

**Speaking the Unspeakable: An Exploration of Key Issues Relating to the Disclosure of
Childhood Sexual Abuse by Adult Clients in the Psychotherapy Space.**

By

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Submitted in partial fulfilment of the requirements of

The Higher Diploma in Counselling & Psychotherapy

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April 2025

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Abstract

This research reviews literature relating to the disclosure of child sexual abuse (CSA) by adult clients in the psychotherapy space. It highlights how a range of silencing factors—such as shame, fear, and societal stigma—may contribute to delayed disclosure until adulthood. The therapeutic setting is found to offer survivors a space to begin narrating their traumatic experiences, with disclosure representing a significant moment in the client’s healing journey. This research emphasises the importance of the therapist’s role in managing and responding to disclosure with sensitivity and care. It concludes that trauma-informed, supportive responses by psychotherapists are essential in validating the survivor’s experience and establishing a foundation for further healing.

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Introduction

There is extensive research on how the lasting impacts of child sexual abuse (CSA) can perpetuate throughout adulthood (Felitti et al., 1998; Fisher, 2017; Herman, 1992; van der Kolk, 2014). Psychopathology in adults, including depression, anxiety, addiction and eating disorders have been linked to earlier experiences of CSA (Hailes, et al., 2019). The ability to have traumatic experiences heard within an environment that is psychologically safe, and in the presence of a non-judgemental, empathic other, is an important factor in the wider healing of these experiences (Chouliara et al., 2012). Available data indicate that delays in the disclosure of CSA until adulthood are common. In a survey of 288 adult female survivors of CSA, Smith et al. (2000) found that 47% had delayed disclosure of their abuse by more than one year, while a further 28% had never disclosed their experience prior to being surveyed. A study by Jonzon and Lindblad (2004) reported that 68% of CSA survivors did not disclose their abuse until adulthood. In Ireland, the SAVI (Sexual Abuse and Violence in Ireland) Report (McGee et al., 2002) found that 47% of adult respondents had told nobody about their abuse until the time of the survey. Additionally, McElvaney (2002) reported delays ranging from 20 to 50 years between the abuse and disclosure among a sample of Irish cases.

While a wealth of research exists regarding the impact of CSA on the client and reasons for the delay in its disclosure, there is significantly less understanding of how the psychotherapy space can support the client in their disclosure. The aim of this research is to examine key issues relating to the disclosure of CSA by adult clients within the immediacy of the psychotherapy space. If the psychotherapist understands why delayed disclosure is common, as well as the therapeutic significance and risks associated with the articulation of traumatic experiences, they can offer crucial facilitation, containment, and support to the client. Clients report that the

therapist's response is significant to them in the disclosure of their abuse. By understanding the elements that constitute a supportive response, the psychotherapist can better assist the client in the difficult but important undertaking of sharing their experience of CSA.

The objectives of this research are to understand the factors contributing to the delayed disclosure of CSA survivors until they present as adults in psychotherapy, to examine how client-led disclosure of CSA occurs in the psychotherapy space and to explore how therapists can meet disclosures with a supportive, trauma-informed initial response.

Chapter One – The Client Experience

1.1 Factors Delaying Disclosure Within Childhood

There are many reasons why decades may pass before someone discloses childhood sexual abuse. While this research focuses on adult survivors, understanding the context of their childhood is key to recognising why disclosure did not occur earlier. Each person's experience of CSA—its psychological and physical impacts, and the difficulty of expressing it—is unique. Therefore, it is not possible to ascribe uniform reasoning as to why, for many individuals, it may be decades before their experiences of CSA are spoken aloud, if ever.

Familial, societal, cultural and circumstantial factors may contribute to the delayed disclosure of abuse by the child. The context in which the abuse occurs, including the family dynamic, cultural and societal attitudes to CSA as well as the safety and support available to the individual are found to influence the disclosure. Safety is a key factor in the decision to disclose. For many victims, a member of their household was the perpetrator of the abuse (Doğru et al., 2024). Herman (1992, pp. 171–172) identifies physical distance, psychological safety, and the establishment of independence from abusers as important factors influencing the decision to disclose. Perpetrators may use implicit or explicit threats of violence, escalate the abuse, or suggest other frightening consequences to force the child to maintain the secrecy (Bădărau & Raiu, 2024), however findings are mixed in relation to whether this is successful in enforcing silence (London et al., 2005).

The familial context also influences disclosure. Survivors of sexual trauma are more likely to delay or abstain from disclosure when they are relationally close to the perpetrator (Smith et al., 2000; Marriott et al., 2016). Children may remain silent out of fear of their parents' reactions

(Hershkowitz, 2007). They may struggle with guilt over the impact that disclosure could have on other family members, or fear rejection or ostracism from the family (Carson, 1990; Yama, 1993; Edwards & Alexander, 1992). Older children may be cognisant that younger, more vulnerable family members could be targeted if they speak out, and may endure silence to protect them (McElvaney, 2008).

Shame, guilt, and self-blame are often implicit in the experience of CSA (Draucker & Martsolf, 2006). Children are unable to consent to sexual activity, and thus the responsibility for their sexual abuse lies solely with the adult perpetrator. The attribution of blame to the perpetrator becomes more complex when considering instances of abuse committed by juvenile peers (Gewirtz-Meydan & Finkelhor, 2020), which is beyond the scope of this research; however, victims remain blameless for their abuse, regardless of the perpetrator's age. Nevertheless, self-blame is a potent feature for the child. A child may feel responsible for their abuse, particularly if they experienced physiological arousal during the abuse, sought connection with their abuser, or were told by the abuser that they were complicit (Herland, 2023). Involuntary physiological responses occur in the body in response to stimuli due to biological mechanisms (Levine, 2010); however, this does not indicate consent or sexual enjoyment on the part of the child. Similarly, sexual abuse involving a perpetrator who is also a caregiver creates a confusing dynamic for the child, who may seek the love and affection they should otherwise have been provided within the abusive framework imposed upon them. Research by Eisikovits et al, highlights parent or caregiver abusers may normalise the abuse as an expression of healthy parental duty, care and affection (2017). Shame has been found to be a powerful factor in the reluctance of male victims to disclose, due to entrenched patriarchal societal beliefs. Male child victims may feel that they should have been strong enough to prevent the abuse, that men should not identify as victims, or

that their sexuality will be questioned if the perpetrator was male (Draucker & Petrovic, 1996, 1997; Rechenberg et al., 2024; Struve, 1990).

Not all child victims who delay disclosure wait until adulthood; some disclose months or years after the abuse occurred. A study by Dođru et al. (2024) found that earlier onset of abuse, lower maternal education, and being female were associated with longer delays in disclosure. Very young children may lack the cognitive or emotional capacity to recognise abuse, contributing to delayed disclosure. Mothers with lower education levels may be less aware of CSA indicators and unsure when or how to seek help. Female victims experienced longer delays, which, in an Irish context, may relate to women more frequently citing shame or embarrassment as barriers to childhood disclosure (Central Statistics Office, 2023). Ungar et al. (2009a) found that youth were more likely to disclose abuse when they trusted that professionals would respond effectively, while fear of family separation was a key barrier.

1.2 Factors Delaying Disclosure Within Adulthood

Many child victims of CSA enter adulthood without disclosing their experiences. Adult survivors often face complex feelings about disclosure, including shame, guilt, fear, isolation, and mistrust. Bădăraiu and Raiu (2024) note that survivors risk judgment, blame, or disbelief when sharing their experiences. Disclosure may disrupt family dynamics built around minimising or denying the abuse, and survivors may fear retaliation from the abuser or others. In incest cases, survivors may also fear societal outrage or discomfort (Herman, 2000, p. 130). The stigma surrounding incest can deepen the survivor's suffering, with cultural and social responses sometimes exacerbating feelings of shame, isolation, and exclusion (Nielsen, 2016).

For some, the delay in disclosing abuse may not have been a conscious decision. Van der Kolk (2014, pp. 192–194) highlights the survival mechanisms involved in the repression of traumatic developmental experiences. Van der Kolk argues that it is possible to carry implicit, physiological memories of past traumas without the need for narrative memory. Significant debate has arisen regarding the later recovery of repressed traumatic abuse memories. Loftus (1993) underscores the suggestibility of human memory and cautions against the creation of so-called false memories (Laney & Loftus, 2005). Other researchers have proposed nuanced approaches to explain the emergence of trauma-related memories. For instance, Betrayal Trauma Theory suggests that when abuse is committed by a caregiver, dissociation or hallucinations may occur as a means for the child to cope with the abuse while maintaining attachment to the parent figure, which is essential for survival (Gómez & Freyd, 2017). Considering the complexities of trauma, memory and the developing brain, it is possible to understand why survivors may not recover memories of what happened to them until many years or even decades, later—if they recover them at all.

Adult survivors of CSA may also experience comorbid issues such as addiction or eating disorders (Stein et al., 2002). During active addiction or severe mental distress, survivors may be unable to process their trauma, instead relying on substances or behaviours to cope. Gabor Maté (2008), reflecting on his work with drug-addicted patients in Vancouver’s Downtown East Side, found that many histories revealed childhood trauma, including CSA and suggests that addiction often represents an understandable response to unmanageable early experiences.

Chapter Two – The Client Speaks

2.1 The Adult Survivor Approaching Therapy

In her work on trauma, Janina Fisher (2017) outlines the context in which survivors arrive at therapy. They may lack a chronological narrative to explain the trauma-related symptoms that dominate their lives and hinder their well-being and capacity to function. Traumatic life events, such as CSA are significant life markers, and victims often describe a clear delineation of who they were before the abuse occurred, and who they became after. This temporal disruption, dividing life into two halves, requires the careful resituating of the trauma narrative into a way which allows the individual to integrate the events into the chronology of their subjective experience. A later chapter will discuss the development and reframing of the trauma narrative in the psychotherapy setting.

Many CSA survivors may not arrive at therapy with a goal of addressing and reconciling their abuse, but with seemingly more contemporary issues and concerns. Survivors may present as otherwise functional individuals who harbour self-destructive impulses or internalised negative self-beliefs that defy explanation relative to the lives they lead. They may minimise, downplay, or deny their trauma history. Rarely does the adult survivor of CSA arrive in the psychotherapy space with an organised, coherent narrative to explain their trauma; instead, they present with a range of symptoms and experiences that help to tell their story.

Disclosure of CSA by adult survivors often results from a combination of factors. Josephson and Fong-Beyette (1987) found that female incest survivors disclosed when they could no longer live with their symptoms and believed speaking out would bring relief. Media coverage also played a role in encouraging disclosure, and many survivors disclosed after being asked directly by a counsellor. This aligns with Courtois (1997), who recommends including questions about early trauma during assessment. Survivors carefully weigh the risks of disclosure against the potential

relief of being heard and the safety and containment of the therapy space can create the conditions needed for survivors to finally voice their experiences.

2.2 The Safety & Containment of the Psychotherapy Space

While the immediacy of the therapy space may support the facilitation of disclosure, it is not the space itself that brings about disclosure; rather, it is a space and a relationship that the client uses to bring into articulation their experience of CSA. Consideration of what can be afforded to the adult client in psychotherapy underpins the possibility that disclosure will occur there. Notable work by Rogers (1967) outlines the importance of empathy and non-judgement, and how, when these are present, the client experiences trust in the therapist, in themselves, and in the telling of their experiences. A systematic review of studies undertaken by Chouliara et al. (2012) illustrates a supportive therapeutic alliance as a key factor in the healing process and a motivator to share difficult personal experiences with a compassionate witness. Safran and Muran (2000) find that the therapeutic alliance is a key factor in treatment success across all presenting issues and treatment modalities.

Interviews with adult survivors of incest indicated that qualities in the therapist, such as calmness, non-judgement, empathy, and honesty, were perceived as helpful by the client (Josephson and Fong-Beyette, 1987). However, the presence of these qualities was not enough to bring about disclosure. Rather, it is client readiness that dictates a client-led disclosure. Courtois (1997) remarks that clients may outright deny or obfuscate a history of abuse with a positive self-report of childhood. This is a conscious or unconscious process, which may be considered part of

the client's avoidance of the abuse, and the therapist is cautioned not to make assumptions that an abuse history is not present based on initial client responses to direct questioning.

The disclosure of CSA by an adult client also constitutes the revelation of a historic crime, which may raise safeguarding concerns for the psychotherapist in the present day. Therapists must also consider their own legislative obligations regarding the handling of such knowledge and navigate how this impacts the therapeutic alliance. They may feel compelled to interrupt disclosure in order to remind the client of the exceptions to confidentiality and mandated reporting requirements (Department of Children and Youth Affairs, 2017). A previously established confidentiality agreement may be referenced at this point. The therapeutic alliance may be compromised where clients experience therapists' safeguarding obligations as a betrayal of confidentiality, with the potential for retraumatisation. The British Psychological Society (2023) suggests that these negative outcomes can be mitigated through the clear explanation of exceptions to confidentiality and the nature of identifiable information in relation to such disclosures. Where mandatory reporting takes place, client involvement in decision-making, where possible, may reinstate a sense of control and trust within the client–practitioner relationship and preserve psychological safety for the client.

2.3 The Act of Speaking

The literature highlights that the experience of unburdening oneself of long-held secrets in the presence of a compassionate witness is a profoundly healing experience for clients. Van der Kolk (2014, pp. 221, 308) writes about the physiological changes that occur within the self when we are able to articulate these complex feelings, as well as the high toll exerted by staying silent.

Leading trauma theorists (Herman, 1992; Levine, 1997; Siegel, 1999; Van der Kolk, 2014) are in agreement that when we can begin to make sense of what happened to us, acknowledge and process painful experiences, we experience emotional release, catharsis, and energetic release.

Van der Kolk (2014, p. 234) highlights the challenge of putting trauma memories into words but argues that speaking about our experiences is a key step toward healing. In his work on trauma, he explains the physiological toll of silence—stress hormones, heightened reactivity, and physical pain result from unspoken trauma. When we break this silence, the body reacts differently; the limbic system activates as we articulate our experience and feel understood by another person.

2.4 Trauma and Language

Disclosures of CSA by adults are primarily verbal. When we share our trauma, we communicate with our full body; we may cry, shake, tremble, or make vocalisations. However, the emergence of the trauma narrative is primarily through language. Van der Kolk highlights the importance of speaking about trauma in relation to helping the individual form a sense of identity and move away from dissociative states. Telling the trauma story can allow the individual to feel a greater sense of connection to the world and others (Fisher, 2017, p. 236).

Though speaking is important, Van der Kolk also highlights the limitations of language. He writes about the need to connect the inner experience with the narrative story being told. The language centre of the brain is insufficient for expressing the totality of the inner experience; however, the trauma story may offer much-needed context, meaning, and explanation for the

inner turmoil being experienced by the individual. Van der Kolk suggests the body can bridge the external, public-facing trauma story with the interoceptive, visceral inner experiences.

In 2006, Annie Rogers applied Lacanian theory to understand the limitations that language affords to CSA survivors and the challenge they face in putting words to their experiences.

Though language can bring about the catharsis of self-expression, Van der Kolk (2014) and Fisher (2017) both caution that trauma can be safely explored without becoming overinvolved in the trauma narrative, and Levine (1997, pp. 201-203) suggests a full narrative record of the memory is not required in order for it to be conveyed. Hall & Lloyd (1989) found that many clients will appear emotionless when describing their abuse and may struggle to identify or express their feelings.

Chapter Three – The Therapist Responds

3.1 The Initial Response

A client's disclosure of childhood sexual abuse (CSA) marks a significant milestone in their healing journey. The therapist's role as a compassionate witness is crucial. In the immediacy of that first disclosure, the way the therapist listens and responds can significantly shape the client's experience and influence outcomes, either positively or negatively.

Disclosure of CSA may be planned or spontaneous, occurring all at once or in fragments. In trauma treatment, Courtois (1999), Herman (1992), and Chu (1998) propose a three-phase approach: the first phase focuses on establishing safety and identifying client resources, the second on working through the trauma and creating a trauma narrative, and the third on reconnection with the self and strengthening skills for more robust engagement with the external world. The therapist's immediate response to CSA disclosure falls within the first phase, focusing on safety and resource identification rather than deep healing work. This foundational response helps set the stage for more intensive healing in later stages.

3.2 Unhelpful Responses

The therapist's initial response to the client's disclosure of CSA plays a crucial role both in how the client experiences this significant moment and in the continuation of their healing process. In studies of the experiences of adult survivors of CSA, Josephson and Fong-Beyette (1987) and Draucker (1992b) explored the initial reactions of therapists as experienced by clients disclosing incest. Unhelpful responses included those from therapists who showed discomfort around the

subject matter, minimised what was shared, or ignored the revelation or attempted to move past it.

Potential issues relating to transference and countertransference must be identified and addressed by the therapist. The disclosure of CSA requires the therapist to listen to experiences of abuse that may be disturbing in nature. Hearing about the traumatic experiences of a client can elicit a strong negative emotional reaction in the therapist (Merriman & Joseph, 2018), and vicarious trauma is a risk factor for therapists working with trauma (McNellie & Rose, 2021). Therefore, avoidance of the trauma disclosure may represent an unconscious avoidance of the material by the therapist. Therapists with personal histories of CSA must be cognisant of how this might impact their emotional response to the client. Cavanagh et al. (2015) highlight the importance of being mindful of over-identification with the client, potential defence mechanisms at play within the therapist. Affective disconnection, minimisation, or rationalisation on the part of the therapist may emerge in countertransference. These responses may communicate to the client a therapist's unwillingness to acknowledge the significance of the disclosure and the impact of the abuse, thus hindering the transmission of empathy within the therapeutic alliance. Cavanagh et al., highlight the importance of seeking supervision when working with trauma and managing the possible empathic strain that may emerge.

The emotional affect of the therapist was found to be significant, with clients reporting negative experiences with therapists who did not remain calm or who expressed anger towards the perpetrator or parents who failed to protect them. Disgust, anger, shaming, or blaming were all unsupportive therapist responses reported by the client (Draucker, 1992b). Therapist responses of shock and disbelief were found by Draucker (1992b) and Ullman (2003) to have destructive impacts on the client's experience. Clients who felt rushed in the process of disclosing, and

clients who felt that therapists were overly preoccupied with the sexual details of the abuse, also reported unhelpful responses (Draucker, 1992b; Josephson & Fong-Beyette, 1987). Shame is a potent feature of the CSA experience (MacGinley et al., 2019), and an over-focus on the details of the sexual abuse may evoke powerful feelings of shame for the client.

If the therapist responds in a manner that is experienced as unsupportive, the familial, cultural, and societal silencing mechanisms discussed in Chapter Two may be reinforced, however, inadvertently. Josephson and Fong-Beyette (1987) found that clients who experienced a negative reaction to their disclosure either did not return to therapy or never spoke about their experience in therapy again.

3.3 Helpful Responses

In similar studies to those exploring unhelpful responses, clients who reported positive experiences noted calmness, an appropriate level of concern for their experiences and an empathic affect in their therapist (Draucker and Martsof, 2006; Josephson and Fong Beyette, 1987). In these instances, therapists encouraged their client to speak, while not seeking specific details or rushing them. A study by Farber et al. (2006) found that the majority of clients seek approval from their therapist after making a disclosure, and that affirming words and recognition of the difficult work done positively impacted the client. Draucker (1992) suggests that supportive responses may include an acknowledgment of the difficulty of speaking about the abuse, while also validating the significance of the experiences and the act of speaking about them. Exploring feelings, assessing the safety needs of the client, and stressing the counsellor's availability and openness to discussing the topic further are additionally important. Calm,

supportive responses include ensuring the client understands they can explore the topic and associated feelings at a pace controlled by them. There is no urgency to begin reprocessing work following disclosure, and client-centered therapy will allow the client to direct the course and the pace of the healing process.

Supportive responses to the disclosure of CSA were found to have a significant impact on clients and their subsequent engagement with psychotherapy. Clients who experienced a helpful response reported increased trust in their counsellor and relief following their disclosure. These clients returned to sessions, continuing to discuss the abuse with their counsellor and with significant others in their lives (Josephson & Fong-Beyette, 1987).

3.4 Risks of Disclosure

While the initial response of the therapist to the disclosure of traumatic material does not encompass the deep trauma work, a trauma-informed initial response must be provided. Fisher (2017, pp. 43–49) highlights the importance of establishing a sense of safety for the client, as well as the need to differentiate between historical memories and present experiences. Through the implementation of mindful, body-oriented approaches Ogden and Fisher (2015) propose that the body can be used as both a sensory window into traumatic memories and an anchor to the safety of the present.

Disclosure should be client-directed; however, it is the responsibility of the therapist to guide the process, mitigating the risk of overwhelm for the client. Rothschild (2000) notes that detailed exploration of traumatic experiences should be avoided until sufficient internal and external resources are in place. Primary emotional responses when speaking about sexual abuse may

include fear, anger, and a perception of the loss of control (SgROI, 1989). Traumatic flooding, or flashbacks in which the system is overwhelmed by the visceral re-experiencing of traumatic memories, is widely cited as a risk in the treatment of trauma (Fisher, 2017; Herman, 1992; Rothschild, 2000; van der Kolk, 2014). Furthermore, it is possible that the client may experience negative impacts, including a flight from therapy to avoid further interaction with the painful feelings and memories associated with CSA. Immature defenses such as denial, dissociation or projection may be enacted by the client in an attempt to cope with the reality of the trauma, and this has implications for the therapeutic alliance (Romans et al., 1999).

Research by van der Kolk (2014) informs us that the individual's trauma narrative—the subjective story that is learned and internalised by the client around their abuse—is itself a trauma-related stimulus. Speaking aloud this narrative, perhaps for the first time, may bring about automimic activation and physiological responses in the client (Fisher, 2017, p. 50).

Trauma-informed theorists agree that while the telling of the trauma narrative is an important part of the healing process, it is necessary to strike a balance between allowing the unburdening and being vigilant to the risk of emotional flooding and overwhelm for the client (Fisher, 2017, pp. 44–45; van der Kolk, 2014). The therapist must support the client to tell their story while paying attention to somatic markers that may indicate the traumatic memory has overtaken the individual's sense of safety and connection to the here and now. Changes in breathing pattern, dilation of the pupils, elevated or lowered heart rate and changes in skin tone are all potential indications of autonomic activation in the client (Rothschild, 2000).

However, CSA presents a more complex trauma that must be met and navigated not through retelling alone. Eminent trauma theorists (Rothschild, 2000; Fisher, 2017, p. 46; Schwartz, 2021) have highlighted the risks associated with the narrative retelling of the trauma and suggested

instead a parts-based approach, which allows the client and therapist to acknowledge the past and its associated feelings, emotions, and memories without becoming overwhelmed by its viscera. Modalities offering a body-oriented approach to the accessing and healing of trauma, such as Somatic Experiencing (Levine, 1997) and Sensorimotor Psychotherapy (Ogden, 2017), emphasise the mind–body connection in relation to trauma and similarly avoid a direct and unregulated engagement with the trauma.

A dual awareness approach offers an intervention for clients who become overwhelmed during the retelling of their story. By differentiating the unsafe past from the safe present, the client can materialise their story while remaining sufficiently grounded in the present. This multi-consciousness approach allows clients to interact with the feelings and emotions of their abused child selves while maintaining a connection to the agency and safety of their present selves (Fisher, 2017, pp. 44-45). While this has applications for the deep healing work that may occur later, it is also applicable to the initial telling of the trauma story.

3.5 Therapist Language

Knowing the risk of retraumatisation, a therapist may avoid the use of certain words or phrases which could bring about an unnecessarily vivid recollection of what happened to their client. However, Fisher (2017) notes the importance of the validation and support provided when the therapist voices, without hesitation, the truth of the client's experience. This can be achieved using language that does not diminish the significance of the client's experience but avoids evoking intense memory-related feelings. For example, referring to “the unsafe home you lived in” rather than “the house where you were brutally violated” (Fisher, 2017, p. 47).

Fisher connects the early keeping of the abuse secret with the later need to be witnessed by the adult survivor. The impulse to speak is itself a trauma-related implicit memory, (Fisher, 2017 pp. 50) rooted in the body's unconscious drive to seek resolution and connection by speaking and being witnessed. A trauma-informed response provides language that assures the client they are heard and believed, and offers the opportunity for the client to transform the narrative of the trauma story. Where once the secret was kept, or a story was disbelieved, there is now a compassionate witness to hear the secret, validate its significance, and convey belief in the person telling it. Van der Kolk (2014) notes that victims and survivors alike are reluctant to remember trauma. The task of sitting with another during the telling of their experience of CSA asks the listener to accept and uphold a dual reality: one in which the profound suffering, fear, and violation experienced by the client in the past are acknowledged, but also held within the safety and containment shared by therapist and client in the present.

Draucker and Martsolf (2006) write that counsellors should seek to validate emotions expressed by CSA survivors so that they can learn to trust and accept their feeling states, and work towards increasing their awareness of deeper and less accessible emotions. Strategies such as naming and describing feelings, responding to feeling statements, making contact statements, and offering empathic responses may all be beneficial in laying the groundwork for later-stage exploration of these feelings.

3.6 Reframing the Sexual Abuse Narrative

Adult survivors of CSA inhabit the experiences of their child selves. Draucker and Martsolf (2006, pp. 64–65) highlight that, in working with adult survivors, initial reframing of the abuse from an adult perspective is important. While this reorientation will continue throughout the course of treatment, much can be offered in the therapist's initial response to the disclosure to

challenge long-held narratives of self-blame and shame. Initial reframing statements may provide validation of client experiences and offer intervention against self-blame or the adoption of responsibility for their abuse as a vulnerable child. Draucker and Martsolf (2006) examine internalised self-beliefs that may emerge in the psychopathology of CSA survivors. Clients may have come to believe that they are inherently flawed as a result of being singled out and abused as children. This unfortunate narrative, as well as feelings of self-blame and shame, are widely reported as thematic for CSA survivors (Feiring, et al., 2009). Initial work to reframe the attribution of blame in the wake of a disclosure may be necessary. Many of the reasons for delayed disclosure outlined in Chapter One of this paper also serve to reinforce the self-blame and shame narrative for victims. Judith Herman (1981) discusses the societal tendency to blame a female child for abuse within a family, assigning a seductive element to the child in order to explain the crime visited upon them, rather than holding the perpetrator solely accountable. In disclosing experiences of CSA, the client may, for the first time, experience the reflection back to them of their own inherent blamelessness in their experience of being sexually abused as a child.

Discussion

This research highlights the prevalence of delayed disclosure among CSA victims, considering the familial, cultural, and societal contexts in which abuse occurs. It also addresses the internalised barriers—such as shame, guilt, and self-blame—that often silence children. For adult survivors, these factors frequently persist, with stigma, family dynamics, and fear of consequences reinforcing the unspeakable nature of the trauma. Psychological defence mechanisms such as repression may persist, while trauma-related comorbidities, such as substance dependency, can further hinder the ability to speak about the abuse.

The adult survivor of CSA may enter the psychotherapy space with a sense of temporal disruption to their identity resulting from the trauma. The therapeutic setting offers the client a space of safety and containment, through which they can begin to articulate their experiences and initiate the healing process. Language acts as a tool to bring narrative structure to the traumatic events that punctuated the story of their childhood; however, it also has its limitations. Non-verbal responses and bodily sensations that accompany the verbal articulation of the trauma must be considered integral to the disclosure process.

Therapists play a vital role in a client's healing journey, particularly when responding to disclosures of CSA. They must act as compassionate witnesses, offering supportive responses, managing disclosure risks, and using affirming language to help reframe the abuse narrative. It is also essential that therapists remain aware of their own emotional responses, managing elements of transference and countertransference, to sustain a strong therapeutic alliance.

Therapists who offer helpful responses have the capacity to affirm and validate their clients' experiences, leading to increased trust in the therapeutic relationship and continued engagement

with the healing work. A phased approach to trauma treatment is recommended, with the therapist's initial response to disclosure laying the groundwork for deeper healing. Therapists must balance bearing witness to trauma with helping the client remain grounded in the present. For many, disclosure in therapy may be the first time they express experiences tied to deep-seated self-beliefs. In this moment, the therapist has the opportunity to listen with empathy and offer an alternative narrative—one that challenges shame, affirms the survivor's innocence, and allows the client to give voice to what had, for so long, been unspeakable.

This research was limited to existing and available literature and, as such, did not include the direct input of clients or therapists as primary sources, a feature which would enrich future study. A trauma-informed theoretical orientation heavily influenced considerations regarding appropriate therapist responses to traumatic disclosure. Given that disclosure can occur at any time and in a wide range of contexts, future research should explore how practitioners without a trauma-informed background can nonetheless offer supportive and effective responses to disclosure.

In conclusion, this research finds that the trauma of CSA is compounded by silencing factors which, for many victims, may result in delayed disclosure until adulthood. Disclosure of CSA by the survivor as an adult client in the psychotherapy space represents a significant milestone in their healing journey. By responding to the disclosure in a manner that is supportive, helpful, and trauma-informed, the psychotherapist can help establish a strong foundation for further healing.

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