

## **In Care Survivors Support Fund/Service Specifications**

### **Introduction and background**

1. The National Strategy for Adult Survivors of Childhood Sexual Abuse, established in 2005 has an overarching aim to raise awareness of the long term consequences of interpersonal\* childhood abuse and improve the quality of and access to services for adult Survivors in Scotland. Since the inception of the strategy we have been able to develop a wider understanding of the issues Survivors face and the support that they require. Alongside this the Scottish Government has made a commitment to implement a number of recommendations of the Scottish Human Rights Interaction Plan on Historical Child Abuse. One key component of these commitments is to establish a 'In care Survivors Support Fund Service' to support Survivors to access services across a wide range of health and wellbeing needs which will enable them to lead full, healthy and independent lives.
2. At this stage the Scottish Government intends that the development of 'In care Survivors Support Fund Service' will build on and enhance the work of In Care Survivor Service Scotland (ICSSS). ICSSS is a wholly Scottish Government funded service established in 2008. ICSSS was contracted to deliver a Scotland-wide information, support and advocacy service to adult Survivors of in care and institutional abuse. The current service provider for ICSSS is Open Secret who through grant funding are contracted to deliver the service until March 2016.
3. In order to develop an enhanced and expanded service for in care survivors a commitment was given to invest £13.5m over 5 years (2015-2020) to support a service which would address the long term effects, as well as current and future needs of those survivors subjected child abuse and neglect\* whilst in care. By 'in care', we mean the residential care setting as defined in the terms of reference of the Historical Child Abuse Inquiry Scotland.  
<http://www.gov.scot/Topics/People/Young-People/protecting/child-protection/historical-child-abuse/terms-of-reference>
4. To respond to the identified care needs of survivors, the Scottish Government requires an organisation, which might be individual or lead if working in partnership with others, to deliver a Scotland-wide service to adult survivors of in care and institutional abuse.
5. This investment will aim to deliver clear pathways of support, care and treatment designed to offer a personal outcome focused service which will meet the individual and often complex needs of survivors of interpersonal childhood trauma\*.
6. The successful bid for this service will be funded via grant arrangements and is subject to satisfactory fulfilment of grant conditions.

7. The service outlined below is a **newly defined** In Care Survivor Scotland Service specification which has been developed in the light of the experiences and evidence collected since 2008.
8. It will be delivered alongside the many other support services both statutory and non statutory that survivors currently have access to. As such, the appointed organisation must demonstrate an understanding of the future vision of a 'In care Survivors Support Fund Service', and its principles. They must ensure that the service embraces the philosophy of the revised SurvivorScotland outcomes ([outcomes framework](#)), by providing an innovative, integrated health, care and support service for in care and institutional abuse survivors, their partners and families.

\*see annex of terms and definitions: “ Interpersonal trauma includes any type of traumatic event wherein another person causes the trauma. Typical examples include childhood maltreatment, child abuse, rape, assault, domestic abuse, emotional abuse, and neglect.” (Thanos K 11-08-15 private communication).

## 9. Underpinning Principles

Survivors have told us that the following principles are key in establishing a support fund service:

*Empowerment, control, choice and continuity* – Survivors want to be able to achieve greater control and authority over their own lives and destiny. They want any future support to be person-centred and life long with the survivor at the heart of the process. Any decisions must be made together with them. The service must be able to offer lifelong support with well managed and appropriate transitions.

*Fairness* – It is vital to ensure that the service is available to all survivors without any discrimination or bias. This also applies to service providers who will need to evidence a proven good track record of good practice and have demonstrated a high quality of service provision.

*Flexibility* – The development of support provision for survivors should look to forging new links and developing innovative and creative approaches to meet their needs. Trying to shape provision only through existing approaches and systems may fail to inspire confidence. Support must be person rather than service led.

*Safety and security* – The support service should ensure that all future services for the care and support of survivors put their safety and security at the centre. Support services must strive to build on trust and minimise fear for survivors. Services must demonstrate robust and rigorous governance and impact evaluation of the support, care and interventions offered to survivors.

*Communication* – The service must innovate and develop the means to increase awareness of the service it offers. It must thoughtfully and sensitively promote the work being done in order to encourage survivors who may not currently access support services to come forward and make use of new support opportunities and resources.

## 10. Delivery Model:

### Essential components of the service delivery model.

- The service will enable and support survivors to **navigate** and **link** to health, social care, third and voluntary sector support, care and treatment services in order to have their needs met. This will involve **case management, advocacy and agreed personal outcomes**.
- The service will offer **transformational change** for the way support is offered and made available to survivors. It will be an **innovative** national Scotland-wide service with outreach capabilities to enable survivors who are experiencing the long term effects of in care interpersonal childhood abuse in all geographical locations to have access to resources, support, care and treatment.
- The organisation delivering this service will be able to demonstrate a vision and value base that puts survivors at the heart of its work. Its governance arrangements and engagement with its service users will inform a continuous improvement environment that is credible to those who use its services.
- Scottish Government recognises that there is significant variation in the accessibility and provision of many sources of support, care and treatment for survivors across Scotland. The service will therefore be based on an **expanded brokerage, development and commissioning model\*** designed around the needs of survivors and providing holistic care.
- The service will be expected to be **innovative** in **brokering** the delivery of **local** services. It must work in **partnership** to develop ways of **building** and **expanding the capacity and capability** of **local** services and negotiate the commissioning of services for survivors when local resources are not currently available.
- The service will engage and work with partners to develop **integrated care, support and treatment pathways** for survivors and increase efficiency and **impact** of services delivered .
- The service is expected to establish locally based support co-ordinators who can offer an initial **trauma informed assessment** of survivor's needs focused on their **personal outcomes** and ensuring the survivors' journey is person rather than service led. These personal outcome conversations form the basis of any **planning** and future **interventions** for survivors.

The support co-ordinators are **not** expected to be clinicians offering counselling but to work to build **trusted relationships** with survivors and to **innovate, develop, commission, advocate** and **broker** across boundaries between health, social care and the third sector to join up local resources and find the means to provide for the needs of the survivor.

- The service must be able to respond to **risk**, particularly in relation to **self harm** and **suicidal ideation**. Staff delivering the service should be aware of and able to **identify** and **respond appropriately** to the risk of suicide and self harm.

Risk assessment should be embedded across the service and also be part of the wider personal outcomes conversations. Risk assessment should be viewed as the start of a **mitigation of suicide or self harm plan for individuals**. The service must have in place training and support for staff to enable staff to be aware, identify and respond to the risk of self harm and /or suicide and the service's planned responses to these.

- The service must establish and define clear **methodologies** for the **rigorous and robust monitoring and evaluation** of the impact of support to the successful achievement of survivors' personal outcomes and associated risks.

\* (Karatzias 2011)

## 11. Scope of service

### Core Service Domains

The core service must enable survivors to have access to information, resources, support and services which meet their needs across a wide range of domains of wellbeing. The domains specified below are not exhaustive nor exclusive.

The service model should not be hierarchical but be flexible enough to meet the real complexity of survivor's needs.

### Discretionary/Flexible Domains

During initial service development consideration of a discretionary payment element of the service can be developed. This will not provide compensation payments to survivors but will provide funding for a range of ad hoc requirements not readily available to meet pragmatic support and social needs and to fulfil personal outcome goals e.g. payment for driving lessons, connection to meaningful activities, a travel pass to enable travel to support services or immediate funeral expenses.

Service providers are invited to propose how this element of the service could be developed and delivered.

**Diagram 3: Core domains of wellbeing**



## **Service Specification**

**The service provider is expected to submit a strategic and operational plan for the proposed service including communication and engagement plans, project delivery plans, financial plans and projections for the delivery of the service as detailed in the following sections. It is essential that the information provided details how they will meet the requirements under each of the following headings.**

### **1. Engagement and Communication**

**The service provider will develop and define a communication process and strategy which clearly demonstrates how the service will reach out to survivors and encourage them to engage with the service. This strategy should be included in the bid.**

This engagement and communication process must be clearly set out and include:

- How the service will be promoted e.g: via internet, press, and other partner organisations such as RCGPS, NHS Scotland and third and voluntary sectors and how this will be sustained on an on-going basis.
- How the service will encourage survivor participation around service development, improvement, monitoring and evaluation e.g. focus groups, quarterly consultation, linking to current survivor support organisations.

### **2. Eligibility**

**The service provider will develop and give details of a process for establishing eligibility and clearly set out the process for onward signposting and referral for any Survivors not eligible e.g. individuals who contact the service but have not been in care.**

The service will be open to all survivors who have suffered adverse effects of interpersonal child abuse whilst in care. Abuse is defined by the Terms of reference of the Historical Child Abuse Inquiry Scotland.

### **3. Access/flow through service**

#### **3.1 Referral**

**The service provider should give details of how it will process referrals from a range of sources.**

The service must offer a range of referral routes. These routes may include:

- Self-referral by the survivor themselves.
- Referral by a family member or carer either for the Survivor or for themselves
- Referral from Health – Primary care: GP, A and E, Midwives, Dentistry, etc.

- Referral from Health - secondary and tertiary services e.g. substance misuse and mental health services
- Referral from Third Sector Organisations
- Referral from Local Authority agency e.g. Social Work, Social care, Homeless service, Education or Housing
- Referral from Police Scotland
- Referral from Justice or Scottish Prison Service

The above list is not exhaustive and the service provider should detail any additions to these access/referral routes or propose any alternative referral routes they deem appropriate.

### 3.2 Access process

**The service provider must give full details of how the process for access to the service will be operationalised detailing any proposed changes to the process in Diagram 1 ( page 18).**

The access process that is envisaged is set out in **diagram 1**. This process must ensure that survivors understand how they will be supported and clearly set out the various steps and roles within the process.

It is essential that the service provider defines and explains the different staff roles so that survivors know who they can expect to speak to about the various steps in their engagement with the service. In order to ensure survivors have access to the level of knowledge and skills required to support them it is envisaged that the person who discusses and co-ordinates their care with them will **not** also deliver that care.

Consideration must be given to how staff will be supported in their roles to encourage trusted relationships but also manage potential dependency and boundary issues. Clear support and supervision structures must be identified and detailed.

### 3.3 Access Requirements

**Service providers must confirm their ability to meet access requirements or suggest an alternative process that can meet survivors expectations of a speedily accessible service. Service providers should detail options for expansion to the hours and give details of scaling up/down the access requirements as the service develops and contacts increase/decrease over time.**

It is envisaged that the **minimum** the service will provide will be

- Telephone:  
A Freephone telephone number operating between 0900-1700 on weekdays with an evening and weekend ansaphone to take messages.
- Online, either by email or via a purpose designed website form.
- Letter or form from website.

Messages should be responded to no later than the next working day if received during the working day, and by the Tuesday following a weekend. There will be the option to review the response time according to the number of contacts.

Telephone, email or online inquiries should be answered personally by *communication support workers* who are able to explain what the service can offer and the process this involves.

### **3.4 First point of contact**

**The service provider must confirm agreement with the access process or suggest an alternative and give full details of how the process for access to the service will be operationalised. This process must ensure that survivors understand how they will be supported and clearly set out the various steps and roles within the process. This must detail the job description and person specification for the roles set out in diagram 1 or any alternative suggested access process.**

**These job descriptions should include the need for staff dealing with initial contact to be trauma aware, have good listening skills and be able to have an empathic response to distress with the ability to be assertive and bounded in their communications with survivors in order to enable survivors to access the expertise and support they need. Consideration must be given to how staff will be supported in their roles to encourage trusted relationships but also manage potential dependency and boundary issues. Clear support and supervision structures for staff must also be identified and detailed (see also section 3.2).**

The Service needs to set expectations for survivors at initial contact about what the service can offer and be clear that the first point of contact is not in itself a telephone counselling service. The access process that is envisaged is set out in diagram 1.

It is envisaged that a *communication support worker* will be the first point of contact for the service. Their primary role with survivors is to register individuals with the service and to arrange appointments with *personal outcome support co-ordinators* for an initial conversation.

The *communication support worker* will have clear boundaries for their role within the service established and will set clear expectations with survivors on initial contact as to their role.

### **3.5 Initial support conversation**

**The service provider must confirm agreement to the service timescales detailed below or suggest suitable alternatives. A process should be developed and details given for reminders of appointments e.g by text, phone or email that will encourage survivors to keep arranged appointments.**

A first conversation or meeting with a *personal outcome support co-ordinator* should be offered and a time and date offered immediately to the survivor within five working days of their first contact. Appointments should be arranged in person at a mutually agreed location, by video or telephone depending on the preference of the survivor.

#### **4. Registration**

**The service provider must detail what details are necessary to register and how registration and any other data will be recorded, securely stored, used and shared in the delivery of services. This must be compliant with data protection regulations and consent of the service user.**

Once registered with the service the survivor will remain so until they themselves decide to deregister. This will ensure continuity particularly at times of transition across domains of need, decrease the need for survivors to have to repeat information and increase engagement with the service.

#### **5. Personal Outcome approaches leading to needs based assessment:**

##### **Background:**

A focus on personal outcomes – making sure that public services are designed to deliver what people want – is a central plank of national policy, in line with the Christie Commission report and the Scottish Government's response.

An outcomes approach to assessment, planning & review aims to shift engagement with people who use services away from service-led approaches. This involves everyone working together to achieve the best possible impact on the individual's life. The philosophy of this approach is one that emphasises the strengths, capacity and resilience of individuals, builds upon natural support systems and includes consideration of wider community based resources.

Personal outcomes approaches involve conversations with the survivor about what matters to them. These conversations lead to needs based assessments and the development of personal recovery plans. Personal outcomes approaches put people at the centre of the support they receive.

The *Joint Improvement Team* have led the way in Scotland to promoting a personal outcomes approach. They have pioneered the development of Talking Points, a user and carer led approach to identifying personal outcomes that informs the design and review of care and support services.

The Scottish Government wishes to continue to promote the adoption of Talking Points as a key component of personalising care and support and delivering the outcomes that are important to people. <http://www.jitscotland.org.uk/action-areas/personal-outcomes/>,

#### **5.1 Personal outcome conversation and establishing care and support plans:**

The service provider must provide details of how they propose to deliver the element of the service set out below. This must include:

- projections of staff requirements and details of expected client numbers;
- options to scale up or scale down requirements as need and uptake of the service is established;
- approaches, models and methods by which personal outcomes will be identified and evaluated e.g Talking Points, IROC <http://www.penumbra.org.uk/innovation/personalised-services/>, or IRISS; and
- the competencies, knowledge and skills required by staff carrying out personal outcome conversations, advocacy and support co-ordination and include full job descriptions, person specifications and levels of professional qualification ( if relevant) and authorisation (see also section 3.4).

Each survivor will be offered a personal outcome based conversation and assessment to begin engagement with the service. It is critical that the outcomes agreed are regularly reviewed, to ensure the continued relevance of support and services, and to support service planning, commissioning and improvement over time.

It is envisaged that the service will provide a national team of support co-ordinators trained in personal outcomes approaches. Co-ordinators will meet with or have some other form of communication (e.g.video link) with survivors to begin building trusting relationships and have conversations to establish and review personal outcomes and needs. From these conversations a pathway to recovery of support, care and treatment will be designed and agreed with the survivor on a needs led basis.

## **5.2 Case Management and Advocacy.**

Survivors have told us that it is often difficult to find out what resources and services are available to them and to negotiate access to services. Advocacy to enable survivors to gain access to support will be a key element of the service. The support co-ordinator will be the point of contact for the survivor but their role will be to co-ordinate and broker services to meet survivors' needs. They will not provide the care, treatment or support themselves unless appropriately qualified and authorised to do so.

## **6. Service Domains**

**The service provider must detail and confirm how they will ensure the delivery of the service domains as set out below. Additionally service providers should set out their proposals of how the discretionary/flexible element of the service could be developed and delivered (see page 6, 11. Scope of Service).**

Services offered to survivors will be determined by personal outcome needs based assessments. Through these assessments a personal support pathway and reviews

will be agreed with the survivor. Through advocacy and case management survivors will be enabled to access support across all domains of wellbeing. These domains will include:

- assisting and facilitating appropriate contact to help support survivors in accessing health and care support e.g. clinical support to include links to mental health and alcohol and substance misuse services;
- assisting and facilitating appropriate contact to help support survivors in accessing support through statutory services e.g. housing, employment, education and legal services including criminal injuries compensation scheme if appropriate;
- assisting and facilitating appropriate contact to help support survivors in accessing support through other appropriate health, voluntary, community and social care agencies including peer support and befriending;
- assisting and facilitating appropriate contact/signposting to help support survivors in accessing files and records from their former care setting;

## **7. Brokering and commissioning.**

**The service provider must demonstrate their experience and skill in brokering service delivery as described in the service delivery model (Diagram 2, page 19). The service provider must outline their proposed process and procedures to commission services where appropriate.**

Delivery of the service is designed around a brokering and commissioning model as laid out in diagram 2 and described under the essential components of the service delivery model section of this document (page 4&5, 10. Delivery Model) .

The service provider is expected to engage and broker appropriately at locality level with statutory and non-statutory agencies and professionals who provide services to survivors of childhood abuse in order to meet the needs of survivors.

Where such services do not exist or access to them is delayed or difficult but required to meet the immediate needs of the survivor the service provider will develop processes and procedures to commission such services.

## **8. Partnership Working**

**The service provider must demonstrate their experience and skill in partnership working giving details of how the service will develop capacity and capability at local partnership levels across the service domains that survivors may need. Service providers should detail staffing requirements and competencies to fulfil this aspect of the service.**

The expanded brokering and commission model of the proposed service is expected to assist in the development, capacity and capability of services at local level, not duplicate or overlay existing services.

It is expected that the service provider will be skilled and experienced in innovating the development of capacity and capability in localities where service gaps may exist

and show experience of partnership working with statutory and no statutory agencies in such developments.

## **9. Governance and Accountability**

**The service provider must provide full details of its governance and accountability processes and structures as well financial management (and that of its partner agencies in the case of partnership or consortium bid). This will include details of staff competencies, qualifications, and professional registration where appropriate. It will detail grievance and complaints escalation procedures on all aspects of the service it proposes to provide. It will also include the process and details of risk assessment and training required for the identification of risk at all levels of service provision including the management and monitoring of the success of the service.**

It is essential that providers of publicly funded services can demonstrate robust governance and accountability structures and financial management procedures.

## **10. Information and Data required for reporting collection, monitoring and service impact evaluation.**

**The service provider must detail the robust methods of data collection for the monitoring and impact evaluation of the service. The section below gives details of the types of data that may be required to be collected and presented but is not exhaustive. Service providers should confirm their ability to gather and present such data and/or suggest any additions or alternatives. Service providers should note that data requirements may change as the service develops and should confirm their willingness to work with the sponsoring division within the Scottish Government to develop any additional data requirements that may be needed in future.**

The service needs to demonstrate through clear, sensitive and accessible reporting how the service offers in-care survivors an holistic integrated pathway of care, support and treatment and the impact thereof. Data will be required to establish how survivors' complex needs are being met, what the impact of support is on their journey travelled and where there are gaps in support.

Satisfaction questionnaire scores are not deemed an acceptable measure of outcomes. The needs of survivors can be complex and this should be reflected in the data presented.

The list below aims to outline the types of data that may be required:

- **Demographics** - the basic demographics of individuals currently accessing the service e.g. survivor, family or carer's, postcode/region, age, gender, marital and employment status. Care setting etc .This data must be given as:
  - **Prevalence data:** overall numbers of people accessing the service from the start of the service
  - **Incidence data:** numbers of new people accessing the service for each three month period of the year.

- **Access data:** which routes survivors and their families use to access the service.
- Time taken to first personal outcome assessment from first contact.
- Domains of wellbeing and support survivors currently access.
- Numbers of survivors accessing each domain.
- Service domains most frequently accessed.
- The methodology and rationale for any sampling methods or comparative statistics used.
- The mean and mode numbers of sessions accessed for each type of support/domain.
- **Complexity data:**
  - variation and complexity for prevalence and incidence data for access to different domains of care and support e.g. How many survivors access one, two, three, four or more domains/support services by name of domain/support service
  - Are there particular combinations of support needs
  - Is there a particular demographic linked to complexity – what are the demographics of people accessing multiple services
  - Are there gaps? Is unmet need identifiable?
- **Impact data:**
  - measures used to demonstrate the impact of services on survivors' personal outcomes e.g. pre and post service CORE 10 total scores as a measure of general psychological wellbeing, Trauma symptom inventory or other measures, uptake of work or other meaningful activity, access to educational courses, reduction and/or change in substance use.
- **Risk data:**
  - details of risk assessments and responses particularly in relation to self harm and suicidal ideation. We are interested in risk assessment as part of wider personal outcomes conversations as the start of a mitigation of suicide or self harm plan for individuals.
  - Identify risks for service success and give RAG (red, amber, green) status.
- **Partnership data:**
  - mapping of partners and local support services.
  - details of any protocol and pathways across partners and identify support gaps.
  - Give details of the numbers of people accessing services referred onto by the service provider.
  - total and monthly number of referrals to other services
  - Uptake of these referrals if known
  - Reason for non-uptake if known
  - to report activity and impact of the service by locality staff
- **Transparency, Efficiency and Value for Money data:**
  - the cost per hour and total cost of provision for the different support services provided i.e running support groups, highly specialist treatment for complex PTSD, advocacy support, personal support,

supportive counselling, befriending, peer group meetings, help to access records etc.

Where relevant and as the service develops we expect the service provider to require partners delivering the interventions to give the following information:

**Advocacy Work** :Specify the knowledge, skills and competencies required of staff acting as advocacy workers.

**Support work** : Specify the knowledge, skills and competencies you require of staff acting as support workers.

**Counselling and Therapy**: Specify the knowledge, skills and competencies you require of counsellors and/or therapists delivering psychological therapeutic interventions to Survivors.

**Models of counselling and/or therapy** used: e.g. person centred, integrative, solution focused, phase based trauma focused, EMDR. Set out how psychological interventions align with recommendations from the Psychology Matrix, NICE and SIGN guidelines where appropriate. For trainee and volunteer counsellors specify the model and level of intervention they deliver, training and supervision arrangements.

**Clinical supervision arrangements** for each counsellor making clear who or which organisation is offering supervision, and accrediting bodies of these supervisors. Detail how these arrangements are governed.

## 11. Sponsorship Arrangements

**The service provider must confirm their ability and willingness to work in partnership with Scottish Government officials in the initial set up and development of the service as well as its on going monitoring and impact evaluation. It is expected that the service provider will nominate a single point of contact to liaise with officials on all matters relating to the service and ensure compliance with service data requests in a timely manner.**

The service provider is expected to report regularly to the Scottish Government sponsoring team on all aspects of the service. This will require regular written reports as well as face to face meetings. During the initial set up and development of the service the provider and sponsor team may seek monitoring information and meet more frequently.

## Check list of information to be included in all applications:

Service providers should ensure that the following information is included and clearly identifiable within their response.

Section	Requirements	Included Y/N
1	Engagement & Communication	
2	Eligibility	
3	Access/Flow through service	
	3.1 Referral	
	3.2 Access Process	
	3.3 Access Requirements	
	3.4 First Point of Contact	
	3.5 Initial Assessment	
4	Registration	
5	5.1 Personal Outcome Approach	
	5.2 Case Management & Advocacy	
6	Service Domains	
7	Brokering & Commissioning	
8	Partnership Working	
9	Governance & Accountability	
10	Data, reporting and impact evaluation	
11	Sponsorship arrangements	

In addition to the checklist above service providers are expected to provide:

- Detailed strategic and operational plans for the proposed service including communication and engagement plans, project delivery plans, financial plans and projections.
- Detailed development plan to set up the service (if required) – this should include the initial preparatory work required including timescales to operation,

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any phased approach being proposed, and any training requirements prior to and during initial set up.

- Detailed proposed organisational and staff structures and governance arrangements.
- Detailed strategic outcomes and aims of the service forecast for the next 5 years and details of how impact will be measured.

**Additionally the service provider must in its response ensure the following:**

- Demonstrate an understanding of the future vision of a Support fund service, its principles, and implications.
- Ensure that the service embraces the philosophy of the revised SurvivorScotland outcomes framework

Diagram 1: Delivery Model – Survivor Experience

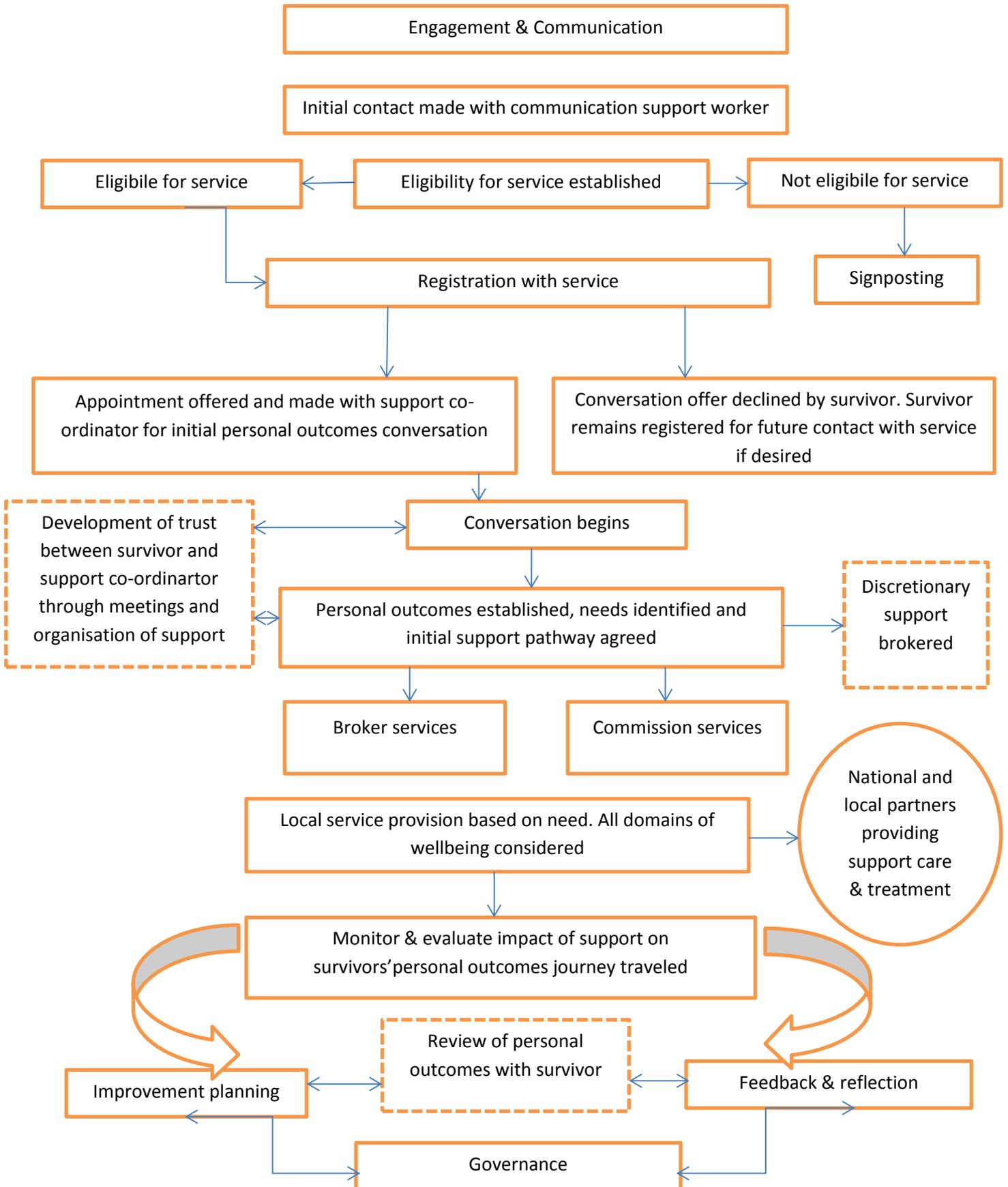
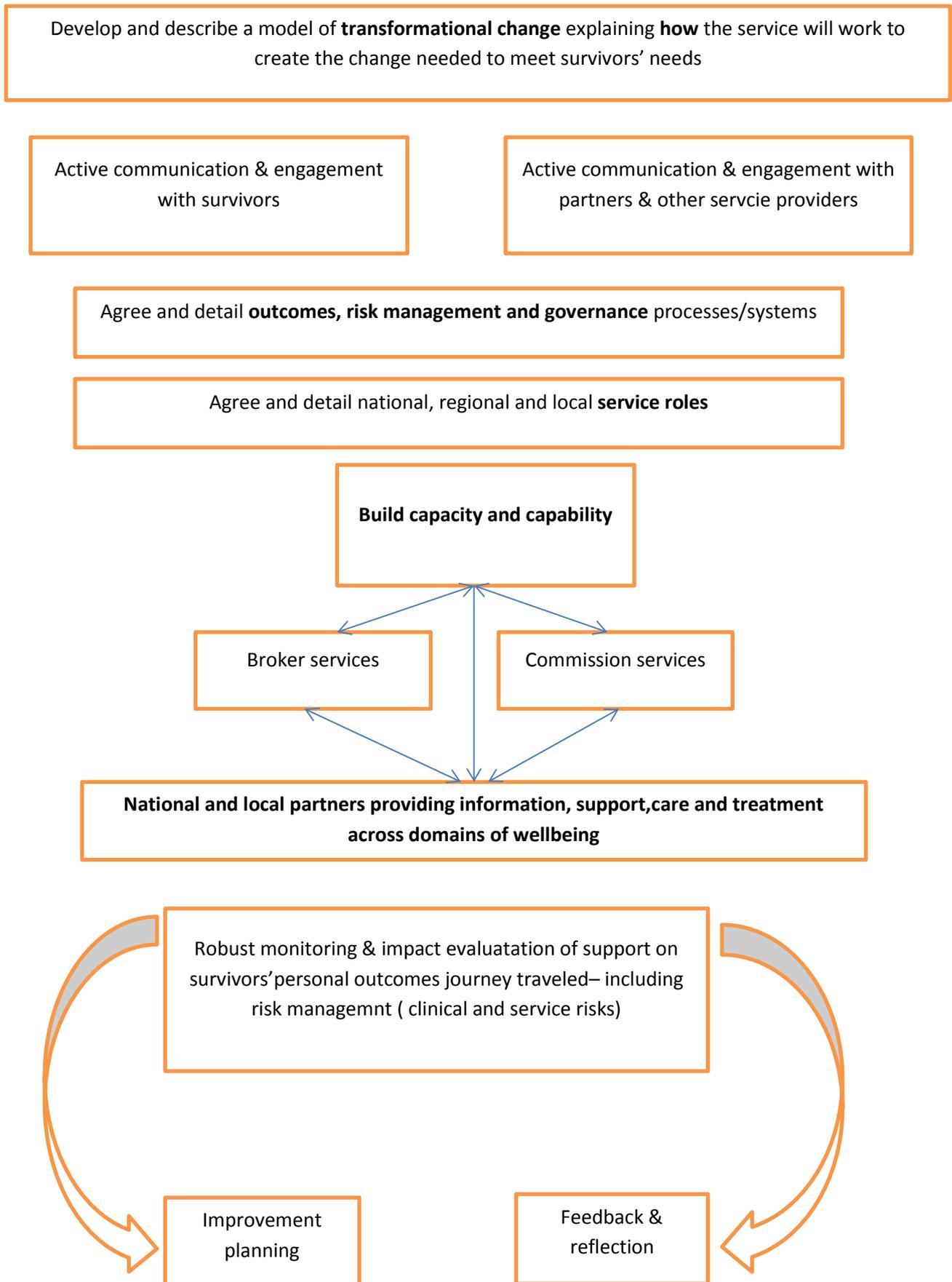


Diagram 2: Delivery Model - Organisational



## Annex of Terms and definitions

**Abuse**-The Oxford Online Dictionary defines this as 'treat with cruelty or violence, especially regularly or repeatedly'. However, separate subtypes of abuse are generally referred to in the literature.

**Child abuse and neglect**- The World Health Organisation (2014) defines this as 'physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment.' Research shows that many people experience more than one type of childhood abuse.

**Childhood Sexual Abuse (CSA)**- defined by the World Health Organisation (WHO 2014) as 'the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society'

(pg75

[www.who.int/violence\\_injury\\_prevention/resources/publications/en/guidelines\\_chap7.pdf](http://www.who.int/violence_injury_prevention/resources/publications/en/guidelines_chap7.pdf))

"Childhood sexual abuse (CSA) involves an interpersonal betrayal of trust, often in primary relationships, during critical developmental periods. This has the potential to compromise the socio-emotional development of the survivor resulting in increased vulnerability to difficulties in regulating emotions, attachment, and one's sense of self (Courtois & Ford, [2009](#))."

### **Emotions and emotion regulation in survivors of childhood sexual abuse: the importance of "disgust" in traumatic stress and psychopathology**

*Eimear Coyle<sup>1,2\*</sup>, Thanos Karatzias<sup>3</sup>, Andy Summers<sup>2</sup> and Mick Power<sup>4</sup>*

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" Interpersonal trauma includes any type of traumatic event wherein another person causes the trauma. Typical examples include childhood maltreatment, child abuse, rape, assault, domestic abuse, emotional abuse, and neglect."

(Thanos K 11-08-15 private communication).