

BMJ Open Believe #metoo: sexual violence and interpersonal disclosure experiences among women attending a sexual assault service in Australia: a mixed-methods study

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ABSTRACT

Objectives Sexual abuse is a strong predictor of future psychiatric problems. A more nuanced qualitative understanding of mental health outcomes, in the context of interpersonal responses from family members towards survivors after sexual abuse, may help to better inform prevention and interventions.

Design A mixed-methods approach included a qualitative timeline method to map and identify contextual factors and mediating emotional responses associated with mental disorder following sexual abuse.

Setting Participants were adult survivors of sexual abuse, seeking support from the Sexual Assault Counselling Service, Sydney Local Health District, Australia.

Participants Thirty women 18 years and older with current or past mental disorder or symptoms were interviewed between August 2015 and May 2016.

Outcome measures A qualitative timeline interview and the Mini-International Neuropsychiatric Interview (MINI, 5.5.0) were applied.

Results The MINI prevalence of current post-traumatic stress disorder was 96.6% (n=28) and of major depressive disorder was 82.8% (n=24). More than half (53%) reported suicidal ideation at some time in their lives. Women exposed to childhood sexual abuse reported being ignored, not believed, or threatened with retribution on disclosing the abuse to others, usually adult family members, at or close to the time of the violation(s). Participants described experiences of self-blame, betrayal, and psychosocial vulnerability as being the responses that connected negative disclosure experiences with mental disorder. Participant accounts suggest that these reactions created the foundations for both immediate and long-term adverse psychological outcomes.

Conclusion A more in-depth understanding of the type and emotional impact of negative responses to disclosure by parents and other family members, and the barriers to adequate support, validation and trust, may inform strategies to avert much of the longer-term emotional difficulties and risks that survivors encounter following childhood abuse experiences. These issues should receive closer attention in research, policy, and practice.

Strengths and limitations of this study

- The study's descriptive data support existing evidence and offer new knowledge concerning girl's disclosure of sexual abuse to parents and family members, and the association with adverse mental health outcomes.
- The qualitative method complied with guidelines for qualitative research, facilitating the description of rich case examples that illustrated some key aspects of the nature of mentally harmful disclosure experiences, including being ignored, not believed, and threatened.
- We acknowledge the non-representative nature of the sample which limits the generalisability of our findings to the wider population of women who have been sexually abused.
- The sample size limits the extent to which the quantitative data could be analysed, noting, however, that the objective in using the Mini-International Neuropsychiatric Interview was to provide an adjunct to the clinical interview in systematically recording relevant common mental disorders.

INTRODUCTION

The #metoo campaign symbolises a belated gender revolution, potentially transforming the pervasive culture of silence and disbelief regarding the sexual abuse of women into one of open public disclosure and acknowledgement. In the wake of global revelations concerning the predatory behaviour of men in positions of power, including in the medical profession, there is an unprecedented opportunity to break the silence for all women exposed to abuse.¹ This potential change in public health policy will be facilitated by supporting research capable of providing more precise data concerning the impact of experiences of abuse on the mental health of survivors across the lifespan in a manner

that identifies key milestones and their consequences in the aftermath, specifically in relation to the sequence of disclosure, family responses to these revelations and the impact of the latter on mental health outcomes both in the immediate and longer-term. An important question that requires more precise definition and analysis concerns the nature of interpersonal responses from family members and the extent to which negative reactions to sexual abuse disclosure play a role in exacerbating adverse mental health outcomes. We applied an in-depth qualitative timeline method to plot the chronological relationship of key traumatic events, interpersonal reactions to disclosure, and the mental health of the girl or young woman over her lifespan. Participants were women attending a hospital-based sexual assault counselling service in Sydney, Australia.

There is ample evidence that sexual abuse is widespread among women. A meta-analysis of prevalence studies found that 24% of adult women globally report exposure to sexual abuse in childhood.² A now substantial body of epidemiological evidence confirms a robust association between exposure to sexual abuse and the occurrence of a wide range of common mental disorders and adverse psychosocial outcomes among women victims, particularly related to depression, post-traumatic stress disorder (PTSD), and suicidal behaviour, occurring both in the short and longer term.^{3–10} Whereas many women are resilient and able to avoid the negative mental health impacts of sexual assault, epidemiological data indicate that the risk of such adverse outcomes following abuse is high.⁷ As such, preventing childhood sexual abuse represents an important focus for public mental health programmes aiming to improve mental health. A further strategy that may avert adverse mental health outcomes is to ensure that girls and young women who disclose sexual abuse are believed and supported in a manner that increases their security and safety.

Despite the limitations of the retrospective method, it may be possible to obtain vital information from adults concerning the chronology of events and interpersonal reactions to disclosure after childhood sexual abuse. For example, retrospective reports indicate that young girls are at high risk of sexual abuse and commonly experience the first onset of mental disorder soon after the event, in many instances a reaction that can lead to recurrent or chronic symptoms.¹¹ As time progresses, the sequence and interaction of mutually reinforcing factors can become complex, particularly in relation to sexual revictimisation, exposure to other forms of trauma and stressors, and the persistence or relapse of mental disorder; a pattern that can become lifelong and lead to substantial disability.^{12–13} These observations suggest that early therapeutic interventions, that is, soon after the first exposure to abuse, may be critical to preventing this harmful trajectory.

There is some evidence indicating that when young girls and women are believed and responded to in an appropriate manner following disclosure of sexual abuse, further intervention, such as the provision of counselling,

is more likely to be successful.¹⁴ Conversely, studies have reported an association between negative disclosure experiences and higher risk of onset of mental disorder, such as PTSD.^{15–16} As yet, however, there are few studies that have sought to qualitatively understand the possible range of sexual assault disclosure responses from parents and relatives (the most likely confidantes), the survivor's associated emotional reaction and subsequent mental disorder as she progresses into adulthood.^{17–18}

In addressing this issue, it is important to specify the way key terms are applied. The term 'sexual abuse' in our study is used in accordance with the WHO's definition. It refers to all forms of sexual assault including rape or attempted rape, unwanted sexual contact, or being subjected to threats to perpetrate such acts.¹⁹ We use the terms 'victim' and 'survivor' interchangeably according to the context. The terms 'mediating emotional responses' and 'mechanisms' are both used to describe emotional reactions following disclosure and leading to mental disorder. Mental disorder and associated symptoms refer to common categories identified in the present study, as elicited by a structured diagnostic instrument, and confirmed in spontaneous accounts of symptoms and associated disability provided by participants in the course of qualitative interviews with professional counsellors experienced in making these diagnoses. The reference point for recording symptoms is the Diagnostic and Statistical Manual of Mental Disorders-IV given that this remained the classification system in use in clinical settings during the course of this study.

Reactions to disclosure from family members

In principle, it would be expected that disclosure of abuse may offer the first step to emotional recovery for the girls or young women in that the emotional support and accurate attribution of culpability to the perpetrator will assist in overcoming feelings of isolation and potential feelings of self-doubt and shame associated with the event. Yet disclosure often evinces unsupportive reactions by others,^{14–20–21} particularly in childhood when one third of these abuses are reported.¹⁸ Girls and young women often delay disclosure for legitimate reasons including anticipation of a negative response from confidantes, and a sense of internal resistance associated with feelings of shame or guilt.²¹ Although it is recognised that parents may not provide an appropriately supportive response to disclosures by children, the precise nature and psychological impact of their responses from the perspective of the survivor require further definition.^{22–23} By tracing the chronological sequence in narrative accounts of events and reactions, it may be possible to throw more light on the relationship between disclosure experiences and the unfolding of mental health outcomes in the short-term and longer-term following abuse.

Several studies have attempted to identify a measurable relationship between disclosure experiences, mental disorder, and the risk of revictimisation.^{5–13–17–18–20–22–24–25} A specific focus has been on negative disclosure, the

woman's experience of shame, and the risk of PTSD symptoms.^{26–28} From a qualitative perspective, the focus has been on disclosure of sexual abuse to professionals and service providers,^{29–31} but these studies have tended not to include sufficient details regarding mental health outcomes in victims. For example, a study identifying either supportive or hostile responses by others to disclosure indicated that this experience influenced the survivor's future decision-making regarding making further disclosures of abuse.³² Other qualitative studies have focused primarily on the dynamic factors that impede or promote disclosure of child sexual abuse, including victims feeling conflicted about their own responsibility for the abuse (this relates to self-blame, discussed below), and anticipation of being blamed or disbelieved.³³

Most studies examining the nature of the responses from family members during childhood have focused on their disbelief.^{17 34} Less attention has been given to attribution of overt blame directed at the victim, and at the extreme, threats made by confidantes, for example, warning the victim that the disclosure will put the safety and the stability of the family as a whole at risk, in order to actively censor or silence the child.

Being exposed to, as well as anticipating, doubt from others can cause women to internalise shame and guilt relating to the event. These feelings of self-blame may be difficult to counter in counselling given victim culpability remains pervasive in society.^{35 36} Women, for example, have had to defend themselves in court against claims of culpability because they were drunk, too trusting, or acting provocatively.^{37 38} Self-blame, reinforced by social norms that attribute responsibility solely to the perpetrator, may therefore act as a powerful mediator of enduring psychological and mental health outcomes in victims. It is possible that relevant pathways to self-blame, and the issues reinforcing that tendency, are not sufficiently explicated in contemporary counselling practices.

Other pathways leading from disclosure to mental disorder

The experience of betrayal is a further factor that may mediate the impact of sexual assault on mental health. 'Betrayal trauma' has been applied where the perpetrator breached trust that should have been expected in the relationship with the victim.³⁹ Less attention has been given to a sense of betrayal experienced when it is the confidante, rather than the perpetrator, who ignores, blames, or silences the victim of sexual abuse. This situation may be particularly confronting to a child, for example, when the disclosure is made to a parent or other older family member in whom the young person has invested complete faith and trust.

One of the recognised consequences of early childhood sexual abuse is that victimised women may also be at risk of revictimisation in later life.²⁵ An important question is whether negative disclosure experiences play a mediating role in the sequence of events that lead to that outcome over the life course. Using a qualitative approach based

on a narrative account of the timeline of events and reactions therefore may assist in clarifying these issues.

Aims

In our qualitative study, we aimed to elicit the survivor's own spontaneous account of the responses of family members to disclosures of sexual abuse; how the survivor in turn responded emotionally to the family member's reaction; and, the influence of that sequence to the unfolding of mental health and related psychosocial problems through later development. To better understand the interpersonal complexity of the survivor's experiences, we applied a qualitative methodology that would enable survivors to explore their experiences in a confidential one-on-one setting with skilled counselors; a process guided by an explicit timeline approach (described hereunder). The specific objectives of the study were to:

1. Document the mental health profile of a cohort of women seeking support from a sexual assault service.
2. Enable disclosure of the sequence of events and responses, and underlying mechanisms, especially related to the disclosure experience, that may have increased risk of mental harm following sexual abuse. We therefore included women experiencing at least one of the common mental disorders assessed.
3. Generate new knowledge that would assist in promoting trauma-informed practice in the sexual assault and wider mental health field.⁴⁰

METHODS

Informing theory

The study complies with Consolidated criteria for reporting qualitative research standards for qualitative and mixed-methods research (COREQ).⁴¹ In relation to the substantive methodology, our study was grounded in the narrative history approach directed in this instance to issues of exposure to sexual assault and subsequent experiences of mental disorder over the course of the woman's lifespan to date.⁴² We aimed to examine reactions and responses to disclosure within a gender-informed rather than a purely psychological framework.^{43–45} A gender framework offers the capacity to combine information garnered within a clinical context with knowledge regarding the wider social factors that may lead to adverse disclosure experiences following sexual abuse, for example, negative parental responses when a child discloses, and the tendency for female victims to resort to blaming themselves.^{44 45} Our inquiry drew impetus from and resonates with the contemporary #metoo movement which has garnered a groundswell of commitment to support the right, and indeed necessity, to speak out about the sexual abuse of women in a manner that critiques the abuse of power in male–female relationships. Our intention was to extend the focus of attention to women who explicitly are neither rich nor famous.

We also apply empirical phenomenology to value women's experiences. The principles of empirical phenomenology hold that a scientific explanation must be grounded in the first-order meanings and experiences of the actors; in this case, women who have been sexually abused.^{46 47} These theoretically supported aims substantiate the importance of a qualitative exploration.

Patient and public involvement

The study was designed and led by mental health professionals with skills in working with sexual assault victims. Patients and the public were not specifically involved in the planning and design of the study, however the research focus on disclosure was shaped by the perspectives of the participants in the course of the broader inquiry. This encouraged participants to explore their historical narratives from a personal and spontaneous perspective, and to offer explanations and speculations regarding the pathways leading from experiences of sexual assault to mental disorder and wider psychosocial difficulties over the course of their lives.

Women attending the sexual assault service were introduced to the study by sexual assault counsellors. The affirming process of sharing stories in the course of our study was noted by their counsellors who continued to consult with women in sessions following the research interview. Participants were asked if they would like to receive information or provide feedback on the study prior to the final analysis. A final report was then sent or made available to all subscribing participants, and the current article will be shared with participants when it is published.

Sampling

We applied a criterion-based sampling strategy to recruit participants at the Sexual Assault Counselling Service, located in the Community Health Service of Sydney Local Health District. Women who met inclusion criteria were 18 years or older whose last experience of sexual assault had occurred at least 1 month earlier and were judged by their counsellors to not be in an immediate emotional crisis that could be worsened by participation. In addition, they met criteria for at least one of the current mental disorders assessed (see hereunder). A woman with a current psychosis was excluded due to difficulty in obtaining a clear narrative (n=1). The team manager met with sexual abuse counsellors to request that they inform eligible clients about the study aims and its value in assisting researchers to understand more about the relationship between sexual assault and mental disorders. Clients expressing agreement were then contacted either in person or by phone by research assistants who provided full information about the study and sought consent from those willing to participate.

Interviews and data analysis were undertaken iteratively, with sampling ceasing when further interviews produced a high level of informational redundancy,

which, in keeping with our broad predictions, occurred once 30 interviews had been conducted.⁴⁸

Procedure

Two experienced mental health professionals were employed as research assistants; one was a social worker and the other a psychologist. The social worker was employed in the sexual assault service which was the recruitment site. The sexual assault service counsellors were engaged by their social work colleague to inform potential participants about the study. The social worker then followed up with clients who agreed in the presence of their counsellor that they wished to be further informed about the study prior to signing consent. Consenting participants were subsequently interviewed by one of the two research assistants. Research assistants applied the Mini-International Neuropsychiatric Interview (MINI; V.5.5.0) via face-to-face interviews as an adjunct to clinical interviews in order to systematically document symptoms of common mental disorders.⁴⁹ We used the timeline qualitative interview method (described below) to enable the counsellor and participant to work together to define actual timepoints where major events occurred (sexual assault, disclosure, the victim's emotional response and her attribution regarding the impact on the onset and course of mental disorder).

Interviews took place in a private room within the central Sydney Sexual Abuse Counselling Service's offices, with only the interviewer and participant present. Interviews were not audio-taped, but detailed notes were written directly onto the visual timeline map and separately recorded by the interviewer (See Timeline method).

Timeline method

The qualitative method involved a timeline format aimed at facilitating the mapping and identification of contextual factors and potentially mediating emotional responses associated with the onset and course of mental disorder following sexual abuse.⁵⁰ On a large sheet of paper, the researcher and participant worked together to plot on a visual timeline the events and emotional reactions of interest to the study, adding extensive notes regarding each element of interest relating to the sequence. The method enabled in-depth recording of interpersonal interactions and the survivor's emotional responses and their associations with mental disorder symptoms across the life-course. A key focus was on the description of events that hindered or helped recovery after the sexual abuse, and those which may have increased the risk for mental disorder or multiple sexual assaults across the lifespan. Specific disclosure experiences that were recorded occurred spontaneously with no prompting by the counsellor. This method enabled researchers to draw tentative temporal connections between the events (sexual abuse), the response of the interpersonal world and the survivor's psychological state, allowing for an

exploration of how each factor might have influenced or impacted on the others.

The timeline interview method and procedure is described in an online report.⁴⁰ Within the mixed-methods approach, the qualitative interview was the primary data source because it provided an account of the descriptive and interpretive associations of women's personal and interpersonal experiences as they affected mental health outcomes following sexual assault.^{51 52} To maintain a specific focus in this paper, we do not include disclosure experiences in extra-familial settings such as in schools, healthcare services or law enforcement.

Analysis

SPSS Version 25 was used to derive mental disorder prevalence rates. Qualitative data were managed using NVivo (QSR International). Data were entered, coded and labelled as themes in NVivo. Data were examined for patterns and sequences directly from large sheets of paper containing the timeline of events and notes. The following steps are consistent with the qualitative data analysis literature.⁵³

We familiarised ourselves with the data, a process which involved reading and re-reading the data, writing down impressions from the quotations and notes taken during the timeline interview, looking for meaning and determining which data conferred value according to the research questions.

Themes or patterns that consist of ideas, concepts, behaviours, interactions and phrases were identified and a 'code' was assigned to those data.

Qualitative studies often use quotations to support themes located in the data. In our study, the historical and social context associated with any quotations from participants was vital to the aim (to identify pathways and mechanisms linking the sexual assault and mental disorder over the life course). On that basis, large transcripts that demonstrated these pathways and mechanisms were entered into NVivo, which was used to organise the data, assign the coding and explore further thematic connections.

On examining the data, the researchers were able to identify illustrative vignettes that represented the themes of interest.

Two research assistants independently identified the themes and sequential patterns. Although the dominant themes were those most often or most compellingly presented, dissonance and ambiguity in the data were judged as potentially valuable in that they helped provide a richer understanding of the contextual and interpersonal factors relevant to our research questions. Minimal discrepancies emerged between the two analysts and these were systematically reconciled via discussions with a third rater.

In keeping with our research aims, we describe vignettes (rather than short participant quotes) to more accurately highlight the mechanisms or the sequence of significant events and related psychological responses.

Ethics

Ethics approval was granted by the South Western Sydney Local Health District Human Research Ethics Committee (15/041).

Personnel, training and supervision

Female research assistants with a master's degree or higher in social work or psychology were selected based on their clinical expertise in counselling and advocacy for women affected by sexual violence, their capacity to reach a high level of technical proficiency and reliability in collecting data, and their commitment to strict ethical standards. Data were collected by two research assistants, who were also investigators. The research assistants completed a 1-day training course on the application of research methods.

The team gave priority to ensuring that the study procedure provided an affirming and positive experience for participants. Referrals to other services, such as specialist mental healthcare, were made if the need was identified during the research interview, however all patients were receiving current ongoing clinical care through the recruitment site, a sexual assault counselling service. Researchers had no connection with participants' clinical care, and data collected for the purposes of the study were not made available to their counsellors.

RESULTS

Demographic and sexual abuse profile

Demographic characteristics of the sample of 30 women are shown in [box 1](#). Mean age of participants was 36 years and 40% were in paid employment.

In almost half the participants, sexual abuse occurred for the first time in childhood. Disclosures of child sexual abuse were most commonly made during childhood to family members. Our study suggests that negative disclosure experiences during childhood are more strongly associated with mental disorder than those made in adulthood.¹⁷

MENTAL HEALTH PROFILE

Mini-International Neuropsychiatric Interview

We derived diagnoses using the MINI Neuropsychiatric Interview supplemented by symptoms disclosed qualitatively during the interview, with the aim of producing a descriptive profile of the help-seeking sample's mental

Box 1 Sample characteristics

- ▶ Number of all participants (all survivors of sexual abuse): 30.
- ▶ Mean Age: 36 years (n=30).
- ▶ Married or in marriage-like relationships: 37% (11 out of 30).
- ▶ Bachelor level or higher university degree: 40% (10 out of 30).
- ▶ Paid employment: 40% (12 out of 30).
- ▶ Experienced rape and/or sexual violence perpetrated by someone not previously known to them: 50% (15 out of 30).

health status. Having any mental disorder was an inclusion criterion for recruitment to our study. PTSD prevalence was 96.6% (n=28) and Major Depressive Disorder was 82.8% (n=24) with substantial overlap or comorbidity as expected.

Qualitative interviews

Self-reported mental health symptoms during qualitative (timeline) interviews provided further insight into the manifestations and course of symptoms, and these qualitative reports provided a high degree of endorsement of the parallel findings obtained from the MINI. Sixteen participants (53%) reported suicidal ideation. Almost all (90%) with suicidal thoughts reported onset of these urges following sexual violence including childhood sexual abuse. Nine women (30%) had attempted suicide. Depressive symptoms occurred in 30 (100%) of the participants at some time following sexual violence. 11 (36%) participants described depressive symptoms prior to the sexual violence. Comorbid symptoms of panic disorder and other anxiety symptoms were also commonly described.

Dominant themes

Childhood exposure to sexual abuse associated with subsequent mental health problems and risk of exposure to sexual abuse in adulthood

Nearly half of the cohort had experienced childhood sexual abuse, either from a family member or from someone known to them but living outside the home. In cases of childhood abuse occurring outside the home by someone previously known, there was almost universal evidence of general neglect in the care and protection of the child in the family. Ten participants (71%) with early childhood sexual abuse reported revictimisation as adults.

As indicated by the details provided hereunder, being ignored, overtly blamed or threatened for the abuse following disclosure appeared from analysis of the timeline interview data to be most closely associated with onset of subsequent mental disorder symptoms and future risk for sexual abuse. Mechanisms linking the disclosure response to the mental disorder were provided by the participants who described feelings of self-blame, psychosocial vulnerability or betrayal as being the emotional responses that connected negative disclosure experiences with mental disorder.

Being ignored or not believed

Instances of being ignored involved either no verbal or emotional response by the confidante (adult member of the family) or lack of any action taken after the revelation was made. Lack of emotional or verbal response or action by a parent or relative was commonly perceived by the victim as not being believed and/or that the parent failed to demonstrate appropriate care. A participant reported that when she disclosed the abuse to her father, he 'went into denial and shut down'. She felt 'very let down and

Table 1 Distribution of disclosure experiences according to confidante/authority

Confidante/authority	Disclosures: ignored	Disclosures: blame or threat
	Number (%)	Number (%)
Police	3 (16)	2 (13)
Parents*	10 (53)	4 (25)
Other close family members*	3 (16)	4 (25)
Fiancé/boyfriend	1 (5)	2 (12)
School counsellors	2 (10)	4 (25)
Total	19 (100)	16 (100)

*Study analysis focused on parents and other close family members.

hurt' by his response. Self-blame was often described as a response to being ignored or not believed at the point of disclosure. In the aforementioned case, the family members to whom the child disclosed appeared to accept the perpetrator (uncle) and his view of events. The perpetrator's perspective was that the victim lied about the sexual assault, and that she was 'crazy'. The victim subsequently blamed herself for the abuse: 'I felt like it was my fault. Like I had given him the wrong message.' *Participant 20 (age 15 at time of sexual abuse, uncle perpetrator)*.

Distribution of disclosure experiences

Seventeen of the 30 participants reported negative disclosure experiences (table 1). Note that two participants reported two disclosures in the ignored category. Five participants reported negative disclosures in both categories (19+16=35).

Being blamed

Blame by family members was often explicit and appeared to be strongly associated with subsequent feelings of self-blame, overt symptoms of mental disorder and suicidal ideation or attempts. Responses of blame included confidante statements such as 'it is your fault because you were drunk' (participant 10) or 'you shouldn't have trusted him' (participant 26).

Being threatened

Disclosure was in some cases met with a direct threat, for example: 'if you say anything it will tear the family apart' (participant B). The implication was that any negative impact resulting from the disclosure (particularly on the family) would be the victim's fault. Threats made by the confidante in relation to potential harm to the family were therefore associated with self-blame. Participant A also experienced a deep sense of betrayal related to a breach of previously assumed trust and support from the relative who responded to her disclosure with a claim of bringing shame on the family.

Protective and recovery factors are described in a previously published report drawing on data from the

present sample.⁴⁰ The sentinel markers for positive change, including alleviation of mental health symptoms, appeared to be exposure to empowering approaches in counselling that challenged a sense of self-blame. Other helpful factors were supportive friends who provided an alternative voice that clearly located culpability with the perpetrator, finding a meaningful and fulfilling occupation, effective criminal justice outcomes in the prosecution of the perpetrator and, in some instances, the use of antidepressant medication to relieve mood disturbances and hence support re-engagement with social activities.

Vignettes

Timeline interviews are intentionally selected to examine temporal associations between factors, such as sexual abuse and mental disorder. Data would lose its intended meaning and effect if decontextualised into short illustrative quotes to communicate the findings, as is common in qualitative studies. We have therefore selected two vignettes with the aim of illustrating the phenomenological mechanisms linking the key events of interest, that is sexual abuse, disclosure and mental illness.

PARTICIPANT A

In participant A's case, sexual abuse was first perpetrated by a family friend and then by her uncle. Common themes in this vignette were disclosure that was ignored, blame and threat of harm to family if the survivor spoke out. The participant made a direct association between negative disclosure-related experiences with those who should have been caring and supportive, and a deeply felt sense of betrayal ultimately leading to self-harm and a suicide attempt.

Her abuse experiences started at 9 years of age. The participant told her father about sexual abuse by a 'family friend' who lived nearby. Her father at the time did not respond to her disclosure. His refusal to respond was evidenced by his silence, and that he continued to be friends and socialise with the perpetrator, including inviting him into their home. Participant A felt that her father did not believe her or did not want to believe her.

Participant A was also sexually abused by her uncle. She disclosed the abuse to her aunt at age 12. Her aunt responded to the disclosure by not believing her story and admonishing her for the claim. The aunt then told participant A that if 'other people knew what happened (it) would bring shame on the family.' The participant later found out (in early adulthood) that her aunt knew of the uncle's history of sexual violence at the time she disclosed to her. She felt deeply betrayed and uncared for. Despite not having any evidence to the contrary to shape her views, the participant had a deep sense of knowing that what had happened to her 'was wrong'. She associated the failed attempt to seek validation and support from her father and then her aunt with a profound sense of betrayal that became destructive. She said these feelings were directly related to subsequent attempts to self-harm.

She left home as a teenager. The trauma and despair led her to attempt suicide. The suicide attempt resulted in hospitalisation, yet the participant did not disclose her history of childhood sexual abuse to medial authorities. She said that in hindsight she felt 'resentment at the system that failed to protect me'. Social isolation led to her being a more vulnerable target for bullies at school. She started using drugs ('a lot of weed') to cope with sexual abuse, bullying and isolation. One turning point in the participant's life was the experience of feeling part of a family and valued as an individual. She was 'taken in' by a friend's mother. The experience of a recovery was associated with 'support from someone who.... reflects on the things about you that are good. Someone who notices your milestones and recognizes your transitions. Who also knows when you fucked up and intervenes to help you'.

The effects of abuse, related betrayal and isolation continued to affect her throughout her adulthood. She described feeling 'lost and vulnerable' and related this to repeated bouts of depression and panic disorder.

PARTICIPANT B

Participant B's story illustrates the predominant theme of not being believed, threat of harm to the family, self-blame, substance use and mental disorder following sexual abuse.

Participant B was sexually abused by her brother at age 8. She recalls him telling her that if she told anyone it 'would tear the family apart'. She internalised a fear of damaging the family and instead blamed herself for the abuse.

At age 8, she told her parents about the brother's sexual abuse. They minimised the abuse and she said there were no repercussions for him. No one mentioned it to her again. By the age of 12, she had developed an eating disorder which she now associates with the self-blame and self-loathing she experienced following the sexual abuse and particularly the absence of having someone to tell her that it was abuse and not her fault. The disorder involved bingeing and purging food, as well as restricting food intake. She was taken to a psychiatrist, who asked if she had been abused by anyone. She remembers saying no because she felt she could not share the memories she had with him.

In the early teenage years, her eating disorder persisted and she started self-harming. She explained, "it was a release and it was soothing in a weird kind of way"; and, "when I cut myself, I could feel the adrenalin, and then I would feel relaxed." She began using cannabis which she said helped her feel better. At the age of 16, she again told her parents about sexual assault by her brother. They quickly dismissed her revelation and told her that she was 'having a nightmare'. Following the disclosure and their response, she experienced insomnia. She said sleep deprivation compounded feelings of self-blame. In early adulthood she suffered from psychosis. The

participant said medication and strategies to ‘manage my overwhelming feelings’ were strengthened by understanding the connection between the denial of abuse and the damaging effects of self-blame. She has resumed contact with her parents and has communicated more to them about the sexual abuse from this new vantage point. She said that her mother is finally ‘realising more what happened to me now’.

DISCUSSION

The insidious nature and high prevalence of sexual abuse have received recent media attention following revelations concerning violations enacted by celebrated and professionally powerful male perpetrators.¹ These cases have generated important public discussion; nevertheless, it is vital to ensure that the focus on sexual abuse by those in positions of power is not confined to those with celebrity and professional status—it is, in fact, a pervasive public health problem across the lifespan for women.^{3 6} This is the first study to undertake in-depth qualitative plotting of interpersonal experiences based on a visual timeline which allowed documenting and elaborating on the possible mediating factors in the sequence of sexual abuse, disclosure experiences in relation to family members and women’s mental health across their life. The qualitative data pointed strongly to an association between negative disclosure responses and adverse mental health and social outcomes over the course of the woman’s life.

Our sample was criterion-based in order to meet the objectives of the study, that is, the women were attendees at a specialised sexual assault service, and all had at least one lifetime common mental disorder. The novel timeline methodology facilitated the collection of in-depth and unique information that can be applied to inform future studies in the field. Common responses to negative disclosure experiences involving family members included being ignored, a reaction which has been described as ‘disbelief’ in other literature; and for the survivor to be explicitly blamed for the abuse at the point of disclosure.^{17 34} We also identified a response to disclosure characterised by threat from the confidante, usually the parent. Threats following disclosure included that the alleged sexual abuse would bring harm to the family in some way. Both vignettes described a threat of harm to the victim’s family related to the disclosure.

We identified possible psychological mechanisms leading from negative disclosure experiences to mental harm. We describe a phenomenological mechanism, where self-blame and at times guilt were associated with being ignored or blamed after disclosure. Our findings highlighted how feelings of betrayal, associated with the trusted parent or relative responding negatively to the disclosure, may be psychologically harmful to the survivor. Previous research has focused on the sense of betrayal relating to the perpetrator being a trusted attachment figure. The present study demonstrates that a different

form of betrayal arises when there is a negative disclosure response by a previously trusted family member.

Overall, our study illustrates the potentially important role that negative disclosure experiences play in generating persisting psychosocial vulnerability in the survivor. Women encountering negative disclosure experiences reported an array of adverse psychosocial outcomes in their subsequent lives including social isolation, drug-taking, recurrent or persisting mental disorder and future risk of abuse, including bullying at school. A general state of psychosocial vulnerability that persists over time may be an important foundation for understanding the risk for adult revictimisation in child survivors of sexual abuse.²⁵ The period immediately following a disclosure, therefore, may prove to be a critical window where survivors are particularly susceptible to effects of either helpful or harmful interventions by confidantes.

Informing communities and families

Promoting education and awareness relating to the risks and consequences of sexual violence against children is vital as a public health measure. Parents need to better understand the importance of responding with affirming and caring responses should they be confronted with disclosures. For this to occur, public campaigns are needed to encourage society as a whole to work towards breaking the silence that protects perpetrators and obscures the pervasive harms caused by sexual abuse against children and women.

Our study also indicates the need for readily available legal and welfare interventions where families knowingly fail to protect or overtly intimidate or threaten children who disclose sexual abuse. Early detection of at-risk children remains a challenge, particularly in families where silence in relation to abuse is the pervasive response. Detection will be facilitated by achieving a high level of awareness and vigilance in identifying hidden sexual abuse and possible negative disclosure experiences across the full array of health, education and welfare professionals most likely to be in contact with children exposed to these violations.

Trauma-informed care

A trauma-informed care approach assists in ensuring that all healthcare practitioners and community agencies are uniformly aware of the psychological and social effects of sexual abuse, and providing them with the knowledge and skills to respond to the needs of the survivor.⁴⁰ Special training should be provided to identify and respond to negative disclosure experiences. Our data offer frontline responders to childhood and adult sexual assault survivors, including social workers, psychologists, psychiatrists, medical practitioners and police officers, a deeper understanding of the possible experiences of survivors who may have been exposed to negative disclosure experiences. In that respect, practitioners need to be apprised of the common types of disclosure responses that their client or patient may have encountered, and to inquire into

and respond appropriately to possible feelings of self-blame, betrayal and psychosocial vulnerability. Inquiring into negative disclosure experiences may be particularly important when survivors have shown a pattern of recurrent or persisting mental disorder, for example, symptoms of PTSD or depression, and/or show a persisting pattern of psychosocial vulnerability such as substance abuse, suicidality and a risk of revictimisation.

Societal change

At a society wide level, cultural and institutional change are needed to overcome denial and silence as a response to sexual abuse occurring in the family. In that sense, from a feminist perspective, there is a close nexus between persisting regressive community values and the microcosm of the family in which gendered victim blaming and silencing occurs, the most likely location for a sexually abused child's first disclosure. The contemporary focus on celebrities and professionals in relation to the global movement to speak out therefore needs to be generalised to everyday life.

In summary, the contemporary public interest in sexual violence, steered by the #metoo movement, has potential power in promoting public acknowledgement of men's culpability rather than women's responsibility. The impetus needs to be harnessed at the community level to overcome denial and victim blaming in the home. In addition, practical responses within services, such as the adoption of a trauma-informed care model, will assist with the incorporation of more targeted interventions for survivors who have been subject to negative disclosure experiences.

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Study reveals negative disclosure experiences of sexual abuse to family members, and how these are linked to mental disorder.

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