Therefore all subsequent interviews were audio-taped with the permission of the interviewee.

Pre-interview procedures: practitioner sample: Interviews proper were preceeded by study aim reiteration, obtaining informed consent to participate, agreement for audio taping and the right to withdraw all or any part of the information from the study at any time. Consent was obtained from all participants.

Interview procedure: practitioner sample: The interviews were semi-structured and utilised the 'theme prompts' (appendix 3) used during the piloting stage, as these were found to be a useful way of helping the participant to begin to generate responses. At the end of the interview, the participant was asked if they wished for any information to be deleted from the transcription of the tape. In all cases, omission or disguise during transcription was requested of any identifying comments (eg named persons, locations or other specific information which might identify the participant or the clients to whom they were referring). Compliance with this request was assured. As soon as possible following interview the audio taped material was transcribed, followed by an initial reading and coding.

Sample two: an older adult woman who had disclosed CSA: One 69 year old woman who had disclosed to her GP agreed to participate following communication from her worker.

Arrangement of interview: procedure and protocol: Prior to interview a letter describing the study and inviting participation was sent to her via her worker (appendix 4). This route of communication was chosen in order to protect the potential participant from being known

to the interviewer prior to her agreement to participate. Following communication to her worker requesting contact, I telephoned to arrange an interview appointment.

Pre-interview procedure: client sample: Prior to commencement of the interview proper, the participant read the information sheets (appendix) and consent form (appendix 6). This participant gave verbal consent for the audio-taped interview to proceed, however, she chose not to consent to the information from the interview being used in the study until the end of the interview (by which time she felt she would know what information she was giving consent for).

Interview procedure: The semi-structured interview proceeded utilising the interview theme prompts. During the course of the interview, a certain part of the interview recording was felt by the participant to be particularly personal and sensitive. Deletion of this material was offered, accepted and carried out. At the end of the interview, the participant was provided with an opportunity to consider her consent for all or any part of the taped material to be used for the study, and her right to withdraw at any time in the future was reiterated. The participant consented to the use of the remaining taped data. The interview was transcribed one week following the interview. This time lapse was intended to provide the participant with time to think about her right to withdraw. No request for withdrawal having been received, the audio tape was transcribed and the text read and coded.

DATA MANAGEMENT:

Transcript categorisation: The transcripts were categorised according to the disclosure experience of the interviewee:

1. Practitioners who had experience of disclosure of CSA from an older adult client. (N=5)
2. Practitioners who had worked with a client who had been referred following disclosure of CSA to her GP. (N=1)
3. Practitioners who suspected CSA but had not experienced disclosure (N=3)
4. An older adult woman with personal experience of disclosing CSA (N=1)

Management of the interview data: Following guidelines offered by Miles and Huberman (1994), the interview data were transcribed verbatim from audio cassette, to a typed copy, as soon as possible after the interview. (This was a lengthy and costly exercise but essential for this method of data analysis). Early transcription created an opportunity for initial data analysis to be undertaken as close to the actual interview as is practical. Miles and Huberman suggest this helps the interviewer read interview notes with the 'feel' of the interview fresh in the interviewers' mind '.. at that point you have a perspective that combines immediacy, with a reflective overview of what went on in the contact.' (p52). Each and every line of the transcript was individually numbered. This method of referencing text enabled the coding of numerically ordered selections of text and facilitated easy access to individual sections of the data for cross checking or referencing.

DATA ANALYSIS.

Initial reading: Upon completion of the typed transcripts, the text was read whilst listening to the relevant audio tape to ensure that the transcript was faithful to the original recording.

Second reading and coding: Transcripts were read and hand written notes and comments were made in the transcript margins. 'The researcher examines and codes the transcript line by line, highlighting important passages and creating theoretical memos (notes, insights, comparison, summaries, questions) during the task.' (Morse and Johnson, 1991). After several texts had been read and notes made, consistency of emerging elements and themes were noted and a 'theme sheet' created (appendix 7). These were subsequently used to record observed elements and themes and to note any new information.

Third reading and calculation of internal consistency: This took place a minimum of two weeks after the initial reading. Unmarked and uncoded copies of the transcripts were re-read. The texts were freshly coded onto a new set of code sheets, and any previously unidentified themes or elements noted. A read - re-read reliability co-efficient was calculated by dividing the total number of agreements by the number of agreements plus disagreements (after Miles and Huberman, 1994, p.66). The co-efficients for read-re-read reliability are described for individual transcripts, and as an average quotient in Table 2

TABLE 2

Transcript	Percentage agreement (elements)	Percentage agreement (themes)
1	95	100
2	92	81
3	90	100
4	93	87.5
5	90	100
6	98	100
7	94	100
8	97	100
9	93	100

Table 2: Read-re-read percentage agreement for elements and themes over time (minimum time gap of two weeks, single reader).

Average percentage agreement across transcripts over time:-

Elements - 93.5%

Themes - 95.5%

Fourth reading and the extraction of research evidence from the data:

To extract the thematic research 'evidence' from the data, each of the transcripts were read in full for a fourth and final time. At this reading, verbatim sentences or paragraphs were transcribed by hand onto an expanded theme sheet. These were then collated into thematic categories and transcribed into typed text (appendix 8). Any new information observed was also noted at this stage. This systematic evolution of data management created a system of thorough text analysis together with coding, reliability checks and data 'extraction'. Further reading of the documents felt inappropriate. New evidence was not emerging at this stage and further analysis of the texts by a single reader was not considered of value to the research question. Adequacy of the data is said to be determined when 'no new data are obtained and when all aspects of the phenomena are richly described' (Morse and Johnson, 1991). However, the potential for researcher bias required attention and so the transcripts were subjected to further scrutiny by external readers.

MEASURES OF DEPENDABILITY:

Researcher bias and calculation of inter-coder reliability: As a tentative measure of the dependability of the data four clinical psychology practitioners agreed to read and code a limited number of the transcripts. As an additional measure to prevent researcher selectivity bias, the transcripts for external readership were 'psuedo randomly' selected using random number tables. This procedure requires the 'blind' selection of a number from the tables (Robson,

1983). In this study each of the transcripts had been allocated numerical codes to render them anonymous. They were selected for inter-coder readership by matching the random number with the first occurrence of that number in the transcript code.

In total, five of the ten transcripts were read and coded by one external reader and inter-coder reliability was calculated (total no. agreements divided by no. agreements + disagreements) and are described in Table 3.

TABLE 3

Transcript	Percentage agreement (elements)	Percentage agreement (themes)
1	74	84
2	69	75
3	70	93
4	80	87.5
5	69	62.5

Table 3: Inter-coder percentage agreement relating to five (randomly selected) interview transcripts.

Average percentage agreement across transcipts

Elements - 80%

Themes - 72.4%

CHAPTER THREE

RESULTS

RESULTS

This study sought to test three hypotheses, all of which were supported.

Hypothesis 1

1. Older adult women who have disclosed CSA to their clinician will reveal specific themes relating to the process of disclosure.

Evidence supporting hypothesis 1. Qualitative data analysis of transcripts of interviews with practitioners who had received disclosures from older adult women and an older adult survivor of childhood sexual abuse revealed four core categories of themes; meta context, context, individual (practitioner) and individual (client) variables. These are fully described in the main body of this results section and summarised in (Table 4).

TABLE 4

Category 1	Meta-contextual variables
Category 2	Contextual variables
Category 3	Individual variables (worker)
Category 4	Individual variables (client)

Table 4. Core categories of themes identified following qualitative data analysis.

The four core categories were identified by the emergence of nineteen themes relating to the process of disclosure. The identified themes appeared consistently across sample one (practitioners) and are summarised in Table 5 (next page).

TABLE 5

CORE CATEGORY	THEME
Meta-contextual variables	Social and cultural values: sexuality and taboo. Social and cultural values: role of religious beliefs Social and cultural values and historical context: society and the media.
Contextual variables	Organisational influences Agency influences
Individual variables (worker)	Worker belief system Worker definition of role Individual style: joining and contracting Individual style: listening skills Individual style: global response Individual style: specific response
Individual variables (client)	Historical life events Health: historical factors Current life events Current health Life stage tasks Disclosure dynamics: building trust Dislosure dynamics: tentative engagement Disclosure dynamics: style of disclosure

Table 5. Themes identified and their relationship to the four core categories

Hypothesis 2

Within participant data analysis will identify key factors (elements) of influence relating to the disclosure.

Evidence supporting hypothesis 2. Within participant data analysis evidenced 59 key factors (elements) of influence relating to disclosure. (eg. elements relating to core category one, theme of sexuality and taboo, were: being silenced, blaming the victim, shame and powerlessness). The elements are sub-categories of data from which the themes appeared to emerge. The elements, and their relationship to themes and core categories are presented as conceptual maps and explanatory descriptions throughout the main body of this Results section (starting from page 57).

Hypothesis 3

Between participant data analysis will identify a consistency of themes and elements across participants.

Evidence supporting hypothesis 3. Between participant qualitative data analysis identified consistency of core categories, themes and a substantial proportion of elements across participants. To summarise this evidence, across participant, within group percentage 'weightings'of the frequency of theme emergence was performed. The two groups were identified as practitioners who had experienced disclosure and those who had not. The percentages were calculated by dividing 100 by the total number of possible responses within themes and multiplying this by the number of actual responses. A response was identified by a practitioner's reference to a theme, (not the number of times that theme was referred to in any one transcript)

$$\frac{100}{\text{No. of possible responses}} = a$$

a x No. of actual responses = % weighting.

eg. If there were three elements identified within a theme and three participants, the total possible responses would be 9. If the number of actual responses were 5, then 100 divided by 9, multiplied by 5 = 55.5%. The across participant, within group percentages attained in this study are presented in Table 6 (next page).

TABLE 6

THEME	Group 1: % responses	Group 2: % responses.
Sexuality and taboo	44.4	33.3
Role of religion	27.7	33
Society and the media	29.1	-
Organisational influence	65	55.5
Agency influence	60	33.3
Worker beliefs	85	33.3
Worker's role/time	65	55.5
Joining/contracting	55	50
Listening skills	90	58.3
Global response	46.6	77.7
Specific response	59.9	55.5
Client life events	39.9	41.6
Client health history	34.1	36
Life stage tasks	20	66.6
Building trust	90	66.6
Tentative engagement	60	66.6

Group 1: Practitioners who received disclosures

Group 2: Practitioners who suspected abuse, without disclosures.

Table 4: Within group percentage responses relating to the identified themes as identified by qualitative analysis of interview transcripts.

Table 6 shows the percentage weight of responses made by each group of practitioners (those who had recieved disclosures of CSA and those who had not but suspected CSA), when asked what factors they considered were important for older adult women survivors of CSA to begin to tell of their experiences.

As can be seen from this table, a wide variation in response 'weights' is evident within both groups. Interview data analysis from practitioners who had received disclosures referred to each of the nineteen themes identified, whilst those who suspected CSA referred to all but one (society and the media).

Where disclosures had been received by practitioners (group 1) , the highest percentage weightings (highest frequency of identification of a theme considered relevant to the process of disclosure across group participants) are represented by individual practitioner variables, listening skills, (core category three) and individual client variables, building trust, (core category four).

The most frequently identified theme considered relevant to the process of disclosure across practitioners who had not received disclosures but suspected CSA was related to individual practitioner variables, global response (core category three).

These descriptive findings are interesting and lead to further questions and hypotheses (eg does the difference between the emphases on the importance of themes between groups influence the process of disclosure for older women?).

MAIN RESEARCH FINDINGS: QUALITATIVE EVIDENCE SUPPORTING HYPOTHESES ONE, TWO AND THREE:

To provide a conceptual overview of the each of the core categories, themes and their related elements, these are mapped diagrammatically and the content expanded in text in the following pages. This is the main body of the research findings and uses participant's own words as evidence for the categories, themes and elements. Additionally, the actual words used provide a depth and richness of meaning which may otherwise be lost in the researcher's interpretation of 'units' of meaning (categories, themes elements). (see appendix * for total raw data).

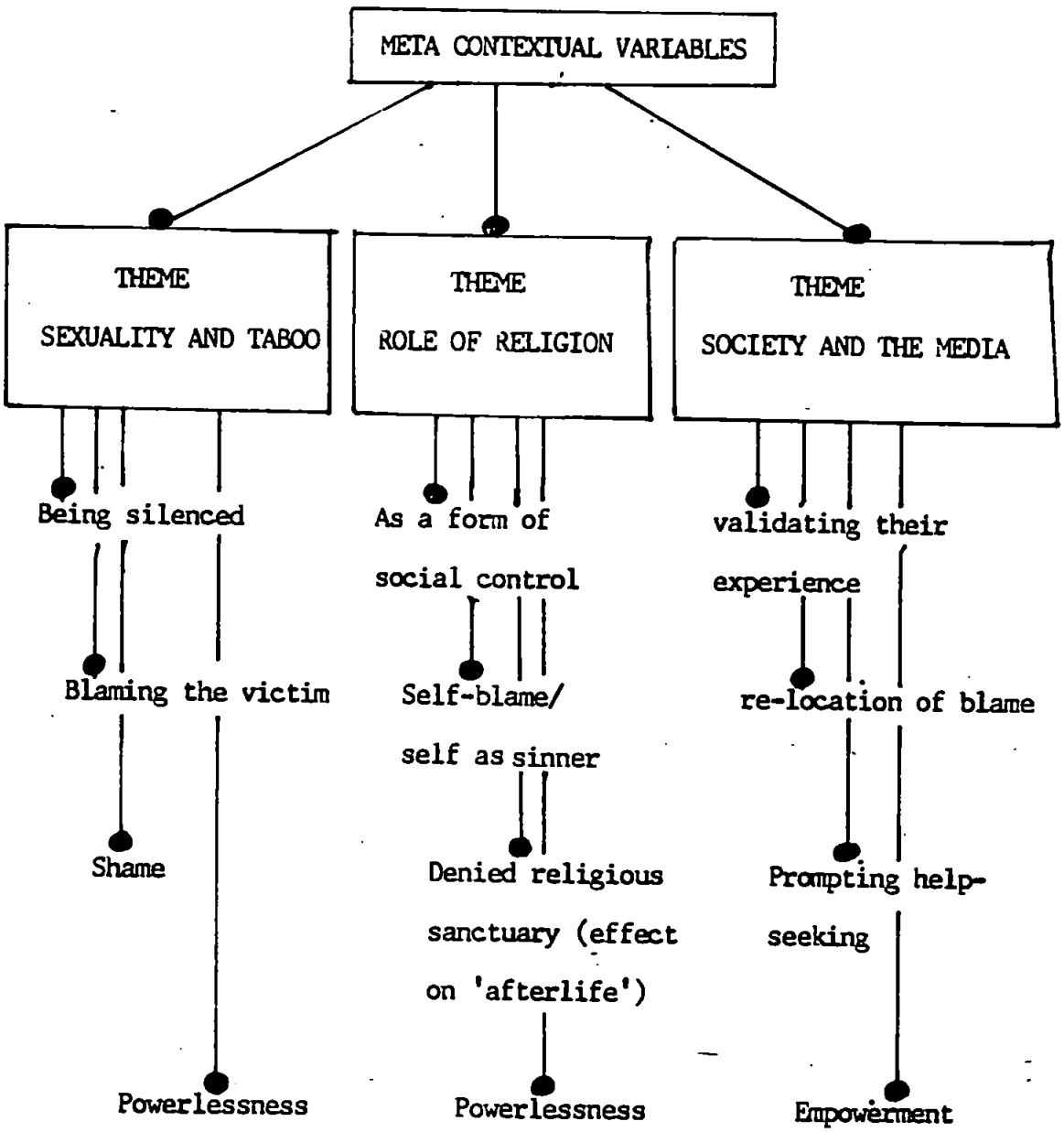

Figure 1

A conceptual map of the elements and their relationship to themes and core category one.

SEXUALITY AND TABOO:

Being silenced:

Two of the four practioners who had experienced disclosure and one who suspected abuse described the impact of social taboos around sexuality on the potential for disclosure. The importance of social conditioning in relation to sexual taboo, and its effect of 'silencing' older women who have been abused was clearly described.

> 'Usually they havn't tried telling and often saying things like, 'it has been taboo', and pushed it out of their minds, or, 'what's done is done and you can't undo it'.
> 'It goes back to the social upbringing, the whole thing about sex and taboo.. where there's been a lot of conditioning, so I think its a lot more difficult to get into the issues.'

In addition, 'Ann' (name changed to protect her identity), the older woman who had disclosed also expressed her sense of the societal 'norms' around sexual abuse when she was growing up.

> 'I just didn't know what was happening because you - in those days you had never heard of such a thing, you just had not, it was very Victorian our upbringing I think in many ways in those days... again its so many years ago it was an unmentionable topic absolutely and I didn't...'

Blaming the victim:

One of the practioners felt that societal messages of taboo include

powerful messages to the victim that she is responsible for her abuse. This also serves to prevent disclosure.

'The person who's disclosing is aware of all those social pressures, so its really important that the person doesn't give any of those signals at all that society is prone to do, all those sorts of rebuffs just reinforce the major message that society gives which is, its your fault if you get abused.'

Shame:

Where women have internalised the social values of sexual abuse as a taboo topic and their fault, sexual abuse becomes unmentionable and shameful. One practitioner suggests..

'.. you can never talk about being abused, its just too disgusting to share'

Ann..

'You were just so ashamed, just dreadful, an overpowering feeling of shame. That's what kept it out, out of the way, I didn't want anybody to know anything about that.. .'

Powerlessness:

The psychological impact of social and cultural taboos around sexuality and sexual abuse for the older women who have been sexually abused as children described in this study appears to be an experience of powerlessness.

'.. what's done is done and you can't undo it.'

Ann..

'A day never went by without my dwelling on it. Day after day, ten minutes several times a day .. .it never really left my mind it just went on and on and on and on.'

'.. of course, I was the only person in the world it had ever happened to, don't forget that. It was, it was very isolating.'

ROLE OF RELIGION.

As a form of social control:

For one worker, the client's descriptions of her childhood environment of stern discipline were bound up with her father's religious beliefs..

...[the client described to the worker] 'he was rotten to me and he was so strict' and she talks a lot about religion, her father was very religious.'

Self-blame/self as a sinner, and denial of religious sanctuary in the 'afterlife':

Religious beliefs appear to have influenced older women's beliefs about having been abused, by creating a sense of personal 'badness', being 'unworthy', and having sinned. These beliefs are often deeply held. Some of the women have been described as very self-punishing as a consequence of their religious interpretation of their experiences.

For one, a cerebral vascular event (stroke) was believed to be self punishment.

'.. it was very bound up with a, very strong religious connotation.. that she was going to be denied from going to heaven because she was so bad.. she saw her stroke as self punishment.'

Ann..

'.. well, I thought I had sinned you see that was the thing (strained voice) can I relieve myself of this sin?'

'.. Oh believe me its just awful it really is awful.. and it stays with you all of your life.'

Powerlessness:

The element of powerlessness emerges from the data through the sense of self-blame, guilt and badness. In addition, perhaps the ultimate powerlessness is the strength of religious beliefs about the punishing power of 'omnipotent others' in relation to disclosure. Not to tell leaves the woman in a vacuum of self-blame, guilt and a sense of self as a sinner and to tell (disclose), when a promise to 'keep the secret' had been made would entail breaking the promise, and this was anticipated to result in punishment.

' ..and the fact that she promised not to tell and the punishment was going to be the telling.'

SOCIETY AND THE MEDIA

Two practitioners described how media coverage of issues around child sexual abuse had impacted upon their older women clients. Where older women had been sexually abused, the television in particular had 'broken the silence' with powerful messages to the women about their role, the perpetrators role and their right to be heard..

Validating their experience:

The media's role in validating the women's experience arises through seeing and hearing people talk openly about sexual abuse of childhood, and providing an environment where their voices can be heard..

> 'People were genuinely recognising the implications of abuse in childhood through the media really, you know, through television programmes like Esther Ranzen and Childline and reading things in the paper. .. and seeing television programmes about it made them realise that they wouldn't be so mad to actually want to talk about it.''

Relocation of blame and prompting help seeking:

Through the media, alternative views of reality have been offered. Older women become exposed to a view of the world in which they are not held responsible for what happened to them, and one in which they do not have to continue to live with the consequences of CSA without help..

> '..although its difficult to try and watch, they are hearing for the first time that its not their fault.'

'Recent publicity with the TV and media has been important to the women who have disclosed to me. Over 50% have felt that the message for them from the media was that its OK to talk about it'

Empowerment:

By challenging the societal and cultural taboos about raising sexual abuse as a public issue, the positive media messages have empowered some older adult women to begin to think differently about themselves and to begin to understand their right to receive help.

SUMMARY. The meta contextual variables of social values, with or without the influence of religious beliefs have been observed by practitioners and an abuse survivor, to influence women's willingness to disclose sexual trauma of childhood. Where society's messages include a powerful message of 'do not talk about sexual abuse' and where the risks of retribution outweighed the telling, many older women didn't, as children or adults. However, as part of our 'historical context', the massive increase in the accessibility and availability of information technology, of which radio and TV are a part, together with more liberal attitudes towards what is acceptable broadcasting material, older women are, perhaps for the first time in their lives, being exposed to positive messages about themselves as survivors of sexual trauma, and empowered to begin to seek help.

CORE CATEGORY TWO.

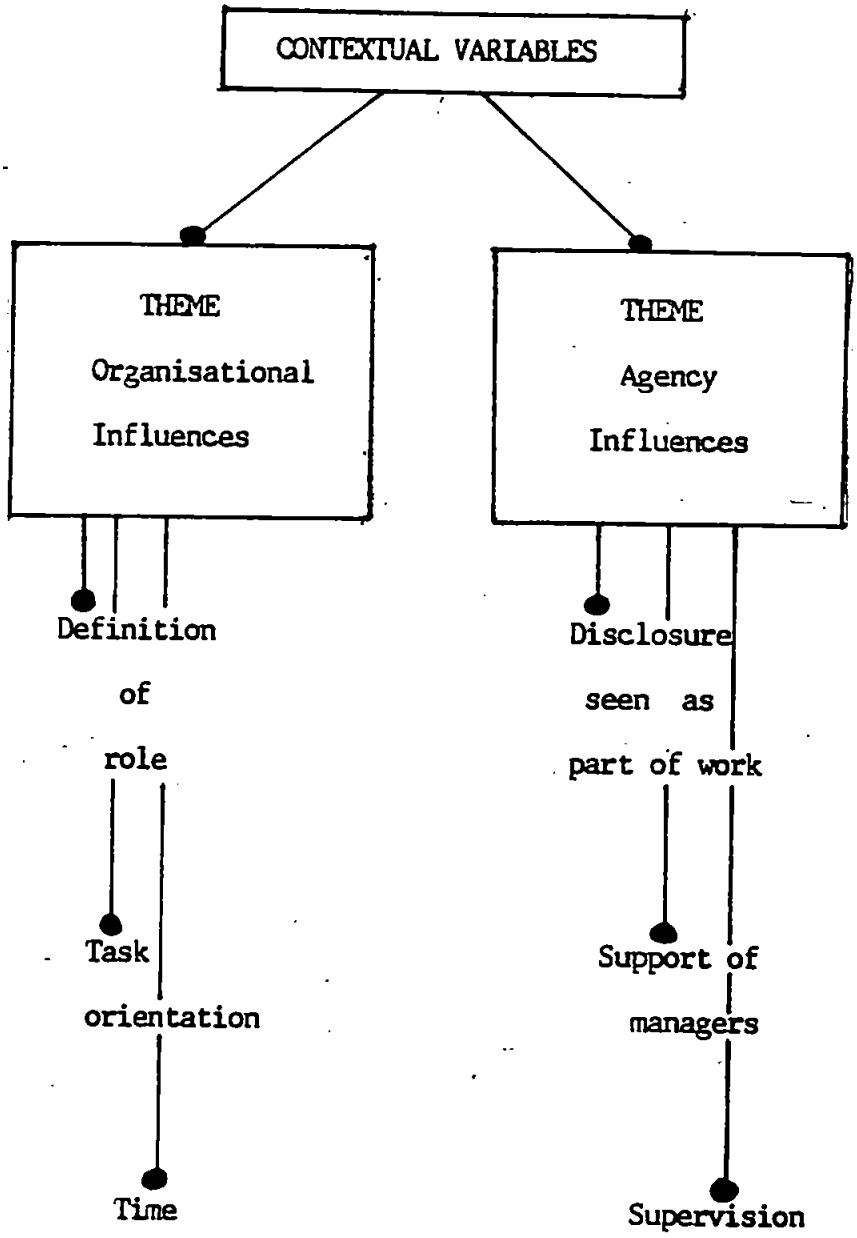

Figure 2

A conceptual map of the elements and their relationship to themes and core category two.

ORGANISATIONAL INFLUENCES.

Definition of role:

The definition of the practitioner's role as an organisational influence upon the process of disclosure for older women was exclusively commented upon by (four of the five) social service employees. It appears these workers are concerned about the recent changes in their role to care management. This has been described as decreasing time available, emphasising practical and financial need and provision, and precluding repeat visits or counselling from that worker. The main impact of this redefinition of role on older women is thought to be lack of flexibility and lack of time..

> [previous disclosure came about].. 'while I was doing routine assessment now we're doing care management, so before care management we had a bit more time to spend with clients... .. we're more like facilitators now. Usually under the new care management you go in to assess their needs. Nobody's going to say all their needs at the first meeting, its ridiculous.'
>
> '[there are] .. restraints in my role as in, I can't step outside and do therapeutic work... they've trusted you enough to disclose and then you say, I'm sorry, I can't do this.'

Task orientation:

The element, task orientation was present in social service practitioner accounts of organisational influences in particular. Health service workers were not noted to have commented on their

organisation as influential to disclosure. For social service employed practitioners, the increased emphasis on task focus and orientation, was felt to be detrimental to the practitioner's relationship with the client for more in-depth issues to come to the surface..

> '... its about assessment work, going in to do financial assessments, doing very tight financial reviews and so forth.. .. I have very, very little time for therapy which is awful.'

Time:

Inextricably bound with definition of role and task orientation was the issue of (available) time. For this sub-group of practitioners, their role change entailed spending less time with clients. For older women who may have been abused as children, lack of time was felt to prevent the development of trust which would be necessary before disclosure might emerge..

> 'Before [care management] we were going in quite a lot, we were giving time for them to talk, time to build a trusting relationship.'
> 'I feel sure that [lack of time] is one of the major things that made her feel she couldn't take it any further.'
> 'There are cases where you feel that people want a commitment from you, they want to know that they're going to see you 'cause otherwise they're not going to open the

door at all, and we're getting pressurised about what you are doing in this case, because now we're care managers we're no longer social workers - our role has been eroded.'

AGENCY INFLUENCE

Disclosure seen as part of their work:

Although most practitioners interviewed felt that receiving disclosure of sexual trauma of childhood should be part of their work where defined as a client 'need', the individual agency was inevitably influenced by the organisational issues previously addressed. By definition, being participants in this study, the practitioners had a sense of hearing disclosure of CSA as being an important aspect of their work. However, there was concern that not all staff saw disclosure as part of their work, partly as a result of lack of training in the area.

'The main issue for me is when a woman has disclosed and they don't get the support they need to do the work because again you aren't trained to do the work.. there are very few people who can actually do it.'

For Ann, it was a supposition that disclosure was a part of the practitioner's work. She saw her GP initially and further disclosures were made to a CPN.

Ann..

'..[she] obviously had sufficient experience to know what

she was listening for.. and otherwise she wouldn't have been in the job really.'

Support of managers:

Mixed comments were found relating to the quality and quantity of support for workers in relation to CSA disclosure. Where managers were perceived as supportive, this was to the worker as a whole and also related to accessing further services for the client. The converse experience suggested that 'managers' were seen as part of the organisational 'whole' which was felt to be very unsupportive.

Supervision:

A number of perspectives were provided which suggested that supervision is an important source of support for workers where CSA is suspected or has been disclosed. For some practitioners, the most helpful and frequently available supervision was obtained through peer supervision groups. Quality of supervision was considered impactful not only on the worker, but also the client..

'If you are being taken care of then you can take care of the woman, but if you are not being held somewhere else, you're not going to be able to do that process with them, and the women are quite astute and they'll soon pick that up and they're going to shut up.'

SUMMARY

Contextual variables as evidenced here, impact markedly on the process of disclosure. Organisational and agency issues were identified by a number of elements focussing on the worker's role, time and support felt to be available. For social service employees particularly, radical changes in their organisational structure were felt to have had an enormous impact on their availability to receive disclosures. These structural changes are part of the historical context of social services and link with other social factors noted within core category one, where social values influence women's willingness to disclose CSA. In addition to these changes, within service support and supervision also moderated the practitioner's sense of confidence and containment to begin, or to continue work with the sensitive issue of CSA. For the older woman who had disclosed, that her worker had a knowledge and skills base for working and thinking with women about their childhood sexual traumas was a foregone conclusion.

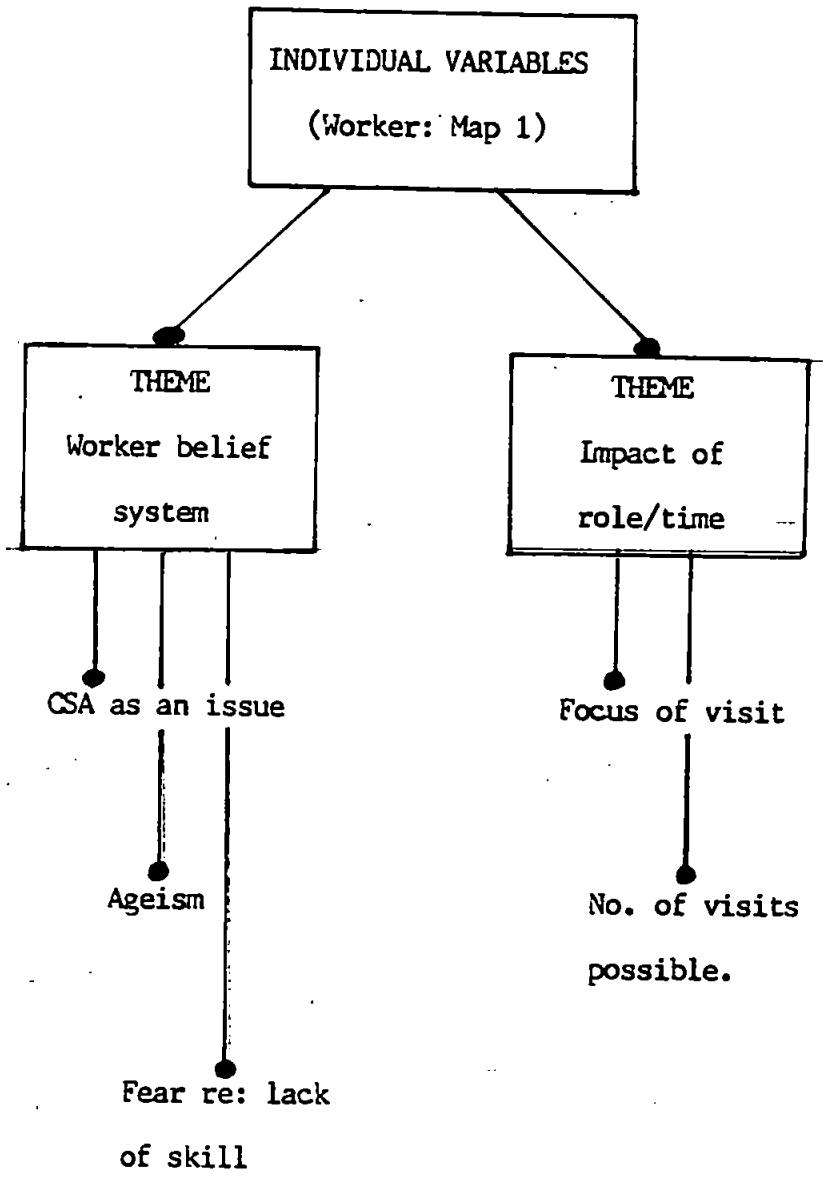

Figure 3

A conceptual map of the elements and their relationship to themes and core category three.

WORKER BELIEF SYSTEM

An individual worker's set of held beliefs influences the process of disclosure in a number of ways. The data revealed beliefs around CSA, ageing and older people, and fears relating to skill deficits.

Sexual abuse of childhood:

Beliefs about child sexual focussed on the 'need to know'. If practitioners fail to hold the view that CSA happens, can have negative long term effects and that older women may disclose CSA for the first time, then they may not 'hear' the tentative clues and cues that women may be providing. Interestingly two vastly different views emerged from the transcripts, with one worker believing that it is not necessary to be aware of the possibility of abuse to pick up on what is being said, whilst others suggest that an awareness of CSA is essential to the process of disclosure..

> 'You need to.. . have a base knowledge of sexual abuse because you can't be open to it unless you have the knowledge of it.'
>
> 'I suppose one of the things still is to, you know, to just be aware that it is there and not to deny it went on, it was going on, it does cause lifetimes of distress but you have to listen.'

Ageism:

Negative ageist beliefs were held by some of the practitioners and were related to the belief that older women have less life to live and an assumption that their life stage could be compared to that of a much younger adult..

'If you've got somebody of 19, 30 or whatever that's disclosing they've got an opportunity to change, be different, start a new life, get a new partner or whatever, somebody of 73, 83 that's then disclosing where are they going to take it? because its opening a can of worms.. where is that going to leave the person?'

'.. 'cause I mean, you do sometimes get the idea that its not worth working with older people 'cause what the heck, they havn't got long to live, that sort of thing.'

Positive ageism was also expressed by some professionals..

'I do believe that elderly people have as much right to counselling, to their experiences being listened to at the end of their lives as at the beginning and even more so really because the rest of their lives is so short.'

Fear re: lack of skill:

Some practitioners held beliefs that they were not skilled enough to work with older women who might disclose or who had disclosed sexual abuse of childhood. These beliefs may or may not have be true, but their impact on the process of disclosure hold the potential for worker to fail to follow through detail which may be related to abuse..

'I think, crikey supposing they do disclose what do I do with it then? What's next? Where do we go from here? .. it all flits through your mind.. .and also is it going to damage

them? you know, am I going to damage them with taking it any further?'

'I was also feeling [as disclosure became imminent] I don't know what to do with this because I've never dealt with this before, I'm not skilled with dealing with this, I don't know that I want to deal with it and yet by then you'd gone to a point where you couldn't for her sake or anything else go back.'

IMPACT OF ROLE/TIME

The impact of the organisational possibilities or constraints on the practitioner's personal interpretation of their role and time available was largely evidenced within core category one (meta-context). Individually, the interview data suggested that the focus of the visit/appointment and the number of sessions possible were seen to bear the greatest influence for practitioners when discussing disclosure of CSA.

Focus of visit and No. of visits possible:

As previously described, many practitioners have found the time-limited, task centred approach required of them frustrating and not facilitative of the development of trust thought to be required to help women begin to tell of their experiences of CSA. Descriptions of the number of sessions which took place before disclosure came about suggest the workers fears are supported..

'We're looking at about four or five sessions to get to the question about sexual abuse.'

'It took something like six or seven weeks [to disclose abuse from partner] and I'd been seeing her twice a week.'

Although Ann appears to describe a quite different experience..

'So I went to the doctor one day about something, a pathetic little thing and all of a sudden (thump) it came out. I think I just could not take it any longer and he was very, very understanding.

However, Ann had known her GP for many years and had reason for repeat visits, perhaps enough to build a sense of trust.

SUMMARY

Individual practitioner's hold beliefs about beliefs about CSA. These included believing it is important to hold beliefs about CSA as a prerequisite to 'hearing' disclosures, whilst an alternative view was held by one practitioner who believed it was not necessary. Other aspects of beliefs evidenced in this study were those held about older people as negative and positive ageist assumptions, and worker fears attributed to lack of skill. In addition, the individual practitioner's interpretation of their role/time suggested that some have experienced women disclosing only after several contact sessions. Whilst Ann's statement appeared to contradict this view, her contact with the person she disclosed to was perhaps less time-intense, but did include many contacts over a period of some years.

CORE CATEGORY THREE.

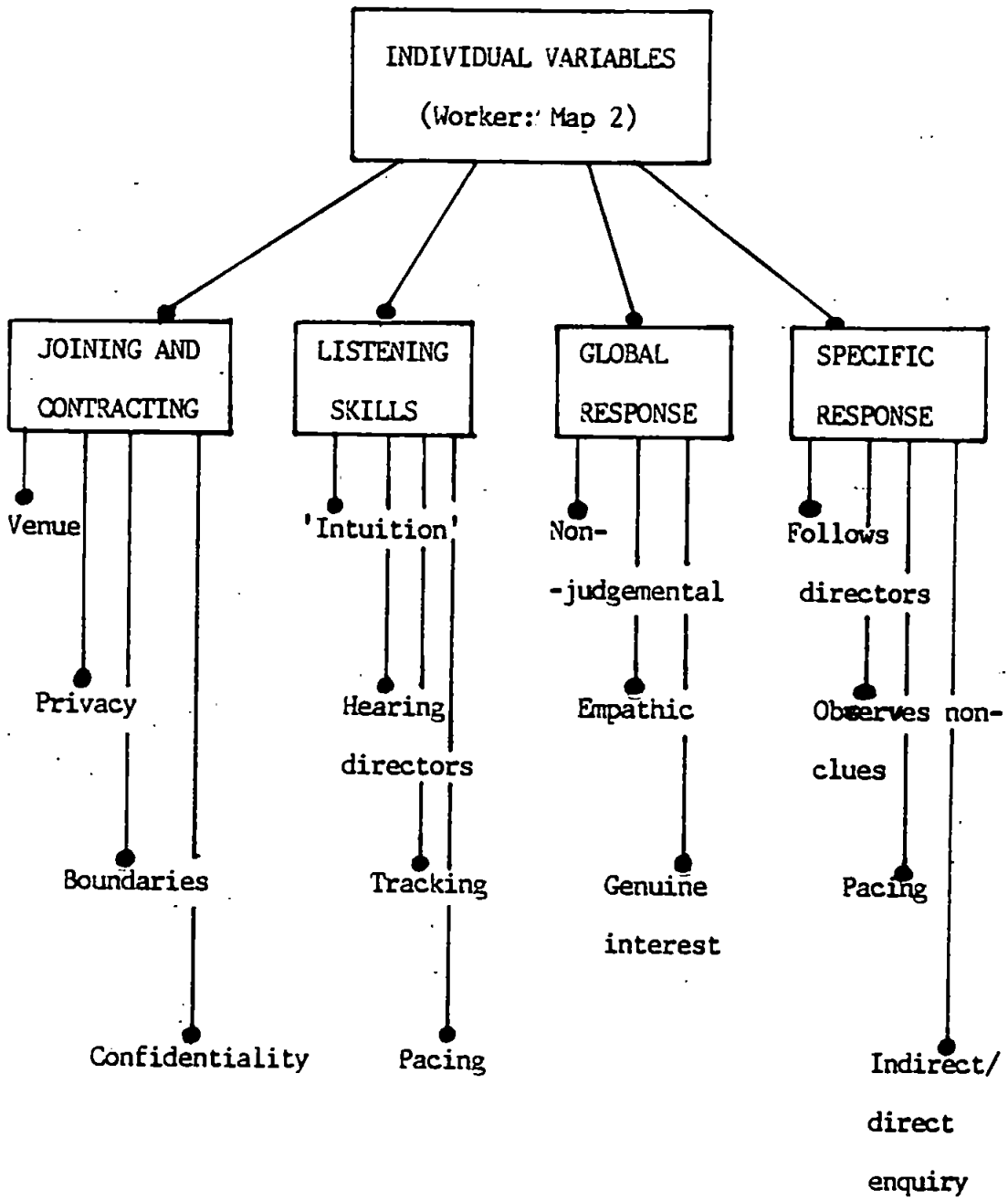

Figure 4

A conceptual map of the elements and their relationship to themes: core category three

JOINING AND CONTRACTING

The skills of 'joining' and contracting with a client were evidenced by the practitioner's style of initial contact, and the creation of a suitable environment (actual and conversational) according to the nature of the planned contact. In response to the study enquiries about what was helpful for older women who may wish to disclose CSA, the elements of venue, privacy, boundaries and confidentiality emerged.

Venue and privacy:

Many of the clients were seen in their own homes, or in their own room within a nursing home. This was strongly associated with the creation of an environment of privacy and safety, this was also thought to help women feel a greater sense of personal control..

> 'The women are seen in the safety of their own home so that they are in control.'
>
> '..we saw her in her own room [at nursing home] so it was completely private.. a safe environment.'

Ann..

> 'I think the fact that she came to me in my own home was a very good thing... .. I think it is the safety and security of your own home.'

Boundaries and confidentiality:

In addition to the attention paid to the physical environment, the definition of working 'boundaries' and the women's right to

confidentiality were expressed. For women who may wish to talk about CSA these were considered essential, as sexual abuse is a violation of personal boundaries..

'Before disclosure there was an informal visit with an offer of four to six sessions and [they were] informed that they could stop at any time.'

'..and making it safe for them, you know, giving them some information about boundaries, about confidentiality and the fact that they were going to share with me, wanting to confirm them.. I think they needed to know where the information was going.'

LISTENING SKILLS

The decision to disclose sexual trauma of childhood appears to be heavily influenced by the listening skills of the practitioner.

Hearing beyond words (intuitions/hypotheses):

Without exception all practitioners who received disclosures described events which suggested that they were able to 'hear beyond' the words being spoken by their client, listen to their intuitions and hypothesise (suspect CSA may be an issue).

'..it was just a feeling that there's more to this than she is actually saying, there is more.. there was a sense of incompleteness, of unfinished business.'

'.. [she] was the sort of patient when you though [indrawn

breath].. this doesn't quite fit. [We] suspected something and I think that was why I was listening to her.. I think the antennae were sharp.'

'Sometimes you 'know' there's more there..'

Hearing 'directors'

Intuitions developed from the ability to 'hear directors'. Directors emerged as if they were signals to the practitioner to listen. If they were not heard then the client may choose not to proceed further.

'Sometimes there are leading questions from the client. Its as if they are talking and holding back. For example, one woman said "Its very hard, you never know what happens at a very young age"..'

'there were certain links with childhood, the past, certain words that kept cropping up.. there are sort of indicators.'

'Its the way people will talk about their childhood, their upbringing. They talk about emotional abuse and how it made them feel and quite often its come into my mind, you know, that there's more to it than that.

Tracking:

The ways in which practitioner's could let the client know that they had heard 'directors' was to 'track' or follow the topic.

'Allowing them to reminisce about their life and showing an interest in that.'

'[I] kept bringing it back to 'What was happening with dad? Where were you? Where was mum?.'

Pacing:

As a listening skill, pacing is noticing the clients verbal and non verbal clues about her level of ease with the topic (non verbal cues are evidenced more clearly within the theme of 'specific response'). Pacing was often based on pre-disclosure material, with practitioner being thoughtful about providing the opportunity for the client to proceed in her own time.

'All the time thinking, well, maybe that's as far as she wants to go and sort of backing off a bit, and she would say it again.'

GLOBAL RESPONSE

The elements of the global response which appeared important to women who disclose or where abuse is suspected were identified as three basic counselling skills; being non-judgemental, empathic and showing a genuine interest.

Non-judgemental:

Being non-judgemental is an implicit act, which is framed within the context of valuing and respecting the client and her experiences.

'.. a way I try to work with my clients is, whatever their framework is, whatever their life experience, I value them

as a person and I don't judge.'

'I gave her my time initially.. I made no judgements at all on what she said to me, I felt like I respected the things she said.'

Empathic:

Empathy came through as a direct reflection from the worker regarding the importance of empathy, or was deducted from empathic responses..

'I do listen, I am a good listener, and showing empathy and being non-judgemental.'

'Initially, when hearing about their original disclosure I was feeling their anger for them..'

Genuine interest:

A genuine interest in the person is inextricably linked with empathic responses. True empathy would be difficult without a genuine interest. In these accounts genuine interest was evidenced by all of the respondents through their hearing and validating of their client's accounts of their lives and difficulties. It was felt that a genuine interest would be essential for women to begin to feel heard and understood and therefore a key aspect of practitioner style in the process of disclosure of CSA.

'A genuine interest was they key thing really, a genuine interest in them as a person and their whole life.'

Ann..

'All I can remember is that it was completely painless and she, she.. she sat down as a friend and had a cup of coffee.. and we chatted..'

'..as far as I know she said well, would you like to tell me? .. and I think I just rolled up my sleeves and started [laugh] all those years - she had to listen.'

SPECIFIC RESPONSE

This aspect of worker 'style' reflects the 'micro skills' evidenced within the professional contact with the client. Specific responses are extremely important to know as they tell us what happens following listening. A practitioner may be very experienced in hearing directors and holding hypotheses about CSA, but may lack the skills to take this further, as one person put it..

'If you're not picking up on them [directors] the woman's not going to disclose... I think she'd try it a few times and in the end she would shut off.'

The specific responses identified in this study were: follows directors; observes and/or responds to non-verbal cues and clues; reflects back; pacing; indirect enquiry and direct enquiry.

Follows directors:

Following a director is a means of hypothesis testing. The practitioner follows the lead and by the response will be able to

confirm or revise the original hypothesis. One worker described this explicitly..

'I had two intuitions really which changed you know, I had to revise that'

For some practitioners acting on a 'director' was acceptable and framed in fairly global terms to allow the client to respond in the way in which she felt most comfortable or appropriate. For others there some doubt and hesitation was described. It was noted that the practitioners who had received disclosures were more likely to respond confidently to a director from a client than those who suspected abuse.

'Generalised questions back [in response to directors] gives them the opportunity to say things.. for example, what was your childhood like? or , Do you want to talk about your childhood.'

'..so then I am wondering whether to perhaps go any further with it to draw attention to it [director], or just to let it go.'

Observes non-verbal clues:

This important aspect of worker client dynamics provides the practitioner with additional information about the client. Non-verbal cues and clues were most frequently noted during the immediate pre-disclosure period and were often noted to be dissonant with the

client's verbal behaviour.

'There's a difference between their body language and what they are actually saying. Its like they're regressing back to the time they are about to tell you about.'
'The extreme quietness with which she told me [about partner abuse, CSA suspected] was like a sort of descent into a very very quiet place and her voice became very very far away and it was almost like she was on the edge of.. kind of.. of her sense of not having any being at all as she told me.'

Pacing:

As a response, pacing is the practitioner's choice of timing of enquiries and interventions. Pacing is linked with creating an environment where the client controls the amount of information she chooses to reveal. Where women are survivors of CSA, pacing is particularly important as being 'pushed into' saying things when they are not ready may result in their feeling exposed and vulnerable (unsafe), thus mirroring abuse dynamics. Ann describes vividly the importance of appropriate pacing for her to tell of her experiences..

'There was nothing dramatic in it, it just went on very nicely, very nicely and the fact that I could sit and jabber away to somebody who was so normal. I never had to be very descriptive which pleased me because I don't like being descriptive about the actual events...'
'It wasn't difficult and you know, it could have been difficult

I think it was her quiet and easy manner.. she was very unpushing.. that was the main thing..'

Practitioners were aware of the need for respectful pacing..

'..giving them options and choices because they're not going to know that they've got any choices at that point because they are going to be powerless.'
'I actually checked with her, I said, 'do you want to talk about this?' and she'd say 'yes', so there were some points where I actually asked her as well as just waiting for her.'

Indirect and direct enquiry:

This element of worker 'style' was reflected in differing opinions as to the perceived level of helpfulness of asking about CSA directly. For one practitioner, not to ask directly was considered to maintain a system of circularity of failing to address abuse as an issue..

'all you're doing is maintaining that circularity and you're also doing what other people outside do.'

Contrastingly, other practitioners felt direct enquiry was an inappropriate method of enquiry for women where sexual abuse of childhood was suspected..

'I never ask outright because I feel that its their right to tell when they feel like it. I respect what they feel

and if they're choosing not to tell me at that point, that's, that's their choice and I will not push them into that.. it needs to be in their own time.'

SUMMARY

Identifying individual worker styles from the interview transcripts provided information relating to the macro skills (joining and contracting and global response) and micro skills (listening and specific response) and their relationship to the process of disclosure of CSA for older women. It appears that disparate views are held regarding the mode of enquiry relating to CSA. The evidence also demonstrated the importance of the practitioner's ability to listen to leading comments, and to observe non verbal clues and cues the women may provide. Although Ann was not aware of this process as part of her worker's repertoire of skills, her comments suggested they were a valuable part of her feeling able to express herself with confidence.

CORE CATEGORY FOUR.

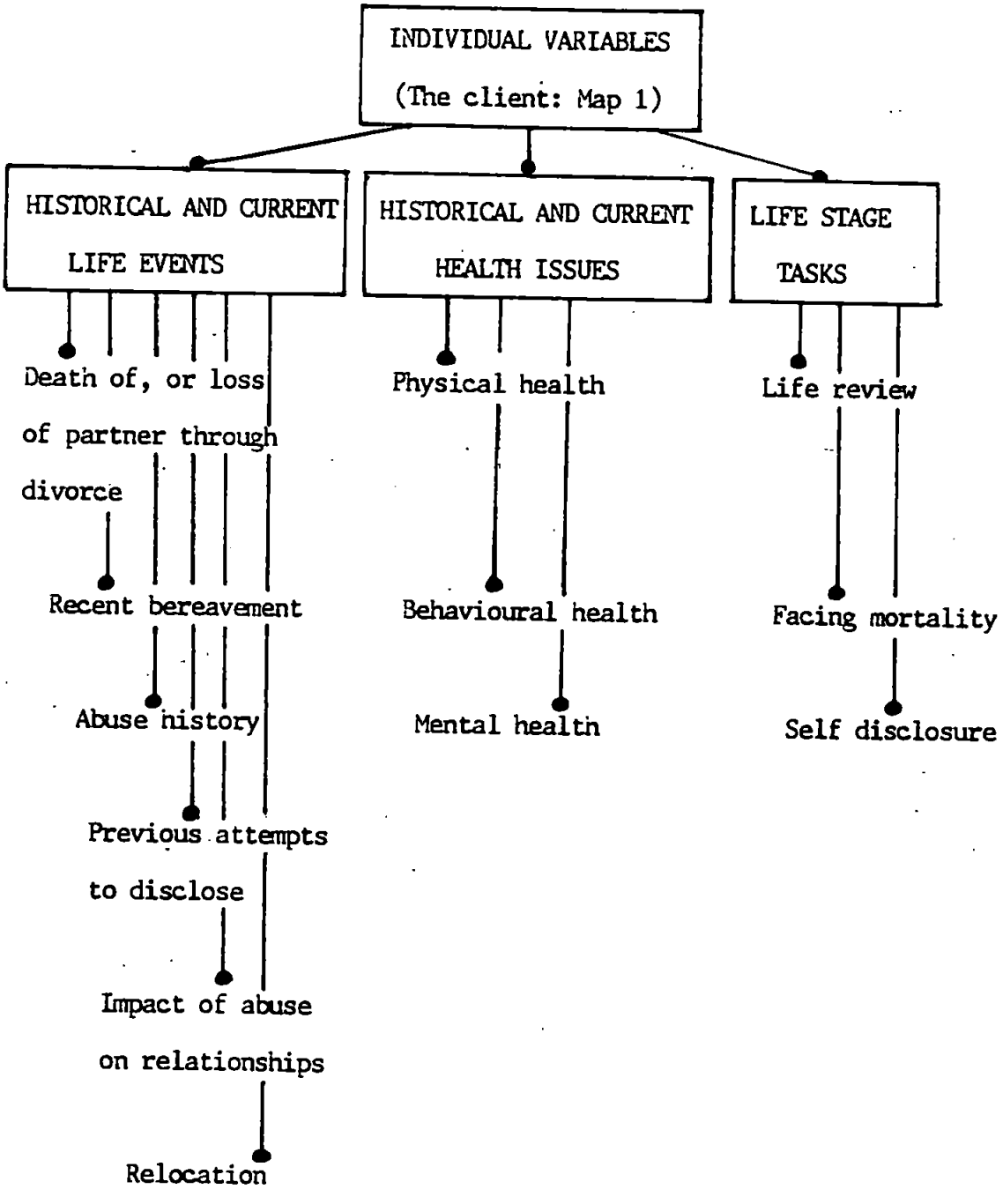

Figure 5

A conceptual map of the elements and their relationship to themes: core category four.

HISTORICAL AND CURRENT LIFE EVENTS

A number of historical life events were shown to be consistent across the women seen by practitioners. These include the loss of partners by death or divorce, a history of abuse other than CSA, negative reactions to previous attempts to disclose, the impact of CSA upon the women's adult relationships, recent bereavements and loss through relocation.

Loss through death or divorce and abuse history:

Although many older women may have a history of loss through death or divorce, for a number of the women described by the practitioners in this study, these events appeared to be particularly traumatic and associated with abuse from the partner.

> 'her husband committed suicide so she started with that.. it eventually came out that she was abused as a child by her father.. . she was abused by her first husband, lost her two children because they were divorced and broke off family ties. Her second husband also abused her sexually and physically.'
> 'I think she clearly saw herself as having been abused - she didn't use that word - by her husband. She used words like 'forced himself on', 'took me by surprise', 'took advantage of me'.. .[the above acts] took place at knifepoint.'
> 'Her husband committed suicide, she was abused by her father and then by her son.'

Recent bereavement:

Four of the women had experienced the death of a partner within the

last two years and this loss was sometimes associated with the onset of symptoms which led to the client being referred.

'[the] symptoms of fear of being alone and agoraphobia began following the death of her husband.'
'Her husband died a few months earlier. She was frightened by he was a very frightening presence in her life.. .even after death clearly he was frightening, making her feel guilty.'

Previous attempts to disclose:

Four of the five practitioners who had received disclosures stated that their clients had chosen not to disclose, or had experienced negative reactions to disclosure..

'she [did not disclose], she said her mother would not have believed her.'
'She did say to her friends something about a special relationship with dad, and they laughed at her and that goes back prior to teenage years so she never said any more, she thought it was quite normal what was happening so she didn't disclose it, didn't say anything else.'
'I know that one of them, the mother said, 'you are imagining things, making it up' and said to them, 'forget it'. The other one had similar feedback from her mother.'

Ann, similarly, had tried unsuccessfully to tell of her experiences..

'The first time I ever tried, I tried on three occasions,

I went to my parish priest.. and.. I can remember on one occasion.. I started to tell and he just - he was not the right sort of person at all.. then I went to see another parish priest... and they, they just didn't know what I was talking about I, I didn't get beyond the first sentence I suppose and I, then I changed the subject, asked them to pray for somebody I think [laugh]. It was al - I don't know what it was [laughter] I certainly didn't get very far but that was many many years ago and then I shut it away for years.'

Impact of abuse on relationships:

The impact of abuse on relationships is an important aspect to consider when looking at the process of disclosure. Meaningful relationships are often built on trust and a sense of self worth within the relationship. For women who have been sexually abused as children, these relational dynamics are often especially problematic around intimacy and sexuality. For women who wish to disclose, the ability to begin to trust their confidant is an important issue.

'.. and she's actually disclosed her abuse and how this has affected her whole life. She's unmarried.. .sometimes you can actually see it in relationships with men, throughout you know, throughout their life.'

Ann..

'the thought of sex with anybody was nauseating [word stressed], absolutely nauseating and I, I remember when... a young student got a little bit too familiar with me and I... .couldn't

retaliate. For most of my life I've had no response really for any loving moments until comparatively recent years.. I think now.. I think it did gradually begin to wash away but there was still that bit which I couldn't get rid of.'

Relocation:

Three of the practitioners who had received disclosures from older women made reference to the fact that these women had recently moved house or into a nursing home. One women disclosed CSA whilst in the nursing home. Relocation is known to be one of the major life-event stressors after death and divorce and could be viewed as a loss for which some degree of grieving would be anticipated. Where past losses or traumas have not been adequately resolved, new grief may create a resurfacing of old traumas. Relocation for older women may be associated with the death of a partner and so their grief may be very intense. The importance of relocation as a trauma which may trigger pain from sexually abusive experiences from the past was succinctly described by one practitioner who links this with loss of control..

'..if you're a child being subjected to abuse you have no sense of control of your destiny much, as a child anyway, but to have your body taken over and used by somebody else totally reinforces that you have no control over your own life. And what happens to you as an adult - an older adult moving into residential care, there's an echo of that feeling - I have no control over this..... echoing from childhood, lack of control.

HISTORICAL AND CURRENT HEALTH ISSUES

Physical, behavioural and mental health:

Physical health issues for older women who have been abused in childhood may be influential in the process of disclosure, as repeated physical complaints for which no organic cause can be found may well be somatisation. Ann described how she had spent her adult life experiencing multiple minor ailments which she described as a cry for help. Her particular symptoms focussed on her reproductive system. Ann believed she had 'all sorts' of diseases including syphilis. At 23 years of age she began to have grand mal epileptic seizures which she believes is associated with the abuse. Her words are powerful.

> 'I think I had a lot of imaginary diseases you know, because I used to.. I don't know I had all sorts of things. I ended up with a hysterectomy when I was in X - because I you know, I had imaginary aches and pains. I think you just hate that part of your body something like that.'
>
> 'I was hit with epilepsy at 23.. and I still connected it up at the back of my mind with the whole thing and for all I know it might be just psychological epilepsy but its remained with me and I do have some brain damage. .. once I've had another grand mal it does tend to black out some, some bits of me..'

One woman where CSA was suspected also experienced fears of serious physical problems where none could be found..

'..she would spend two or three hours in the lavatory sort of dealing with.. saying that she'd got a terrible problem with her rectum and in fact when medical tests were done she had noth - no problem at all.'

Physical health issues for two of the other women described by their practitioners focussed on exacerbation of physical symptoms which decreased their mobility, increased their dependence and created a situation where they were housebound and socially isolated. Behavioural and mental health problems also held the potential for creating dependency and social isolation with past and current histories being reported which included depression, agoraphobia, anxiety, low esteem, 'psychosis' and obsessionality. One practitioner suggested that social isolation increased the woman's focus on her life and life events..

'..on their own with their own thoughts and probably been thinking these things through on their own day after day.'

Social isolation in the here and now may be a very symbolic for women who have been abused, reflecting the isolation they felt as children. Ann describes how the abuse perpetrated on her caused her to feel very alone, and how she built behavioural and psychological defences to help her cope..

'I was the only person in the world it had happened to.. it was, it was very isolating, yes and.. it causes you.. you

get a strange manner sometimes, you can, you can get a sort of.. you're not so keen for people to see how wretched you are that you develop not exactly a permanent giggle but a permanent semi-laugh.. you get by with a grin.'

In addition to multiple health issues being a 'signpost' to the practitioner that past traumas may have influenced current health this may be the only 'director' the woman has available with which to express her distress. Practitioners in this study also noted expression and control of intense anger as an indication to them that their clients may have been abused. The anger may surface as part of their work on other issues eg grief..

[why did you suspect abuse?] I think maybe it was the anger and the uncontrollable grief, more than one would expect in the situation, that she was in much more anger and much more grief, and so controlled.. sort of saying, oh, I musn't do this and suddenly she put the lid back on it again.'

.. she is so furious she doesn't know what to do with her anger - she's been abused by men all her life and controlled by them and yet devastated that the one she was married to has died.'

For one woman who disclosed, a similarly intense but starkly contrasting style of affective response was observed.

'She had a very flat affect, completely, she was very unresponsive when you spoke to her and never really looked people in the eye, she always looked at your left shoulder.'

Thus, where CSA has been disclosed or suspected, it is the intensity of the expression of affective responses that have been observed and reported.

LIFE STAGE TASKS

The theme 'life stage tasks' was characterised by three elements, life review, facing mortality and 'self' disclosure. For older women who have been abused this appears to be a specific theme as they enter the 'third age', where there are many years to look back on. Practitioners have noted that disclosure of CSA, or suspicions of abuse arose during these tasks..

'In all three cases I would say it [disclosure] was part of their life reminiscence.'

'Reminiscing about their lives and putting it in order, you know, before their death. Its definitely coming to terms with the end of their lives.

'..disclosing to themselves first and then sharing it with me. they're sitting with their thoughts and reminiscing on their life patterns.'

SUMMARY

Individual variables relating to women who have been abused and disclosed or where abuse had been suspected emerged in this study as centred around the impact of life events, health issues and the life-stage of being an 'older adult'. These variables are interactional, traumatic life events in addition to the abuse will have an incremental impact on the physical and emotional health of the individual. What is striking in these findings is the consistency with which these women have re-experienced abuse, loss, difficulty with interpersonal relationships, poor physical and emotional health, relocation and social isolation. Within the context of this study, these have been the variables practitioners and Ann have chosen to talk about. Therefore they are of importance, and their impact often reviewed during the life-stage tasks.

CORE CATEGORY FOUR

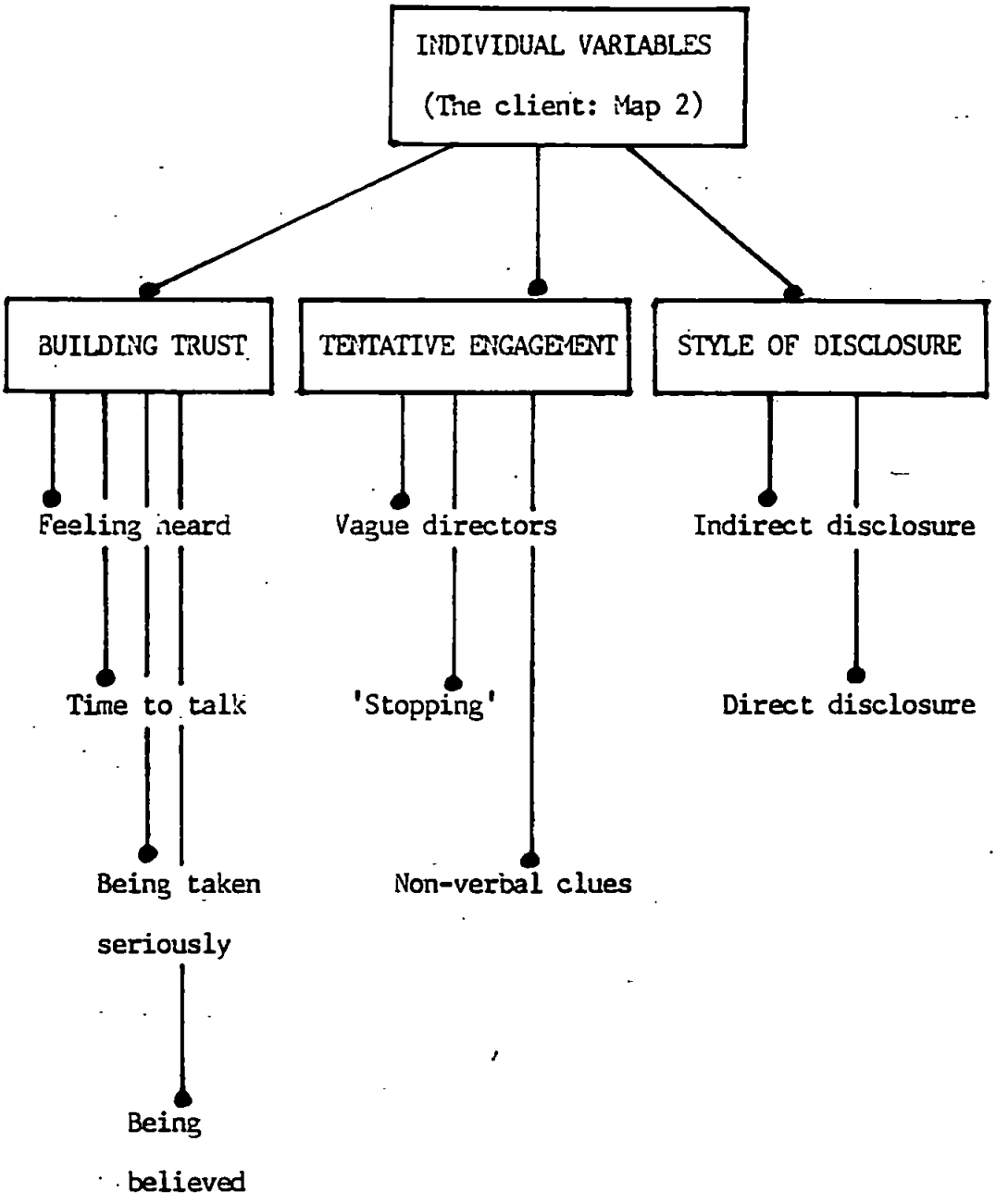

Figure 6

A conceptual map of the elements and their relationship to themes: core category four.

DISCLOSURE DYNAMICS

The themes of building trust, tentative engagement and style of disclosure were evidenced in part throughout the core categories and themes previously described. However, it appeared that specific elements characterised these themes and created a sub category of themes which related to the act of disclosure of sexual abuse by older women.

BUILDING TRUST

For women who have been abused, learning to and building a relationship built on trust may be difficult. The dynamics of child sexual abuse entail a violation of trust that one will not be hurt or harmed by an adult. Although sometimes not explicit in the texts, the elements of feeling heard, time to talk, being taken seriously and being believed seemed to be the factors associated with the women's subsequent disclosures.

Feeling heard:

For Ann, feeling heard came first from her GP. Despite her impression of his harshness, she felt understood.

> 'He was very good and he sat and listened in his own surgery with people waiting in the waiting room.. . it was nothing to do with the doctor 'cause he was a funny old stick and.. a very harsh appearingly, a very harsh manner but a very very understanding man.'

For the other women described by practitioners the sense that the women felt heard was part of the dynamics of their interaction. The practitioners responses suggested that the women felt heard. Ann, describes her practitioner as a 'quiet listener', and someone she could 'jabber away to' as relating to her experience of feeling heard.

Time to talk:

This element is bound with the practitioners availability of time, but as Ann described her GP above, it is the impression of being provided with time which appears to be important. In relation to her mental health practitioner time felt unlimited..

> '..I never felt that [time was limited] at all with 'M' not once,.. if she did have a set time, but she must have done obviously she couldn't just give me the whole of her day - but I was completely unaware of it.'

On asking a practitioner on how trust developed with her client prior to disclosure of CSA she described how taking the time to be with someone and listening was important.

> 'You're going into someone's home. People are grateful for very little, an an occupational therapist I would make life a little bit easier, more independence 'cause most of them are lonely, say yes to a cup of tea [and] just talking around different issues over a period of time.

This description includes all the qualities expanded upon in core category three (worker variables) with time, joining, and listening skills being blended into a coherent whole.

Being taken seriously and being believed:

Being taken seriously was again indicated by the practitioner's style. Where their listening skills enabled them to pick up on issues raised by the client which appeared meaningful or important. For women who may wish to disclose not to be taken seriously would indicate that the practitioner would be unlikely to believe them if they were to disclose. I asked Ann what would have been the most unhelpful response that her practitioner could have made, what would have prevented her from saying the things she needed to say. Ann was clear that it would have been if 'M' had been 'pushy' or 'breezy'..

> 'If she'd done that - no thank you. I think I'd have dried up.'

TENTATIVE ENGAGEMENT

Vague directors and 'stopping':

Tentative engagement is a term which describes how women who may begin to disclose take risks. They tentatively engage their worker with a thinly disguised abuse related issue and then see if this has been picked up on. Frequently, the women have been noticed to begin offering bit of information as 'vague directors' (previously

described) and then to stop. Stopping is hesitancy or a retraction of directors.

> [just before disclosure] '.. she was still testing, still trying to work out whether she could trust me or not, so she was very hesitant to begin with talking about leaving the bedroom, being scared of big adults.'

Where stopping occurs, there is often a marked change in the flow of the conversation which can take the shape of an apology or change to another topic. Where the latter occurs it may be that the woman feels suddenly very vulnerable and unsafe and decides to reduce her sense of exposure..

> '..they'll share so much and then they'll stop and often 'Oh I'm, wasting your time, you're very busy'
> 'There is this thing of putting the lid back on it and being frightened to let the lid off because everything will go out of control.'
> 'It almost feels as if they stop short, you know, like there's more, you just get the feeling there's more to be said. The classic sort of cut off is - 'Oh you don't want to hear about this I'm sure you get much worse people..'

Non-verbal clues:

Several of the practitioners reported subtle changes in the non-verbal behaviour of the women as they were thinking about the abuse or about

to disclose. Described previously in this results section under worker variables (observes non-verbal clues), this powerful communication from the client could be missed unless the practitioner was able to 'listen' to what was not being said as well as what was. For a number of the practitioners interviewed, immediately pre-disclosure, the dynamics in the room changed..

> '[the] emotional intensity increased in the room in the session when the client disclosed.. she was quieter, a lot more thinking.. and then [she] said she wanted to say something about her father that she'd never spoken to anybody else about.'
> 'Its like they're regressing back to the time they are about to tell you about.'

STYLE OF DISCLOSURE:

The women described in this study have evidenced different styles of disclosure which can be very broadly categorised as direct or indirect. There does seem to be a sub-category of 'sequential' but when taken literally, a sequential disclosure appears to be a series of 'mini disclosures' through vague directors which end with a clear disclosure.

Indirect disclosure:

It is important to keep in mind that an indirect disclosure is still a disclosure, it is the style of approaching the telling which is being described. Where disclosures are indirect, women seem to have found saying the words difficult and are often helped by the practitioner

through careful tracking, to reach a point where it is possible to confirm or deny abuse. One woman disclosed without words..

'I mean, we say disclosure but she never actually said 'I was sexually abused', or 'my father did this' or - it was never like that... . at the point where she actually said, it was by pointing towards her - between her legs - and that was the sexual part of her.'

The above woman had also appeared to disclose 'sequentially', the practitioner describes the 'snowball' effect of the information as their work progressed together..

'..it was a sort of progression, it was a bit like a snowball you know, the more that you picked up, the more you thought oh no, that, that you were aware that she was going to tell you something and it just sort of got bigger and bigger.'

Direct disclosure:

Whilst all direct disclosures may contain many of the qualities of indirect disclosure (eg tentative engagement), where a disclosure was described as direct, it was experienced as a sudden, almost unexpected event. The main difference between indirect and direct disclosure in these accounts appears to have been an apparent confidence (or bravery) in using language which directly describes abuse..

'I just went in and did what I had to do there and she asked me to sit down for a cup of tea which I did.. we were just talking about the old days and about her family and she seemed a bit depressed and lonely and then she just started on about her life, she mentioned things from her childhood.. . and about how she met her husband and what happy lives they'd had and how he died.. . and then she just came out with it, she'd had a very sad life and the she was abused as a child - she didn't seem embarrassed about it, that was the - yes, very direct.'

Although this practitioner describes the disclosure as 'very direct', we can see from this section of transcript how many of the factors previously described are clearly here. Time, life review, low mood, lonely, directors about her childhood, the death of her husband, and then the disclosure.

Ann also felt that her disclosure was direct..

'So I went to the doctor one day about something, a pathetic little thing and all of a sudden (thump) it came out'

In previous core categories, it has been demonstrated that Ann had experienced years of somatisation to the point of hysterectomy, had tried to disclose purposefully three times before, and had repeatedly visited her doctor with multiple minor complaints The disclosure may have seemed sudden to her, but she had been trying for over 50 years.

SUMMARY

The dynamics of disclosure as described in this section draw together many of the variables described in the main body of the research results, and cannot reasonably be decontextualised. However analysis of the data evidenced specific elements that appear related to the act of disclosure (as a part of the whole process of disclosure). Actual disclosure of CSA for older adult women appeared to be influenced by the three main themes of building trust, tentative engagement and the style of disclosure. Whilst building trust is an ongoing process throughout the contact between practitioner and client, the development of trust appears to influence the woman's willingness to risk tentative engagement. Tentative engagement was identified as the expression of 'directors', non-direct abuse related material. Strongly associated with directors was 'stopping', a communicational act which suggested that the women needed to be sure she felt safe that the practitioner could hear what she needed to say. Finally where disclosure of CSA occurred, the structural properties of direct and indirect disclosure were examined. In this study, the similarities of these two choices of style appeared to outweigh the differences and the evidence suggested that the disclosures described by participants in this research were all indirect over time, with some appearing 'direct' according to the words used or the experience of suddenness of disclosure.

CHAPTER FOUR

DISCUSSION AND CONCLUSIONS

DISCUSSION

Summary

The focus of this study was the process of disclosure of sexual abuse during childhood, for older adult women. The initial aim was to interview older adult women who had been sexually abused as children, who had disclosed to practitioners during clinical contact. It was possible to connect with and interview one older woman survivor of CSA. In addition, practitioners who had worked with older women who had disclosed CSA or who strongly suspected CSA also generously offered their time, to be interviewed, and thus became a main resource for this study.

In all, interview transcripts from nine practitioners and one older woman who had disclosed CSA were analysed. The purpose of the interviews was to explore the existence of identifiable and consistent elements in the process of disclosure. An aim of this study was to provide a descriptive, client centred exploratory account which could be conceptualised, mapped and decribed and that these conceptualisations and descriptions might provide new information from which an preliminary understanding of the process of disclosure for women who are older might evolve. Additionally, it was hoped that the findings generated could be used to create a framework, or model of the process of disclosure for older adult survivors of CSA, and that this might serve to enhance and enrich clinical knowledge and practice. These aims were conceived in response to the paucity of research existing in this area for older women and to realise these aims, three main hypotheses were tested.

1. Older adult women who have disclosed CSA to their clinician

will reveal specific themes relating to the process of disclosure.

2. Within participant data analysis will identify key factors (elements) of influence relating to the disclosure.

3. Between participant data analysis will identify a consistency of themes and elements across participants.

The testing of these hypotheses remained possible with the change of participant base as the practitioner's interviewed had either received disclosure of CSA from older adult women, or had strongly suspected that CSA disclosure was likely.

All three hypotheses were supported. In all, 59 key factors (elements) were identified as related to the process of disclosure for older women survivors of CSA. It was possible to subcategorise the elements into nineteen themes. It was also observed that the themes appeared to constitute four core categories, meta context, context, individual (practitioner) and individual (client) variables. This 'clustering' of themes into core categories made it possible to begin to consider the data at a higher level of abstraction and created an overview from which the data could be more concisely described. Miles and Huberman (1994) suggest 'Clustering is a tactic that can be applied at many levels of qualitative data... In all instances we're trying to understand a phenomenon (sic) better by grouping and then conceptualising objects that have similar patterns or characteristics' (p.249).

Further analysis: measures of reliability: To assess reliability the interview transcripts were re-read and re-coded with a minimum two week time lapse between readings. This analysis revealed a

reliability co-efficient (percentage agreement across readings) of 93.3% for individual elements, and 95.6% for themes. Additionally five of the transcripts were read by four external readers to control for subjectivity bias. The external reader's transcripts were psuedo randomly selected as a measure of control for researcher selectivity bias. External readership provides a measure of inter-coder reliability. Reliability is important when we want to know if information is valid or not. In psychometrics, validity is determined if an instrument measures what it purports to (Kline, 1986). In this study the interview itself could be considered both instrument and evidence. In qualitative research, validity is determined when the 'meanings emerging from the data have [been] tested for their plausibility, their sturdiness, their 'confirmability' - that is, their validity. Otherwise we are left with interesting stories about what happened, of unknown truth and utility' (Miles and Huberman, 1984, p11). Reliability should ideally be over 90% for evidence to have high validity and is desirable. A measure of 70% would suggest only moderate levels of validity. In this study, inter-coder reliability was moderate across readers with an average co-efficient of 80% relating to elements and 72.4% relating to themes. These findings are discussed further in the critique.

The research findings and their relationship to existing literature:

This qualitative study exploring the process of disclosure of sexual trauma of childhood for older women has identified a broad range of factors believed by practitioners to be relevant to this process.

Practitioner's reported experiences of older women disclosing sexual abuse, and practitioner's reported experiences of older women who they strongly believed may have been abused were frequently supported by the actual experience of an older adult survivor of CSA.

The conversations described in this study show in detail and depth the factors which influence disclosure. These range through meta contextual variables of societal rules about discussing sexual abuse set within a historical context; the impact of the organisational structure within which a practitioner is employed, the individual beliefs and skills held by the practitioner and the individual life experiences and beliefs about disclosure held by the older woman herself. From the complex, interactional, yet patterned factors identified, we can begin to understand the process of disclosure for older adult women as more than the act of disclosing, the influence of the context within which a woman who had been abused is embedded, is part of that process.

Many of the women described in this study were influenced by their social/historical context. The power of social values to silence, and maintain the silence of older women who have been sexually abused in childhood should not be underestimated. Ann' provided vivid testimony to this with her description of her ovewhelming experience of having sinned, of the sense of shame she felt, and how this influenced her willingness to talk about the abuse. Limandri (1989) points out that to percieve a 'condition' as stigmatising results in an 'underlying feeling of shame' and to avoid the feeling of shame, 'disclosure must be avoided' (p69).

In this study, women had either not previously attempted to

disclose, based on their fear of not being believed or like Ann, had negative reactions to their initial attempts to disclose These findings are consistent with those reporting the experiences of younger women who had disclosed or made attempts to disclose and where disbelief, minimising, blaming or other invalidating reactions result in lack of trust in others (Timmons-Mitchell and Gardner, 1991), and thus influenced women's decision whether or not to disclose. A social context of non-supportive reactions to disclosure of CSA for younger women can lead to psychological symptoms, and low self esteem (Testa, Miller, Downs and Panek's, 1992). A past and current history of physical, behavioural and mental health difficulties was evident in the findings of this study.

In response the the main research question 'what influences older women who may wish to disclose', practitioners and Ann (the older adult survivor) made reference to physical or psychological symptoms, how these are linked to the abuse and are a 'cry for help'.

If a woman's distress has been somatised, the older woman is likely to be subject to ageist assumptions regarding her symptoms (eg she is symptomatic because she is old). Allers, Benjack and Allers (1992) point out that the residual effects of CSA for older women are 'not the effects of advanced age, but lifelong in nature.' (p.14) and all of the women focussed upon in this study have had long lives, with their ages ranging from at least 60 to 80. When women's minds know that it is dangerous for them to disclose (physically and/or psychologically), then women's bodies find ways in which to help them express their distress. We know from research with younger adult survivors of abuse that physical symptoms of unknown aetiology are

often symbolic representations of the abuse trauma (Walker et al 1988), and we know from Ann's account how her physical symptoms were clearly and directly related to her reproductive system. Lechner et al (1993) argue that the 'violated body of a childhood sexual abuse victim may express the pain and damage of the assault in tangible, physical ways, in addition to the often described emotional sequelae of abuse (p.636). We also know that when informed of a history of CSA, a large proportion of primary care physicians express doubt about the veracity of the disclosure, doubt about the mental stability of the victim and/or consider the abuse irrelevant to medical care (Moeller, 1993, Introduction this study p.24). Derlega, Margulis and Winstead (1987) point out that 'failure to discuss a traumatic event (child abuse, rape, spousal death) with another person may have serious health consequences' (p208).

From the perspective of the practitioners, the potential to maintain women's silence is feared as a consequence of their own contexts. Recent changes in organisational structure for social service employees has impacted upon their prescribed and perceived role and available time. The importance of this change of role and lack of time was perceived to be related to the negative impact this has upon development of trust between the woman who may wish to disclose and her practitioner. Ann found her perception of unlimited time with her practitioner important in building a trusting relationship. Limandri suggests that essential conditions under which a disclosure may occur include 'a trusting and sustained relationship with another and privacy within the disclosure.' (p70).

Other findings in this study which are consistent with the

literature describing the process of disclosure for children and younger adults, are those which described the process of tentative disclosure. The women described here were frequently noted to begin to refer to their experiences of abuse in a distanced, disguised manner. Often using generalisations (eg my childhood was very difficult) quickly followed by a closure (oh, but you don't want to hear about that!). These 'directors' may or may not have been 'heard' by practitioners. Those practitioners who not only heard 'vague directors' but also 'tracked' or 'followed' them (eg asked more about it) were notably those who had received disclosures. Practitioners who had not received disclosure, but suspected CSA, were noted to hear directors, but chose not to 'take the lead' (through fear of making things worse or fear of lack of skill of dealing with the consequences). It is of course possible that for the latter, there was no disclosure to be made, but the influence of the practitioner should not be underestimated. Following disclosure, one woman client of a practitioner in this study was asked by her practitioner why she had not told her (many) psychiatrists, she replied..., 'They didn't listen.' Research with children shows how disclosure follows a distinct pattern where an anticipatory phase (thinking about telling) is followed by rehearsal (self disclosure and anticipating the consequences) and (if it feels safe enough) indirect or vague indicators (Sauzier, 1989). Limandri (1989) suggests the process of disclosure of stigmatising conditions is an 'unlayering process' which includes 'invitational disclosure' with cues that something is wrong to 'invite' the respondent to notice. (p74). The impact of the professional upon the survivor is crucial. Bryer, Nelson, Baker-

Miller and Krol (1987) conclude that 'Extreme confusion and shame render patients particularly unable to initiate disclosure of abuse; professionals not initiating discussion of the topic can transmit a message confirming survivor beliefs in the need to deny the reality of their experience.' (p.1430).

For many older women survivors of CSA wishing to talk about their experiences, perhaps one of the main differences for them compared to younger adult survivors is not so much the experience of the telling per se, but the length of time the 'secret' has been held and the silence maintained. This study has elucidated two levels of understanding of the process of disclosure of CSA for older women. It has demonstrated the emergence of themes which are consistent with existing literature (as described above). It has also highlighted factors and issues specific to older women, for whom the process of disclosure is one which will have begun over almost fifty years ago, at the time when they were sexually brutalised. It is then that the decision to tell or not to tell, and therefore, the process of disclosure began. It is also worth remembering that fifty years ago, one of the most prominent psychological theorists of that time was still lecturing and writing about his belief that reports of childhood sexual abuse by adult women were untrue 'almost all my women patients told me that they had been seduced by their father. I was driven to recognize in the end that these reports were untrue and so came to understand that hysterical symptoms are derived from phantasies and not from real occurrences (Freud [1933], 1973, p154). Older women living as children during this time, were bound to be influenced by the social context in which they spent their developmental and early

formative years, and thus must be considered as impacted upon by their historical context. It is reassuring to note, and be reminded that in this study, these older women have not been frozen in time, (to assume so would be extreme ageism!) and for many, their access to current media messages, validating the trauma of their experience has placed them firmly in a different time-context and encouraged some to begin to tell of their experiences. I do however experience concern about the power of the media coverage of 'false memory syndrome' and its potential impact to create self doubt about the reality of a women's remembered experiences, and to keep women silenced.

Drawing heavily on Fontes' (1993) ecological model describing pressures on children not to disclose, I would like to suggest a model related to the process of disclosure for older adult women who have been sexually abused as children and come into contact with health and social service practitioners. This model is an attempt to integrate the findings of this pilot study to create a meaningful diagrammatic summary of the findings of this pilot study.

A MODEL OF THE PROCESS OF DISCLOSURE FOR OLDER ADULT WOMEN

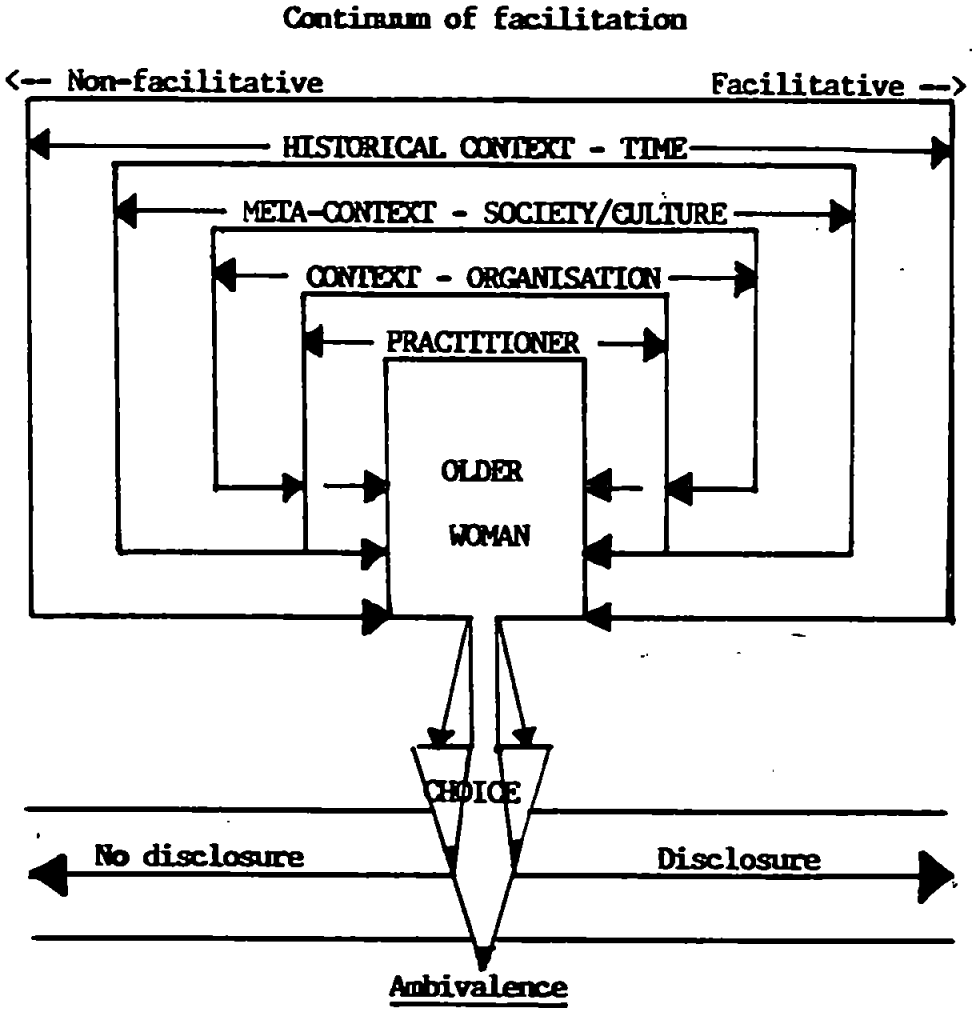

Figure 7: A context model of disclosure integrating the findings of this study and illustrating the influence of contextual variables as facilitative or non-facilitative of disclosure of CSA for older women in reciept of health and social services.

The context model of the process of disclosure for older adult women shows how the woman is embedded within multiple layers of contextual influences. At any time, any one of these layers may be experienced as facilitative of disclosure of sexual abuse, or non-facilitative of disclosure. The strength or weight of the interaction of permissive and/or non-permissive contexts will influence the older woman's decision whether or not it is safe to disclose. Our social and cultural context is set within the context of time and is not separable. It is the social rules of a given time which will be influential. For older women, their place within their historical/social context throughout the course of their lives will impact upon them, interacting with their previous experiences or attempts to disclose. Thus, for some women, the tentative current social rule broadcast by the media is one of facilitation. However, this message is itself set within other powerful messages within our society which are non-facilitative (eg suggestions that women falsely remember being abused: false memory syndrome).

In this model, the woman's immediate environment and relationships are part of her social and cultural context. In the analysis of data from this study it was noted that loss through relocation, or recent bereavement (most often widowhood) and social isolation were potential precursors to disclosure of CSA. Those supporting the older woman at these times are necessarily influenced by wider society, and themselves will appear able to hear (facilitative) or not (non-facilitative), what she has to say.

The most immediate contact, where permission to 'share one's innermost problems' may be assumed, is with the health or social

service practitioner with whom she has contact. The practitioner is influenced by her/his social-historical context, the organisation within which he/she is embedded, and will hold their own unique integration of beliefs and skills relating to childhood sexual abuse and older women. The context model shows how the employing organisational factors impact directly upon the practitioner, and impacts upon the woman through her practitioner.

Where there is no perceived disparity between the contextual forces of non-facilitation/facilitation of disclosure, the woman may experience mixed messages about the appropriateness, safety or benefits of disclosure which may result in her being in the position of an approach/avoidance conflict where motivations vacillate (disclosure v silence). Here, a state of ambivalence is likely to ensue until a shift in contextual patterns changes contextual forces, either in favour of facilitation, or non-facilitation of the disclosure of childhood sexual abuse.

Critique

Availability of a representative sample: This original design for this study rested primarily on the successful connection with and eventual interviews with older adult women who had disclosed sexual abuse of childhood. Although I believe the findings which have emerged have provided invaluable new information which to date have not been explored (at least in published material), the aim was to have been understanding from a number of women's personal experiences of what was important for them. I was delighted that Ann (an older adult survivor) chose to be included in this research, not only did the information derived from our interview provide a wealth of information and serve to enrich and enhance the findings throughout, she was also great fun to be with, and represents the 'up-side' of researching. Additionally, I feel enormous gratitude to the practitioners whose commitment to improving services for older women motivated their participation and generosity with their time for interview. As a result, the findings of this study have provided a thorough and detailed analysis of the process of disclosure of childhood sexual abuse for older women, through the experiences of an older adult survivor of CSA, supported and expanded upon by the experiences and perspectives provided by practitioners in older adult services who had received disclosures or suspected CSA. However, had a detailed and thorough canvassing of the services, and the potential for interviewing women been carried out prior to this study (a mini feasibility study), then different questions may have been asked, or links made well enough in advance for the practitioners to feel less worried about 'letting a researcher lose' on their ex-clients. Given

the nature of the research topic, it would have been appropriate for me to have given more careful thought to, and about these issues.

The research process: The interview format upon which this study was conducted focussed upon responses to the main research question of 'what makes it possible for older adult women to begin to disclose experiences of childhood sexual abuse'. This main question was supported by 'theme prompts', the purpose of which was to provide focus and clarification. At the time of initial planning for this research, this format felt essential for beginning to identify and understand what, if anything is relevant to the process of sexual abuse disclosure for older women. However, in this study, this method of enquiry generated many opinions from practitioners relating to the process of disclosure, which were embedded within the texts alongside their accounts of actual disclosures, or of the interactions with the client when CSA was suspected. The complexity of this material necessitated careful and thorough scrutiny in an attempt to separate opinion about the process of disclosure from their experience of the process. I am aware that opinions guide actions and thus form meaningful data in themselves, but the focus of this study was the experience of, rather than opinions about disclosure of CSA for older adult women.

To help minimise extraneous information, this study might have benefited from a sharper focus at the outset of the interview. It would have been appropriate and possible to have made explicit that the requirements of the interview were to identify factual information relating to a specific client, or clients. Alternatively, or in

addition, by following the methodology of grounded theory more precisely, the most effective and valid method of keeping data interpretation as close as possible to the meanings and experiences perceived by the participants, would have been to have discussed the initial codings and interpretations with the participants themselves, and their comments incorporated into the final analysis (Stiles, 1993). This method of data generation ensures that meanings are less likely to be misinterpreted and therefore misrepresented. In this study, lack of available time influenced what was possible, however with hindsight, improved data representativeness may have been achieved within the time available if the focus had been on fewer participants (eg four or five rather than ten), and those who did participate were involved in discussions about, and the interpretation of their data.

The need for a research discussant: My experience of carrying out this research has led me to hold the firm belief that the researcher using qualitative methods needs to identify and work closely with a discussant. The primary purpose of this role would be that of a second person becoming immersed within the research material, but through their conversations with the researcher, not their reading of the texts. The discussant acts as a sounding board, where ideas can be exchanged, meanings thought about, with the intention of providing greater depth of understanding and interpretation of the research material. A secondary gain of meeting with a discussant would be support with the 'weight' of the research. In this study, the volume of data was anticipated, but the reality of it an unenviable experience.

Measures of reliability: Without the benefit of being present at the interview, external readership risks further misinterpretation of the data, taking further away from the participant's meanings. However, where second interviews with the participants are not possible or practical, external readership is an invaluable resource 'checking out' that what the researcher thinks she/he has found is there, thus minimising the potential for researcher subjectivity bias. External readership can also provide an opportunity for the recognition of new leads and potential themes.

The moderate intercoder reliablity co-efficients in this study (80% for elements, 72.4% for elements) were calculated by dividing the number of agreements with the total number of agreements plus disagreements. It would appear that the above reliablity measures are typical of what one would expect upon a first intercoder reading. Miles and Huberman point out that 'you don't usually get better than 70% intercoder reliability using this formula. Each coder will have preferences - and each vision is usually legitimate. Clarifying these differences is useful..' (p64). Re-reading and discussing with external readers may help clarify areas where shared meaning exists but has not become explicit. Whilst inspecting the elements and codes identified by external readers for this study I became aware that essentially we were in agreement, but slight differences in interpretation meant disagreement rather than agreement in the final calculations. If I had had the courage to ask four very busy clinicians to re-read the transcripts with me for a second time in order to discuss them, intercoder relability may well have improved (but my relationship with my colleagues may not!).

Research omissions: My final criticism of this research is related to its lack of attention to issues relating to the practitioner/client relationship in detail (eg transferential issues), and the gender of the practitioner. In this study, of the nine practitioners, seven were women and two were men. All the survivors of abuse were women (in keeping with the research criteria, but also consistent with the experience of practitioners contacted). As a feminist practitioner, I am acutely aware of the salience of gender issues within the context of childhood sexual abuse. We know from existing research that many more girl children than boy children are sexually abused, and that the vast majority of perpetrators of sexual abuse are men (Driver and Droisen, 1994; Doyle, 1994; Parton, 1990). Given what we know, it is negligent to have failed to address this issue altogether. Although not identified by any reader as an element or theme, where the gender of the practitioner was raised as an issue, one of the male practitioners wondered retrospectively if his female client (who had not disclosed CSA) would have preferred talking to a woman. Ann, an older adult survivor of CSA stated clearly that she would not have been able to talk comfortably about her experiences to a man.

Gender is an issue in the process of disclosure of childhood sexual abuse and this study would have benefited from considering raising gender as an open ended question within the interview theme prompts.

Conclusion and future directions

Through detailed qualitative analysis of the transcripts from in-depth interviews with an older adult survivor of childhood sexual abuse and practitioners who have worked with older women who have disclosed sexual abuse of childhood, the aims of this study have been realised. It has been possible to provide an initial, tentative, client centred account of the process of disclosure of CSA for older women by conceptualising the influencing factors as core categories, themes and elements, mapping and describing them. The findings of this pilot research have suggested that for older adult women, disclosure of CSA is a process, and the direction of the course of this process (attempts to disclose, decision to disclose, decision not to disclose) is a function of the context(s) within which she is embedded.

Whilst many of the findings of this study are consistent with existing research describing the process of disclosure of CSA for younger adults and children, as far as I am aware, this important aspect of the lives and experiences of older adults has not previously been researched, making this study a true 'pilot' in this area.

By integrating the findings of this study into a coherent 'whole', and drawing upon an example of an 'ecological model' of children's process of disclosure (or non-disclosure)(Fontes, 1993), a 'context model' of facilitation or non-facilitation of disclosure of CSA for older adult women was created. This model shows how older women in receipt of health or social care, who may wish to disclose CSA are impacted upon by their historical context, their wider and immediate social/cultural contexts and the direct influence of their

practitioner. The direct influence of the practitioner is subject to her/his own social/historical context, their employing organisation's prescription for their role vis a vis older women and older women's distress, their own interpretation and implementation of the prescribed role and their beliefs and skills relating to older adult women, childhood sexual abuse and the potential for older women to disclose CSA. The findings of this study suggest an older women's decision whether or not to disclose childhood sexual abuse is both bound by, and a function of her context. Thus, context is both part of, and contributory to the process of disclosure.

The emergent conceptualisations of factors relevant to the process of disclosure of CSA for older women in this pilot study provide a framework from which an understanding of this process can be further explored. It is only once a statement has been made that it can be either supported or refuted, and I see this study as having made a tentative statement. It is impossible to say categorically that this statement of findings will be found informative to practitioners and researchers with an interest in the needs of older women, but the findings could be used to sensitise practitioners to the factors to which they might attend (eg tentative disclosure through directors), and generate new questions and hypotheses which require answers beyond the piloting stage, for example, is the information derived from these interviews and subsequent analysis consistent across further research samples. In addition, it might be helpful to know if there are differences between practitioners who receive disclosures and those who don't (eg beliefs, attitudes, style, gender). When a client gets to experience not feeling heard

(tentative disclosure not addressed) this can be powerfully experienced as not being listened to ('They didn't listen'). This highlights the importance of (sensitively) 'checking out' our hypotheses, to see if what we think we have heard, is what is being said. In this study, whether or not a practitioner 'tracked directors' appeared relevant, but was purely speculative, as the (group 2) practitioner's suspicions of abuse may have been unfounded. Practitioner variables are important, and a greater understanding of the impact of the 'person of the practitioner' upon a woman's willingness to disclose feels essential.

I am of the opinion that further research can most fully be of assistance to older women who have been sexually abused as children, by emphasising the importance of listening, hearing, validating and valuing what they have to say. Qualitative studies are one way of achieving these aims.

Older women who wish to talk about their experiences of childhood sexual abuse are entitled.
Older women are entitled to be listened to.
Older women are are entitled to be heard.
Older women are entitled to a voice with which to shatter the silence.

Epilogue

This study has been my first experience of focussing exclusively on qualitative methodology. I have experienced a variety of emotion throughout the course of this study. I have been deeply and painfully moved by the accounts of women's lives, describing how they have lived

with the consequences of childhood sexual abuse. I have felt humbled by their tenacity and strengths as they continue to struggle with their pain and try repeatedly to let us know how they feel.

I have been encouraged by the sensitivity and dedication to the needs of older women survivors of sexual trauma expressed by the practitioners I have met. I have also become aware that many practitioners do not appear to 'hold in mind' that older women may have histories and lives which have been shaped by sexual trauma.

Many times I felt overwhelmed, firstly by the power of the emotions generated by the material content, and secondly by the sheer volume of data and amount of dedication and time that has been required to repeatedly read, code, analyse and collate the data into a meaningful whole.

However, now as tentative conclusions have taken shape, my experience is a sense of connectedness with Ann, (a survivor), the practitioners, and the women they described. These people and their words have provided a depth and richness to this study, which have been made accessible through qualitative description... ..I am enriched by them.

APPENDICES

APPENDIX 1

ETHICS COMMITTEE APPROVAL

Exeter District
Research Ethics Committee
Dept. of Medical Affairs
Level 2
R D & E (Wonford)
Barrack Road
EXETER
EX2 5DW

Tel: 0392 402369
Fax: 0392 402067

In reply:
1. Please quote Study Number
2. Address to the "Chairman"
(Please do not use Chairman's name to avoid misdirection)

Our Ref: PG/sks/541

21 June, 1994

Ms Katrina Laydon-Walters
Department of Clinical and Community Psychology
Church Lane
Heavitree
Exeter EX2 5SH

Dear Katrina

Study 541- Sexual Trauma of Childhood: Older Adults

Thank you for attending our recent Research Ethics Committee meeting with Miss Titley and presenting your study to us.

The Committee found it very useful to have their questions answered and, now that we have established that this really is a pilot study and that you are not intending to draw general conclusions from the results, the Committee are happy to give their approval for the study to go ahead.

As we discussed at the meeting, I think it is important that you seek the opinions of your subjects' clinicians as to the veracity of the disclosures. You also agreed to change the wording of the patient information sheet of section 2 (iii) to "..... will in no way effect your future medical care". I would be grateful if you could send me a copy of the amended patient information sheet for our records.

It is recommended and it would be helpful to the Ethics Committee if you would be kind enough to supply us with a report of the outcome of the study or, if it extends over a period greater than a year, interim annual reports in addition. If publications arise, we would also be very grateful for copies.

You are reminded that it is incumbent on you to inform the Chairman of the Ethics Committee of any serious adverse event that takes place during the conduct of this investigation. This notification should be made to the Chair within 24 hours of the event.

The Committee wishes you every success with this project.

With best wishes,

Yours sincerely

Dr Peter Gentle
Chairman
Exeter Medical Research Ethics Committee

P.S. Many thanks for your patience

APPENDIX 2

LETTER TO PRACITTIONERS

THE PROCESS OF DISCLOSURE FOR OLDER ADULT WOMEN, SEXUALLY ABUSED DURING CHILDHOOD

I am undertaking this research, as part of my final year of training as a clinical psychologist. In this project, I hope to identify what it is about the process of disclosure of sexual abuse during childhood, that enables older adult women to begin to tell of their experiences. This project is being supervised by Marian Titley.

My research is in two parts. The first is a preparatory stage, in which I am hoping to find opportunities to talk with practitioners who have worked with older adult women who have disclosed, to learn more about this process, and to discover from their experience their thoughts and ideas about what has and has not been helpful. I anticipate that this important preliminary stage will assist me in the main research interviews. Here, I hope to be able to make contact with (through practitioners), and hold interview conversations with up to six older adult women who have already disclosed sexually traumatising experiences during their childhoods, to learn from them, their personal experiences of the process of disclosure.

It is my hope that the information derived from this qualitative study will be informative to practitioners who work with abuse survivors, particularly older adults.

If you think you may be able to help me (at either stage) and would be willing to talk with me on the telephone, or perhaps to meet with me, I would be delighted to hear from you.

I can be contacted at home on (0392)72344 (answerphone if I am not in), or a message can be left at the Dept. of Clinical Psychology, Exeter (0392)403170.

Many thanks, Katrina Laydon-Walters.

APPENDIX 3

THEME PROMPTS

INTERVIEW THEME PROMPTS

1. Demographic information and permission to proceed.
   eg. Introducing self (interviewer)
   Purpose of study
   Information sheet
   Consent form
   Participant details:- name, age, etc.

General:

Could you tell me in your own words what it was that helped to make it possible for them to disclose their experiences of abuse?

Clarifying:

What would they say had been least helpful for them
What would they say had been most helpful

Previous attempts:

Had they ever tried to tell their experiences before?
In what ways?
To whom?
What happened?

Disclosure and affect:

Can you describe what you/they were thinking or feeling just before they began to tell of their experiences?
Thoughts and feelings during disclosure?
After disclosure?

Specifics-worker:

Could they tell me a little about the person they disclosed to?
Was there something about them that helped to make disclosure possible?
How could they have helped you more, or made it easier for you?

Abuse impact and relationship to disclosure:

Looking back, how would they describe the impact of the abuse on their lives

Now, as an older adult, would they say there are any particular problems or difficulties that they have faced as older women because of their experiences?

Did these things influence their readiness, confidence or willingness to tell of their experiences?

Validation of strengths:

It takes great strength to keep painful experiences to oneself. It also takes great courage to tell of painful and traumatic experiences. Women's strengths and courage are often un-recognised. It is clear you have both strengths and courage.

What would you say have been your greatest strengths?

What other strengths do you have?

If I were to ask someone who knows or knew you well, what would they say your strengths are?

Conclusions-future directed:

To conclude our interview:

Can you tell me, If there is anything you think would be helpful for other older women, (who have had similar experiences), to know about beginning to tell of their abuse?

What would you like practitioners to know about when they are working with older women who may want to disclose abuse?

Ending-Future support:

Thanks/feedback re: interview.

Time to re-locate in here-and-now (re-orientation/de-briefing).

End of interview information sheet and details of support.

Ending

Goodbyes

APPENDIX 4

LETTER TO 'ANN', A SUVIVOR OF CHILDHOOD SEXUAL ABUSE

Dear

I was wondering if you might possibly be able to help me. My name is Katrina Laydon-Walters, and I am a trainee clinical psychologist, here in Devon, and I am hoping to carry out a research study focussing particularly on senior adult women. I am writing to you, following Lynn Adams' suggestion, that you may be willing to meet with me.

I am unsure about how much you know about my research study, so I would like to tell you a little about it here, and hope that this isn't repeating things you already know about it.

My research is concerned with how women begin to tell of their experiences of childhood abuse. I am aware that many women have lived for many years, with the difficult, and often painful knowledge that they had been abused during their childhood. I am also aware that for some women, they have, somehow, found it possible to begin to tell someone of their experiences of what happened to them, perhaps for the first time. Both living with the knowledge of being abused, and sharing that knowledge with someone else must require an enormous amount of strength and courage. I am moved by such courage, and believe that there will be many other women who really are strong enough to share their experiences, but just don't know how to begin.

I believe that I (and others in my profession), can learn so much from listening carefully to what you have to say. Hearing how it has been for you, can help us to begin to understand what the sharing of those experiences has been like for you and how it became possible to begin to talk about such sensitive matters. Listening to you, and other senior adult women who have had similar experiences, this valuable

information can then go towards helping us to help other women who may wish to talk about their experiences.

All the information gathered during the course of this study will be anonymous, so that no one could identify you in any way. Your privacy is considered of the utmost importance.

Given the sensitivity and private nature of your life experiences, I know that it might be difficult to think about, or talk further about how you began to tell of these things. If you feel in any way, that this would be upsetting for you, difficult for any reason, or that you simply prefer not to talk about it, I fully understand, and would suggest that to take part in this study might not be timely for you just now. I know that you will know what is right for you.

Should you believe that meeting with me is not the right thing for you at this time, I would like to take this opportunity to thank you for 'hearing' me through this letter, and wish you well, now and in the future.

However, if you think taking part in this study would be your preference and you would like to meet with me, I would be very happy to arrange an appointment with you for sometime in the near future.

I look forward to hearing from you.

Yours sincerely

Katrina Laydon-Walters
Clinical Psychologist in training.

APPENDIX 5

INFORMATION SHEETS

(1)

Information Sheet

Participation in this study is entirely voluntary. To help you decide whether or not you wish to take part, and for your information, the following describes a little more about the study and your rights as a participant.

1. The Proposed Study

i) The proposed study hopes to identify what enables older adult women to begin to tell of their experiences of sexual trauma of childhood. It also acknowledges women's strengths and hopes to identify those which have been important to you. It is hoped this will be achieved by an individual interview which, with your permission, will be audio taped. It is estimated that the interview will take approximately one and a half hours to complete the interview.

ii) It is hoped that this study will provide new information which will go towards providing more informed and comprehensive services for women.

2. Your right not to participate or withdraw.

i) Taking part in this study is entirely voluntary. You are under no obligation to take part, or to answer any questions.

ii) Your right to withdraw. You have the right to change your mind and withdraw from this study at any time, before, during or after the study.

111) Non-participation or withdrawal from the study will in no way effect the clinical services your are currently receiving.

3. Confidentiality and Consent.

1) The information obtained during this study will be guaranteed absolute anonymity. All documents will be coded to prevent identification. The anonymous information will be used together with anonymous information from other women who have taken part, as the basis of the study.

ii) Your written consent to participate will be sought prior to your taking part in this study. As discussed in section 2, you can withdraw your consent at any time.

4. Personal Support or Counselling.

i) Should you feel in any way uneasy or distressed following our interview, confidential support or counselling is available for you. You can access this support by contacting me (Katrina Laydon-Walters)

or Ms. Marian Titley, Clinical Psychologist at the address given below.

5. Further Information.

Further information about this study is available from a number of sources.

i) The clinical supervisor for this study:
Ms. Marian Titley, Clinical Psychologist
Department of Clinical And Community Psychology
Church Lane
Heavitree
EXETER
EX2 5SH
Tel: (0392) 403170 (Answerphone available outside office hours)

ii) The researcher:
Ms. Katrina Laydon-Walters
Department of Clinical And Community Psychology
Church Lane
Heavitree
EXETER
EX2 5SH
Tel: (0392) 403170 (Answerphone available outside office hours)

iii) The Research Ethics Committee.

Enquiries or comments about this study will be treated in confidence.

Address:
The Chairman
Exeter District Ethic Committee
Dept. of Medical Affairs
Level 2
R D & E (Wonford)
Barrack Road
EXETER EX2 5SH
Tel: (0392) 402369

APPENDIX 6

CONSENT FORM

CONSENT FORM

Please cross out as necessary

Have you read the Patient Information Sheet? ..... yes/no

Have you had an opportunity to ask questions and discuss this study? ..... yes/no

Have you received satisfactory answers to all your questions? ..... yes/no

Have you received enough information about the study? ..... yes/no

Who have you spoken to? Dr/Mr/Mrs _____

Do you understand that you are free to withdraw from the study:

* at any time
* without having to give a reason for withdrawing
* and without affecting your future medical care ..... yes/no

Do you agree to take part in this study? ..... yes/no

Signed_____ Date_____

(Name in block letters)_____

APPENDIX 7

THEME SHEETS

THANK YOU for agreeing to help.

Enclosed you will find an interview transcript (or transcripts), 'theme sheets' and instructions. However, for this particular piece of research it is important not to be constrained by existing frameworks, as this is exploratory research, hoping to identify new information, and I may well have missed something important. If whilst reading the transcript you feel there is something which has not been included on the 'theme sheets', please feel free to note these in the space below, and I will ensure they are included in future analyses.

Katrina.

ADDITIONAL COMMENTS

SHEET 1 Code:

Listed below are a number of themes drawn from the transcripts of audio-taped interviews. The focus of the interview was the process of disclosure of childhood sexual abuse, for older adult women. The themes have been generated through identification of a number of key elements within the interview texts. These are described alongside the theme titles below.

As you read the enclosed transcript(s) please tick beside any theme element you notice in the text. (eg. a comment about quality of supervision would come under Worker Themes, 'Agency Influences' (sheet 1) and would be ticked alongside 'supervision'. Thank you for your invaluable help!

THEME	KEY ELEMENTS
ORGANISATIONAL INFLUENCE:	a) Definition of role b) Task orientation c) Staffing levels d) Time e) Workload
AGENCY INFLUENCE:	a) Disclosure as part of work b) Support of managers c) Supervision
WORKER BELIEF SYSTEM:	a) CSA happens b) CSA can have long-term negative effects c) Older adults may have suffered CSA d) Older adults may disclose CSA
WORKER'S DEFINITION OF ROLE AND AVAILABLE TIME	a) Focus of visit b) No. of referrals c) No. of possible visits d) length of visits (available time to listen)

...continued - sheet 2

SHEET 2 Code:

Themes: worker (cont)...

THEME	KEY ELEMENTS
INDIVIDUAL STYLE: Joining and contracting	a) Venue b) Privacy c) Boundaries d) Confidentiality
INDIVIDUAL STYLE: Listening skills	a) Hearing 'beyond words' (intuition) b) Hearing 'directors'* see below c) Tracking or following topic d) Pacing
INDIVIDUAL STYLE: Global response	a) Non judgemental b) Empathic c) Genuine interest
INDIVIDUAL STYLE: Specific response	a) Follows directors b) Observes non-verbal cues c) Reflects back d) Pacing e) Indirect enquiry f) Direct enquiry

* Directors are vague indicators from the client that something may have happened in childhood, or in relation to particular people or events.

... continued sheet 3

... sheet 3. code:

THEMES: CLIENT

THEME	ELEMENT
HISTORICAL LIFE EVENTS	a) Death of partner (over 2 yrs prev) b) Multiple losses c) Abused by partner d) Abused by other (not CSA) e) Previous attempt to disclose: negative experience
HEALTH HISTORY: Phys./behav./affect.	a) Under/overweight b) Pelvic pain c) Episodes of depression d) Agoraphobia e) Low esteem (shame/guilt) f) Mistrust g) Hostility h) Fear
CURRENT LIFE EVENTS	a) Recent close bereavement b) Exacerbation of physical health probs. c) Decreasing mobility d) Increasing dependence e) Social isolation
CURRENT HEALTH Phys./behav./affect.	a) Decrease in quality of physical health b) Depression c) Agoraphobia d) Appetitive problems e) Low esteem (incl. guilt/shame)
Other affective.	a) Overt distress b) Intense anger
LIFE STAGE TASKS	a) Life review b) Facing mortality c) 'Self' disclosure

... continued sheet 4

Sheet 4. code:

Themes: client (cont)

THEME	ELEMENT
DISCLOSURE DYNAMICS I: Learning to trust	a) Feeling heard b) Time to talk c) Being taken seriously d) Being believed
DISCLOSURE DYNAMICS II: Tentative engagement	a) vague directors b) 'stopping' * see below c) non verbal cues
DISCLOSURE DYNAMICS III: Style of disclosure	a) Indirect b) Direct

* 'Stopping' is hesitancy about, or retractions of directors (eg. I know you are busy; you must think me a silly old fool; you don't want to hear all this etc.)

APPENDIX 8

THEME DATA

Organisational influence:

Definition of role:

[disclosure came about] while I was doing routine assessment now we're doing care management, so before care management we had a bit more time to spend with clients
we're more like facilitators now. Usually under the new care management you go in to assess their needs. Nobody's going to say all their needs at the first meeting its ridiculous

Part of my role is to do initial assessment for [a] befriender scheme... [there are] restraints in my role as in, I can't step outside and can't do therapeutic work... They've trusted you enough to disclose and then you say, I'm sorry, I can't do this.

.. and I also knew that my bond was going to be time limited you know by the hospital protocols and things like that.

I have very, very little time for therapy, which is awful.

Task orientation:
..its about assessment work, going in to do financial assessments, doing very tight financial reviews and so forth.

Time:

[disclosure came about] while I was doing routine assessment now we're doing care management, so before care management we had a bit more time to spend with clients
[re: disclosure] somebody willing to listen and giving them the time and somebody they could trust because it wasn't on the first meeting, it was after I had been there a few sessions
[time as a factor?] definitely with elderly women, unless they were an intensive case of yours when you can go in a bit more often, we're more like facilitators now. Usually under the new care management you go in to assess their needs. Nobody's going to say all their needs at the first meeting its ridiculous
Before, when we were going in quite a lot, we were giving time for them to talk, time to build a trusting relationship

.. and I also knew that my bond was going to be time limited you know by the hospital protocols and things like that.
I think as long as they [client] know that its going to be time limited I don't think that's too much of a problem as long as you can make sure that you do a really safe handover to someone else.
I think we're probably coming across people all the time who have deep underlying problems that we're not dealing with because we havn't go time, not because we don't want to, not because we don't even notice that they're there, but we just havn't got time.

I was only able to work short term with that lady ...
I feel sure that's [lack of time] one of the major things that made her feel she just couldn't take it any further.
In our practice there's six months or a year before there's another review held and I didn't think that would be useful for this lady.
There are cases where you feel that people want a commitment from you, they want to know that they're going to see you 'cause otherwise they're not going to open the door at all, and we're getting pressurised about what you are doing in this case, because now we're care managers we're no longer social workers - our role has been eroded.

Agency influence:

Disclosure as part of work:

The main issue for me is when a woman has disclosed and they don't get the support they need to do the work because again you aren't trained to do the work .. there are very few people who can actually do it.

Support of managers

(agency x) are dreadful, they don't care for their workers

Manager experienced as supportive re: client who disclosed

Supervision

Team experienced as supportive re: worker as a person.
Supervision available if requested.

Peer supervision is helpful.
Supervision needs to be built in.
[supervisor] .. must give you permission which is what I look for in the client.

If you are being taken care of then you can take care of the woman, but if you are not being held somewhere else you're not going to be able to do that process with them anyway, and the women are quite astute and they'll soon pick that up and they're going to shut up.
Preparing yourself inwardly for the work enables you to be able to contain it and can leave as a person and not as a wreck.
... you need to be able to that that until supervision time .. at times I will call for supervision outside supervision hours, so that if its been a tough session I will say 'I need ten minutes'.
I think that I would probably feel that if I had a supervisor that wasn't hearing what I carried from the woman I wouldn't be telling her because I wouldn't trust her.

Peer supervision had been important.

Worker belief system:

Worker does not need to be aware of the possibility of abuse to pick up on what is being said

Its very clear that you have to have in your head that you are accepting of this [A] else you're gonna block to begin with.
You need to have done some work on yourself on how that is [own feeling re: abuse] and have a base knowledge of sexual abuse because you can't be open to it unless you have the knowledge of it. .
If the worker isn't experienced in abuse they're not going to pick those up [directors].

There was an internal picture of some sort of abuse, some sort of misfit.... I suppose one of the things still is to, you know, to just be aware that it is there and not to deny it went on, it was going on, it does cause lifetimes of distress but you have to listen.

[fear of making things worse] I suppose as well, its a bit of fear for me because I think, crikey supposing they do disclose what do I do with it then? Whats next? Where do we go from here?.. it all flits through your mind.. and also is it going to damage them? You know, am I going to damage them with taking it any further. I think fear is probably predominant.
I mean, you've got every right to be treated as someone fifty years younger..
'cause I mean you do sometimes get the idea that its not worth working with older people 'cause what the heck, they havn't got long to live, that sort of thing.

Positive and negative ageism:

I do believe that elderly people have as much right to counselling, to their experiences being listened to at the end of their lives as at the beginning and even more so really because the rest of their lives is so short.

If you've got somebody of 19, 30 or whatever, that's disclosing they've got an opportunity to change, be different, start a new life, get a new partner or whatever, somebody of 73, 83 that's then disclosing where are they going to take it?, what are they going to do with it? because its opening a can of worms.. where is that going to leave the person? [worker wanting client to be helped to take responsibility for 'opening can']
If you've had a lifetime of suppression I think it takes a lot more work to get into the issues.

[disclosure] may be harder [for older women] because of harboured feelings over time.

Worker belief system: cont.

Fear re: lack of skill.

I mean, I was also feeling [as disclosure became imminent] I don't know what to do with this because I've never dealt with this before I'm not skilled at dealing with this I just, you know,, I don't know that I want to deal with it and yet by then you'd gone to a point where you couldn't for her sake or anything else go back.

Worker definition of role and available time

Focus of visit:

Part of my role is to do initial assessment for [a] befriender scheme...[there are] restraints in my role as in, I can't step outside and can't do therapeutic work... They've trusted you enough to disclose and then you say, I'm sorry, I can't do this.

its about assessment work, going in to do financial assessments, doing very tight financial reviews and so forth.

No. of visits:

We're looking at about four or five sessions to get to the question about childhood sexual abuse.

It took something like six or seven weeks [to disclose abuse from partner] and I'd been seeing her twice a week.

Worker style: joining and contracting

Venue:

The women are seen in the safety of their own home so that they are in control.

The client was seen in her own home

we saw her in her own home, so it was completely private, a safe environment.

Seen in her own home.

.. we saw her in her own room [at nursing home] so it was completely private .. a safe environment.

Boundaries:

Before disclosure there was an informal first visit with an offer of four to six sessions and informed that they could stop at any time
They knew the sessions were up to one hour.

So the choice we gave her was for her to contact if she wanted to pursue something in the region of therapy work with the clear understanding that we would talk about painful issues from the past.

By showing boundaries you are actually saying, yes, I can hold this, I can contain this and its OK to do this piece of work in these boundaries and you will be safe within this.

It [session time] was at a set time each week and she knew I would be coming.

[I give some] information about my role and the work that I do and making it safe for them you know, giving them some information about boundaries, about confidentiality and the fact that what they were going to share with me, wanting to confirm them.. I think they needed to know where the information was going to.

Confidentiality:

Confidentiality was assured during the first visit, it was important to give them control.

I guess the thing is that you set the scene, then whatever is said is confidential.

giving them some information about boundaries, about confidentiality and the fact that what they were going to share with me, wanting to confirm them.. I think they needed to know where the information was going to.

Worker style: listening skills

Hearing beyond words (hypotheses and intuition):

It felt like these were unresolved things and there were certain links with childhood, the past, certain words that kept cropping up... there are sort of indicators.
The hypothesis that I had was that this [A] had happened... that for me was a major consideration that had to be checked out.

As early as the second visit I may get some feelings about abuse. When this happens safety and own control is reinforced.

Sometimes you 'know' there's more there, and its going to be after one or two visits that you are really going to come to the nitty gritty of what's going on the really.

I'd gone in knowing this was a possibility that she'd been abused from reading the notes ['directors' in notes] and I'd had a couple of meetings with her before where she hadn't actually said anything but I felt as though I was being tested. You get the sense of- that you're being tested out.

I recognised quite early on that there was an underlying problem.
... there were suspicions about her relationship with her husband who was her carer.
.... it was the sort of patient when you thought (indrawn breath).. this doesn't quite fit.
[we] suspected something and that I think was why I was listening to her.. I think the antennae were sharp.
I knew at some point what she was going to tell us was about some from of sexual abuse long before she actually did, now how, I don't know, its one of those intangible things.
.. and from then on [following hypothesis of abuse] I had to be terribly careful not to feed her things because she was so uncommunicative, I mean, you know, it would have been very, very easy to, you know, set up a sentence and said, 'is that right?'
I had two intuitions really which changed you know, I had to revise that.

.. it was just a feeling that there's more to this than she is actually saying, there is more.. there was a sense of incompleteness, of unfinished business.

I remember feeling a sort of it wasn't quite natural [her relationship with her father] it made me feel a little bit uneasy.
Its a feeling of it not being quite a natural relationship you know, I mean there's a way of talking that a girl might have of talking about her relationship with her father which would feel appropriate or not feel quite right, and I remember feeling that it was not - something slightly unnatural.

I felt intuitively with quite a few of my people that there is something in the past and I've also felt the blockages are up.
They talk about emotional sort of abuse and how it made them feel and quite often its come into my mind that, you know, there's more to it than that.

Intuition: cont.

it happened by piecing together the fact that it had been something during adolescence, it has been something to do with her father, something that she was not allowed to tell about, something that made her feel guilty, something that her brother was involved with, something that her mother didn't know about and quite clearly it had started when her mother was ill.

Hearing 'directors':

Sometimes there are leading questions from the client. Its as if they are talking and holding back. For example, one woman said "Its very hard, you never know what happens at a very young age"

there were certain links with childhood, the past, certain words that kept cropping up... there are sort of indicators.

I'd gone in thinking, if she does make any comments at all today I will pick up on that 'cos I felt as though the sessions that I'd seen her before she was testing.

If you're not picking up on them [directors] the woman's not going to disclose... I think she'd try it a few times and in the end she would just shut off.

Every time, she locked the door, but then she threw you the key.
Then she'd just say 'yes', and she wouldn't tell you any more, so you'd, you'd go on for a bit and then you'd think, oh, she doesn't want to answer you know, just sort of leave it, and then she'd say it again, she'd start again.

..its the way people will talk about their childhood, their upbringing. Quite often here older people talk about more emotional abuse from their parents.. and I've come across several women that seem to be - that seems to affect the way they are now. They talk about emotional sort of abuse and how it made them fell and quite often its come into my mind that, you know, there's more to it than that.
The one that I've got in mind, she says things like, 'it all goes back to my father, my problems all started with my father, he was rotten to me he was so strict.
She came back and said that it was something like that things had been buried for so long that she didn't feel she wanted to rake it up and work on it, you know, that sort of thing. You could almost see something was there.

Tracking or following topic:

I may have said, 'Do you mean sexual interfering?' and she said yes.

Allowing them to reminisce about their life and showing an interest in that

[I] kept bringing it back to 'What was happening with dad? Where were you? Where was mum?

Pacing:

Allowing them to reminisce about their life and showing an interest in that

All the time thinking, well, maybe thats as far as she wants to go and sort of backing off a bit, and she would say it again.

Worker style: Global response:

Non-judgemental:

I think they came to trust me and like me. I do listen, I am a good listener, and showing empathy and being non-judgemental.

It is a way I try to work with my clients is whatever their framework is, whatever their life experience, I value them as a person and I don't judge. Other things which help I think is a feeling of being valued.

I gave her my time initially... I made no judgements at all on what she said to me, I felt like I respected the things she said.

I feel I ought to make it as safe as possible for them because I suppose I recognise that perhaps they are going to feel, you know,, that I am not going to listen, or not going to hear what they are saying.

Empathic:

I think they came to trust me and like me. I do listen, I am a good listener, and showing empathy and being non-judgemental.

Initially, when hearing about their original disclosures and the reactions, I was feeling their anger for them really.

Genuine interest:

A genuine interest was they key thing really, a genuine interest in them as a person and their whole life

Validates client's reality of her history.

Worker style: specific response

Follows directors:

I may have said, 'Do you mean sexual interfering?' and she said yes. Generalised questions back [in response to 'directors'] give them the opportunity to say things.... eg what was your childhood like? or do you want to talk about your childhood?

.. so then I am wondering whether to perhaps go any further with it to draw attention to it [director] or just to let it go.

Observes non-verbal cues:

The space between you also feels important, sitting at more of a distance at the beginning and then closer over time
[non verbal cues at the point of disclosure] There is a difference between their body language and what they are actually saying. Its like they are regressing back to the time they are about to tell you about

.. not so much saying things, but being aware of the way she's talking and feeding back things she's saying to me. .

.. because in the end I said 'where did it hurt?' and ... and at that point where she actually said it, was by pointing towards her.. between the legs.. and that was the sexual part of her.
.. just occasionally she would look up and you'd suddenly find her looking up at one or the other of us.
she was very unresponsive when you spoke to her and never really looked people in the eye, she always looked at your left shoulder.

The extreme quietness with which she told me [about abuse from partner, A suspected], was like a sort of decent into a very, very very quiet place, and her voice became very very far away and it was almost like she was on the edge of .. kind of.. of her sense of not having any being at all as she told me.
..it sort of occurred to me that it was the.. her terror at uttering these things about her husband or just her going so far into herself to sort of collect the images and reproduce them.

Reflects back:

For me it was the kind of knot in the stomach job, its still usually the knot in your stomach and alarm bells in your head... and the alarm bell in my head is 'Oh, I need to listen to this' its like the alarm bell to 'wake up' and be ready for this one.
.. not so much saying things, but being aware of the way she's talking and feeding back things she's saying to me. .

Pacing:

I try to help them feel relaxed and comfortable
As early as the second visit I may get some feelings about abuse. When this happens safety and own control is reinforced.

It was quite clear there were issues but it was up to her whether she wanted to work on it.

[Its important to be] giving them options and choices because they're not going to know that they've go any choices at that point because they are going to be powerless, so a helpful thing to do would be to start the process off in a good way, a respectful way.

I actually checked with her, I said, 'do you want to talk about this' and she'd say 'yes', so there were some points when I actually asked her as

well as just waiting for her.
Sometimes we went over the same ground.

Indirect enquiry:

I have never asked about abuse as a direct question, but used generalised comments like 'some people'

I never ask outright because I feel that's their right to tell when they feel like it. I respect what they feel and if they're choosing not to tell me at that point, thats , thats their choice and I will not push them into that.. it needs to be in their time.

.. because in the end I said 'where did it hurt?'

Direct enquiry:

I may have said, 'Do you mean sexual interfering?' and she said yes.

Its more a problem for us about asking the question in the first place which is about disclosure for me. I am sure its about workers not asking direct questions to check it out.
[if you don't ask directly] .. all you are doing is maintaining that circularity and you're also doing what other people outside do.

Other:
Validation:

Once someone has disclosed I acknowledge the difficulty and pain and thank them for telling me that

Client: historical life events:

Death of partner (over 2 years)

and her husband committed suicide (client 1)
Her husband committed suicide. (client 2)

Multiple losses

it was like coming to terms with her whole life really, doing everything in order, and her husband committed suicide so she started with that. She'd lost two children and it eventually came out that she was abused as a child by her father as well. She was abused by her father, she was abused by her first husband, lost her two children because they were divorced and broke off family ties. Her second husband also abused her sexually and physically. (client 1)
Her husband committed suicide, she was abused by her father and then (physically abused) by her son. (client 2)

Abused by partner

She was abused by her father, she was abused by her first husband, lost her two children because they were divorced and broke off family ties. Her second husband also abused her sexually and physically. (client 1)

There were suspicions [of abuse] about her relationship with her husband, who was her carer.

I think she clearly saw herself as having been abused - she didn't use that word - by her husband. She used words like, 'forced himself on,', 'took me by surprise', 'took advantage of me'.
[above acts took place] at knife point.

Abused by other (not A)

... and then (physically abused) by her son. (client 2)

Previous attempt to disclose, negative experience

[had not attempted to disclose] she said her mother wouldn't have believed her.

Some have never told a soul, and they are in their 80's

.. what she did do, she did say to her friends something about a special relationship with dad, and they laughed at her and that goes back prior to teenage years so she never said any more, she thought it was quite normal what was happening so she didn't disclose it, didn't say anything else.

When both women had tried to tell someone what happened in their earlier lives, it had been put under the carpet, with her mother saying, 'don't worry about it, its happened, now, lets get on with your life'. That happened to both of them, I know that one of them, the mother said 'you are imagining things, making it up' and said to them 'forget about it'. The other one had similar feedback from her mother.

.. I said - 'Have you ever told anybody before?' and she said 'no' - I said 'What about one of your psychiatrists?' and another one of her [few] sentences came out, she said, 'they didn't listen'
.. she promised not to tell, and the punishment was going to be the telling.

Client: Health history: (phys/behav/affect)

Epilepsy.
Epilepsy attributed to the abuse.

Multiple minor ailments:

Seen as a 'cry for help'

Appetitive disorder:

She had at various times put herself on bizarre diets.

Episodes of depression:

She had a history of manic depression

Agoraphobia:

She was talking about being in her bedroom for months on end and not actually coming out because she was afraid to go out.

Hostility:

She was very abusive, verbally abusive and became physically abusive as well [description connected with staff attempting to moderate (control) her smoking.

Fear:

she attended an anxiety management group.

[she was afraid] of being alone

Fear of abusive husband.

Other:

Psychiatric history:

We knew very early on that she'd had a previous and very long history of psychiatric problems and long periods of in-patient treatment... [it was] knowing some of those things that had happened to her in the past that provided me with a key later on to be able to help her talk about what was really bothering her.

Long psychiatric history, paranoia, suicide attempts.

Client: current life events:

Re-location:

[she had] recently moved to the area from up country and tried making a new start.

[she] had recently been admitted to a nursing home [where she disclosed].

.. and she had to go into a nursing home and she's had to come to terms with that as well.. and that was her biggest fear.

The readiness to disclose seems to come about as a result of other processes as well, things which start a person to go through the bereavement process, whatever losses or whatever traumatic experiences, then it seems to bring those issues up again, and moving from their own home to residential care.
.. its also the thing about control as well. I think maybe as a child certainly if you're being subjected to abuse you have no sense of control of your destiny much, as a child anyway, but to have your body taken over and used by somebody else totally reinforces that you have no control over your own life. And what happens to you as an adult - an older adult moving into residential care, there's also an echo of that feeling - I have no control over this, society doesn't allow me to stay in my home, make it possible, and again things are being done to me, and maybe like medical procedures, catheterisation, that's another example of those reinforcements .... echoing from childhood, lack of control.

Serious illness of close family member:

I think the whole thing would have been different I suspect if he [husband] had not been taken ill because I wouldn't have had the same reasons for being there and he was very protective of her and didn't want people to see her when he wasn't there.
The disclosure took place sometime later [when husband in hospital]

Recent close bereavement:

... and her husband committed suicide.

symptoms of fear of being alone and agoraphobia began following the death of her husband.

Her husband had died a few months earlier. She was frightened by him, he was a very frightening presence in her life... even after death clearly he was frightening, making her feel guilty.

[recent death] .. of her husband.

Exacerbation of physical or mental health problems:

.. she's just flipped her lid and we've had to section her.

She'd been very, very agitated indeed and things had gone really right up the chute again and she was in a really bad state....[this] coincided with the time her husband came out of hospital.... It was within a day of his first visit to her at the nursing home that she started to get very, very agitated, to, to exhibit some very infantile behaviour, she wanted to be fed and all sorts of things.

Decreasing mobility:

.. her MS exacerbated to such an extent that we couldn't do much for her.

She came in with decreased mobility and virtually bed-bound.

Increasing dependence:

.. her MS exacerbated to such an extent that we couldn't do much for her.

She came in with decreased mobility and virtually bed-bound.

Social isolation:

... on their own with their own thoughts and probably been thinking these things through on their own day after day.

This lady come in with general worries first of all feeling lonely and isolated.

She'd been slightly excluded from the sort of normal lounge [in nursing home] where people were because it [religious delusions] were too distressing for some of the other people.
[her husband] had been known to refuse to allow help into the house although she was physically dependent and would qualify for help from social services.

[her children] were very resentful of her [believed she had brought abusive fathers' early death] and wanted to have her admitted to a psychiatric unit, believed her to be 'mad'.

Peer support:
.. and her friend actually said that it would be a good idea to see somebody.

Client: current health: (phys/behav/affect)

Singlehood and relationality:

.. and she's actually disclosed her abuse and how this has affected her whole life - she's unmarried - she actually partly is unmarried because she stayed and looked after her father. [re: client she knew who had disclosed elsewhere]
.. sometimes you can actually see it in relationships with men, throughout, you know, throughout their life.

.. the sorts of things that happened in their lives as a result of the abuse, things like one of the ladies saying she had a poor sexual relationship with her husband.

[she] never got the job she felt she could have done and also could never have a relationship [through caring for perpetrator father]

Decrease in quality of physical or mental health:

.. she's just flipped her lid and we've had to section her.
.. her MS exacerbated to such an extent that we couldn't do much for her.

She was seen by the family and by the psychiatric services at different times as being mad... she was psychotic.. and I got involved at a time when her family were trying to have her committed to hospital as they were absolutely certain that she was mad.
There were elements of paranoia.. and a strange sort of irrational behaviour that wasn't actually psychotic, like she would spend two or three hours in the lavatory sort of dealing with.. saying that she'd got a terrible problem in her rectum and in fact when medical tests were done she had noth - no problem at all.

Depression:

In one case the lady was quite depressed, she just wanted to - it was like coming to terms with her whole life really, doing everything in order, and her husband committed suicide so she started with that. She'd lost two children and it eventually came out that she was abused as a child by her father as well.

[She was] referred with general worries, query depression.

Housebound:
She became very housebound, her MS exacerbated to such an extent that we couldn't do much for her.

She was afraid to go out alone and afraid to stay in alone.

She came in with decreased mobility and virtually bed-bound.

Appetitive problems:

.. she just ate and ate and went up to 30 stone.

Low esteem (incl. guilt/shame):

she hasn't got a lot of self-worth

she needed constant encouragement from the staff.

Both of them were self blaming and punishing, not only punishing themselves because of what had happened, but like a double punishment, punishing themselves now through not being in control.

Overt distress:

She'd been very, very agitated indeed and things had gone really right up the chute again and she was in a really bad state.

Anger;

.. she was so distraught and quite destructive.
Intense anger:
.. and she was very angry, very very angry with her father.
She is so furious she doesn't know what to do with her anger - she's been abused by men all her life and controlled by them and yet devastated that the one she was married to has died.

[why did you suspect abuse?] I think maybe it was the anger and the uncontrollable grief, more than one would expect in the situation, that she was in much more anger and much more grief, and so controlled, .. sort of saying, oh, I musn't do this and suddenly she put the lid back on it again.

I sometimes wonder about anger, you know, in people when there's sometime suppressed anger whether that's due to some sort of abuse in the past. She's so angry.. [and throws things at me] she threw this pile of underwear at me her daughter was supposed to have tampered with.

I feel there is a sense of anger and resentment [towards non-perp. mother].. [she says] if only she [mother] had listened and talked to me then, perhaps I wouldn't have had this life that I have had now.

Anxiety:

she attended an anxiety management group.

There's sometimes little things about their cleanliness and hygiene.. just being a bit obsessional about it.. some things about what's a sense of right and proper.. a structure and the way things are perhaps organised and under control.

Flattened affect;

She had a very flat affect, completely, she was very unresponsive when you spoke to her and never really looked people in the eye, she always looked at your left shoulder.

Fear:

She had this feeling of fear... that she was not going to be allowed to die, that she was just, she was going to be kept alive for ever and not be allowed a place in Heaven, so it was very very painful for her, dreadful, agony really.

She was afraid to go out alone and afraid to be in the house alone.

She operated at night because it was safer, she moved house all the time.

Client: life stage tasks:

Life review:

In all three cases, I would say it [disclosure] was part of a life reminiscence.
I was there at the right moment in their lives when they are reviewing their worth really, and that's when they're usually lonely.

Use of genogram over the first few weeks helped to look at family [of origin] dynamics.

Sometimes when they start to think about their growing up it just sort of jangles a little bit, and.. makes you think that there maybe something that isn't quite right.

Facing mortality:

Reminiscing about their lives and putting it in order, you know, before their death. Its definitely coming to terms with the end of their lives.

'Self' disclosure:

.. disclosing to themselves first and then sharing it with me. They're sitting with their thoughts and reminiscing on their life patterns.

Disclosure dynamics I: Learning to trust:

Worker consistency:
She did know that I was going to turn up again, I think perhaps that's something she took more notice of than I perhaps saw a the time.

Time to talk:

[How does trust develop?] You're going into someone's home. People are grateful for very little, as an OT I would make life a bit easier, more independence 'cause most of them are lonely, say yes to a cup of tea [and] just talking around different issues over a period of time.

We're looking at four or five sessions to get to the question about childhood sexual abuse.

[she disclosed after] about seven or eight weeks during which, the times at which I had seen her had been quite significant.

Being taken seriously:

both had disclosed to their GP's prior to disclosing to me, so I think the process was helped because they already felt that the problem had been recognised, with value given to it.

Disclosure dynamic II: Tentative engagement:

Vague 'directors'

Sometimes there are leading questions from the client. Its as if they are talking and holding back. For example, one woman said "Its very hard, you never know what happens at a very young age"

I don't think she said sexual abuse or anything like that .. I think she said something about her father wasn't very pleasant, had interfered with her a lot.
I think they give off clues really, they'll share so much and then they'll stop and often.. 'Oh, I'm wasting your time, you're very busy.

There were certain links with childhood, the past, certain words that kept cropping up .. there were sort of indicators.

sometimes women will say 'Oh of course my childhood wasn't very good'.
[just before disclosure] she was still testing, still trying to work out whether she could trust me or not, so she was very hesitant to begin with because she was talking about leaving the bedroom, being scared of big adults, I believe my question was 'can you think of a time when you were scared of an adult?, which is a very open question, she could have said 'it was yesterday in the shop', or 'it was my father' and she said 'it was my father.

Every time she locked the door but then she threw you the key.
[in response to question as to why the diet] 'I did something dreadful'

.. it is like a cry for help thing that's sort of saying, I'll let a little bit out and then I just want to see what your reaction is so if I do it this way its sort of, I can't control it but really I can.

I realised there was a relationship there which had, which she.. at the very least sort of experienced as ambivalent you know... it made me feel a little bit uneasy, and then later, she told me about his extreme anger and she'd actually made a suicide attempt.

'Stopping' (hesitancy or retractions of directors)

.. and a lot just say, 'am I boring you?'
they'll share so much and then they'll stop and often.. 'Oh, I'm wasting your time, you're very busy.

Every time she locked the door but then she threw you the key.

There is this thing of putting the lid back on it and being frightened to let the lid off because everything will go out of control then.

.. it almost feels like they stop short - you know, like there's more, you just get the feeling there's more to be said.
The classic sort of cut off is - 'oh you don't want to hear about this, I'm sure you get much worse people, but anyway that's my sad story'.

Non verbal cues

Just before disclosure its almost as though they are not actually with you. There is a difference between their body language and what they are actually saying. Its like they are regressing back to the time they are about to tell you about

[prior to disclosure] emotional intensity increased in the room in the session when the client disclosed .. she was quieter, a lot more thinking.. and then [she] said she wanted to say something about her father that she's never spoken to anybody else about.

..all this time she rarely looked at either of us just occasionally she would look up and check and you'd suddenly find her looking up at one or other of us.

The extreme quietness with which she told me [about abuse from partner, A suspected], was like a sort of decent into a very, very very quiet place, and her voice became very very far away and it was almost like she was on the edge of .. kind of.. of her sense of not having any being at all as she told me.
..it sort of occurred to me that it was the.. her terror at uttering these things about her husband or just her going so far into herself to sort of collect the images and reproduce them.

Disclosure dynamics III: style of disclosure:
Indirect:

Other [emotional] abuse disclosed prior to sexual abuse.

I mean, we say disclosure but she never actually said 'I was sexually abused', or 'my father did this', or - it was never like that. at that point where she actually said, it was by pointing towards her - between the legs - and that was the sexual part of her.

'it was my father' [whom she was afraid of].

Sequential:

.. it was a sort of progression, [the disclosure] it was a bit like a snowball you know, that the more you picked up, the more you thought, oh no, that, that you were aware that she was going to tell you something and it just sort of got bigger and bigger.

Direct:

.. well, its very vague now but I just went in and did what I had to do there and she asked me to sit down for a cup of tea which I did . . we were just talking about the old days and about her family and she seemed a bit depressed and lonely and then she just started on about her life, she mentioned things from her childhood. .and about how she met her husband and what happy lives they'd had and how he died. . and then she just came out with it, she'd had a very sad life and that she was abused as a child - she didn't seem embarrassed about it, that was the - yes, very direct.

Society and media:

Recent publicity with the TV and media has been important to the women who have disclosed to me. Over 50% have felt that the message for them from the media was that its OK to talk about it, that it stirs it up and although its difficult to try to watch, they are hearing that its not their fault for the first time.

People were genuinely recognising the implications of abuse in childhood through the media really, you know, through television programmes like Esther Ranzen and Childline and reading things in the paper and seeing television programmes about it made them realise that they wouldn't be so mad to actually want to talk about it.

Society and taboo:

Usually they having tried telling and often saying things like, 'It has been taboo' and pushed it out of their minds, or, 'what's done is done and you can't undo it'.

It goes back to the social upbringing, the whole thing about sex and taboo.. where there's been a lot of conditioning, so I think its a lot more difficult to get into the issues.

The person who's disclosing is aware of all those social pressures, so its really important that the person doesn't give any of those signals at all that society is prone to do, all those sort of rebuffs just reinforce the major message that society gives which is, its your fault if you get abused.
.. its that sort of far reaching effect that is what had got to be achieved before many women feel safe to disclose, particularly older women who were so socialised into being submissive - not talking about anything quite nice.
I mean, you can talk about smelly feet or other disgusting body habits but you can never ever talk about being abused its just too disgusting to share.

Culture/society: religion:

... [she describes] 'he was rotten to me and he was so strict' and she talks a lot about religion, her father was very religious.

The other woman [of two clients] believes she is to blame, believes she has an evil part to her.

The form of her distress and delusions were taking, was that she - it was very bound up with a, a very strong religious connotation.. the form that her agitation was taking was that she was going to be denied from going to Heaven because she was so bad.. she saw her stroke as self punishment.
.. and the fact that she promised not to tell and her punishment was going to be the telling.

AN EXAMPLE OF DISCLOSURE:

Hearing 'beyond words' (intuition and hypotheses); hearing 'directors':

[Interviewee:]
.. the actual disclosure.. .happened by piecing together the fact that it had been something during adolescence it had been something with her father, something that she was not allowed to tell about, something that made her feel guilty, something that her brother was involved with, something that her mother didn't know about and quite clearly it had started when her mother was ill and her mother had been looked after at home most of the time, but it had gone on for a number of years, and it was sometimes day, sometimes night and she couldn't, made to promise not to tell anybody

Following directors and indirect enquiry:

.. and I said, 'was it something that hurt?' and she said "Yes it hurt" and I said 'was it something that hurt physically?' and she'd say "yes", and we'd say 'did it hurt you in yourself as well did it hurt you as a person' and she'd say "yes", so it was very much a sort of, just a step-by-step sort of thing and then we actually and then I at one point I said .. 'is it something.. ' - 'cause it was so difficult not to feed her - in the end I said 'where did it hurt?'

Non-verbal disclosure:

and she said there - (interviewee points towards her genital region) that's not what she said, she didn't even say, down here or down there, thats all she did. At that point where she actually said it was by pointing towards her - between the legs - and that was the sexual part of her.

Client 'stops' and returns to associated fears:

Yeh, thats all she did and you know that you just dealt with her own personal (inaudible on tape) and it was heartbreaking because she still would go back then to these awful things and how she put herself on this diet and that she would not be able to have a place in Heaven because of what a dreadful thing she'd done.

Client's non verbal behaviour:

.. and all this time she very rarely looked at either of us just occasionally she would look up and check and you'd suddenly find her looking up at one or other of us. I think she was testing us to see if we were still there.

Why the silence?:

It was one of the other questions fairly soon after this I said, 'Have you ever told anybody before?' and she said "no" I said, 'what about one of your psychiatrists?' and another of her sentences came out, she said, "they didn't listen".

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