# Managing disclosures of sexual abuse from adults

The practitioner's immediate verbal and non-verbal responses to a disclosure can have a significant impact on the survivor:

- **Accept the information** – the practitioner should show they have heard the information, accepted it and say they believe that children are never responsible for the abuse.
- **Express empathy and caring** – looking at the person and simple statements of concern can convey both compassion and interest, for example, "I'm really sorry this happened to you"
- **Clarify confidentiality** – tell the client whether you have to notify anyone else and ask them how they want the information recorded in their case notes.
- **Acknowledge the prevalence of abuse** – survivors can feel very isolated and alone in their experience. Providing information about the prevalence of abuse can be helpful, for example, "We know that as many as one in three women and one in seven men are survivors of childhood sexual abuse. It is sad to realize that so many children have suffered in this way."
- **Validate the disclosure** – the practitioner should validate the courage it took to disclose and communicate that they believe what they have been told. Visible distress needs to be acknowledged, for example "I see that this is painful for you right now. What can I do to help?"
- **Address time limitations** – if a client discloses a history of abuse and the practitioner can only spend a few minutes with them afterwards, it is important that the time constraints are communicated in a way that will not leave survivors feeling dismissed or that they have done something wrong by disclosing.
- **Offer reassurance** – after disclosure clients may feel vulnerable and exposed. Practitioners should reassure them that they applaud their courage in talking about past abuse

- **Collaborate to develop an immediate plan for self-care** – practitioners may need to prepare clients that they may have unsettled feelings or flashbacks to their abuse as an immediate after effect of disclosure. They should work to make a specific plan for self-care. For example, “Sometimes talking about past abuse stirs up upsetting memories, tell me what you can do to look after yourself if this happens to you.”
- **Recognise that action is not always required** – the client may just want the practitioner to have the information and not necessarily expect the practitioner to do anything else except to be present with them in the moment. Not all survivors want or need to be referred to a mental health practitioner. By offering a referral before exploring the survivor’s intentions, it may look like the practitioner has judged the survivor to be “not okay”. It is important to first reinforce the acceptance of the survivor after the disclosure and explore the presence and effectiveness of supports (e.g. friends, family, counsellor etc.). This provides useful information about current resources and helps identify gaps. Raising the issue of referral to a mental health practitioner may be best postponed to a later interaction.
- **Ask whether this is the patient’s first disclosure** – this may help the practitioner get a sense of whether the survivor has previously taken any steps to address the abuse. It may also help them learn whether there were any previous poor responses to disclosure, what supports the clients have in place and what they may need.
- **Use the information to support the client** – over time the practitioner may seek to understand the survivor’s reasons for disclosing and determine what (if anything) they want from the practitioner. For example, “Knowing this will help us to give you better support. Let me know what you need. I know that this abuse happened and if you need to talk about it or have any questions you can talk about them with me.” This may help the survivor express their needs or preferences.

  **(Schachter et al, 2008)**

SAVE the situation: The acronym *SAVE* is a guide for responding effectively and compassionately in a variety of emotionally charged situations

***S****TOP* Stop what you are doing and focus your full attention to the present situation

***A****PPRECIATE* Try to appreciate and understand the person's situation by using the helping skills of empathy and immediacy. Empathy involves imagining the other person's experience (thoughts, feelings, body sensations) and communicating an understanding of that experience. Immediacy is verbalising one's observations and responses in the moment, using present tense language.

**For example**, "Your fists are clenched and you look angry. What is happening to you?" or "You seem upset" or "I doubt there is anything that I can say that will make this easier. Is it okay with you if I sit here with you for a few minutes?"
Of the patient is unable or unwilling to answer. the practitioner can shift the focus to determining possible ways to be helpful (e.g. "How can I help you?"

***V****ALIDATE* Validate the other person's experience. For example, "Given what you have just told me, it makes sense that you feel angry.

***E****XPLORE* Explore the next step/s. For example, "Who can I call to come and stay with you? or "This has been difficult for both of us. I am not sure where to go from here. Can I call you tomorrow to see how you are doing?

# What not to do! Survivors have identified the following responses as clearly not helpful

- Conveying pity (e.g. “Oh, you poor thing”).
- Offering simplistic advice (e.g. “Look on the bright side,” “Put it behind you,” “Get over it,” or “Don’t dwell on it, it’s in the past.”).
- Overstating or dwelling on the negative (“A thing like that can ruin your whole life”).
- Smiling (while you may hope that your smile conveys compassion, a neutral or concerned expression is more appropriate).
- Touching the person without permission even if you intend it as a soothing gesture.
- Interrupting (let the individual finish speaking).
- Minimizing or ignoring the individual’s experience of abuse, the potential impact of past abuse, or the decision to disclose (e.g., “How bad could it be?”, “I know a woman that this happened to and she became an Olympic gold medallist”).
- Asking intrusive questions that are not pertinent to the examination, procedure, or treatment.
- Disclosing your own history of abuse.
- Giving the impression that you know everything there is to know on the subject.
- If clinicians think that they have inadvertently responded to the disclosure in an inappropriate way, or if the patient’s non-verbal feedback suggests a negative reaction to their initial responses, they should immediately clarify the intended message and check with the survivor for further reaction.

**(Yes You Can! Nelson and Hampson, 2008)**