

Institutional child sexual abuse and suicidal behaviour:

Outcomes of a literature review, consultation meetings and a qualitative study

*Martina O’Riordan
Dr. Ella Arensman*

National Suicide Research Foundation 2007

The study was commissioned by the National Office for Suicide Prevention



NATIONAL SUICIDE RESEARCH FOUNDATION



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



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Foreword

Reach Out – The National Strategy for Action on Suicide Prevention launched by An Tánaiste and Minister for Health & Children in September 2005, recognises the potential vulnerability of victims of abuse and the need to improve support services.

This research will help to set out a way forward by identifying risk and protective factors for survivors of abuse. It is critical that survivors and the various survivor groups play a central role in determining the nature of the research. However, it is equally important that the research is undertaken by an independent research body such as the National Suicide Research Foundation.

This first phase of the research has given strong indications of what these risk and protective factors are and what improvements to services are required. The second phase of the research will strengthen these initial findings with the experiences of individual survivors.

The value of the research for Ireland will be the continued recognition of the needs of survivors, the value of survivor groups and the importance of continuing to expand the general and specific services available to survivors.

Geoff Day,
Director, National Office for Suicide Prevention.
November, 2007

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Executive Summary

This study was commissioned by the National Office for Suicide Prevention (NOSP) in response to action point 19 in the *Reach Out- National Strategy for Action on Suicide Prevention 2005-2014*. *Reach Out* identified survivors of childhood abuse as a potentially vulnerable group and highlighted the need to increase awareness and improve support services.

This report consists of three parts: 1) a literature review, 2) the outcomes of consultation meetings with survivors of institutional child sexual abuse, and 3) a qualitative study involving specialist support services. The literature review highlights the dearth of research currently in this area, with only three studies internationally focussing directly on institutional child abuse and thirty-six secondary studies looking at long-term effects of child sexual abuse on adult suicidal behaviour and mental health. Group consultation meetings with survivors were held in six different counties with approximately ninety people in attendance. Four individual consultations were also held. Topics discussed at these meetings included life course, situation around time of suicidal thoughts, aspects in relation to the abuse experience and the Redress Board. The qualitative study focussed on the views of the specialist support services on risk and protective factors for suicidal behaviour amongst the survivor population.

On 25th November 2006 a seminar was organised by the NSRF and NOSP in Cork for survivors and representatives from the National Counselling Service, the HSE Mental Health Directorate and the Mental Health Commission. At this seminar the outcomes of the 3 levels of the study were discussed and participants were invited to present their feedback, which is incorporated in the current report.

Key findings and recommendations include:

- There is a lack of studies addressing the relationship between institutional child sexual abuse and suicidal behaviour and related mental health difficulties, as well as protective factors. Future research should focus on the effects of child sexual abuse perpetrated by both adults and by peers.
- Studies focusing on the consequences of child sexual abuse in general have revealed consistent evidence of an association with adult suicidal behaviour, in particular non-fatal, as well as suicide ideation.
- The qualitative study found that alcohol and/or drug abuse and social isolation are major factors associated with suicidal behaviour among survivors of institutional child sexual abuse. A wide range of other, less frequently reported mental health difficulties included inadequate coping skills,

impulsive behaviour, PTSD, anti-climax following attendance at the Redress Board and depression.

- Relationships, children and education were major protective factors identified by the specialist support services. Other less frequently reported protective factors included support from survivor groups, being employed and receiving counselling.
- Considering the wide range of mental health difficulties experienced by survivors of institutional abuse, a multidisciplinary treatment approach is required within the support services. This would include further collaboration with other mental health services and is in accordance with recommendations of the *Vision for Change* Report (2006) .
- The overview of factors obtained through the qualitative study should be further validated by research directly involving people with a history of institutional child sexual abuse, as well as physical and emotional abuse and neglect.
- During consultation, a number of the survivors explained that the experience of being abused in an institution has led to anxiety regarding the possibility of receiving nursing home care in later life. This fear of what might happen to them as they grow older must be given appropriate consideration as a risk factor for suicide ideation among survivors. This also indicates that the long-term effects of being resident in an industrial school during childhood have yet to be fully explored and understood.

Introduction

On 11th May 1999, An Taoiseach Bertie Ahern apologised on behalf of the Irish Government to its citizens who had been abused in institutions as children. Children could be placed in institutional care either by referral from the local health authority, by private arrangement or by order of the courts. These institutions were run by religious orders and funded by the public. From the Industrial Schools Act of 1868 to the eventual decline of industrial schools in 1969, over 105,000 children were placed in this state care system. The number of industrial schools peaked in 1900 with 8,000 children in 71 schools. By 1969 there were 2,000 children in 29 schools. The Cussen Report of 1934 was the first investigation into the operation of the industrial schools. Despite concerns regarding overcrowding and standard of education, Judge Cussen concluded that the system was satisfactory (Raftery & O'Sullivan, 1999). The suitability of the institutional care system came into question again in the late 1960s when allegations of abuse began to emerge in the media. In response to growing criticism the Government commissioned District Justice Eileen Kennedy to conduct the first formal enquiry into the extent of the abuse. The ensuing Kennedy Report of 1970 recommended that institutional care was not appropriate for children. The industrial school system was replaced by foster care in 1984 as payment per head funding for children in industrial schools was abolished. In that year responsibility for the industrial schools was formally transferred from the Department of Education to the Department of Health & Children (Statute Instrument 358 of 1983). However, it was not until media attention in the 1990s with documentaries such as *Dear Daughter* and *States of Fear* that the picture of widespread abuse, deprivation and neglect became evident. Despite similar histories of institutional abuse in countries such as Canada and Australia, the consequences have not been systematically addressed in any research to date.

Studies examining the relationship between childhood trauma and adult suicidal behaviour have reported evidence that the two are frequently linked (Brodsky et al, 2001; Peters & Range, 1995). Twelve of the one hundred young people who were abused in children's homes in Clwyd, North Wales have since taken their own lives (Stein, 2006). The SAVI (Sexual Abuse and Violence in Ireland) Report outlined that 16% of men and 20% of women in Ireland experienced sexual abuse as children (McGee et al, 2002), which can be considered high in the international context. Participants in the SAVI study were also asked if their abuser held a position of authority at the time. Religious ministers and religious teachers constituted the largest single category of authority figures as abusers of boys at 5.8 %. For girls, babysitters constituted the largest group at 4.2%. The prevalence and consequences of sexual abuse of men as opposed to women requires greater attention in research studies. To date there is little information on the long-term effects of child sexual abuse on men's adult mental health and coping strategies.

In Ireland, indications for an association between clerical childhood sexual abuse and suicidal behaviour have been highlighted in the *Ferns Report* (Government Report, 2005). Consequently, the *Reach Out - National Strategy for Action on Suicide Prevention, 2005-2014* has identified survivors of abuse, particularly those from state institutions, as a group that should be prioritised for suicide prevention and mental health promotion initiatives. The strategy states that the problem of non-disclosure, especially in the case of men, further compounds the risk associated with abuse. *Reach Out* has recommended further research, information and training on the risk of suicidal behaviour associated with sexual and/or physical abuse. A further action point from *Reach Out* is an evaluation of the National Counselling Service (NCS) model of counselling service provision. The NCS was established in September 2000 with the aim of listening to, valuing and understanding those who have been abused in childhood, in particular those abused in institutional care (NCS, First Report, 2002). The NCS was established under the former health board system with ten branches nationwide. The service is delivered locally in each area of the Health Services Executive and is intended to be directly accessible and confidential.

As part of the Government's response to addressing the long-term effects of abuse in state institutions the Commission to Inquire into Child Abuse was established in 2000. It was set up with the following primary objectives:

- To investigate abuse of children in institutions, why it happened and who was responsible
- To report directly to the public within two years about what happened in the past; what should be done to help survivors of abuse now; what should be done to protect children not in the care of their parents both now and in the future.

The Commission consisted of two committees: the Confidential Committee and the Investigation Committee. The first involved the disclosure of abuse in a confidential setting without the knowledge or presence of the perpetrator or representatives of the relevant institution. The latter involved a full investigation of the experiences disclosed and the presence of the accused or representatives of the institution who might challenge the account given. Survivors could decide which Committee was most appropriate for themselves. The Redress Board was established under the Residential Institutions Redress Act of 2002 to make 'fair and reasonable awards' to people who experienced childhood abuse in state institutions.

The National Office for Victims of Abuse (NOVA) was set up as part of the overall Government strategy for supporting survivors of institutional abuse. It is funded by the Department of Health and Children. The Management Committee of NOVA comprises representatives of the three main survivor support groups, the Aislinn Centre, Right of Place/Second Chance and Survivors of Child Abuse, United Kingdom (S.O.C.A, UK). The service at NOVA has been suspended on a temporary basis from September 2006 while negotiations are underway regarding its future. The survivor support groups have been instrumental in highlighting the consequences of abuse and the needs of those who experienced institutional abuse.

This report highlights the need for the consequences of institutional child sexual abuse to be explored in a systematic way. It is hoped that in a second phase we will be able to conduct a long-term empirical study addressing physical and emotional abuse along with other risk and protective factors relating to suicide among people who were resident in institutions during childhood.

It is in the absence of any systematic approach towards investigating the relationship between institutional abuse and suicidal behaviour that this study was undertaken. The report includes the outcomes of three studies:

Part I: A review of the literature on the relationship between institutional child sexual abuse and suicidal behaviour

Objectives:

- To examine, through literature review, whether there is a relationship between institutional child sexual abuse, suicidal behaviour and related psychopathology.
- To identify gaps in the available research and evidence.

Part II: Outcomes of consultation meetings with people who experienced institutional child sexual abuse

Objectives:

- To report on the main outcomes and observations from both group and individual meetings with people who experienced institutional child sexual abuse.

Part III: Specialist support services available for people who experienced institutional abuse in Ireland: a qualitative study

Objectives:

- To investigate referral procedures and treatment models provided by the National Counselling Service.
- To obtain information on factors associated with risk of suicidal behaviour as well as protective factors through interviews with health care professionals in the NCS.

Part I: A review of the literature on the relationship between institutional child sexual abuse and suicidal behaviour

Methodology

In order to perform a comprehensive literature review, several keywords were identified and entered as search terms in the relevant databases. The databases searched were: PubMed; PsychINFO; SocINDEX; Science Direct, Child Abuse & Neglect (from 1995 onwards). The keywords focussed on various issues to do with institutional child sexual abuse and suicidal behaviour. The following search terms were used: *institutional abuse, child sexual abuse, clerical abuse, clergy, abuse, residential abuse, industrial schools, reformatories, suicide, suicidal behaviour, self-harm, deliberate self-harm, attempted suicide, overdose, self-injury, self-poisoning, suicide ideation, psychopathology, depression and PTSD.*

In order for a study to be included in the literature review it had to meet one of the following inclusion criteria:

- (1) The study investigated the nature or long-term effects of institutional abuse or child sexual abuse
- (2) The study examined the relationship between institutional abuse/child sexual abuse and suicide, deliberate self-harm and/or suicide ideation

Methodological quality of studies

The methodological quality of the studies was checked against four criteria. These were as follows:

- (1) Operationalisation/definition of institutional abuse or child sexual abuse or suicide ideation, suicide attempt or deliberate self harm
- (2) Selection of the sample
- (3) Measures of institutional abuse or child sexual abuse used
- (4) Appropriate statistical analyses

The studies were rated independently by the two authors and then cross-checked to ensure reliability.

Results

Number of available studies and methodological quality

The literature search revealed three primary studies and forty-five secondary studies, thirty-six of which met the inclusion criteria for review. Four Government reports were also included.

Given that there were four quality criteria, the possible range of quality scores was between 0 and 4. The actual range of scores was from 0.5 to 3.66.

Outcomes of the review

Institutional child sexual abuse and suicidal behaviour

There is a distinct lack of research into the relationship between institutional child sexual abuse and suicidal behaviour. Even in the primary studies, those which specifically refer to child sexual abuse in residential institutions as opposed to abuse in the community, the risk of future suicidal behaviour is only mentioned briefly in one of the three studies. This study refers to media reports of a situation in Clwyd, North Wales where twelve of the one hundred young people who were abused in children's homes there have since taken their own lives (Wolmar, 2000, in Stein, 2006)

Outcome: The relationship between institutional child sexual abuse and adult suicidal behaviour remains unresearched. There is thus a lack of knowledge about the risk and protective factors for suicidal behaviour and deliberate self harm among persons who experienced institutional abuse.

Institutional child sexual abuse and adult mental health

A recent study in Canada by Wolfe et al. (2006) examined the long-term impact of physical and sexual abuse of boys in a religiously-affiliated institution. Of the 76 men who participated, 42% met DSM-IV criteria for current Post Traumatic Stress Disorder, 21% for alcohol and 25% for mood-related disorders. Over one-third of the sample suffered chronic sexual problems and over one half had a history of criminal behaviour. However, the lack of comparison with a control group of non-institutional abuse survivors limits the ability to specify unique patterns of mental health issues pertinent to those who have experienced abuse in institutional settings.

Outcome: Men who had experienced severe abuse as children in an institutional setting demonstrated serious mental health difficulties. The findings suggest that male abuse survivors often attempt to control their distress through substance abuse. They may suffer long-term post traumatic stress symptoms that may interfere with many aspects of daily life, such as employment, family and peer relationships, and self-regulation. This study highlights the importance of mental health professionals becoming familiar with the particular assessment and treatment needs of this group. However, it is limited by the lack of a comparison group of non-institutional abuse experiences.

Childhood sexual abuse and suicidal behaviour

Ystgaard et al (2004) found a 35% prevalence of severe child sexual abuse among suicide attempters consecutively admitted to a hospital in Oslo over 26 months. The odds ratio of exposure to sexual or physical abuse was highest among those who both repeated suicide attempts and self-cutting. However, no follow-up research was undertaken. In a study by Brodsky et al (2001), adult inpatients experiencing a major depressive episode were more likely to have made a suicide attempt if they reported a history of sexual abuse or physical maltreatment. Research into suicidal behaviour among street youth found that sexual abuse and physical maltreatment abuse that occurred prior to leaving home were independent predictors of suicide attempts for both males and females (Molnar et al, 1998). Among adolescents incarcerated at three juvenile detention centres in the US, childhood sexual abuse was found to be an independent predictor of suicidal ideation and non-fatal suicidal behaviour (Esposito & Clum, 2002). In a longitudinal study by Silverman et al (1996) participants who had been abused demonstrated significant impairments in functioning at ages 15 and 21, including emotional-behavioural problems and suicide attempts. Roy (2004) found that patients in treatment programmes for substance abuse, who had first attempted suicide before the age of 20 years, reported significantly more often being sexually abused, along with emotional abuse and physical neglect. In a retrospective medical review of adolescents presenting to an Accident & Emergency department following a suicide attempt, Vajda & Steinbeck (1999) reported that a history of sexual abuse is one of the major risk factors among those most likely to re-attempt suicide within 12 months.

Outcome: International research indicates that childhood sexual abuse is a predictor of adult suicidal behaviour. A lack of follow-up studies following first assessment limits the understanding of other risk factors and protective factors associated with occurrence and prevention of repeated acts of suicidal behaviour.

Childhood sexual abuse and suicide ideation

In a sample of female university students in the US, Gutierrez et al (2000) found a positive relationship between history of abuse, 'repulsion by life' and suicide ideation. Unfortunately, male students were not included in this study. Peters and Range (1995) found that female university students had stronger survival and coping beliefs and more fear of suicide than men. Both men and women who were sexually abused as children had significantly higher levels of suicide ideation as college students compared to those without an abuse history. Sexual abuse by peers was equally associated with adult suicide ideation as sexual abuse by adults. Among a group of male child sexual abuse survivors in the US, Ponton & Goldstein (2004) found that 55% of the sample had symptoms of suicidality.

Outcome: In samples from university students there is a significant link between childhood sexual abuse and suicide ideation. Child sexual abuse by peers has a similar relationship to adult suicidality as sexual abuse by adults. Females appear to have stronger coping mechanisms than males which may be considered a protective factor. However, further research is required to confirm this effect.

Childhood sexual abuse by peers

Shaw et al (2000) found no significant differences between survivors of childhood sexual abuse by peers and that by adults for the type of sexual abuse, penetration or use of force. Peer abuse was more likely to occur in a school setting, a home or a relative's home. Those abused by peers were found to have clinically significant sexual preoccupations and borderline clinically significant symptomatology. Sperry and Gilbert (2005) reported that in comparison to abuse by peers, abuse by adults tended to be more intrusive and intra-familial. However, both groups rated their experiences as equally negative. Participants abused by peers anticipated less support from parents and more anger from mothers.

Outcome: There is evidence to suggest that childhood sexual abuse perpetrated by peers has similar long-term negative effects to abuse by adults.

Childhood sexual abuse and Post Traumatic Stress Disorder (PTSD)

In a sample of adult survivors of child sexual abuse, Rodriguez et al (1996) found that 72% met the DSM-III-R criteria for current PTSD and 86% met the criteria for lifetime PTSD. Peleikis et al (2004) found that child sexual abuse in females increased the risk for PTSD after 16 years. In a sample of female university students, Hetzel and McCanne (2005) and Schaff and McCanne (1998) found that combined childhood sexual abuse and physical maltreatment and sexual abuse only groups reported significantly higher levels of PTSD symptoms than those who experienced physical abuse alone or those without an abuse history. A study in New Zealand by Briggs and Joyce (1997) found that the severity of PTSD symptoms in survivors of child sexual abuse was associated with the severity of the abuse (i.e. whether actual sexual intercourse was involved). Again, this study exclusively focussed on female participants.

Outcome: The research suggests a relationship between child sexual abuse and post traumatic stress disorder in adulthood, with the severity of the abuse linked to the severity of symptoms. Further research with both male and female abuse survivors is required to obtain greater understanding of this link.

Childhood sexual abuse and adult mental health

A study in New Zealand by Mullen et al (1996) found that a history of sexual abuse in females was associated with increased rates of psychopathology, sexual difficulties, decreased self-esteem and interpersonal problems. Similar findings were reported in a study of males in South Africa where child sexual abuse involving physical contact, including any sexual touching, genital contact and penetration was found to be associated with elevated scores on the Brief Symptom Inventory which includes depression, anxiety and interpersonal sensitivity (Collings, 1995). In a study of female outpatients at a psychiatric hospital in the US, 25% of participants with major depression reported a history of child sexual abuse (Zlotnick et al, 2001). Cheasty et al (2000) found that among female patients at three GP practices in Ireland, a positive association existed between severe child sexual abuse and depression - all those who had experienced penetration were depressed as adults. Modestin et al (2005) reported that among medical students at a university in Zurich, sexual abuse predicted borderline pathology and severe child sexual abuse also predicted physical health problems. Tanskanen et al (2004) also identified childhood sexual abuse as being more prevalent among persistent depressives than controls who had no depressive symptoms either at baseline or on follow-up. Similar findings were reported by Wurr and Partridge (1996) in a UK study where 46% of psychiatric inpatients reported a history of childhood sexual abuse.

Outcome: International studies provide evidence that people who have experienced childhood sexual abuse are at risk of developing mental health problems in adult life. These difficulties include depression, sexual difficulties and decreased self-esteem. The need for increased awareness of the long-term effects of child sexual abuse is highlighted.

Childhood sexual abuse and social isolation

In a sample of undergraduate students at a Canadian university, Abdulrehman and De Luca (2001) found that participants who experienced childhood sexual abuse exhibited impaired social behaviour. These survivors had significantly fewer friends and social contacts and more social adjustment problems compared to the control group that had not been abused. Jonzon and Lindblad (2006) found that adult female survivors of childhood sexual abuse who displayed 'good coping' and 'support compensation' had significantly better health than expected in spite of severe abuse. In the US, Gibson and Hartshorne (1996) found that university students who had experienced sexual abuse were found to be lonelier and less likely to utilise their social support systems. Similar findings were reported by Irwin (1996) who examined the relationship between childhood trauma and adult dissociative tendencies. Esposito and Clum (2002) also found that both problem-solving confidence and social support moderated the relationship between childhood sexual abuse and suicide ideation.

Outcome: There is evidence to suggest that persons who have experienced childhood sexual abuse may become socially isolated in adulthood. Professionals working with survivors of child sexual abuse should focus on the development of social support systems as a protective factor.

Childhood sexual abuse and future substance abuse

Wolfe et al (2006) found that 21% of their sample of male survivors of institutional abuse had met criteria for alcohol related disorder, as per the psychiatric classification system of the DSM-IV. Likewise, in a group of men who had been sexually abused by priests and referred for psychiatric review, Ponton and Goldstein (2004) found that 88% met the criteria for current substance abuse. Molnar et al (2001) also found that when other childhood adversities were controlled for, significant associations were found between childhood sexual abuse and substance use. In a female sample, Thompson et al (2003) reported that being sexually abused in childhood and raped in adulthood was associated with risk of substance dependence.

Outcome: Research has indicated a link between childhood sexual abuse and substance abuse in adulthood. Professionals working with those who have been abused in childhood should be aware of the likely risk of their clients abusing alcohol or other substances which may impede their therapeutic progress.

Government Reports

The Ferns Report

- The Ferns Report was published in October 2005 following an investigation into over 100 allegations of child sexual abuse made between 1962 and 2002 against 21 priests working in the Diocese of Ferns.
- Oral hearings commenced on Monday, 15th September 2003 and were substantially completed by February 2004. More than 90 witnesses gave oral evidence and a further 57 submitted written statements.
- The task of the Ferns Inquiry was not to establish whether the complaints that were made were of a genuine nature, rather it was involved in identifying the response by the Church and public authorities to such complaints.
- The experiences of 81 identified victims were brought before the Inquiry. Of these, 55 were male and 26 were female. Two men and one woman had taken their own lives by the time of the Inquiry, while 2 women and 1 man had attempted to do so.
- The Ferns Report acknowledges that *“child sexual abuse is, according to studies, linked with depression and post-traumatic stress disorder, emotional and behavioural problems, interpersonal relationship difficulties and suicidal behaviour in both childhood and adult life”* (page 19). Feelings of anxiety, difficulty forming relationships and depression were among the negative experiences reported to the Ferns Inquiry by those who had experienced abuse.
- The Inquiry concluded that the nature of the response by the Church authorities in the Diocese of Ferns to allegations of child sexual abuse had varied over a forty year time period. This was attributed to growing public and professional awareness of the nature and consequences of child sexual abuse, along with the different personalities and management styles of successive Bishops. From 1960 to 1980, child sexual abuse by priests was considered to be a moral problem. The priest in question would be transferred to a different diocese as punishment for a period of time, before being allowed return to his former position. By 1980 such priests were referred to a psychologist, but despite concerns expressed by the psychologist these priests were still appointed to curacies. It also became apparent that seminarians against whom allegations of abuse were made were still deemed suitable for ordination.

- However, the Inquiry is satisfied that at present the Diocese of Ferns operates to a very high level of child protection. From his appointment in 2002, Bishop Walsh has taken effective steps to ensure the safety of children and reviewed all outstanding allegations in conjunction with a new Advisory Panel. It is hoped that the procedures now in operation will serve as a model both for other dioceses and other organisations facing allegations of child sexual abuse.

Outcome: The Ferns Inquiry revealed a high prevalence of child sexual abuse by the clergy in the Diocese of Ferns. The inquiry also provided indications for an association between childhood sexual abuse and suicidal behaviour, both fatal and non-fatal, and long term effects such as feelings of anxiety, difficulty forming relationships and depression. The Inquiry hopes that procedures are now in place so that should the type of abuse that took place in the Diocese of Ferns ever occur again, that victims would be believed and appropriate action taken against the perpetrators. The Inquiry is also satisfied that a maximum penalty of life imprisonment has been fixed for the more serious offences involving child sexual abuse.

The First Report of the National Counselling Service (NCS; HeBE, 2002)

- The National Counselling Service (NCS) was established in September 2000 as part of the Government's response to the needs of those abused as children in state institutions.
- The core purpose of the NCS is to listen to, value and understand those who have been abused in childhood, in particular those abused in institutional care. The service aims to assist clients to live more satisfying lives, and in learning from their experiences strives to prevent further abuse in Ireland. In its first year, almost 2000 people availed of the service. Of this number, 33% were survivors of institutional abuse. Experiences of sexual and physical abuse as well as extreme deprivation and neglect have been highlighted by the clients.
- The first report of the NCS (September 2000 to September 2001) identifies the importance of survivor support groups as a mechanism for communication and feedback and as a link to clients. The majority of clients (55%) referred themselves for counselling, which was encouraged by the provision of a free phone contact number in each of the ten former health board areas.
- Reasons for seeking counselling are varied with the most commonly reported being feelings of depression and anxiety, relationship difficulties, worries about parenting their own children or problems coping with everyday life. Suicidal thoughts or behaviour led 5% of the clients to attend counselling. Multiple mental health difficulties were reported by 22% of clients at the time of their initial meeting with the counselling service.

Outcome: During the first year of the NCS, one-third of clients were survivors of institutional abuse. Clients attended counselling for a number of reasons including feelings of depression and difficulty coping with everyday life. However, research needs to be done into levels of stress and burnout among counsellors/therapists dealing with such emotive issues. Survivor groups were happy with the service in general, although it was felt that waiting lists could be improved.

The Second Report of the National Counselling Service (NCS; HeBE, 2003)

- In the second and third years of the NCS, self-referrals of clients had increased to 61% of service users. Clients were 61% female and 39% male. The number of male clients attending the NCS is significantly higher than figures usually reported for men in counselling. The largest group of clients (39%) was aged between 26 and 39 years; these were followed by 35% of clients aged between 40 and 50 years. In the second and third years the proportion of clients reporting a history of institutional abuse backgrounds had decreased from 33% to 29%. It was also reported that approximately 19% of all clients referred to the NCS failed to attend their first appointment, often due to not being ready for counselling or being fearful as to what counselling involves.
- The NCS also offers a wide range of group therapy as an addition to individual counselling. Group work is also available at the pre-counselling stage, as support to clients who are awaiting ongoing counselling, in a psycho-educational context and as a progression from individual therapy.
- Future goals of the NCS following the second report included the need to measure outcomes by offering clients the opportunity to give feedback on their experience of the service, counselling itself and how the therapy they have received has affected their everyday lives. Initial plans for an information database were revised following feedback from survivors. The system that has been developed has the protection of clients' rights as a central tenet. It was installed in 2002 and upgraded in 2003. A national working group was also established to examine the issues around waiting times and to make recommendations with regard to this.
- The establishment of a National Helpline was also one of the key priorities from the second report of the NCS. A needs assessment carried out in March 2003 found that volunteers at Right of Place received an average of three calls from survivors each night, while the Project Leader reported an average of five emergency calls each week. The SOCA UK office recorded 3,913 calls which they regarded as 'serious' in the year August 2001 to August 2002. Of those, 164 were classified as 'high risk', which refers to clients who had made previous suicide attempts and/or were considering suicide at the time of the call. The Aislinn Centre also recorded between 50 and 100 phone calls per week.

Outcome: In the second and third years of its operation the National Counselling Service had a client base that was 29% institutional abuse survivors. Significantly more male clients were reported than the traditional numbers for men in counselling. Plans were put in place to obtain feedback from service users, to manage waiting lists and also to establish a National Helpline for survivors.

The Survivors' Experiences of the National Counselling Service (SENCS) Report (RCSI, 2003)

- The SENCS report aimed to assess the quality of services provided by the National Counselling Service from the perspective of service users. Semi-structured interviews were conducted with 300 survivors from the ten health board regions (prior to the formation of the HSE). Overall, 62% of participants chose to be interviewed by telephone, and the interviews were of approximately 45 minutes duration. The age range of survivors interviewed was from 19 to 74 years; 59% were women and 41% were men. Institutional abuse survivors comprised 36% of the sample.
- Findings suggest that satisfaction ratings with specific aspects of service accessibility were generally high. For example, 91% were satisfied with the freephone service, 80% were satisfied with the initial interview and 79% were satisfied with the location of the centres in terms of the distance they had to travel. However, some individuals found the initial interview distressing if it was followed by a waiting period (as was the case for 33% of clients).
- With regard to quality of service, 94% of clients were satisfied with confidentiality, 95% reported satisfaction with the professionalism of the office personnel, 76% were happy with the duration of individual counselling sessions and 92% were satisfied with counsellor sensitivity.
- For the minority who were unhappy with the quality of service the main themes which emerged involved a lack of feedback or interaction during the counselling session and a feeling that counsellors/therapists lack an understanding of the life experiences of those who have been abused as children.
- A number of recommendations were made following this assessment of service users' experiences. These included the importance of providing an accessible service, providing a timely service, providing an out-of-hours service where necessary, providing an easily-contactable service for distressed clients, providing clients and staff with an opportunity to participate in service evaluation and quality improvement activities, providing clients with the opportunity to attend group therapy and providing opportunities for future research.

Outcome: The Survivors' Experiences of the National Counselling Service Report found that clients generally rated their experience of the service quite positively. A number of recommendations were made to improve both the accessibility and quality of the service.

Summary

- There is a lack of studies addressing the relationship between institutional child sexual abuse and suicidal behaviour and related mental health difficulties.
- Studies focusing on the consequences of child sexual abuse in general reveal consistent evidence for an association with adult suicidal behaviour, in particular non-fatal, as well as suicide ideation.
- Research indicates that the consequences of child sexual abuse by peers are similar compared to abuse by adults in terms of suicidal behaviour and mental health difficulties.
- There is consistent evidence that child sexual abuse is associated with post traumatic stress disorder (PTSD) in adulthood, with the severity of the abuse linked to the severity of the PTSD symptoms.
- Research indicates that people with a history of child sexual abuse are at risk of developing mental health problems (incl. depression, sexual difficulties and decreased self-esteem) in adulthood.

Recommendations

1. Further research into risk and protective factors for suicidal behaviour among persons with a history of institutional child sexual abuse

There is a need for more research into risk and protective factors for suicidal behaviour among persons with a history of institutional child sexual abuse, in particular studies using controlled and prospective designs.

2. Research into consequences of institutional child sexual abuse should focus on abuse by both adult and peer perpetrators

Research into the consequences of non-institutional child sexual abuse shows that short-term and long-term effects are similar for situations in which the perpetrator was an adult or a peer. Therefore, future research into the consequences of institutional child sexual abuse should focus on both abuse by adult perpetrators and peers.

3. Further research into consequences of institutional* child sexual abuse among men

The majority of studies addressing consequences of child sexual abuse have been carried out among women and currently it is unclear whether the consequences for women are similar to those for men. Therefore, future research should focus more strongly on consequences of child sexual abuse among men and include a gender comparison.

**This also applies to consequences of general child sexual abuse.*

Part II: Outcomes of consultation meetings with people who experienced institutional child sexual abuse

Overview

- The NSRF held six group consultation meetings with survivors who were members of Right of Place. These took place in Tralee, Limerick, Waterford, Enniscorthy, Galway and Cork, with approximately ninety people in attendance overall. There were also four individual consultations with members of different survivor groups in addition to a detailed letter received from a survivor. The purpose of the research study was outlined to those in attendance at the consultation meetings along with the topics to be discussed in the interviews of the second phase. Survivors shared their views on a number of issues including the relevance of the study, what they would like to see occurring as a result of the study, their own views on the relationship between institutional abuse and suicidal behaviour and so on.

Relevance of the study

- Overall there is a positive reaction among survivors to the study that is being undertaken. Reasons for supporting the study include a belief that sexual abuse and suicide should not be a taboo subject, and that as survivors get older they may find themselves on their own and more at risk of suicidal ideation. A frustration at the insufficient attention given to institutional abuse survivors by Government agencies to date was also expressed in the consultation meetings.
- Many of the survivors present at the consultation meetings had experienced the trauma of a friend and fellow survivor or a family member attempting to or taking their own lives. Others outlined how they had considered suicide themselves or had deliberately harmed themselves in the past.
- For many people this was the first time they had been openly asked about their experiences and they reported feeling better for having had the opportunity to talk about them. A number of survivors however expressed some hesitation at participating in research for academic purposes only without the appropriate additional support measures being put in place.
- A recurrent theme at the consultation meetings was that previously survivors did not speak about the abuse they suffered because of a fear that they would not be believed. In fact, despite the extensive media coverage in recent years of cases of abuse in institutions, some survivors have still not told their partners what they experienced in childhood. Reasons for not wishing to explain this part of their lives include not wanting to upset their partner with a full disclosure of abuse or being afraid that their partner will be unable to deal with the knowledge and thus their relationship may suffer.

- Survivors had numerous insights themselves with regard to risk and protective factors for suicidal behaviour among persons who have experienced institutional abuse. Many referred to alcohol abuse, depression, lack of education, difficulty obtaining employment and social isolation as being risk factors. A frequently recurring theme was the belief instilled in them by those in charge of the institutions that nobody else wanted them and that they would never be successful in life. Much of the abuse took place at night in the institutions and thus many survivors find it very difficult to sleep, even now. Night time therefore is often when they need someone to talk to and the lack of a 24-hour helpline, apart from the Samaritans, was mentioned by a number of survivors. Protective factors mentioned by survivors included relationships, children, contact with survivor groups, being able to secure steady employment and obtaining an education after they had left the institution. A desire to not lose strength or be seen to give up in the eyes of the perpetrator can also be a protective factor against suicidal behaviour for abuse survivors. Others engage in writing stories and poetry or art and drama to release some of the tension they feel inside.

Life course

- Survivors who came to consultation meetings found themselves in institutional care for a number of reasons. These included the death of one or both parents, parents being unmarried, parents being perceived by the authorities as being unfit to look after them, parents having financial limitations, or perhaps their mother already having been placed in an institution run by a religious order when she was pregnant.
- Sibling relationships were very much discouraged in the institutions with siblings either being kept apart or placed in different institutions. Children who went in as babies could be in the same industrial school as a sibling but completely unaware of it. In some cases they left the institution either believing they had no brothers or sisters or not understanding what it meant to have a brother or sister. There were examples of those who knew they had siblings being told by those in charge that they did not.
- Upon leaving the institutions at the age of sixteen survivors took various pathways in adult life. Many found the outside world too difficult to cope with, especially when they were used to large self-contained institutions and big dormitories with a strict routine and hundreds of other people around. Consequently, a recurrent theme was the return to institutional life, for example, by joining the army.
- Survivors recalled the difficulty of adjusting to life outside while trying to avoid drawing attention to themselves. Many went to England, as you could ask for advice about simple things such as taking a bus and excuse your lack of knowledge by saying you were unfamiliar with the country. Others spoke

of trying to understand that you had to pay for food in supermarkets or learning to go to bed at night in a room on your own with no noise or people around you.

- Trying to 'fit in' socially on the outside was difficult given the sense of shame attached to growing up in an industrial school. Survivors explained how they would invent a story to tell their new work colleagues or friends of where they grew up and where their families were now. They recall being 'on the outside' of their circle of friends, lacking in confidence and being careful not to be caught out in their stories.
- Relationships were a particularly difficult issue for survivors given that industrial schools for older children were always single sex. Many of the men look with a certain degree of humour now at how they really did not know anything about women or 'what to do with them' when they came out of the institutions. Given the prevalence of sexual abuse in the industrial schools, survivors did not have a comprehension of what constituted normal consensual sexual behaviour between adults. Furthermore, the nuns made a particular point of warning girls to stay away from men without giving them any actual sex education. For many there is a sad sense of missed opportunities for the relationships they did not get to experience in their younger years.
- Marital disharmony or separation arose quite frequently in discussions with survivors. For many this related back to when they told their spouses about their experiences in the institution. For others it resulted from the pressures of long periods of unemployment or alcohol abuse. Furthermore, growing up in an institutional environment meant that survivors had a lack of experience in forming lasting relationships and had no model to learn from.
- Those who had children outlined the difficulties in parenting when you have had no role models yourself. For example, some recalled giving their children everything they wanted without establishing boundaries, or others were unsure of how to be affectionate with their own children in an appropriate manner. Others felt they were being too regimental with their children as the strict regime of the institution was the only parenting model they had experienced. The need to constantly reassure their children of their self-worth and to build their self-esteem was also frequently mentioned. This was to counteract what they themselves had been taught in the institutions: that they were wanted by nobody and would never amount to anything. For many parents who had grown up in institutions, having children almost allowed them to have a second childhood, to 'grow up' with their children and to experience all the things they did not have the opportunity to do themselves.
- Finding employment was difficult for many as they had left the institutions with low levels of literacy. Some spoke about being 'institutionalised' in their employment, i.e. staying in the same job with the

same company for all of their working lives. Others spoke of an eagerness to please and for approval because this affirmation of self-worth was not forthcoming during their childhoods in institutions.

- Some of the survivors tried to return to education later in life to make up for what they did not receive in their school days. For others there was a certain pride in seeing their children do well in school or university, knowing that they had supported them to do so. They would also refer to their children helping them when they needed to write a letter or read documentation.
- As children the survivors were frequently hungry and the food they did receive was of poor quality. Consequently, it was observed that food and mealtimes are a particularly significant aspect of their daily lives now.
- Some of the survivors explained that the experience of being raised in an institution has led to anxiety regarding nursing home care in later life. This fear of what might happen to them as they grow older must be given appropriate consideration as a risk factor for suicide ideation. This also indicates that the long-term effects of being resident in an industrial school during childhood have yet to be fully explored and understood.

Situation around time of deliberate self-harm or suicidal thoughts

- Survivors who had attempted to take their own lives or who had considered doing so spoke about their situations around this time. The emerging themes included not having the support of their partner, feeling depressed or experiencing a sense of hopelessness, being under the influence of alcohol or the commencement of counselling and opening up to the past. Feeling that there is no one to talk to who will understand is also frequently mentioned as an issue around the time of suicide ideation.
- Those who did not go ahead with their plans to take their own lives frequently refer to their children as being a protective factor. It was noted that the holding influence of children is present even where the marriage itself has almost broken down.
- A large number of the survivors who participated in consultation meetings had experienced the death of either a friend or family member through suicide. The situation around the time of taking their own life sometimes reflected a detachment from the world, where a depressed individual seemed happier in the weeks running up to their suicide than they had been for some time. In other cases it may have taken the survivor by surprise as there did not appear to be explicit warning signs.

Aspects in relation to the abuse experience

- The issue of child sexual abuse by peers emerged during some of the consultation meetings. It became evident that this abuse had similar effects in adulthood as sexual abuse perpetrated by the staff of an institution. Survivors reported a sense of helplessness when one of the older boys was abusing someone in the next bed, because if you intervened there was a risk of you being the next victim.
- Along with sexual abuse, severe physical abuse, emotional abuse and neglect were also common experiences among survivors. It is our intention to explore these levels of abuse in a second phase of the research. Among the examples of emotional abuse was the practice of authorities in the industrial schools always identifying the children by their numbers rather than by name. The children were also generally poorly clothed, often without having underwear. Given that in some of the institutions the children had to attend class in the local village school, they could see the clothes that their classmates who lived in the community had, which once again reinforced the feeling of being different from their peers.
- There was some evidence amongst survivors of adult re-victimisation: people who had been abused as children in institutions entering abusive relationships in adult life. In some cases the abuse started after the survivor had told their partner of what happened to them in childhood. There are examples of women who had been brought up by nuns and had no sex education falling pregnant quite soon after leaving the industrial school. These women found themselves placed in a Magdalene Laundry and back in the institutional cycle again.

Complaints procedures including the Redress Board

- It was suggested at one of the consultation meetings that a relevant theme to include in the study would be to ask people about their experiences with the Redress Board. For many survivors, there was a feeling that this procedure would in some way be recompense for what they had gone through and that they would come away from it with the tools to build a better quality of life for themselves. More often than not the reverse occurred. Redress for many was a traumatic experience of recounting the story of an abusive childhood to a panel of professionals who would then decide, based on a points system, how much this experience was worth. Those who had managed to build a good life for themselves on leaving the institution felt that they were somehow penalised for this when it came to allocating financial awards - that if they had presented at Redress as a homeless person with chronic alcohol problems they would be seen as being more traumatised and thus deserving of a higher settlement.

- Redress was a particularly traumatic time for survivors who had not yet attended counselling. The experience of telling your story for the first time to a panel of strangers with whom you had built up no rapport, and who were only interested in the facts of your case, was a terrible ordeal. While there was often emergency counselling offered, the survivor might not be familiar with the aims of counselling and might thus go home in an anxious state without professional support.
- Survivor groups encourage their members to attend a monetary advice bureau in order to ensure their Redress award is used wisely. There are examples of survivors spending the money quickly on frivolous items, new found friends or alcohol, with the danger that they would soon be back where they started with no provisions made for the future. Others are almost afraid to spend their awards for fear that they would lose it all, and thus they have not improved their quality of life either. There is a mechanism in place where a survivor can appoint someone else to be a trustee on their behalf so that their access to their award is limited but they can still enjoy it in an appropriate manner.

Mental and physical health issues

- Many survivors have experienced mental and physical health difficulties in adult life. Depression, bipolar disorder and post traumatic stress disorder were evident. Psychosomatic effects such as migraine and diarrhoea were mentioned by some of the survivors. However, those who had attended counselling, either through the NCS or other services, were positive about the effects on their mental and physical well being. Some of the survivors reported finding it difficult to cope when their counsellor was on annual leave and they had to miss therapy sessions (the NCS guidelines on annual leave is described in more detail in Part III).
- Survivors are concerned about the apparent over-use of medication as a treatment tool, in particular by GPs. Many feel that the professionals do not understand their unique situation as survivors of institutional abuse and that greater awareness is necessary.
- In the absence of a 24-hour Helpline or emergency number, survivor groups are providing much of the out-of-hours support for their members. Staff of these groups report frequent telephone calls in the middle of the night from members who are feeling suicidal. Generally without any professional training the staff are doing their best to support the survivors who make these calls, often intervening on their behalf with the psychiatric services. However, the National Counselling Helpline Service is now operational and is available Wednesday and Thursday evenings from 6 to 10 pm and from 8 pm to 12 am at weekends.

- Trans-generational mental health issues also need to be addressed. There have been some examples among survivors who are anxious for their adult children who are perhaps struggling with addictions or appear to be depressed or suicidal. With no parenting model themselves, survivors are often unsure how to deal with these issues or even what services are available for their children and how to access them.
- Along with the research, the authors also facilitated workshops on *Awareness of Depression and Suicidal Behaviour* at the survivor group centres. These sessions have been well received. The workshop approach gives the group an opportunity to speak out about their own experiences and learn both from the researchers and from each other. It has been observed that survivors can generally speak openly about suicide and depression as these are issues that they experience frequently in their peer group.

Available support and contact with health care professionals

- Survivors were generally positive about the National Counselling Service and their relationship with their counsellors. Those who had completed counselling were frequently seen encouraging other survivors to avail of the service that has been established for them.
- There were some negative comments made in relation to the counselling service. Survivors mentioned that sometimes it feels like the therapist is watching the clock so that the session does not run over time. Also, if a counsellor is on annual leave a survivor may have to go several weeks without a therapy session which can be a very difficult experience for them.
- As mentioned previously, the lack of a 24-hour professional helpline was highlighted by a number of survivors. This is putting considerable pressure on staff of survivor groups.
- Survivor groups are a tremendous support for those who have experienced institutional abuse. These groups assist survivors in areas such as housing, education and preparation for Redress as well as providing an opportunity for survivors to meet each other in a friendly relaxed environment. As previously mentioned, some survivor groups also offer emergency 24-hour support to their members, although this is a great drain on the staff of the group who are generally not professionally trained.
- A number of survivors spoke about the tendency of GPs and psychiatrists to prescribe medication as the main treatment method for depression. This concerned them as they did not see it as the most effective model for them, although some felt that if they were not on medication now they would be in poor mental health.

- Frequently, concern was expressed about patients being discharged from psychiatric wards too soon. While they understand the capacity problem concerning crisis beds they feel that the circumstances of some of their fellow survivors should necessitate keeping them in for observation for a longer period of time. Some of these people have nowhere to go when they are discharged. There was some discussion about the usefulness of a nursing home or 'halfway house' for survivors who have to leave hospital but are not well enough to return to independent living in the community.

Part III: Specialist support services available for people who experienced institutional child sexual abuse in Ireland: a qualitative study

Methodology

Sample

All 10 branches of the National Counselling Service received letters inviting the director and a member of frontline staff to participate in a semi-structured interview of one hour's duration. The letter was followed up by a 'phone call from the researcher to arrange a time and date for interview.

Interview Instrument

A semi-structured interview was developed by the NSRF covering themes such as referrals, treatment models, supervision of staff, challenges, factors associated with suicidal behaviour among persons who have experienced institutional abuse and protective factors. While the focus of this research is on institutional child sexual abuse, the nature of the participants' experience infers that physical and emotional abuse would also be discussed at times during the interview.

Response

A total of 15 professionals offering specialist support services to survivors of institutional abuse participated in the study. All who were approached decided to participate in the study, a response of 100%. A manager and a member of frontline counsellor/therapist staff from seven of the ten branches of the National Counselling Service took part. In the NCS, the manager of a branch is the Director of Counselling who encompasses both a managerial and a clinical role. When saturation was reached among the NCS staff, no further interviews took place.

The co-ordinator of MASC (Male Abuse Survivors Centre) in Galway was also interviewed. Unfortunately due to time restraints during the first phase, further branches of the Rape Crisis Centre or other non-statutory agencies could not be included in this initial research.

Data management and analysis

The interviews were recorded and later transcribed. The tapes were kept at a secure location to be destroyed following completion of the report. A thematic analysis was performed on the data to elicit the main themes from the recorded interviews. Recurrent themes and sub-themes were drawn from the transcribed information.

Background

The NCS has been in operation since September 2000 and approximately 20% of NCS clients are survivors of childhood institutional abuse. It is funded by the Health Services Executive. MASC is in operation since October 2000 and 5% of its clients are survivors of institutional abuse. MASC was developed from the Rape Crisis Centre and amalgamated with this service in October 2006.

Results

Factors associated with suicidal behaviour

All the professionals who participated in the interviews were asked to identify what they considered to be the factors associated with suicidal behaviour among people with a history of institutional abuse. Table 1 below lists those risk factors, and the number of professionals out of the fifteen participants who mentioned each factor.

Table 1: Factors associated with suicidal behaviour among people who experienced institutional abuse

Factor	Number of professionals (out of 15) who identified this risk factor
Alcohol/drug abuse	13
Social isolation	5
Inadequate coping skills	3
Impulsive behaviour	3
Post Traumatic Stress Disorder	2
Anti-climax post Redress	2
Depression	2
Anxiety	2
Paranoia	2
Sleep difficulties	2
Chaotic lifestyles/constantly moving from place to place	2

A number of factors were reported once, such as low self-esteem, homelessness, mental illness, unemployment, media triggers, bereavements, abusive comments, fear of not being believed, flashbacks, guilt of being critical of carers, a professional leaving and not having disclosed to their partner that they have been in an institution.

As can be deduced from the above table, abuse of alcohol and/or drugs is the most frequently cited factor associated with suicidal behaviour in this client group. The following are some of the comments made in relation to the effects of alcohol and drug abuse:

“I think substance misuse is really one of the biggest risk factors and I think that’s a mixture of just mood changes, the ups and downs of people who are using drugs or alcohol, plus the depressive effect, people just get very, very depressed. And it’s not so much they want to die, but they want to put an end to all the chaos”

“It is my understanding that if the client is using alcohol or drugs it is a major risk factor and it can lead to impulsive behaviour, so that’s a very huge risk factor”

“You already know that people who abuse alcohol and drugs are already at a more significant risk than the general population, and you just simply add another load onto that. For clients who have substance abuse problems, that’s a real risk factor for them”

Social isolation was the second most frequently cited risk factor. The counsellors/therapists tried to verbalise the complete aloneness of some of their clients and the sense of having nobody to turn to. Here, it is important to know to what extent social isolation is related to the abuse or to being raised in the environment of the institution:

“That sense of utter aloneness that clients can often feel, and being different... I think that would be a high risk, say people who don’t have those connections, people who may have come through the institutions and have no friends or network and cut off all connections”

“If they don’t have any support person in their life, and that’s one of the questions we ask them at intake appointment, ‘who would be there to support you if you were going through a particularly difficult time’ and we want to have their name and contact number. And that’s part of the whole thing of managing the suicide ideation, should it present, and sometimes people don’t have anybody, that’s the reality”

“I think the main risk factor would be feeling ‘I’m totally alone, there’s nobody here, nobody cares about me’ when I hear that, that there’s nobody there for them”

A lack of sufficiently developed coping skills can also be a factor associated with suicidal behaviour among survivors, and three of the specialist support services interviewed mentioned this. One of the observations made was that survivors who experienced family life prior to being placed in institutional care have more adequate coping mechanisms in adult life:

“I suppose it’s quite difficult to generalise I think around that area but my sense in working with the survivors is that people who have spent their formative years in the environment of their parents, whether it be chaotic or otherwise, seem to have less coping difficulties, in some ways their coping skills appear to be more finely tuned than people that were put into an industrial school at a very young age”

Impulsive behaviour, which can often be fuelled by alcohol, is also considered a factor associated with suicidal behaviour:

“It’s the clients who turn that anger back in on themselves that are very much at risk, clients who are very impulsive and who operate on a very short fuse. Again, if you put alcohol or any substance into that mix it is very dangerous”

Table 1 above indicates that there can be a variety of factors related to suicidal behaviour among persons who have experienced institutional abuse in childhood. Various types of mental disorders, depression, anxiety, paranoia and post traumatic stress disorder are all considered likely contributors to suicide ideation or suicidal behaviour. Media triggers can also recall to mind the horrors of their experiences, be it court cases or films about institutional care, such as ‘Song for a Raggy Boy’. Those who have not told their partners that they were in an institution are also considered to be at risk of suicidal behaviour. The pressure of keeping a whole era of their lives a secret along with the fear of not being believed can be a significant risk factor.

“I don’t think she will ever tell him because when he [husband] hears the [television] programmes he says ‘look at all those dreadful people lying just to get money’, so of course she is never going to. ‘That never happened’, he says, so she will never tell him now. Well, she says she will not. So all her life this was a piece kept away. Her deepest friends don’t know; her dearest friends. And her husband knows nothing”

Table 2: Protective factors against suicidal behaviour among people who experienced institutional child sexual abuse

Protective factor	Number of professionals (out of 15) who identified this protective factor
Relationships (incl. marriage)	12
Children	7
Education	4
Survivor groups	3
Employment	3
Counselling	1
Pet	1
Literacy	1
Ability to detach	1
Level of understanding trauma	1
Anger as fuel to get on with things	1
Link with some family, some sense of self	1
Information obtained about themselves	1

As can be seen from Table 2 the ability to form lasting relationships, including marriage, is considered a significant protective factor against suicidal behaviour, with 80% of professionals interviewed alluding to this:

“Certainly relationships, if somebody feels there is somebody that cares about them. Even the companionship of people who may have been in institutions as well”

“I think in terms of good relationships. If people have good relationships, not only are those relationships supportive but there can be that bit of reluctance to bring on to somebody you really love the legacy of the grief of suicide”

“Having a support person in their life that they trust enough to talk to or to admit that they are having a difficult time and that would then extend out to having a support network”

“It’s like some of the survivors that went on to marry, in a stable relationship, seem to have done better in their lives”

Seven of the fifteen professionals interviewed cited having children as a major protective factor against suicidal behaviour. One of the primary holding functions of the parent-child relationship is the parent's unwillingness for the child to be forced to live with the apparent stigma of suicidal behaviour:

“And if they have children, I will actually bring in that one of the legacies it will leave in your family is that this is a way of dealing with issues, and your children are more likely than they were before to actually see suicide as a coping strategy if things are very bad”

“People who do have children, they don't want to inflict that pain on their children. That would certainly be one protective factor for holding people back”

“And I'd say the protective factors then would be the opposite, knowing that somebody cares, children, women in particular will say and there's a man who has suicidal ideation, wouldn't want to leave the stigma with their children”

The lack of any formal education in the industrial schools led to many survivors leaving the schools with minimal skills or academic knowledge. Those who went on to receive an education after leaving the institutions are considered to be at somewhat less risk of suicide by many professionals:

“You know if they managed to reach some kind of educational level in the job and that can hold them”

“Obviously education or the lack of education is huge. People that did get a reasonable education have had the ability to have the skills to get further, to get into the workforce at some level”

Having links with the survivor groups is also considered a protective factor. Such links can help the individual to see that there are others who have endured similar experiences and that they can be a support for each other in difficult times. These groups can also help with more practical issues:

“Right of Place have been very good over the years in linking people in with other services, in terms of practical social welfare kind of needs, that kind of thing”

“His life was so chaotic before he ever came in contact with any of the services...he's just got great support from Aislinn, and has gotten good support from this service over the years and he really was somebody who was able to take the opportunity when the support came”

Survivors who have been able to secure employment for themselves are also considered overall to be of lower risk of suicidal behaviour. However, the possibility of gaining employment is linked to the likelihood of a person having received some form of education or skills training:

“People that did get a reasonable education have had the ability to have the skills to get further, to get into the workforce at some level”

Other protective factors alluded to include the client’s ability to understand their own deep level of trauma and the course and consequence of such trauma. In some cases the survivor’s anger towards his/her abusers can be a ‘fuel’ to keep going, to prove to their abusers that they could make something of their lives:

“Then, you know, there are people who are fighters and copers; people have been angry but they have managed to use that anger as a fuel to get on with things, to prove wrong the nuns and priests who said ‘you are useless and you’ll never be anything’. They use that as a kind of fuel”

However, from Tables 1 and 2 it is apparent that in the opinion of those offering specialist support services, the factors associated with risk of suicidal behaviour outweigh the protective factors among people with a history of institutional abuse.

Staff complements

A staff complement of six whole time equivalent counsellors/therapists, one director and an administrator is the general make-up of each NCS branch. However, in certain areas such as the East Coast in particular, staff shortages have been experienced.

In MASC there is a director and six to seven part-time counsellors who work on a voluntary basis.

Staff training

Counsellor/therapist staff at the NCS are required to hold an accredited qualification in psychology, social work, nursing or medicine. In addition, an accredited qualification in counselling or psychotherapy or a relevant postgraduate qualification is required, plus a minimum of two years experience in counselling/psychotherapy. A relevant postgraduate qualification refers to a full-time masters degree in clinical or counselling psychology, in which case the stipulation of two years experience does not apply. Further training opportunities are also available to NCS staff, including a bursary of up to €400 each for any workshop or course they wish to undertake during the year.

The staff at MASC are either qualified counsellors who give a portion of their time voluntarily or trainee counsellors who are required to have a number of hours of client contact.

NCS staff are positive about the access they have to further training courses:

“I have had, for example, in this past year a staff member here completed her course in Supervision and that was paid for entirely by the HSE. And they get time off to do it. They are very much facilitated”

“Since I started here I have always been doing some course or other”

Referrals

In 2005, survivors of childhood abuse in institutions accounted for 20% of all referrals to the NCS. The majority of clients refer themselves. However, in 2004 and 2005, 32% of all referrals came from outside agencies. Sources of referral include mental health services, GPs and legal services. Survivor groups are also instrumental in advising those who have experienced institutional abuse to avail of the counselling service.

“On average around 70% of our referrals are self-referrals”

“Our own institutional referrals, 25 to 27% of our referrals for the first four years have been from an institutional context. But it has dropped off a little”

“The survivor groups like Right of Place would also have promoted us and would encourage people to attend and usually give out the numbers so while people might self-refer, they might have originally got the information from people like the survivors’ groups”

Sometimes when a client has completed counselling an issue may arise for them and they will wish to re-refer. The manner in which re-referrals are dealt with appears to differ between the various branches of the NCS:

“They go back on the waiting list and they are having to wait again to get back into the service”

“The other option we find very good for using with survivors is to leave three sessions in a bank for them so that if they have difficulty they can contact the service and they can access, I can see them on a one-off and I can offer them two further sessions... by saying there’s two or three sessions in the bank it’s amazing how people can let go a lot easier. And since we started that, there’s very few re-referrals, it’s interesting, with that client group”

“They can go on the top of the list, they don’t have to go on the waiting list but it will depend on whether I have a spot to take them on”

MASC get their referrals from a number of sources, including from the Health Services Executive:

“We get most of our referrals through the Rape Crisis Centre, we get quite a few from an advert that we put in the papers... we’ve had doctors refer to us, we have even had the HSE refer to us though they have their own service. We have found that, and this is word of mouth by individuals concerned, that some are not too happy about being counselled by a group of people who they feel represent the very source of some of the abuse and need a choice”

Initial/Intake appointments

All but one of the seven branches of the NCS interviewed invite clients for an ‘initial’ or ‘intake’ appointment following their referral but prior to being placed on a waiting list. Overall, nine of the ten branches of the NCS follow this procedure of the ‘initial/intake appointment’. This first meeting involves obtaining pertinent information from the client including background, whether abuse occurred in an institutional setting or in the community, if there are other comorbid issues such as alcohol or drug addiction and details of a support person who can be contacted should an emergency situation arise.

Initial appointments require skill on behalf of the counsellor/therapist to ensure that the client is not opened up and then left waiting several months to commence counselling. In fact the reason for not holding intake meetings in the seventh branch was that *“it is not good for clients to open up”* when they are being put on a waiting list.

The following are some comments made by managers and frontline staff regarding these appointments:

“I think there is a great skill to an intake appointment, for example, I never allow a trainee to do an intake appointment. Because there is a specific skill involved in asking a question without probing. And it’s quite opposite in many ways to what we do in therapy which is ask questions that are appropriate and probing” [Manager]

“I suppose the focus is on getting some background but certainly not trying to, not really deepening the exploration of the person’s issues too much because they are aware actually from the phone call that there is a long waiting list for counselling. But you need to be mindful of that in that first session, that you are not going to start opening up things that you really don’t have an opportunity to follow on with” [Counsellor]

“you don’t want people to open up about a whole lot of stuff and then say we might see you in eighteen months, so you are actually really keeping it quite low key. That presents its own difficulties”

[Counsellor]

Treatment models

The National Counselling Service is client-centred in nature but also benefits from having staff who are trained in a variety of different treatment models and from various professional backgrounds which is reflected by the following example:

“My psychotherapy training was as a family therapist. Before that I worked in addiction, and before that I was in nursing”

“I come from a humanistic Rogerian non-directive background”

“You bring your own training to it, because I would be Rogerian, psychoanalytic as well because my supervisor has psychoanalytic training. I would be influenced by her and I’m actually doing the training in it at the moment”

“I suppose my training would have an underlying kind of humanistic client-centred focus anyway as does the service, so you are kind of always bringing that increasingly as I work with this client group what helps me understand I think is more of a psychodynamic model, and also a developmental model, but given a particular person and particular issues, whatever is useful”

Clients always engage in individual counselling initially, but in certain areas there is also an option of group work. The experience of being part of a group can be very helpful to some survivors, helping them to understand that their feelings are not unusual and that there are others who have similar stories to tell. Unfortunately, the likelihood of a lack of anonymity, particularly in rural areas, means this option cannot be made available to all.

“The counsellors/therapists are working in kind of small provincial towns and our attempts to offer group-work to them struggles because most people know one another in a small provincial town. And there is a certain degree of anonymity that is required for group-work”

“We don’t do group, no. In the beginning there was very little demand, maybe three or four, but geographically they were very spread out and it wouldn’t have been economical to just bring three or four together. At the moment, there’s nobody”

“We do have a group, an ongoing group here. And that runs for one-and-a-half hours a week and everyone who is in that group has been in individual therapy. One of our therapists is training at the moment in group analytic therapy and it’s part of her course requirement that she run this group as well. It’s gone very well, we’ve had two, the third one will start next month. And some people have continued from group to group, it’s running very well. And we’ve also done some life skills groups...in assertiveness, life skills, stress management. There’s different types of groups you see and for an individual to go into a therapy group it’s really important that they are given their own individual therapy”

Supervision and support of staff

The NCS regulations state that each counsellor/therapist can have a maximum of sixteen client contact hours per week. Staff then have team meetings every two weeks for 1.5 hours. External supervision also takes place every two weeks for 1.5 hours. In addition to this counsellors/therapists have monthly supervision meetings with their line manager.

Counsellors/therapists in the NCS are entitled to 27 days annual leave per annum. Where leave is anticipated, clients are informed and the counsellor decides if an alternative care arrangement needs to be put in place for any of his/her clients. This is then negotiated with the Director and/or colleagues.

The supervision and support offered by the NCS to its frontline staff is rated highly by the counsellors/therapists:

“I think the supervision is absolutely essential and I think the peer supervision with our colleagues, I think that is just as essential and the support of your manager”

“We have external supervision, an hour-and-a-half a fortnight, and I find that invaluable”

“We have an hour of designated supervision with an external supervisor fortnightly, and then every second Friday we meet as a team, and the first piece of that is peer supervision. The whole theme of our AGM last year was vicarious traumatisation, so there really is an acknowledgement of the depth of distress that you are actually holding sometimes. And I think that you ignore it at your peril”

Self-care

In addition to the formal supervision and support offered by the NCS to its counsellors/therapists, it is also important that frontline staff are mindful of their own self-care. The potential for vicarious traumatisation is high given the nature of the abuse experiences and life course of this client group. Counsellors have developed their own coping mechanisms to counteract the possibility of stress or eventual burnout:

“I really try and ensure that I’ve done what I feel I needed to do. If at all possible to debrief with somebody here before I leave. For me what I notice is, let’s say once I am at home then I increasingly have a desire to not be operating from my head ...I go walking a lot, really for exercise which is nice but it actually really helps to clear me, I listen to music, even I walk home at the moment and its brilliant because I think about sitting in the car or sitting in the bus, I’d be getting stressed about something else then, whereas I find that I use my senses to kind of take me out of my thoughts”

“I garden now, and I could often just go home and not even get into my gardening clothes and just go out, it could have been a really awful, awful day, you would have heard awful things, but just to get to the soil and to just be with that, I find that very helpful”

“I would have to be very careful of lifestyle, so that I can be ok and together sitting in front of clients. I meditate myself, I find meditation very grounding. I walk half an hour into work and half an hour home, I find that very de-stressing”

One experienced therapist alluded to the fact that working with survivors of child sexual abuse is more challenging than any of her previous client groups:

“I’m a very experienced therapist, I mean all the years in alcohol services witnessing very traumatic history, but there is a depth to this that has struck me as even beyond what I witnessed in alcohol services”

Waiting lists

The NCS has a national policy on waiting times which prioritises clients who experienced abuse in institutions as children. The length of time a client is required to wait for counselling varies between the different HSE areas. This can be from one or two months in some areas and up to two years in city centre locations. There is a national policy group on waiting list management within the NCS to address this issue.

Links with other organisations

MASC amalgamated with the Galway Rape Crisis Centre on 1st October 2006 because of inadequate financial support. It had originally stemmed from this facility.

As mentioned in the section on referrals, the NCS have established links with a number of other agencies such as general and mental health services, GPs, educational services and voluntary organisations. Various branches of the NCS report links with the survivor group Right of Place if there is a local group in the area, or in Dublin there will be referrals from the Aislinn Centre. The majority of NCS counsellors/therapists have contact with local addiction services as alcohol/drug abuse may often have to be dealt with prior to the commencement of counselling.

In Wexford there is a facility called the Self-Harm Intervention Programme (SHIP). It is a counselling service that started in June 2004 and is linked to the Comhar Adult Counselling Service, which is the local branch of the NCS. The aim of SHIP is to provide short-term counselling contracts to individuals who are experiencing self-harm or suicide ideation. There is a maximum number of 12 sessions and it is available to clients of sixteen years. This service is not exclusively for survivors of abuse, although a significant number of SHIP clients have experienced childhood abuse either in institutions or in the community. It was initially developed on a pilot basis and the therapeutic model is not fully agreed upon but it is considered “*a low threshold easy access service*” for clients. These clients can then be linked back in with the NCS if the need arises.

Challenges to therapists

Given the nature of working with people who experienced institutional abuse, counsellors/therapists were asked what they considered to be the greatest challenges posed to themselves. Answers varied and included challenges to one’s own religious beliefs, the realisation of the levels of abuse which these clients have experienced, seeing clients whose pain was such that they simply could not avail of the counselling service and trying to be open with clients while maintaining an objective professional viewpoint:

“I suppose from a religious perspective...my own betrayal of trust and in listening to stories from survivors and how the absolute power of the Church and even today I get irritated at how they try and defend themselves. And I know they are not the people that were there in the 40s and 50s of course, but it is all about protection of the organisation. And I think from a religious perspective it is very, very difficult to actually come to terms with that”

“It really does alter in some ways your views of people in general because you just know the capabilities that we all have I suppose, to do unbelievable harm to each other given certain circumstances. Sometimes,

some days I might be very well able to leave what happens here but on another day for whatever reason and its often not the most objectively horrific things that I've heard but something just kind of knocks you and you are left really holding that and it's in your mind when you are leaving"

"I think the biggest challenge in working with institutional people is...they weren't able to avail of the one session where they could really use it"

"I think the challenge is to be open enough to be with clients, that you can be open enough to be empathic, and to also be, I don't like to use the word 'detached', I'm trying to think of another word, so to keep that balance right, that you can be open enough to take in what's being said and absorb it, but not to absorb it in such a way that you are weighted down. You need to be able to cut off in a way, and to get that balance right, that takes experience and time to build that. And to counter that with the cumulative effect of working with severe abuse sometimes, because it is a cumulative effect over years. It can wear you down like the drip of water on a rock"

One therapist spoke about her own 'outrage' that people should have had to experience such traumatic lives, why a young child should be taken from his/her parents and placed in an institution where they experienced no love or sibling attachments and then 'thrown out on the street at 16/17'. The apparent hopelessness or 'deadness' that her clients often feel is a significant challenge to the counsellor herself, along with the difficulty in building a trusting therapeutic relationship given the negative trust experiences of this population.

Challenges to the service

For MASC, the primary challenges to the service at time of interview were financial as they received little funding from the state. They received 10% of costs to run the service from the HSE but outside of that they relied on private donations, conferences, concerts and other such fund raisers. Hence, as previously mentioned, they amalgamated with Galway Rape Crisis Centre in October 2006.

For the NCS, the issue of funding is not as pertinent as they are a HSE service, although evidently more counsellors/therapists would mean shorter waiting lists. The following are some of the challenges alluded to by management of the NCS:

"We've always had demand way outstripping supply so there have been the waiting lists and we have been struggling with that and trying to manage that, so in some ways the challenge has been to manage that effectively. Now that things like Redress, Commission, are beginning to come to an end after five years, they are not finished yet, we are beginning to start looking at what might be other needs out there and looking at the future vision of the service"

“I feel that the individual nature of the work will have to continue. My vision has been for a much broader provision of therapies within group sessions/educational settings, and we are limited to two years with each client. That’s the limitation to the therapy. There is a limit of two years”

“Ideally what I would like, especially for my counsellors who have been with me from the beginning, who have full caseloads, is to be able to give them a variety of client group. Because I don’t want to lose them, I don’t want them to burn out, and so if they can get, if I can have them continue to work with our institutional clients but also have people on their list who are dealing with depression or anxiety, and things like that in a more generic service, I think it would be better for us as a service to be developing in that way and to be moving into a more closer alliance in primary care, working in a multidisciplinary way”

“What we do experience is that many of the clients from an institutional context need long term therapy, by long term I mean in excess of two years, sometimes three to four years. And that therefore means that your caseload is pretty much static. So I guess that would be one of the biggest challenges in recognising that”

Summary

- The majority of referrals to the NCS are self-referrals, followed by referrals by GPs and psychiatric services. The majority of referrals to the MASC are through the Rape Crisis Centre.
- At least 20% of the referrals to the NCS in 2005 were clients with a history of institutional child abuse.
- Although clients with a history of institutional abuse are prioritised over non-institutional clients in the NCS, the time on waiting lists is long. Based on figures for 2005 the national average waiting time is 11 months, ranging from 2 months to 2 years across the various branches of the service.
- The NCS is primarily client-centred, with a wide range of treatment models including Rogerian and psychodynamic approaches.
- Peer supervision and external supervision are provided for counsellors in the NCS on a structural basis.
- According to health care professionals in the NCS, alcohol and/or drug abuse and social isolation are major factors associated with suicidal behaviour. A wide range of other, less frequently reported mental health difficulties included inadequate coping skills, impulsive behaviour, PTSD, anti-climax post Redress, depression, etc.
- According to health care professionals in the NCS, relationships (incl. marriage), having children, having pursued/completed education were major protective factors. Other less frequently reported protective factors included support from survivor groups, being employed, receiving counselling, etc.
- A major challenge for both the NCS and MASC is to obtain increased funding in order to reduce the waiting lists, to provide long-term therapy for the clients (up to 4 years) and to establish a multidisciplinary treatment approach.

Recommendations

1. Increased funding for NCS and MASC

In order to reduce the waiting lists, enabling the service to provide long-term therapy (up to 4 years) and to establish a multidisciplinary treatment approach, increased funding is required for the NCS and MASC

2. Multidisciplinary treatment approach

Considering the wide range of mental health difficulties experienced by survivors of institutional abuse, a multidisciplinary treatment approach would be required within the support services including further collaboration with other mental health services. This is in accordance with Recommendation 9.1 of the *Vision for Change* report of the expert group on mental health policy which states that to provide an effective community-based service a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families should be developed.

3. Validation of factors associated with risk of suicidal behaviour and protective factors among persons with a history of institutional child sexual abuse

The qualitative study revealed a preliminary list of factors associated with risk of suicidal behaviour and protective factors among persons with a history of institutional child sexual abuse. The overview of factors obtained through interviews with the NCS and MASC should be further validated by studies directly involving people with a history of institutional child sexual abuse as well as physical and emotional abuse and neglect (see also in recommendation 1, Part I (page 23)).

4. Development of service plans following the conclusion of the Commission and the Redress Board

Given that the closing date for applications for Redress is past since December 2005 and the Commission is beginning to wind down, the needs of survivors are likely to change in the coming years. The staff of the NCS mentioned 'anti-climax post Redress' as being a factor associated with increased risk of suicidal behaviour. It would be beneficial to have a more systematic approach to identifying such risk factors and any other gaps which have been noted in service provision. At present the NCS Steering Group and Directors of Counselling develop annual service plans based on the existing and future demand for counselling. The management of the NCS should be further encouraged to formulate plans for the future of the service and to address the changing needs of the institutional client group.

5. Supporting and valuing survivor groups

The important role played by survivor groups as a protective factor has been highlighted by the specialist support services. The support offered by these groups should be recognised and valued.

6. Developing further specialist support services

Based on an adaptation of the NCS model, the Wexford Self Harm Intervention Programme (SHIP) is an effective means of quickly accessing a service for a short-term period. While SHIP is not dedicated solely to survivors of childhood abuse, it fills a gap for many such survivors who may otherwise be on waiting lists for longer term counselling. Other services like this which operate with a maximum number of approximately twelve sessions would be very useful for clients with suicide ideation who need to be seen in a timely fashion. The NCS have noted the importance of the link between a service such as SHIP and themselves in terms of service integration for all survivors of childhood abuse, but in particular those who experienced abuse in an institutional setting.

7. Further evaluation of programmes

The SENCS report is a useful example of service users' views on the counselling service which was established for them. Further evaluation both of the NCS - and any other support services that may be established - should be promoted as central to developing a service of benefit to both clients and staff.

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