FACTORS PROMOTING NEGATIVE SYMPTOMS AND STRENGTH FACTORS FOLLOWING INSTITUTIONAL CHILD ABUSE IN RESIDENTIAL SETTINGS

By

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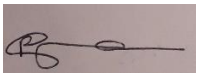
Signature of Candidate: 

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Abstract

The overall aim of the research presented in this thesis was to explore the negative impacts of institutional child abuse occurring in a residential setting, along with developing a better understanding of strength factors that protect against these negative impacts. A further aim was to examine the role that disclosure of institutional abuse plays in recovery. A mixed method approach was used. This included a systematic review of the literature, a Delphi study exploring the view of professionals, a qualitative survey examining the view of victims[1], and a Rapid Evidence Assessment of serious case reviews and online reports. Following this, a series of questionnaires were used to further explore the findings from earlier studies. Overall, findings revealed a range of negative impacts including to mental health and wellbeing, future life chances in relation to relationships and employment, and changes to behaviour. Strength factors were identified, such as positive self-esteem, proactive coping, and resilience. Personality functioning difficulties in relation to the self and negative experiences prior to placement in care were found to exacerbate the impacts of institutional abuse. Finally, it was noted that responses to disclosure play a role in future outcomes for the victim and that a lack of understanding and social support may act as barriers to disclosure. The practical implications of the research are outlined and discussed.

[1] The term victim and survivor are used interchangeably in this thesis reflecting the use of both terms in the literature included (e.g., Carr et al. 2010; Spröber et al. 2014). However, it is acknowledged that both terms may have different connotations (Jordan, 2013), and the importance of understanding individual preference when referring to the experience of individuals who have experienced institutional abuse is noted.

Overview of the Thesis

This PhD programme aimed to better understand the relationship between institutional child abuse and future negative impacts. Furthermore, it aimed to examine factors that exacerbate or protect against these negative impacts. To this end, a systematic review of 39 papers was conducted to better understand what is already known about the impact of institutional child abuse in the current literature. This resulted in the development of the following themes: 1) Resulting lasting effects on wellbeing and behaviour; 2) loss of trust in others; 3) negative impact on future life chances; 4) factors exacerbating negative impacts of institutional abuse; 5) factors protecting against negative impacts; 6) the barriers to and usefulness of intervention for survivors; 7) polarisation between replicating abuse towards others or trying to protect them; 8) survivor's interpretation and response to abuse recall; 9) motivation to disclose, nature and impact of disclosure. These findings illustrated the need for better understanding of factors that exacerbate and protect against the negative impacts of institutional abuse from the perspective of victims and professionals who work with them.

The lack of research in this area and need to include the voices of victims and professionals was addressed in Study 1. This study consisted of two parts, the first (1a) explored factors considered important to explain the negative impact, from the opinions of experts who have worked with individuals who report institutional abuse. A Delphi method was used to seek consensus between these experts, with 24 participants engaging in the first quantitative round, and 16 completing the final round. Items where consensus was reached were then examined for common themes. The second part (1b) added the views of those who reported institutional abuse using a qualitative survey method. Data for 10 participants were included in the final sample and were thematically analysed. Overall, it was found that institutional abuse had several negative impacts, including on mental health and wellbeing and that factors, such as self-esteem and support, protected against these impacts. Finally, it

was indicated that responses to disclosure impacted how an individual responds to their experiences of abuse. Findings from Study 1 indicated the need for a more in-depth understanding of the role of disclosure in recovery. Furthermore, a greater level of understanding was needed in relation to the role of strength factors that help victims recover.

This was addressed in Study 2, which consisted of a Rapid Evidence Assessment of 34 serious case reviews and online reports examining institutional child abuse. This study highlighted the impact of the care environment as a barrier to disclosure. Findings also demonstrated that several behaviours (such as substance misuse) reported as outcomes of institutional abuse in previous studies were being used as coping strategies. This indicated a need to better understand the complex relationship between the consequences of institutional child abuse, such as Post-Traumatic Stress Disorder (PTSD) and factors that may exacerbate these impacts (e.g., negative thoughts about the self and the care environment) and those that protect against them (e.g., resilience), and how disclosure plays a role in these relationships.

Study 3 aimed to address this need using a sample of 384 participants: 93 individuals who reported experiences of institutional child abuse, 191 who reported child abuse in a home setting only, and 100 who did not report child abuse. The prediction that individuals who reported disclosing their abuse will differ in their level of PTSD symptoms compared to those who do not was supported and individuals who disclosed their abuse reported higher levels of PTSD. Furthermore, those who reported institutional abuse reported higher levels of PTSD than those who did not report abuse, but not more than those who reported abuse in a home setting. However, the prediction that individuals who reported institutional abuse perpetrated by a carer would report higher levels of PTSD symptoms when compared to those abused by someone else was not supported. Furthermore, the prediction that individuals who reported a more negative care environment would report higher levels of PTSD symptoms than those who reported lower levels of a negative care environment was also not supported

in the sample of individuals who have reported institutional abuse. This study also aimed to explore the potential mediating role of the factors raised in studies 1 and 2 (e.g., personality functioning, resilience, and strength factors) on the relationship between experiencing institutional abuse and later PTSD symptoms, relationships, and placement in secure care. Findings indicated that institutional abuse was directly associated with PTSD. In addition, an indirect effect of institutional abuse on PTSD symptoms was found through the mediating role of personality functioning but not with strength factors or resilience. Institutional abuse was not significantly associated with placement in secure care as an adult or currently being in a relationship.

Overall, the current PhD programme of research has resulted in a better understanding of the negative impact of institutional child abuse and associated strength factors. This work indicated the need for a conceptual model capturing the impacts of institutional child abuse as current models of child abuse do not capture some of the key elements specific to institutional child abuse. As a result, an integrated model of the negative impacts of institutional child abuse, and factors that influence the extent to which these impacts are experienced was developed. It is hoped this will be used to structure future research and to support the identification of important factors when working with individuals who have reported institutional abuse.

Chapter 1 – Setting the Scene

Institutional child abuse has been defined as, "any system, programme, policy, procedure or individual interaction with a child in placement that abuses, neglects, or is detrimental to the child's health, safety, or emotional and physical well-being, or in any way exploits or violates the child's basic rights" (Gil, 1982, p. 9). This abuse may be perpetrated by those working in institutions or by other peers in these settings (Stein, 2006). While the impact of child abuse has been widely researched, the focus has been more on the consequences of sexual and physical abuse than emotional abuse (e.g., Bottoms et al., 2016). In addition, most of the research into the impact of child abuse focuses on abuse perpetrated by family members, acquaintances, and strangers. Far less research has explored the consequences of abuse in institutional settings (Lueger-Schuster, Kantor, & Weindl et al., 2014). These settings can include residential care centres, schools, churches, reformatories, and recreational facilities, for example, managed by secular or religious organisations (Gallagher, 1999). The settings can be interchangeable, including community and social institutions, and do not necessarily have to be residential (Sullivan & Beech, 2002). Thus, a key component of institutional abuse is the setting in which it occurs.

It may be the case that the large body of research into the impact of child abuse cannot be directly applied to that which occurs specifically in an institutional setting. For example, many children who are placed in institutional care, such as in foster care, have had adverse childhood experiences before placement in care (Havlicek, & Courtney, 2016). This may result in a cumulative impact of multiple traumas for those who then experience abuse in an institutional setting such as industrial schools and reformatories (Carr et al., 2010) that separates this form of abuse from that occurring in a home setting. Furthermore, a large body

of research into the impacts of institutional child abuse has focused on sexual abuse. However, it has been noted that other forms of maltreatment such as emotional and physical abuse will also likely have negative impacts on victims and should equally be considered (Lueger-Schuster, Kantor, & Weindl, et al., 2014). Therefore, this PhD will include sexual, physical, emotional abuse and neglect as these forms of abuse often co-occur (e.g., Havlicek & Courtney, 2016; Knefel et al., 2015). This thesis will focus specifically on institutional abuse to allow for the development of understanding in relation to the impacts of institutional abuse and if, and how, this differs from abuse in other settings. Throughout this thesis, institutional abuse will therefore refer to child maltreatment that occurred in an institutional setting (i.e., where the child is in placement). While other definitions have included non-residential settings, this thesis will focus on residential settings. For the purpose of this thesis, 'residential' will refer to settings where the child is under the care of an institution, or an individual governed by an institution, (e.g., foster carer) outside of the biological family where the institution or individual is responsible for the wellbeing of the child during their stay, such as care settings. This includes, but is not limited to, orphanages, foster care, residential children's homes, industrial schools, and boarding schools. Medical settings, schools, and religious institutions will only be included if the child is residing at the institution overnight without parental care. This definition has been chosen due to the differing dynamics noted in residential settings compared to non-residential settings such as the potential for increased isolation (Green, 2001) and the impact of parental separation (e.g., Chen et al. 2019).

Research has indicated a high prevalence of institutional child abuse[2] occurring in institutional care, such as sexual, physical, and emotional abuse, of between 50% and 93%

[2] Referred to in this thesis as institutional abuse

(Sherr et al., 2017). The long-term consequences of sexual, physical, and emotional abuse and neglect in institutional settings on adult survivors have been reported in recent inquiries, including in both residential and non- residential settings (Independent Inquiry into Child Sexual Abuse, 2020; Report of the Historical Institutional Abuse Inquiry, 2017). These impacts may include low self-esteem and low self-worth (Report of the Commission of Inquiry into Abuse of Children in Queensland Institutions, Forde, 1999). Notably, despite the prevalent nature of institutional abuse, no model explaining the negative impacts of institutional abuse and factors that exacerbate or protect against these impacts has been developed. This is important as the nature of institutional abuse has been reported to be complex (e.g., Knefel et al., 2015[3]). Therefore, a model explaining the impact of institutional abuse and those factors that reduce the likelihood of these impacts will help to organise these complex interactions.

1.1 Research exploring the impact of child abuse regardless of setting

When aiming to understand the effects of institutional child abuse it is useful to begin with the impact of child abuse overall, where no setting is specified, as a considerable amount of research has been conducted in this area. Furthermore, some similarities have already been found with similar abuse occurring in an institutional setting, such as the potential for this to lead to PTSD (Lueger-Schuster, Kantor, & Weindl et al., 2014[4]). Research exploring the impact of child abuse has indicated that outcomes following child sexual, physical, emotional abuse or neglect may include depression, anxiety, post-traumatic stress disorder,

[3] The sample for this study included those who reported experiences of child abuse in Catholic Church settings (where it was not noted if the setting was residential) and in foster care settings.
[4] The sample for this study was comprised of individuals who experienced abuse by an individual who was affiliated with the Australian Catholic Church. It is not clear that all abuse occurred in a residential setting, though the sample included those who experienced abuse in a boarding school setting.

developmental trauma, suicidal behaviour, and loss of future life chances with regards to relationships and education (e.g., Herrenkohl et al., 2013; Norman et al., 2012; Van der Kolk, 2005). Research has also explored individual forms of abuse, in terms of understanding the impact of each (Maniglio, 2009). This is beneficial to enable practitioners to identify whether different approaches are needed when working with individuals who report different forms of abuse.

A large body of research has focused specifically on exploring the impact of sexual abuse (Maniglio, 2009). Sexual abuse can be defined 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, or else that violates the laws or social taboos of society" (Norman et al., 2012, p. 2). The impact of sexual abuse was explored in an earlier systematic review of the literature conducted by Maniglio (2009). This included 14 review articles, covering a total of 587 studies (n>270,000), published between 1966 and 2008. Findings revealed issues with mental health and personality (self-esteem impairment, suicide ideation and behaviour, anxiety, dissociative disorder, PTSD, problems with alcohol abuse, eating disorders, psychotic symptoms, and borderline personality disorder), risk-taking behaviour (such as unprotected sexual intercourse), physical health (such as chronic pelvic pain and non-epileptic seizures) and re-victimisation. Of these impacts, depression was one of the most noted mental health issues related to child sexual abuse. Nevertheless, physical, and emotional abuse were not considered in this systematic review. This is important as it has been noted that multiple forms of child abuse commonly occur together (Carr et al., 2010; Landers et al., 2021) and that multiple experiences of abuse can lead to cumulative impacts (Afifi et al., 2014). Therefore, if these other forms of abuse are not examined and controlled for, then it is not possible to conclude if these impacts are a result sexual abuse alone or are

also impacted by other co-occurring experiences of physical and/or emotional abuse. Furthermore, it cannot be established if the impacts are a result of one form of abuse or multiple forms of abuse resulting in cumulative impacts. As a result, research exploring only one form of abuse is unable to explore the interacting impact of other forms of abuse so may not be able to give a clear picture of how and why these impacts occur.

Despite this, research examining the impact of other forms of abuse, such as physical abuse, has found similar impacts to that of sexual abuse. Child physical abuse has been defined as, "the intentional use of physical force against a child that results in - or has a high likelihood of resulting in - harm for the child's health, survival, development, or dignity." (Norman et al., 2012, p. 2). A meta-analysis conducted by Norman et al., (2012) covering 124 studies with a collective sample size of all studies n=209,1269, including studies focussed on non-sexual forms of abuse, showed they had similar impacts to sexual abuse (Norman et al., 2012). As with sexual abuse, physical abuse was found to increase the risk of mental illness and personality challenges. This included depressive disorder, eating disorders, anxiety disorders, increased suicide attempts and suicide ideation, PTSD, and panic disorder. There was also evidence for increased risk-taking behaviour, such as smoking, sexually risky behaviour as measured by sexually transmitted infections, and physical health problems (Norman et al., 2012). Physical abuse was noted to be related to an increase in behavioural and conduct disorder and issues relating to alcohol consumption. In some cases, this relationship was influenced by the frequency of the abuse, where increased levels of abuse were related to increased symptom levels. This was the case for the relationship between physical abuse and anxiety disorder, but not depressive disorder (Norman et al., 2012). This illustrated the similarities between the impact of sexual abuse and the impact of physical abuse.

In their meta-analysis Norman et al. (2012) also found similar impacts of physical and emotional abuse, including increased risk of anxiety disorders, eating disorders, and suicidal behaviour. Child emotional abuse can be defined as "both isolated incidents, as well as a pattern of failure over time on the part of a parent or caregiver, to provide a developmentally appropriate and supportive environment" (Norman et al., 2012, p. 2). This may also be referred to as psychological abuse. Despite some similarities between the impact of sexual, physical, and emotional abuse, differences were also noted. For example, increased levels of physical abuse led to an increased likelihood of anxiety, in contrast, while emotional abuse was related to risk of anxiety, the amount of anxiety was not dependant on the level of emotional abuse experienced. These deviating patterns demonstrate the potential for differing impacts for different forms of abuse.

This potential for differing impacts is further supported when considering the impact of neglect. Neglect comprises, “both isolated incidents, as well as a pattern of failure overtime on the part of a parent or other family member, to provide for the development and well-being of the child—where the parent is in a position to do so—in one or more of the following areas: health, education, emotional development, nutrition, shelter, and safe living conditions” (Norman et al., 2012, p. 2). Some similarities with the impact of neglect and physical and emotional abuse have been found, such as the increased likelihood of mental disorders. Like physical abuse, increased levels of neglect led to an increased likelihood of depression, but the *level* of neglect did not predict levels of anxiety. However, some differences were noted. For example, whilst physical and emotional abuse related to an increased likelihood of smoking in later life, neglect did not (Norman et al., 2012).

As can be seen, a sizeable body of research has begun to explore the effects of child abuse empirically. However, limitations of the research are noted. For example, Norman et al. (2012) found that the relationship between physical abuse and depression was impacted by the method employed. Here stronger odds ratios were found when depression was measured using a structured interview, compared to a self-report symptom checklist. They also noted inconsistencies in the definition of maltreatment commonly used in research in this area. In addition, Maniglio (2009) noted issues with poor sampling, a lack of match comparisons, and failure to control for confounding variables, such as other forms of trauma and the family environment. The current PhD aimed to overcome some of these current challenges by considering key issues, such as previous trauma, and adopting a multi-method approach to its enquiry.

The importance of exploring previous trauma is supported further as research has supported the notion that there is a cumulative impact of multiple forms of child abuse (e.g., Carr et al., 2010). It is therefore important for research focusing on a single form of abuse to control for the others. Research into multiple forms of abuse being explored in the same study has been conducted (Auslander et al., 2016). This research has supported the conclusions drawn previously, namely that whilst there are many similarities in the impact of sexual, physical, and emotional abuse, there are also several differences. For example, Auslander et al. (2016) found, in a sample of 237 girls aged 12-19 years, that emotional and physical, but not sexual abuse was related to a higher frequency of aggression. Post-Traumatic Stress and depression also fully mediated the link between emotional abuse and aggression. However, the same was not found for the association between physical abuse and aggression where the association was not significant when control variables (such as the number of mental health services the participant had received, race, and living situation such as placement in

congregate care) were also analysed (Auslander et al., 2016). This demonstrates the need to consider the potential differing impacts of different forms of abuse. It also raises the question as to whether these differences also occur when comparing different forms of abuse when these forms of abuse occurred in an institutional setting.

1.2 Can the findings of research exploring the impact of child abuse in other settings be applied to child abuse occurring in an institutional setting?

To understand if the body of research exploring the impact of child abuse can be applied to child abuse specifically occurring in an institutional setting, it is important to understand the uniqueness of the institutional setting. This includes the potential for institutional abuse to result in increased cumulative trauma because of experiences before the institutional abuse occurred, leading to the placement in the institutional setting, along with the placement in institutional care itself. This cumulative impact can be understood through the lens of poly-victimisation where an individual experiences multiple differing forms of victimisation (Finkelhor et al., 2006). It is highlighted that poly-victimisation resulted in greater trauma symptoms when compared to repeated exposure to the same form of victimisation (Finkelhor et al., 2006). This is a key consideration as research has clearly highlighted the increased negative impact of multiple forms of trauma when compared to a single experience (Afifi et al., 2014). For example, in a sample of school-aged children and adolescents, it was found that experience of one trauma was common; 63% for children (6-12 years old) and 89.5% for adolescents (12-20 years old). The number of traumatic events was highly predictive of trauma symptoms. In addition, the number of traumatic events was more predictive, overall, than a specific traumatic event. The sex of the victim and age were controlled for in this study (Gustafsson et al., 2009), which was a strength of this study, as

research has indicated a potential sex difference in how trauma impacts males and females who report institutional abuse (Knefel & Lueger-Schuster, 2013[5])[6]. Thus, supporting the notion that poly-victimisation results in more severe consequences.

The notion of poly-victimisation is consistently supported in the literature (e.g., Davis et al., 2019). However, it must be noted that some individual experiences of victimisation specifically ‘‘parents broke things or hurt each other; been threatened and been made to do sex things” in adolescents and having ‘‘been hit and been threatened” in children contributed independently to trauma symptoms regardless of co-occurring traumatic events (Gustafsson et al., 2009 p. 278). This would therefore suggest that it is important to consider both the individual forms of victimisation and poly-victimisation in order to account for the potentially differing impacts of individual occurrences and the overall cumulative impact to ensure the interactions between these can be fully understood.

The cumulative impact of multiple traumatic events is a significant finding when considering the impact of institutional abuse, as initial placement in the institution may, itself, act as a form of trauma and have a range of negative impacts (e.g., Hunter, 2001). *Attachment Theory* (Bowlby, 1973, 2005) may be applied here to provide an explanation for the negative impact that being placed in an institution may have, drawing on the negative impact of removing a child from a primary caregiver. This sense of attachment may also be related to *Self-Determination Theory* (Deci & Ryan, 2002). This theory suggests that individuals are driven by a need to grow and achieve fulfilment. Self-Determination Theory (Deci & Ryan,

[5] This research included those abused in a foster care setting or in a Catholic Church setting, though it was not specified that the church setting was residential.
[6] Sex difference was explored in the current PhD research in the systematic review but was not highlighted in Study 1 and Study 2, with other variables such as coping strategies and resilience being highlighted as more important. These factors were therefore taken forward to Study 3.

2002) posits that for individuals to achieve this psychological growth they must feel competence, relatedness, and autonomy (Deci & Ryan, 2002). This theory has been widely supported in the literature and cross-culturally with these concepts being highly related to motivation (Church et al., 2013; Milyavskaya et al., 2011). The application of Self-Determination Theory (Deci & Ryan, 2002) here may be in considering the issue of relatedness, namely the need for people to feel a sense of attachment to others and a sense of belonging. This may be impacted not only by institutional abuse but also by the initial placement in an institution (Biehal, 2014). These theories (e.g., Self Determination Theory and Attachment Theory), while not specific to institutional child abuse, could therefore lead to an obvious expectation that being placed in an institution may result in negative impacts. This has certainly been supported by Schaverien (2011) who drew a comparison between placement in a home setting and placement in the institutional setting of a residential boarding house. Schaverien (2011) outlined the reciprocal relationship that is commonly present in a family home, where members change and grow in response to each other, with the child impacting the environment around them and vice versa. However, Schaverien (2011) reflected that this is not the case in boarding schools, for example, where the child must conform to and change to fit the environment rather than being able to influence the environment. It has further been suggested that this need to conform can result in difficulties later in life (Schaverien, 2011) highlighting potential challenges of placement in an institutional setting.

Numerous reviews of the literature have supported the potential negative impact of institutional placement, in residential settings, in domains such as intellectual, behavioural, physical, social, and emotional impacts (Johnson, Browne & Hamilton-Giachritsis, 2006; MacLean, 2003). These can include higher rates of disorganised attachment and lower rates

of secure attachment (Quiroga & Hamilton-Giachritsis, 2016), higher rates of conduct problems and hyperactivity, substance dependence prevalence and depression symptoms (Hunter, 2001), increased likelihood of mental health diagnosis (Mutiso et al., 2017; Zeanah et al., 2009), and negative impact on cognitive development (Berens, & Nelson, 2015; Ijzendoorn et al., 2008). These impacts could be reduced in those removed from institutional care (Zeanah et al., 2009), or with early intervention (Johnson et al., 2006). Challenges may also include lack of education or employment, involvement in crime and increased likelihood of placement in prison (Courtney & Dworsky, 2006; Stanley, 2017). However, it must be noted that the post institutional environment is not consistently controlled for in these studies and can play a role in the outcomes following institutionalisation (MacLean, 2003). Furthermore, the environment of the institution at the time of placement is often not considered. This is important because it is noted that environmental factors such as exposure to young people with significant adjustment problems and adult conflict whilst in care (Carr et el., 2019) impact outcomes following institutional abuse. Furthermore, it is highlighted that institutionalisation does not always lead to poor outcomes (MacLean, 2003). Therefore, while the impact of *placement* in an institution may overlap with the impact of institutional abuse, thus exacerbating these effects and resulting in further challenges, it is also important to consider the impact of other related factors such as pre and post care experiences that may also play a role in later outcomes.

Another factor that may influence this relationship, as noted earlier, is the experiences of these children before placement in care. Havlicek and Courtney (2016) found that 70.9% of individuals in a foster care sample had self-reported experiences of abuse before placement. Of those, 47.7% reported one type of trauma, 31.8% reported two forms, and 19.3% three (neglect, physical abuse, sexual abuse). Notably, these scores differed from

official records, where for 82.5% of children there was an abuse or neglect allegation, 61.4% reported one type of abuse, 30.2% reported two types of abuse and 8.4% reported three types of abuse. Despite the discrepancies between self-report and official records, this research indicates that these pre-existing negative experiences may have influenced the child being placed into care and may also be contributing factors to the later outcomes for these children due to the cumulative impact described previously (e.g., Afifi et al., 2014).

It is important to note that not all individuals who are placed in a residential setting go on to experience these negative effects of placement in care, with others overcoming them (Mota et al., 2016). Research has noted that some individuals begin to adapt to the new environment in a residential setting, that a 'stable secure' environment is important, and that treatment for institutionalised individuals can increase resiliency (Hawkins-Rodgers, 2007). For example, in a sample of institutionalised adolescents, it was found that positive relationships with significant others (e.g., teachers and carers) was related to increased resilience and decreased deviant behaviour (Mota et al., 2016). These factors relating to the quality of the institutional environment, therefore, are seen to have a protective effect against possible negative outcomes of placement in care and should be considered when examining the impacts of institutional abuse. This demonstrates the need for research to explore the impact specifically in relation to institutional child abuse to capture these nuances in the additional impact of the institutional environment that are not captured when exploring abuse in other settings.

1.3 Research exploring the impact of child abuse in an institutional setting

Research exploring the effects of institutional child abuse has found some similarities with the negative impact of abuse that occurs following child abuse in a non-institutional setting. Positively, research into the impact of institutional abuse has explored the impact of multiple forms of abuse simultaneously, such as that exploring abuse that occurred in long term care (e.g., Carr et al., 2020). For example, Lueger-Schuster, Kantor, and Weindl et al. (2014) found, in a sample of 448 adult survivors of institutional abuse (75.7% men), that PTSD may be related to sexual, physical, and emotional abuse. When taken together with the notion that PTSD may occur following abuse that did not occur in an institutional setting, as discussed earlier (e.g., Maniglio, 2009; Norman et al., 2012), this shows that similarities may be found between the abuse that occurs in an institutional setting and that occurring in other settings, with both having the potential to result in PTSD.

In addition to exploring multiple forms of abuse occurring in institutional care Lueger-Schuster, Kantor, and Weindl et al. (2014) also considered adverse experiences before placement in care. In this study (Lueger-Schuster, Kantor, Weindl et al., 2014), individuals with PTSD had higher negative family factors present before institutional abuse when compared to those without PTSD. This included neglect, serious illness of a parent, poverty, substance use within the family, physical violence, emotional distance from family, and separation from siblings. Whilst no specific pre-abuse event was found to influence the later development of PTSD, those with higher levels of PTSD reported a higher number of these experiences. These pre-existing factors may also be related to PTSD directly (e.g., Haj-Yahia et al., 2009) and therefore may make it difficult to establish the cause of later PTSD in those who have also experienced institutional abuse. This complexity is also supported by

research, with a sample predominantly consisting of men (77.3%), who have reported at least one form of institutional child abuse. It was found that institutional child abuse may lead to complex PTSD[7] (Knefel et al., 2015). A strength of the current literature base is therefore the acknowledgement of the role of previous trauma in the later impacts of institutional abuse. However, a greater level of understanding is needed to explore how these early experiences exacerbate the impacts of institutional abuse, such as with the use of in-depth qualitative research.

Another similarity between the impact of abuse in an institutional setting and abuse that did not occur in an institutional setting is the differing impacts of different forms of abuse. For example, Fitzpatrick et al. (2010) reported that men and women who were survivors of sexual abuse, that occurred in a residential institutional setting, experienced more negative consequences when compared to those who had reported other forms of maltreatment in the same environment. These individuals showed higher rates of PTSD, antisocial personality disorder, and substance abuse including alcohol. In contrast, there were less severe outcomes for victims of physical abuse, followed by victims of emotional abuse. This illustrates the need for further research to take multiple forms of trauma into account to better understand the relationship between *types* of abuse and the cumulative impact.

This section has shown that the consequences of institutional abuse may vary. Thus far the factors that influences the outcomes of institutional abuse that have been described in this thesis have focused on those which exacerbate the negative impacts. However, research has also begun to explore factors that protect against the negative impact of institutional abuse, which will be referred to in this thesis as strength factors.

[7] The definition of complex PTSD is discussed on page 52.

1.4 The importance of strength factors in protecting against the impact of abuse

Not all individuals who have reported institutional abuse later suffered from the full range of negative effects reportedly associated with institutional child abuse in residential settings (Lueger-Schuster, Weindl, & Kantor et al., 2014[8]; Sheridan & Carr, 2020). Therefore, being resilient appears important in responding to institutional child abuse. Resilience is where individuals can achieve 'normal' tasks despite significant hardship (Jaffee et al., 2007). A multidimensional model of psychological resilience, the *Three-Part Model of Psychological Resilience* (De Terte, Stephens, & Huddleston, 2014) has been developed, which indicates that cognition (e.g., optimism, adaptive coping), the environment (e.g., social support), and physical behaviour (e.g., adaptive health practices) are important to building resilience. Models of resilience specifically concerning institutional abuse are not yet, however, apparent in the literature. However, Lueger-Schuster, Weindl, and Kantor et al. (2014) did consider factors related to resilience in a sample of 185 adult survivors of institutional abuse (141 men). Optimism and task-orientated coping led to better mental health outcomes in those who had reported institutional abuse. Interestingly, this research also found that education and social support, which have generally been noted to be important to recovery following child abuse (e.g., Sperry & Widom, 2013), did not have a protective effect. This study illustrates that some factors, such as optimism and coping style, may account for differing outcomes following institutional abuse. However, there has been less focus in the literature to date on strength factors, with most literature focusing on identifying negative impacts of institutional child abuse. Therefore, this PhD extended previous research with an in-depth exploration of strength factors.

[8] Using the same sample as Lueger-Schuster, Kantor, and Weindl et al., (2014).

1.5 What role does disclosure play in the impact of institutional abuse?

One factor that may play a key role in the development of negative outcomes, following institutional abuse, is the response to disclosure (McTavish et al., 2019). It is reported by Lueger-Schuster, Weindl, and Kantor et al. (2014) that individuals who had reported institutional abuse but perceived themselves to have higher levels of social support, demonstrated fewer negative emotional reactions when discussing their abuse compared to those with lower perceived social support. The influence of disclosure has been explored in more depth when considering the abuse that occurs in a non-institutional setting. For example, in a survey of child sexual abuse survivors, Ullman (2007) reported that 44.9% of individuals noted that they felt better after disclosure and only 15% said they felt worse. More research is required, however, to examine how disclosure may operate both as a positive and/or negative factor in symptom management (Rush et al., 2014).

The importance of social support in the role of disclosure is substantiated by Collin-Vézina et al. (2015), in a sample of 67 adult survivors of abuse not specific to an institutional setting, who reported that fragile social support may act as a barrier to disclosure in individuals who have suffered sexual abuse. As institutional care is characterised by frequent placement changes, the social support of individuals in care may differ for those who experience abuse in other settings. In examining the experiences of survivors of child sexual abuse in residential institutions (n=24), Colton et al. (2002) found that most of them reported having no help, not being taken seriously, and even being punished for disclosing. As a result, disclosure of abuse and the impact of this needs to be explored further.

1.6 The current research

As can be seen from the literature presented, research has explored the impact of childhood abuse and begun to explore this more specifically concerning institutional abuse. However, the latter remains in its infancy, with little known regarding the full range of potential impacts. There is a need to broaden the scope of research to include a wider range of impacts and strength factors and to explore the potential role for disclosure. This PhD aimed to add to existing research by capturing the impacts of institutional abuse across multiple forms of abuse and considering strength factors in-depth, thereby building on previous literature, and ultimately offering a preliminary conceptual model outlining the impact of child abuse in an institutional setting. This is needed because of the potentially different impacts between institutional abuse and abuse in a home setting (Fitzpatrick et al., 2010). The remaining chapters in this introduction [9]will expand further on these issues. Chapter two will include a literature review focused on the *prevalence* of institutional abuse and the *context* in which this occurs, to capture the uniqueness of the institutional setting. Chapter three will explore existing literature regarding the *impact* of institutional abuse and examine how this may fit with existing models of the impact of abuse. This will be followed by Chapter four which will detail the rationale for the current research, identifying the distinct environment in which institutional abuse occurs, the role of the cumulative impact of trauma, and the absence of an integrated model to capture these issues.

[9] For the remaining chapters, where research outside of this thesis is referred to as exploring institutional abuse, this will be institutional abuse that is consistent with the definition outlined in this thesis (see page 14-15). Where included research varies from this definition (e.g., also includes non-residential settings) this will be explicitly noted.

Chapter 2 – Prevalence of Institutional Abuse and the Context in which it Occurs

2.1 Structure of the chapter

The prevalence of institutional abuse, perpetrator characteristics, and organisational context will be first examined. This will set the scene for later evaluation of the application of theory and models of the impact of child abuse in non-institutional settings in Chapter 3.

2.2 Prevalence of institutional child abuse

The prevalence of institutional abuse has been explored in a review by Sherr et al. (2017) comprising of nine studies, with an overall sample of 2,995 children (1452 of whom were girls). Maltreatment was defined as violence or abuse in institutional care. Prevalence rates of institutional abuse were found to range from 50% to 93% (Sherr et al., 2017), which was higher than figures found concerning abuse occurring in the general population (e.g., Euser et al., 2014), supporting the need to understand this specific form of abuse.

While Sherr et al. (2017) used a broad definition of maltreatment in their review, individual studies have explored more discrete forms of abuse across types of institutions such as residential care versus foster care. Prevalence rates of physical and sexual abuse in institutional care in the Netherlands in 2010 were explored in a study of 329 adolescents (56% men) aged between 12 and 17 years (Euser et al., 2014; Euser et al., 2013). Rates of both physical and sexual abuse were higher in residential care (physical: 304 in 1,000, sexual: 280 out of 1000) when compared to foster care (physical: 164 in 1,000, sexual: 168 out of 1000). It was reported that these prevalence rates were higher when compared to the rates of

physical abuse (95 per 1,000, Euser et al., 2014) and sexual abuse (0.8 per 1000, Euser et al., 2013) in the general population.

However, caution must be taken when interpreting these figures, specifically as the prevalence rate may vary as a function of the source of reporting. Specifically, it has been noted that prevalence rates of sexual abuse in an institutional setting were 3.5 per 1000 individuals. This was found based on the reports of 264 professionals who worked in residential or foster care in the Netherlands with children aged between 4 and 17 years of age (Euser et al., 2013). Therefore, professionals, when asked, reported a lower prevalence of institutional sexual abuse when compared to research asking victims directly. Despite the lower figures when compared to self-report, the prevalence remained higher than reported experiences of sexual abuse in a home setting. This reduced prevalence in official records of cases of institutional maltreatment that were investigated when compared to self-report is supported by Havlicek and Courtney (2016), who noted that 45.7% of individuals in their research self-reported experiencing child abuse or neglect when in foster care. Officially investigated reports of institutional maltreatment, however, noted a prevalence of 20.7%. This indicated a marked difference between sources. In addition, care must be taken in generalising findings across countries. Euser et al. (2013) focused on the Netherlands and thus it may not generalise to other countries. This is important, as it has been suggested that the prevalence rates of reported child abuse, not specific to an institutional setting, do differ across countries, such as a comparatively lower rates found in China when compared to international prevalence rates (Finkelhor, et al., 2013).

While researchers such as Euser et al. (2013) and Havlicek and Courtney (2016) have explored the source of reporting, the severity of abuse is not examined. This is also important

as differences in prevalence rates have been found based on the severity of the reported abuse. For example, Carr et al. (2010) explored the difference in prevalence rates based on the type and severity of abuse in a sample of 247 adult survivors (135 men, 112 women) of institutional abuse from industrial schools and reformatories in Ireland. Rates of reported physical abuse, emotional abuse, and neglect were above 90%, whilst rates of sexual abuse were at 47%. Prevalence rate by sex was not noted. Severity was measured by asking participants what the most severe form of abuse was that they experienced. For sexual abuse, responses were coded as non-contact, sexual touching and masturbation, attempted penetration, and penetration. In relation to sexual abuse in an institutional setting, sexual touching and masturbation were more common when compared to actual or attempted penetration, or non-contact exposure of the perpetrator's genitals (Carr et al., 2010). Thus, the specific form of abuse being measured may impact the prevalence reported.

Much of the research noted in this chapter thus far, including Carr et al. (2010), does not consider the perpetrator of the institutional child abuse where it is noted that prevalence rates may differ based on the perpetrator and setting for abuse for example prevalence rates of child maltreatment reported by nursing staff during inpatient stays was 19.0%, but by caregivers in care facilities was 11.6% (Clemens, et al., 2019). Furthermore, research often focuses on abuse perpetrated by an adult only. This may limit their findings as the prevalence of institutional abuse perpetrated by peers may not be captured which is noted to be an important element of understanding institutional abuse and has been highlighted as an issue to consider in relation to boarding schools for example (Brown et al., 2020). A review by Sherr et al. (2017) found only one study exploring the prevalence rates of peer-on-peer abuse specifically (e.g., Euser et al., 2014). This study reported that 9% of individuals who were victims of institutional abuse in residential care reported peers of 18 years or older to be the

perpetrators (Sherr et al., 2017). Although this appears considerably lower than reports of abuse by staff noted in previously cited research, the relationship of the perpetrator to the victim should be considered when exploring research on institutional abuse to explore if the impacts of abuse differ based on who perpetrates the abuse.

The time spent in care may also contribute to prevalence rates of institutional abuse. Hermenau et al. (2014) studied 35 children (53% boys) placed in care between birth and 4 years of age and 35 children placed in care between the ages of 5 and 14 years in Tanzania. Eighty-nine per cent reported that they had experienced one adverse childhood experience in institutional care (lifetime physical, emotional, and sexual abuse; neglect; and parental loss during childhood). This was more common in those who entered care at a younger age when compared to those who entered later. Breakdown of prevalence between sex was not noted by Hermenau et al. (2014). This is interesting because there is a debate in the literature as to whether the prevalence of institutional child abuse differs based on the victim's sex (e.g., Gray et al., 2015a; Rus et al., 2013; Witt et al., 2019[10]). Despite this, the research indicated that age placed in care was related to increased prevalence of institutional abuse. However, it was not clear what the mechanism for this was, for example, whether it was the age of the child that is a risk factor, or whether it is that they have spent longer in institutional care so there has been an increased opportunity for them to be abused.

The impact of sex on the prevalence of institutional abuse was explored by Gray et al. (2015a) in a sample of 1,357 orphans (614 boys and 439 girls) in institutional care aged between 10 and 12 years from Cambodia, Ethiopia, India, Kenya, and Tanzania. They found that 50.3% of these children reported institutional sexual or physical abuse. Prevalence of

[10] Not all the institutions captured in this research were residential placements.

sexual or physical abuse applied almost equally to each sex (91.7% in boys, 90.3% in girls). Rus et al. (2013), however, found rates of physical abuse to be higher among boys, and these were two times more likely to report severe punishment than girls. Similarly, Euser et al. (2014) reported that 31% of boys and 18% of girls reported physical abuse. However, in terms of sexual abuse, Euser et al. (2013) reported that 60% of those reporting it were girls. This highlights inconsistency in the literature regarding the difference in prevalence rates of institutional abuse in boys and girls. Gray et al. (2015a) also adopted a broader definition of abuse, and as indicated, the type of abuse and definition used may influence findings regarding prevalence, which may influence the different findings that emerged in these studies.

Of note is that 99% of individuals who reported institutional abuse suffered two or more forms of abuse; 98% three or more, 91% four or more and 44% all five forms of abuse recorded, namely sexual, physical, emotional abuse, and physical, and emotional neglect (Carr et al., 2010). This demonstrates that experiencing multiple forms of abuse was common. This was further supported by Rus et al. (2013) in a sample of 1,391 children (743 boys, 648 girls) in residential care institutions in Romania between the ages of 7 and 20 years. Of these individuals, 39.5% had reported being "severely punished or beaten" by a staff member, with 31.8% reporting that this had happened frequently. As noted by Afifi, et al. (2014) this may result in cumulative trauma. Therefore, not only the prevalence but the breadth of abuse must also be considered when exploring the impact of institutional child abuse.

In general, the research has indicated that several factors influence prevalence estimates when exploring institutional abuse. These may include the type of abuse and

definition used, the specific institutional setting, the sex of the individuals, the source of reports, or the time spent in care (e.g., Carr et al., 2010; Euser et al., 2014; Sherr et al., 2017). The research has indicated that prevalence may be higher in some institutions, such as residential care, when compared to the general population (Euser et al., 2014). These higher prevalence rates demonstrate the importance of further exploration of the context in which institutional abuse may occur and the impact it may have. The type of care placement and care environment (e.g., atmosphere, level of security) is thus of value to consider.

The type of care placement has been explored by Euser et al. (2014) in a sub-sample of their research, where they found prevalence rates of 305 in 1000 adolescents, in secure care, who reported institutional abuse in this setting. While research has explored the prevalence rates of childhood trauma in secure settings (e.g., McKenna et al., 2019), research has not yet examined the prevalence rates of institutional child abuse of those in adult secure care, such as prison and secure psychiatric facilities. This is important as research has illustrated the increased prevalence of experiences of child abuse more generally in forensic populations (Levenson et al., 2016). Whilst accepting raised prevalence rates of institutional abuse, the question that arises next is how abuse can be facilitated in such settings that aim to protect children.

2.3 How abuse can be facilitated in institutional care

The *Theoretical Model of Maltreatment in Out-of-Home Care* (Nunno, 1997) states that four factors contribute to maltreatment occurring in an out-of-home care setting. These are: the child's characteristics, the carer's characteristics, the environment of the facility, and external factors. Regarding child characteristics, a small amount of literature has explored

individual differences concerning the child. It was noted that children with higher level of needs, such as requiring one-to-one supervision, being violent, or suicidal, were more likely to report institutional abuse. Sex also played a role with boys more likely to report physical abuse and girls more likely to report sexual abuse in this study (Nunno, 1997). Furthermore, only two factors were found in this model to be important in relation to external factors, where it was noted that maltreatment was at its highest at the beginning and end of the school year and when "layoffs" of staff were threatened. Nunno (1997) reported that a larger body of research has revealed more factors important to the perpetration of institutional abuse that relate to the staff/caregivers and organisational environment/culture, which are explored in the following sections.

2.3.1 Who perpetrates institutional abuse?

It has been suggested that there are similarities in the modus operandi of perpetrators of institutional abuse when compared to perpetrators of non-institutional abuse. This includes the use of several methods, including threats, grooming, and rapport building (e.g., Martschuk et al., 2018[11]). However, these conclusions are based on limited data in some instances (e.g., Martschuk et al., 2018; six cases). Research by Spröber et al. (2014), with a larger sample (n=1050), explored differences within institutions and found that patterns of abuse related to the time and extent of abuse did *not* differ between secular and non-secular institutions (Spröber et al., 2014). Secular refers to those connected with religion and non-secular to those not related to religion. These similarities are important because the perpetrator and abuse characteristics have been found to influence the impact of child abuse (e.g., Spaccarelli, 1994), as will be examined later.

[11]Both Martschuk et al. (2018) and Spröber et al. (2014) do not solely focus on residential institutions.

Nunno (1997) explored characteristics of the caregiver responsible for the abuse. Relevant factors included: demographic variables such as age and sex, and work-related variables such as status within the organisation, satisfaction at work, and lack of training. Most perpetrators were found to be men with older caregivers more likely to justify a use of higher levels of force towards children than younger caregivers (Nunno, 1997). This finding regarding sex was further supported in a later systematic review (including a total sample of 17,183 participants), which found that a higher level of perpetrators were men in proportion to the number of men working as carers (Kamavarapu et al., 2017[12]). However, it was noted that such differences are not always found specifically in research using anonymous survey as opposed to analysis of confirmed reported of abuse, thus it has been suggested that this difference in findings may be a result of biases in the way abuse cases are processed between men and women (Kamavarapu et al., 2017). The use of anonymous survey may help to overcome these biases, though further research is needed to confirm if these methodological issues are the only factor underlying these differences. Despite the potential for bias, there is, nevertheless, a growing acceptance of the existence of female sex offenders. This is supported by recent increase in literature exploring female perpetrators. In a sample of 71 cases from 2000-2016, based on sources such as court reports, media reports and online sentencing databases, it was noted that female perpetration of institutional abuse does occur (Darling et al., 2018[13]). Female offenders were described as commonly offending alone, with little or nothing in their previous employment records to raise any concerns (Darling et al., 2018). Therefore, when considering the impacts of institutional abuse, abuse by all perpetrators should be considered, regardless of sex.

[12] This article explores institutional abuse of individuals who are over the age of 18.
[13] This article does not solely focus on residential institutions.

In addition to demographic variables, work-related variables are also clearly a factor for consideration. For example, staff with low status and decision-making power were more likely to use force and were found to be more authoritarian (Nunno, 1997). This was substantiated by Kamavarapu et al. (2017) who noted that perpetration of institutional abuse was more common in direct care staff. This supports some level of consistency in this finding. Though it was noted that direct care staff were more numerous than supervisors, therefore, impacting the ability to draw firm conclusions (Kamavarapu et al., 2017).

Other variables that may help to explain the likelihood of engaging in institutional abuse are less well researched but may include attitudes, such as lack of satisfaction in the role, resentment towards children and job stress (Nunno, 1997), burnout, personal stress (Kamavarapu et al., 2017), and disempowerment regarding ability to protect children (Parkin & Green, 1997). Some of these factors are specific to institutional abuse, arguably demonstrating some unique elements and thus substantiating the need to explore the impact of institutional abuse as a specific form of abuse. Another unique element of institutional settings that must be considered is the organisational environment (Nunno, 1997).

2.3.2 Organisational environment

The organisational environment may certainly play a role in facilitating the perpetration of institutional child abuse with the influence of factors such as the powerlessness of children in some settings being noted (e.g., Lynch & Minton, 2016). Palmer and Feldman (2017)[14] propose that organisational culture can be considered a social factor

[14] This article does not solely refer to residential institutions.

that may influence the likelihood of institutional abuse occurring. They based this on *Finkelhor's Precondition Model of Child Sexual Abuse* (Finkelhor, 1984) that proposed for child sexual abuse to be perpetrated in a general setting several preconditions must be met. These are, that the perpetrator must be motivated to perpetrate abuse, they must overcome external and internal inhibitors, and they must overcome the victim's resistance to abuse. When applied to an institutional setting, as has been applied by Palmer and Feldman (2017), it suggests that individuals within the institution must be motivated to perpetrate child abuse and be able to overcome inhibitors before they commit institutional abuse. However, there are limitations to applying this model. For example, it has been indicated that there are aspects of the model that are vague, specifically concerning how the vulnerabilities noted in the model (such as need to intimacy) lead specifically to the described motivations (Ward & Hudson, 2001). Therefore, when applying this in the context of institutional abuse, it is not clear how vulnerabilities in the perpetrators of institutional abuse directly result in their motivation to perpetrate institutional abuse. Ward and Hudson (2001) also note that the model does not give sufficient attention to developmental trajectories. Further, ensuing models such as *Marshall and Barbaree's Integrated Theory of the Aetiology of Sexual Offending* (Marshall & Barbaree, 1990; revised by Marshall, Anderson & Fernandez, 1999) have indicated further factors that may contribute to the development of child sexual offending, looking at ecological factors. These include biological influences, childhood experiences, and cultural context, none of which are acknowledged in Finkelhor's model (Finkelhor, 1984). Whilst Marshall & Barbaree's model has not yet been applied to institutional abuse, it indicates that it may be useful to consider the impact of the environment within an institutional setting in more detail, such as the *cultural context* in which the abuse had occurred. This is shown to be important in this context as the setting of an institution is shown to be different to a home setting with increased isolation and the impact of the

organisational leadership (Green, 2001) playing a role in the likelihood of abuse, which will be explored in the remained of this chapter.

Whilst Finkelhor's model (Finkelhor, 1984) does include issues such as external inhibitors, which may encompass the leadership of the organisation, leadership is not explicitly explored in the model. This is a potentially unique aspect of institutional child abuse when compared to abuse occurring in a home setting. The notion that leadership is important in the perpetration of institutional abuse has been supported by Green (2001), who conducted an ethnographic study and noted that the term 'charismatic power' is often used to explain how individuals can perpetrate abuse for so long in these institutions. This is arguably a personality characteristic that is seen to induce devotion in those who see them as a leader, demonstrating how leadership styles may interact within the institutional context and influence the likelihood of institutional abuse. This may be one of the unique factors of this form of abuse. It could also be applied to understand some of the barriers to whistleblowing (e.g., Royal Commission into Institutional Responses to Child Abuse, 2017), namely a reluctance to report to the leaders of the organisation (Wright et al., 2017). Specifically, this would be relevant in an institution that has charismatic leaders as this can result in loyalty from followers (Parry, & Kempster, 2014) if an individual feels loyalty to the leader and the leader is supportive of the abuse, then this may inhibit whistle blowing.

The role of leadership in the perpetration of institutional abuse can be understood further by applying seminal psychological concepts, such as obedience. Obedience has been used in psychological literature to explore the concept of collective violence. This may apply to the perpetration of institutional abuse, which is reported to be frequently perpetrated by multiple offenders (Spröber et al., 2014) and therefore may be beneficial to explore in order

to better understand the context in which institutional abuse occurs. Milgram (1974) identified obedience as a key factor for committing acts that are far removed from social norms of acceptable behaviour. However, it is noted that of the prompts used in the Milgram paradigm only the fourth resembled an order "You have no other choice, you must go on" (Burger et al., 2011, p.464) and that the more a prompt resembled an order, the less likely they were to continue. Indeed, it may have been the case that as this was the last prompt given, disobedience was the consequence of the participants becoming intolerant of being prompted. This brings into question whether obedience is sufficient to encourage an individual to commit a heinous act. If applied to the context of institutional abuse, this may suggest that more than obedience alone is needed for an individual to commit such abuse as a result of a leader's orders.

Based on the criticism identified in the previous paragraph, it has therefore been suggested that Milgram's findings may be reinterpreted as identification with the experimenter and their scientific work as opposed to obedience, because participants were more likely to respond to prompts that illustrated the importance of the scientific work (Griggs, 2017; Reicher & Haslam, 2011). This links to *Social Identity Theory* (e.g., Tajfel & Turner, 1986), which notes that individuals gain a sense of belonging from the groups they belong to. This leads to in-group favouritism and out-group differentiation. This seminal theory is still supported more recently in empirical research showing its consistency over time (Davis et al., 2019). In support of the application of this theory to the current issues of institutional child abuse, it has been explored concerning the responses to allegations of child abuse, where it has been indicated that group loyalties act as a motivation to disbelieve allegations against other members of the group (Minto et al., 2016). As noted previously such loyalties may act as a barrier to whistle blowing. This highlights the importance of

understanding the institutional environment when considering the impacts of institutional abuse as this lack of whistle blowing may result in more prolonged exposure to the abuse, thus increasing negative impacts (Knefel & Lueger-Schuster, 2013[15]).

The notion of in-group and out-group introduced in Social Identity Theory (e.g., Tajfel & Turner, 1986) also links to the concept of *moral disengagement* (Bandura, 1999). According to Mastroianni (2015), the notion of obedience may reflect an oversimplified view of collective violence and does not account for atrocities carried out not under orders. The concept of moral disengagement may overcome some of these issues. Moral disengagement is the cognitive restructuring of acts seen as inhumane so they may be viewed as worthy or benign. This occurs using techniques such as minimising the negative impact of one's actions, dehumanisation and victim blame, diffusion of responsibility and development of moral justifications (Bandura, 1999). The application of this to sexual offending has been noted in the literature, where it was identified that individuals who had committed sexual offences had higher total scores on the Moral Disengagement Scale when compared to non-sex offenders in a secure setting (Petruccelli et al., 2017). Scores on moral justification, attribution of blame, advantageous compassion, and dehumanisation of the victim were higher in the forensic sample when compared to the student control sample. However, it was noted that the results of the subscale analysis should be interpreted with caution as the validity of the subscales was not supported in the research (Petruccelli et al., 2017).

Despite this, the notion that moral disengagement may allow for the perpetration of institutional abuse specifically may be supported in the literature. For example, it was noted

[15] This research included those who reported abuse in a foster care setting or in a Catholic Church setting, though it was not specified that the church setting was residential.

that if children in the institution are seen as ‘dangerous’ or ‘deviant’ or hard to control this may also play a role in the perpetration of institutional abuse (Palmer & Feldman, 2017). Notably, there is little expansion by the researchers as to what the term ‘dangerous’ actually refers to. However, a focus on control could lead to a desensitisation to the children’s needs and may then also lead the children to distrust staff (Green, 2001) and may results in clear distinctions between groups. The institutional culture and view of the children may also tie into the influence of a ‘macho culture’. Specifically, Palmer and Feldman (2017) reported that in this culture both men and boys may be more likely to commit sexual abuse. Such cultures may be allowed to develop as a result of isolation (Kamavarapu et al., 2017). For example, it was noted that living in these settings, individuals can often be isolated from the outside world (Parkin & Green, 1997). Whilst geographical isolation was not always prominent, (as supported by Goffman, 1961) many homes were socially isolated from the community (Green, 2001). This can allow for the development of cultures that differ from the wider community. This indicates another way in which institutional settings may differ from abuse that occurs in a home setting and highlights the specific need for research to explore the impacts of institutional abuse as a distinct form of abuse based on the differences in the context in which it occurs, as will be explored in this thesis.

2.4 Summary

Overall, the problem of institutional abuse can be seen in the raised prevalence rates. Numerous factors have been found to affect these rates, such as the type of abuse and definition used, the specific institutional setting, the sex of the individuals, the source of the reports, the perpetrator of the abuse or the time spent in care. Research has also explored factors, such as the environment and culture, that may influence abuse prevalence rates in

settings specifically designed to protect children. This demonstrates some challenges when applying research and theory based on abuse in non-institutional settings to that occurring in an institutional setting. Therefore, further research specifically exploring the impact of abuse occurring in an institutional setting is required. In addition, clear gaps are noted in the literature, specifically the need to better understand the impact of the environment on the likelihood of emotional or physical abuse or neglect occurring, where the literature often refers exclusively to factors increasing the likelihood of sexual abuse specifically. Research should also consider the role of this unique environment in effecting the negative outcomes following institutional abuse. Thus, the impacts of institutional abuse require attention. This forms the focus of the ensuing chapter.

Chapter 3 –Exploring the Impact of Institutional Child Abuse: Applying Theory and Models from Non-institutional abuse.

3.1 Structure of the chapter

The previous chapter identified that there are unique elements of institutional abuse that make it different from abuse that occurs in a non-institutional setting. The importance of considering the impact of pre-institutional trauma and the environment has also been noted in earlier chapters. Hence, it is important to examine current models and theory exploring the impact of child abuse to establish if they encapsulate these issues and if they can be applied to explaining the impact of institutional child abuse. The current chapter will therefore explore the empirical literature relating to the impacts of institutional abuse [16]and how it relates to current models and theory of the impact of child abuse that does not specifically occur in an institutional setting. This will allow for consideration of the applicability of these models and theories to institutional child abuse. No model or theory currently focuses specifically on the *impact* of institutional abuse. Consequently, theories and models will be applied in this chapter to support the understanding of the potential negative impacts of institutional abuse. This will include exploration of the development of trauma symptoms, impacts on other mental health issues, and effects on behaviour, and finally factors that influence exacerbate or protect against these impacts will be considered.

[16] A more detailed summary of the literature exploring the negative impacts of institutional abuse (such as to wellbeing, future life chances, and behaviour) and strength factors following institutional child abuse, along with issues relating to disclosure can be found in Chapter 5 which outlines results from a systematic review of the literature. However, relevant literature will also be examined in this chapter to allow for arguments to be made regarding the fit of empirical evidence exploring the impacts of institutional child abuse to current theory and models exploring child abuse more generally.

3.2 The development of trauma symptoms following child abuse

Post-Traumatic Stress Disorder (PTSD) is reported to be a common outcome following both child abuse more generally (Maniglio, 2009), and that which occurs in an institutional setting specifically (Lueger-Schuster, Kantor, Weindl et al., 2014[17]). PTSD is a psychiatric disorder that can be experienced by individuals who have witnessed or experienced a traumatic event. Symptoms clusters include intrusive thoughts, avoiding reminders of the trauma, negative thoughts and feelings and arousal, and reactive symptoms (e.g., being irritable) (American Psychiatric Association, 2017). The empirical literature has supported an association between experiencing institutional abuse and later trauma symptoms. For example, the link between experiencing institutional abuse and symptoms of Post-Traumatic Stress Disorder has been reported (Lueger-Schuster, Kantor, & Weindl et al., 2014). In a sample of 246 adult survivors of institutional abuse, 54.7% of whom were men, a moderate positive correlation was found between the number of trauma symptoms in adulthood and reported institutional sexual and emotional abuse in childhood (Carr et al., 2010). Carr et al. (2010) found that 59.9% of those who reported institutional abuse had clinically significant levels of avoidance of reminders of early trauma, 46.2% had impaired self-reference, 44.1% symptoms of dissociation, 41.7% symptoms of depression, 38.5% anxious arousal, 35.2% maladaptive tension reduction, 35.2% anger, 23.9% sexual concerns and 12.6% sexual dysfunction.

The degree of PTSD resulting was found to differ based on the form of abuse experienced. Using that same sample, Fitzpatrick et al. (2010) found that PTSD levels were highest in individuals who reported severe sexual abuse when compared to physical and

[17] It was not clear that all of those who participated in this study experienced abuse in a residential institutional setting.

emotional abuse. The level of PTSD was also higher in those who reported a greater degree of isolation (Lueger-Schuster, Kantor, & Weindl et al., 2014). These findings support the argument made in Chapter 2 regarding the importance of the environment (e.g., being isolated), and equally, the importance of considering the type of abuse reported. However, it should be noted that this research (Lueger-Schuster, Kantor, & Weindl et al., 2014) relates specifically to religiously affiliated institutions. This is common with research into the impacts of institutional child abuse (e.g., Carr et al., 2009; Lueger-Schuster, Weindl, & Kantor, 2014[18]; Rassenhofer et al., 2015[19]; Wolfe et al., 2006). This is important as institutional abuse can occur in a range of settings and not all are religiously affiliated, while no difference was reported between secular and non-secular institutions in relation to the patterns and types of abuse reported differences in settings have been found to be related to differing outcomes, with those abused in protestant institutional reporting higher levels of psychosocial impacts (Spröber et al, 2014[20]). Therefore, these findings may not be easily applied to all settings and research is needed to explore the impacts in the broader context of institutional abuse outside of solely religious institutions.

This empirical literature (Carr et al., 2010; Fitzpatrick et al., 2010; Lueger-Schuster, Kantor, & Weindl et al., 2014) is in-line with theoretical understanding and empirical evidence of the impact of trauma in a wider context and fits with the *Information Processing of Trauma Model* (Hartman & Burgess, 1993). Specifically, that experiencing child abuse can result in the development of PTSD (Pratchett, & Yehuda, 2011). The development of trauma following abuse is captured by Hartman and Burgess (1993) who use an information processing approach to propose that to resolve the impact of traumatic events, the memory of

[18] Using the same sample as Lueger-Schuster, Kantor, and Weindl et al., (2014).
[19] Not all the participants in this study reported that the institutional abuse occurred in a residential setting.
[20] This research is not based solely on abuse occurring in a residential setting.

the event must be transferred from active memory to past memory. If a traumatic event stays in active memory or is maintained by a defence mechanism such as dissociation, repression, or fragmentation, it can result in trauma symptoms. This model incorporates four phases of information processing in victims. Phase one includes factors that were present before the trauma, such as individual differences and the social context (e.g., age, family structure). Phase two is referred to as trauma encapsulation (Hartman & Burgess,1993, p.51). This refers to factors relating to the experience of the trauma, including the offender's behaviour, the thoughts of the victims (e.g., denial, repression), and how the information is stored. Phase three encapsulates the impact of disclosure, and how this may have a positive or negative impact, based on the response of the family and the community. The final stage is post trauma (Hartman & Burgess,1993, p.52) which refers to behavioural patterns after the trauma that may be missed and characterised as mental illness or character pathology, such as avoidance and aggression. Finally, the model includes reference to the use of intervention, such as the transfer of the trauma to past memory. It is noted that elements at each stage of this model may influence the degree of trauma symptoms experienced. This model is therefore useful to consider when examining the impacts of institutional abuse specifically as it considers the potential outcome of trauma symptoms that are known to be a potential consequence of institutional abuse (e.g., Carr et al., 2010). Furthermore, it also considers factors that may exacerbate these symptoms such as experiences prior to the abuse and response from others which are also important when considering the impacts of institutional abuse as noted (e.g., Lueger-Schuster, Kantor & Weindl et al., 2014). For example, research into the impact of institutional abuse has shown that a lack of response following disclosure can lead to feelings of victimisation and a loss of respect for authority (Colton et al., 2002; Wolfe et al., 2009). This therefore indicates useful elements of the Information Processing of Trauma Model (Hartman & Burgess, 1993) that can be applied to institutional child abuse.

The strengths of the Information Processing of Trauma Model (Hartman & Burgess, 1993) can be considered as a benefit when applying this model to explore the impacts of institutional abuse. Specifically, it is well grounded in theory and based on theory relating to human information processing more generally. *Information Processing Theory* (Huesmann, 1998) is a seminal theory that postulates that an individual's interpretation of the information they receive from the environment is influenced by their past experiences (Huesmann, 1998). The importance of information processing in relation to trauma has been well supported in practical application. For example, this concept underpins the contemporary trauma intervention Eye Movement Desensitisation Repossessing (EMDR), which focuses on how traumatic memories have been processed, moving active memories to past memories, and has been supported when reducing trauma symptoms in individuals who have reported child abuse (Valiente-Gomez et al., 2017). In effect, this research illustrates the ability of the Information Processing of Trauma Model (Hartman & Burgess, 1993) to explain trauma symptoms, which applies to the experiences of institutional child abuse as trauma symptoms are a reported outcome (Lueger-Schuster, Kantor, & Weindl et al., 2014).

Despite the strengths of the Information Processing of Trauma Model (Hartman & Burgess, 1993) noted in this chapter, criticisms must also be considered before concluding on the applicability of this model to understanding the impacts of institutional child abuse. Specifically, it has been criticised for having no explicit means to operationalise when ‘adequate processing’ has been completed, only that it is important to allow for behavioural disturbances to be overcome (Freeman & Morris, 2001). While this model may aid in understanding the development of trauma symptoms following institutional abuse and factors which may exacerbate these, such as response from others, this is explained through the way

the memory of the abuse is processed and the model does not allow for an understanding of the level of processing of abuse memories that is needed to overcome the impacts of abuse. Therefore, while the Information Processing of Trauma Model (Hartman & Burgess, 1993) is somewhat beneficial to apply to understanding the impacts of institutional abuse, it is not sufficient alone.

The evidence presented in this section demonstrates similarity between the impact of child abuse that occurs in an institutional setting and that which occurs elsewhere and illustrates the potential benefits of applying current models of child abuse, specifically the Information Processing of Trauma Model, to the impact of institutional child abuse. However, it is noted that PTSD symptoms may be higher in those who experience abuse in an institutional setting when compared to abuse in a home setting (e.g., Euser et al., 2014), thus questioning the applicability of broader models specifically to institutional abuse. In addition, when compared to the literature exploring the link between *institutional* child abuse and PTSD, the link between child abuse in a broader context and PTSD symptoms has been explored to a greater extent than is currently captured in the empirical literature relating to institutional abuse specifically. For example, the impact of mediating variables has been examined in more depth and it has been noted that the relationship between experiencing child abuse and PTSD symptoms is mediated by emotional regulation (John et al., 2017). The need for a diagnosis in addition to PTSD that capture the broader impact of early negative childhood experiences including the effects to emotional regulation has therefore been identified. Specifically, a diagnosis that captures the long-term consequences on social and professional functioning as a result of those negative experiences. Therefore, before general models of the impact of trauma can be applied to institutional abuse, these mediating factors must be further explored to consider if they are also important to capture in a model of the

impacts of institutional child abuse. However, research in this area is developing and empirical literature has demonstrated that interpersonal childhood trauma in an institutional setting leads to difficulties with emotional regulation (Weindl et al., 2018) suggesting these challenges may also be applicable to the impacts of institutional child abuse.

As a result of the complexities in understanding prolonged trauma, such as those discussed in this chapter, the concept of Complex PTSD (C-PTSD) was therefore developed (Ringel & Brandell, 2012). Interestingly, whilst there is a current debate regarding the utility of C-PTSD in the literature, there is still a lack of a clear definition (Bryant, 2012). Despite this, there is a consensus that it is a variant of PTSD, and whilst it may include some symptoms that overlap with Borderline Personality Disorder (Emotionally Unstable), it differs in Emotional Dysregulation, which is a primary issue in addition to other PTSD symptoms (Bryant, 2012). Therefore, research that explores these impacts in more depth will be beneficial to establish if and how the experience of institutional abuse may result in C-PTSD.

While C-PTSD is not currently recognised in the fifth edition of The Diagnostic and Statistical Manual (DSM-5), it is included in the International Classification of Diseases (ICD-11) (Hyland et al., 2018). C-PTSD is characterised by the inability to self-organise, self-regulate, or use relationships to regain self-integrity. It can lead to issues such as affect dysregulation, disorganised attachment patterns, and impaired self-development (Ford & Courtios, 2009). Developmental Trauma Disorder (van Der Kolk, 2005) *"the child version of CPTSD"* (Sar, 2011 p.1) was also formulated in 2005 as a diagnosis for children with complex developmental trauma histories as opposed to those experiencing a single traumatic event. This condition can result in emotional, behavioural, and cognitive disturbances in

children (Ringel & Brandell, 2012). It has also been seen as the childhood version of C-PTSD (Sar, 2011). Therefore, it can be argued that C-PTSD may capture the more multifaceted nature of institutional abuse that has been described in the empirical literature, in terms of both complexity (Lueger-Schuster et al., 2018) and the impact of emotional regulation (Weindl et al., 2018). This therefore indicates that for previous theory and models of child abuse more broadly to be applied to the understanding of institutional abuse, they must capture these complexities. While models such as the Information Processing of Trauma Model (Hartman & Burgess, 1993) do capture complexities such as the importance of pre-trauma experiences, less focus on emotional regulation is noted, which is a key issue to consider in relation to the impacts of institutional abuse (e.g., Weindl et al., 2018).

This importance of understanding the impact of abuse on emotional regulation is in line with research conducted by Perry and Pollard (1998) noting the neurological impact of trauma on the developing brain and its impact on issues such as emotional regulation. This can have serious consequences both in childhood, when a large proportion of brain development occurs, and in later life. When a threat is experienced in the environment, stress-response mechanisms are activated. These mechanisms affect the peripheral nervous system, immune system, neuroendocrine responses, and promote survival functions (Perry, & Pollard, 1998). When the threat is removed, the systems return to equilibrium. However, when the stress is severe or prolonged, these mechanisms may become overactive or fatigued. Therefore, the system is not returned to equilibrium. Instead, a "trauma-induced homeostasis" (Perry, & Pollard, 1998 p.36) develops, which is less flexible and is maladaptive (Perry, & Pollard, 1998). The neurological impact of trauma has been widely supported in the literature (see Anda et al., 2006; De Bellis, & Thomas, 2003; Gorman et al., 2002). These alterations can affect several brain functions, including emotional regulation, memory, arousal, and

aggression (Anda et al., 2010). Consequently, it highlights the potential need to consider C-PTSD when examining the impact of institutional abuse as exposure to this form of abuse is often prolonged (Rus et al., 2013).

Empirical evidence has supported the importance of understanding C-PTSD when considering the negative impacts of institutional abuse. For example, in a sample of 229 adult survivors of institutional abuse, it was found present in 21.4% of adults. However, women had significantly higher levels than men (women: 40.4%, men: 15.8%; Knefel, & Lueger-Schuster, 2013). Notably, those who had C-PTSD had reported institutional abuse for longer than those who had PTSD (Knefel, & Lueger-Schuster, 2013[21]). This evidence would support the applicability of C-PTSD and Developmental Trauma Disorder (in children) to aid the understanding of the negative impact of institutional abuse, though, the distinction between types of abuse is not drawn out in Knefel and Lueger-Schuster's (2013) research. This is especially important given the potential for adverse childhood experiences before placement in care that may add to this complexity and increase the likelihood of C-PTSD (Knefel & Lueger-Schuster, 2013) and for different forms of abuse to result in differing level of trauma symptoms (Fitzpatrick et al., 2010). Thus, indicating a limitation of this research. Furthermore, while C-PTSD may be a beneficial concept to consider to understand the complexities of institutional abuse, this concept alone does not explain all the negative impacts, such as other mental health related symptoms (e.g., Spröber et al., 2014). Therefore, further exploration of alternative models and concepts is needed to better understand the vast range of impacts following institutional abuse.

[21] This research included those who reported abuse in a foster care setting or in a Catholic Church setting, though it was not specified that the church setting was residential.

3.3 The impact of child abuse on other mental health issues and wellbeing

The presence of other mental health related symptoms following the experience of institutional abuse, in addition to trauma symptoms, has been documented in the empirical literature, as noted. For example, in a large sample of 1068 individuals aged between 20 and 49, maltreatment whilst in institutional care was a significant predictor of mental health symptoms (Villegas & Pecora, 2012). In addition, most victims of abuse in religiously affiliated institutions (73.6 to 80.2%) reported at least one psychiatric problem. In a sample of 1050 victims of institutional abuse (of those identifying their gender 614 respondents were men, 412 women) depressive episodes, post-traumatic stress syndrome, and anxiety or obsessive-compulsive disorders were the most common self-reported diagnoses (Spröber et al., 2014). This empirical evidence supports the likelihood that institutional abuse has the potential to result in a broader range of symptoms than PTSD and C-PTSD alone.

As has been demonstrated, the impact of institutional abuse on future mental health and wellbeing is well documented in the literature. This was supported further by Lueger-Schuster et al. (2018), who explored the impact of abuse (sexual, physical, and emotional) and neglect in foster care settings[22], by comparing 220 survivors of abuse in these settings, aged between 29 and 87 years old, to a comparison sample of 234 aged between 40 and 86 years old who were exposed to child abuse within their families. They found that those who reported abuse in foster care reported higher levels of anxiety, depression, somatisation, personality disorder (avoidant, compulsive, paranoid, borderline and anti-social), and PTSD symptoms. Indeed, it was noted that individuals abused in foster care reported higher levels of all forms of abuse, as measured by the Childhood Trauma Questionnaire. They also

[22] Foster care is captured in the definition of an institutional setting used in this thesis as the child is in out of home care and it is a residential placement.

reported higher levels of revictimization in adulthood and reported more abuse in their family of origin before placement in care. As a result, the increased negative symptoms may also be attributed to the cumulative nature of the trauma (e.g., Afifi et al., 2014). Importantly, no non-abused control group was used. As a result, it is not possible to compare these figures to a matched sample to explore how this differs from what would be expected in the general population.

The probability of a broader range of symptoms emanating from institutional abuse is a persistent finding in the literature and is supported by the findings of Benedict et al. (1996) where a non-abused control group was also included. They explored the impact of institutional abuse in a sample of 78 children with substantiated maltreatment reported between 1984 and 1988 and 229 non-maltreated controls. It was found that significantly more children who reported maltreatment in foster care had physical health, developmental, behaviour, and mental health problems, when compared to those who did not report maltreatment whilst in foster care. Specifically, sexually abused or neglected children were more likely to have mental health problems when compared to the physically maltreated and non-maltreated groups. Moreover, the sexually maltreated group also reported more depressive symptoms when compared to any other group. This study only explored substantiated reports, however, and it should be noted that a large proportion of institutional abuse remains undisclosed (Royal Commission into Institutional Responses to Child Abuse, 2017[23]). Therefore, these findings cannot be naturally applied to institutional abuse, which is not disclosed. This is a common challenge with research in this area. Positively, this research explores types of abuse and uses control samples, which as previously noted in this chapter

[23] This source refers to both residential and non-residential settings.

are important, in terms of supporting more empirically the argument that institutional abuse can have a serious impact on mental health symptoms in the future.

The negative impact of institutional abuse on mental health was further supported by Wolfe et al. (2006) which also extended this to impacts on feelings of betrayal and loss of trust. In a sample of 76 men aged between 23 and 54 years old, who were pursuing claims of abuse against a surrogate caregiver, it was found that 59.2% of participants who reported institutional abuse, presented with a current Axis 1 disorder[24] and 88.2% in total had, at some point, suffered an Axis 1 disorder. The most frequent of those being, PTSD, alcohol disorder, and major depressive disorder. Significantly high scores on the experiences, depression, defensive avoidance, and dissociation scales, and the trauma and dysphoria factor scales were also noted. Overall, 27.5% of the men sampled had also experienced confusion about their sexual orientation in their late teens and early twenties, with 21.7% currently experiencing this, whilst 66.2% in total reported a history of sexual problems in their relationships. In addition, almost all of those surveyed expressed a sense of betrayal and loss of trust extending beyond the interpersonal, into a loss of faith and devaluation of the church. This highlights that impacts to mental health and wellbeing go beyond specific mental health diagnoses and also include impacts to interpersonal functioning. Therefore, it is important that when applying broader models of child abuse to institutional abuse specifically these impacts to interpersonal functioning must be captured.

When considering the applicability of previous broader models to institutional abuse it is noted that impacts on mental health and wellbeing are captured to some extent by the

[24] Axis 1 disorders are outlined in the DSM-IV as mental health and substance use disorders. This multi-axial system is not used in the more recent DSM-5 (Substance Abuse and Mental Health Services Administration, 2016).

Information Processing of Trauma Model (Hartman & Burgess, 1993), where Post Trauma (Hartman & Burgess,1993, p.52) behaviour patterns, such as avoidance or aggression are noted, but mental health impacts and loss of trust more specifically are not as clearly captured. Therefore, additional theory and models must be applied to explain these outcomes. To this end, *Betrayal Trauma Theory* (Freyd, 1994) becomes useful to consider. It has been noted that interpersonal trauma, trauma which involves other individuals, such as abuse, as opposed to non-interpersonal trauma such as natural disasters, can have particularly detrimental effects due to the betrayal involved in the breaking of the assumptions of social relationships (Freyd, 1994). According to Betrayal Trauma Theory (Freyd, 1994) there are two dimensions of trauma that influence resulting symptoms. These are a threat to life or fear, and social betrayal. A threat to life can result in feelings of anxiety, hyper-arousal, and intrusive memories whereas social betrayal can result in dissociations, numbness, and constricted or abusive relationships. Birrell and Freyd (2006) argued that when a trauma includes both dimensions, the most severe symptoms occur. This theory may therefore be of use when considering the impacts of institutional child abuse where feelings of betrayal (Wolfe et al., 2006) and fear (Bode & Goldman, 2012) are noted. This indicates the potential applicability of Betrayal Trauma Theory (Freyd, 1994) to explain some of the negative impacts of institutional abuse in relation to mental health and wellbeing.

Support for the assumptions of Betrayal Trauma Theory (Freyd, 1994) continue to be evidenced. For example, Edwards et al. (2012) noted that impacts to mental health are more severe when abuse is perpetrated by a relative or individual living in the family home when compared to a stranger or friend where less betrayal may be experienced. However, when considering the applicability of Betrayal Trauma Theory (Freyd, 1994) to institutional abuse, limitations of the theory must also be considered. For example, a key element of this theory is

the notion that betrayal can be overcome with a lack of memory of abuse experiences that occur to enable the child to maintain attachments to an individual who is important to their survival (Freyd, 1994). These considerations are important in relation to institutional abuse where it is noted that some victims may try to protect the perpetrator and maintain the attachment bond (Royal Commission into Institutional Responses to Child Abuse, 2017; Smellie et al., 2020[25]; Soares et al., 2019). However, the mechanisms under which this forgetting occurs have been questioned, for example it has been highlighted that a desire to forget the experience may not necessarily translate into an inability to remember. It is also noted that the perpetrator of the abuse may not always be successful in other areas of caregiving, thus limiting their importance in the child's ability to survive (McNally, 2007). Therefore, when applying this theory to the impact of institutional abuse the quality of care, outside of abuse, and the overall quality of the care environment may be beneficial to consider to explore how much this potential forgetting, whether this be a conscious or sub-conscious repression, may occur and if the level of care provided by the perpetrator impacts this.

In addition to the impact of betrayal and the breaking of the assumption of trust, the breaking of other assumptions has also been noted to impact mental health. For example, *Assumptive World Theory* (Janoff-Bulman, 1989) posits that traumatic experiences can violate an individual's core assumptions. It is proposed that an individual's world view is based on three basic assumptions; that the world is meaningful, the world is benevolent, and the self is worthy. When an individual is faced with evidence that contradicts these assumptions, there can be a negative impact on their mental health (Janoff-Bulman, 1989). Whilst this theory was first presented in 1989, empirical research continues to support its

[25] This source referred to school settings, both residential and non-residential.

assumptions (e.g., Carr et al., 2010; Valdez & Lilly, 2015). For example, empirical evidence has reinforced the argument that diminished world assumptions mediate the relationship between interpersonal trauma and depression severity (Lilly et al., 2011). This theory may therefore be beneficial when applied to institutional abuse in explaining the ensuing mental health symptoms. It can be seen to have specific links to institutional abuse where impacts to self-worth are noted as a result of institutional abuse (Goldman & Bode, 2012) and therefore may underlie the development of mental health symptoms as the assumption of the self as worthy is broken. Though this theory focuses on the impacts to mental health following the breaking of these assumptions and does not necessarily explain changes in behaviour. This illustrates the need to better understand theories and models explaining changes in behaviour following abuse as this is also relevant to institutional abuse (Wolfe et al., 2006).

3.4. The impact of child abuse on behaviour

The empirical evidence supports the notion that experiencing institutional abuse may be linked to behavioural outcomes. For example, in relation to physical abuse, a significant moderate correlation was found between the level of violence experienced by the children in an orphanage and the level of aggressive behaviour demonstrated by the children who resided in the orphanage (Hermenau et al., 2011). Regarding criminal activity, in a sample of 76 men (aged 23-54), who reported experiencing abuse in a religiously affiliated institution, it was found that many reported a history of crime. Nearly half had been arrested for property crime, or substance-related offences, and others for violent offences (nearly 40%) (Wolfe et al., 2006). However, it is important to note that it may be challenging to establish causation in this relationship as the level of delinquency before entry into care was not controlled for. This is a challenge with research in the area of establishing which outcomes are related to institutional abuse, to institutional placement, and/or to factors outside of the institutional

placement, such as prior abuse (e.g., Lueger-Schuster, Kantor & Weindl et al., 2014). Whilst empirical research into the impact of institutional abuse on future behaviour is less well researched, the concept is in line with psychological theory, such as *Social Learning Theory* (Bandura, 1977) and *General Strain Theory* (Agnew, 2001). Although these theories do not explore the impact of child abuse, they may aid in the understanding of them and will hence be examined.

Social Learning Theory (Bandura, 1977) proposes that behaviour can be learned through observing the behaviour of others, specifically if there is a connection between the individual and the observed other. Thus, it may be suggested that survivors of institutional abuse could learn to re-enact their abuse towards others. Research into the impact of victimisation, carried out in a survey of adolescents who had reported sexual victimisation, suggested that some victims can learn to behave like their abusers. Of those surveyed, 216 were sexual offenders and 93 had committed non-sexual offences (Burton et al., 2002). It was noted that adolescents who sexually offended were more likely to have a closer relationship with their perpetrator and longer exposure to sexual victimisation (Burton et al., 2002). While the applicability of Social Learning Theory has therefore been supported in relation to experiences of sexual abuse, this has yet to be explored specifically in relation to institutional abuse. In addition, as can be seen from these figures, not all individuals go on to engage in criminal behaviour. This is in line with criticism of Social Learning Theory in relation to its reductionist approach which must be considered when applying this model to explain the impacts of institutional abuse. Therefore, strength and protective factors become important to explore and will be examined in section 3.5.

Changes in behaviour following experiences of abuse may also be understood by applying General Strain Theory (Agnew, 2001) to the impact of child abuse which captures the impact of individual coping on later outcomes. This theory proposes that when an individual experiences a strain in life, it leads to negative emotions, thus a coping response is required. If an individual experiences a strain and has no alternative coping strategies, they may then resort to maladaptive coping such as criminal behaviour. This is more likely if the strain is seen as severe and unjust (Agnew, 2001). Child abuse has been identified as a severe strain (Agnew, 2013; Wemmers et al., 2018). Self-control has been reported to moderate the impact of strain on later criminal behaviour, though repeated exposure to strain could reduce an individual's levels of self-control (Agnew, 2001). The applicability of this to the impact of child abuse has been supported by research that has indicated that self-control mediated the relationship between child abuse and delinquency (Bunch et al., 2018), thus, supporting General Strain Theory (Agnew, 2001) and its applicability to the impact of child abuse. In addition, the application of this theory to child abuse has relevance where early childhood sexual or physical abuse was related to offending in adolescents (Watts & Mcnulty, 2013). The relationship between sexual abuse and offending was mediated by depressive symptoms in both boys and girls, though with regard to girls, it was also mediated by the child's closeness to their mother. While the empirical literature has found support for the applicability of General Strain Theory (Agnew, 2001) to the impacts to behaviour following child abuse (Bunch et al., 2018; Watts & Mcnulty, 2013), this has not been explored specifically in relation to the impacts of institutional abuse. However, it is noted that institutional abuse may be seen as a severe strain based on the negative outcomes it can cause (e.g., Lueger-Schuster, Weindl, & Kantor et al., 2014) and also may be linked to criminal behaviour (Wolfe et al., 2006) where effective coping has been seen to reduce negative impacts (Lueger-Schuster, Weindl, & Kantor et al., 2014). Therefore, elements of General

Strain Theory (Agnew, 2001) are present in the institutional abuse literature. While they are yet to be empirically tested together as a specific test of this theory, this may indicate the potential utility of General Strain Theory (Agnew, 2001) when trying to explain the relationship between institutional abuse and later behavioural changes. While this theory was not developed specifically in relation to examining the impacts of child abuse, models have examined these impacts specifically and may be useful to consider in order to explain the potential impacts of institutional child abuse.

An example of such as model was posited by Van Wert et al. (2016) who developed *A Conceptual Model of the Relationship between Maltreatment and Externalizing, Anti-social, and Criminal Behaviour problems* (Van Wert et al., 2016), exploring the impact of child maltreatment on externalising antisocial and criminal behaviour. They proposed that challenging behaviour in children may develop as a result of cumulative disadvantages, which may include, biological disadvantages (e.g., genetic predisposition) and interactions with the environment (e.g., exposure to maltreatment). Behavioural problems and maltreatment are seen as reciprocally related. It is highlighted that cumulative effects of multiple risk factors (e.g., marginalisation) increase the likelihood of both maltreatment and the development of criminal behaviour. While this model, if applied to institutional abuse, may help to explain the potential outcome of challenging behaviour, it is limited by lack of specificity in terms of specific detail in relation how these factors interact. However, it is a complex area, so a multifaceted model is needed. This limitation shows the difficulties in identifying the direction of the relationship between maltreatment and challenging behaviour as the model highlights this to be a reciprocal relationship, however, more longitudinal research is needed to establish cause and effect. Positively, this model considers the impact of biology, such as the impact of child maltreatment on brain development (De Bellis, 2005) so

may be considered less reductionist than other models and theory that do not consider both biological and environmental impacts. This conceptual model is also grounded in multiple relevant theories and models. These include Attachment Theory (Bowlby, 2005), and Social Learning Theory (Bandura, 1977) described previously, as well and *The Ecological Model of Human Development* (Bronfenbrenner, 1994) and *Life Course Theory* (Laub & Sampson, 1993) thus supporting the strengths of this model when applying it to understanding the impacts of institutional abuse, as these theories are all considered relevant to this form of abuse.

Specifically, The Ecological Model of Human Development (Bronfenbrenner, 1994) proposes that development is influenced by an interaction between the individual's characteristics, and the environment in which they live (Janson & Fraser, 2006). According to this model, certain environmental aspects will increase the likelihood of the development of pathology (Szapocznck & Coatworth, 1999). It is suggested that the extent to which children are likely to develop externalising behaviour will be dependent on the availability of a positive environment including from peers, family, school, and the wider community (Tabone et al., 2011). It is noted that this model has been supported by a body of empirical literature, though due to the comprehensive nature of the model, it can be challenging to truly test all levels of the environment (Van Wert et al., 2016). Despite this, its relevance to institutional abuse can be seen in relation to the key consideration given to the environment, with the literature highlighting the important impact of the environment following institutional abuse (Carr et al., 2019; Lueger-Schuster, Weindl & Kantor et al., 2014).

Regarding the Life Course Theory (Laub & Sampson, 1993), children who have positive relationships with caring family members and positive school environments are less

likely to demonstrate delinquent behaviour, although changes in antisocial behaviour are expected over time based on the strength of these positive relationships. It is suggested that significant life events or positive social support in adulthood can mitigate the impact of childhood events. Nevertheless, there may still be an impact of cumulative disadvantage caused by early delinquency, which may limit opportunities for further development. It is noted that whilst some empirical evidence has applied this to the impact of child maltreatment, further work is needed to fully incorporate the impact of child maltreatment (Van Wert et al., 2016), though some elements of this theory clearly apply to institutional abuse such as the important role of cumulative trauma (e.g., Carr et al., 2010).

While the Conceptual Model of the Relationship between Maltreatment and Externalizing, Anti-social, and Criminal Behaviour problems (Van Wert et al., 2016) is grounded in relevant theory and supported with empirical literature as discussed, it focuses only on outcomes relating to externalising, antisocial, and criminal behaviour. As noted, a broad range of impacts can result from institutional abuse including other changes to behaviour such as avoidance. Even so, this model does consider the importance of cumulative risk. Its importance is demonstrated by research focusing on the number of adverse experiences that lead to increased risk of negative impact following maltreatment, despite the type of severity of the experience (Evans et al., 2013). However, it has been suggested that the concept of cumulative risk does not give insight into how adversity leads to increased risk for psychopathology (Sheridan et al., 2017). That shortcoming is tackled by *The Deprivation and Threat Model* (Sheridan & Mclaughlin, 2016) of the impact of adversity. This model proposes two dimensions of adversity, firstly deprivation (the absence of cognitive and social stimulation), and secondly threat (experiences involving harm or threat of harm). Moreover, it is proposed that emotional, cognitive, and neurobiological pathways mediate the

relationship between threat and deprivation and developmental outcomes. Thus, that deprivation will impact the development of higher-order cognitive processes, whereas threat will impact the children's understanding of fear, which will in turn impact emotional processing.

This model has been supported by empirical research, which indicates that deprivation (neglect) and threat (sexual and/or physical abuse) have different outcomes. Specifically, that threat predicted the use of avoidant coping strategies, but deprivation did not (Milojevich et al., 2019). In addition, this use of avoidant strategies partially mediated the longitudinal relationship between experiences of threat in childhood and future symptoms of depression and PTSD, but not externalizing behaviour (Milojevich et al., 2019). This model can therefore be applied to the impact of institutional abuse to some extent. Specifically, in the exploration of the two constructs deprivation (such as in the care environment) and threat (such as the abuse that occurred). This is a benefit of the model when applying it to institutional abuse as it not only explains changes in behaviour such as avoidance, but also captures their important role in the development of other outcomes, including mental health symptoms.

This change in behaviour has also been explored in models of child sexual abuse, that are not specific to any setting that take an alternative approach to explaining the impact of abuse on behaviour, focusing on conditioning. Hoier et al. (1992) have applied cognitive and behavioural approaches to understanding child sexual abuse in *A Cognitive Behavioural Model of the Impact of Sexual Abuse* (Hoier et al., 1992). Specifically, the seminal principle of classical conditioning is used here to describe how neutral stimuli become associated with abuse stimuli and a response is elicited (e.g., raised heart rate, fear). This is used to explain

future changes in behaviour as a result of abuse as, over time, these neutral stimuli adopt the response even when the abuse is not occurring. Operant conditioning is also used by Hoier et al. (1992) to explain changes in behaviour such as avoidant behaviours, through negative reinforcement (the removal of negative stimuli), and compliance behaviours through positive reinforcement (a positive consequence). It is suggested that these behaviours become long term through generalisations to other behaviours and stimuli. This development of avoidant behaviours is consistent with potential outcomes following institutional abuse (Lueger-Schuster et al., 2018) highlighting the applicability of Hoier et al.'s (1992) model to institutional abuse. Though further research is needed to explore the role of reinforcement specifically in samples of individuals who have experienced institutional abuse.

Despite the need for further empirical research to explore the role of reinforcement and avoidance specifically in relation to institutional abuse, this notion is in line with *the Emotional Avoidance Theory* (Polusny & Follette, 1995). This theory refers to a person's reluctance to experience unpleasant internal events (such as thoughts or feelings). It is suggested that patterns of behaviour are adopted, such as substance abuse, to avoid these negative experiences. The behaviour is then reinforced by the reduction of these negative events. These models consider the impact of the environment, which is important to understanding institutional abuse as previously noted. However, this theory also has a narrow focus regarding the impact of abuse with a specific focus on behavioural outcomes as is common with the models and theories described in this chapter. This is important as institutional abuse has a variety of outcomes in addition to changes in behaviour such as loss of trust in others (Wolters, 2008[26]). This again demonstrates the need to consider multiple models and theories when explaining the impact of institutional abuse.

[26] The specific institutional setting in which the abuse occurred was not specified in this article.

3.5 Factors that influence the impact on institutional abuse

3.5.1. Factors the exacerbate the impacts of child abuse

Several factors may impact the extent of the negative outcomes following institutional abuse (Carr et al., 2019). This includes a feeling of betrayal, the environment in which the abuse occurred, attachment, sex of the victim, and previous exposure to trauma (e.g., Lueger-Schuster et al., 2018). For example, Edwards et al. (2012) found that victims of sexual abuse perpetrated by relatives or nonrelatives living in the home had higher levels of depression, anxiety, suicidality, panic, and anger when compared to those who reported sexual abuse perpetrated by strangers, friends, or relatives not living in the home, which is suggested to illustrate the important role of betrayal as noted previously. This notion has more recently been explored and supported when considering abuse in an institutional setting specifically (Lueger-Schuster et al., 2018), demonstrating its relevance. Specifically, it was noted that an individual may feel betrayed not only by the perpetrator of the abuse but also by the institution. *Institutional betrayal* refers to an institution where there is a lack of appropriate response to the disclosure of child maltreatment and the child is unable to escape the environment (Lueger-Schuster et al., 2018). It has been noted that this institutional betrayal is an independent predictor of PTSD. This was the case when trauma experiences were controlled for (Wright et al., 2017). This supports the potential applicability of *The Traumagenic Dynamic Model* (Finkelhor & Browne, 1985) to explaining the impact institutional abuse and factors that exacerbate it.

Traumagenic Dynamic Model (Finkelhor & Browne, 1985) is a seminal multiple dynamic model that proposed that betrayal, stigmatisation, traumatic sexualisation, and powerlessness could all account for the psychological impact of sexual abuse on victims. In this model, traumatic sexualisation refers to how a child's sexual behaviour is shaped in a

developmentally inappropriate way, such as the child being rewarded for sexual behaviours. The concept of betrayal refers to the child learning that someone who they should be able to depend on has caused them harm. Powerlessness refers to the child's self-efficacy being disregarded. Finally, stigmatisation is the negative connotations that are communicated to the child regarding the abuse such as shame. It is proposed that each of these elements increases the potential for negative outcomes following child abuse. This model also captures the notion that factors in the individual's life before and after the abuse such as family background or institutional response may also be incorporated into this framework and may influence the psychological outcomes of sexual abuse (Finkelhor & Browne, 1985), which has been identified as being important to understanding the impact of institutional child abuse.

This model has arguably been seminal in the area of child sexual abuse (Krayer et al., 2015). However, the evidence for it has been based predominantly on clinical experience rather than empirical evidence, querying the generalisability and reliability of the model (Freeman & Morris, 2001). Consequently, Feiring et al. (1996) built on the Traumagenic Dynamic Model (Finkelhor & Browne, 1985) using the empirical literature base relating to the impact of cognitive processes on behaviour and focused on the role of stigmatisation (Freeman & Morris, 2001). Specifically, they noted that child sexual abuse will likely result in the negative self-evaluative emotion of shame. They emphasise the importance of cognitive attribution processes, about the abuse, in the link between child sexual abuse and shame. This shame may then lead to poor adjustment (Feiring et al., 1996). This is consistent with findings in relation to the impact of institutional child abuse (Wolters, 2008), supporting the potential applicability of this model.

Positively, the Traumagenic Dynamic Model (Finkelhor & Browne, 1985) does also address key issues raised in the literature relating to the negative impact of institutional child abuse such as the impact of prior trauma (Lueger-Schuster, Kantor, & Weindl et al., 2014). However, there is a need for models of institutional abuse to include a clear focus on individual resilience, which along with isolation, are also factors related to the outcomes of institutional abuse (Lueger-Schuster, Weindl, & Kantor et al., 2014). These factors are not captured in the Traumagenic Dynamic Model (Finkelhor & Browne, 1985). Despite this, this model (Finkelhor & Browne, 1985) may be also relevant to institutional abuse where the powerlessness of the children is noted as a result of the potentially strict environment (Nunno, 1997; Royal Commission into Institutional Responses to Child Abuse, 2017). The environment is, however, considered to a greater extent by Spaccarelli (1994).

Spaccarelli (1994) argued that past models of the impacts of child abuse do not place enough emphasis on environmental factors, for example, family environment, quality of parent-child relationship, and community environment (Spaccarelli, 1994). This model is based on the *Transactional Theory of Development* (e.g., Sameroff & Fiese, 1990), which indicates that the outcomes of childhood development, whether positive or negative, are influenced by interactions between the person and the environment. It is argued that events related to the abuse (such as coercion and trust violation) and the disclosure of the abuse (such as victim blaming), influence the risk of maladaptive outcomes, such as psychological symptoms. Elements of this theory are clearly in line with other related theories. For example, the importance of this child-caregiver relationship, in terms of childhood development, is well-grounded in theory. Specifically, Attachment Theory (Bowlby, 1973, 2005) which posits that it is important for children to have a strong emotional attachment with at least one caregiver. Being placed in the care of strangers may result in children

showing ‘strange detached’ behaviours. In such situations, it is indicated that signals which would normally trigger attachment behaviours may become ‘blocked’. According to Bowlby the mental structures that control selective exclusions of stimuli may start to exclude these signals (Bowlby, 2005). This concept has long been applied to the impact of child sexual abuse (Alexander, 1992).

Abuse by an individual who is responsible for their care may impact the child's attachments to that caregiver. Disruption of this relationship could then result in an insecure form of attachment which may be related to negative psychological symptoms (Briere et al., 2017). It is suggested that a resistant attachment predisposes the individual to re-victimisation, and symptoms of anxiety and fear; whilst a disorganised attachment predisposes an individual to dissociative coping and high risk of PTSD, and avoidant attachment leads to denial-based coping and avoidance of abuse memories (Alexander, 1992). This theoretical understanding can be applied to the impact of institutional abuse to explain that disruptions to caregiver/child relationships resulting from institutional abuse will be likely to negatively impact a survivor's future psychological wellbeing.

Attachment has been noted to impact many areas, including core beliefs regarding the self, the world, and others (Skarzynska & Radkiewicz, 2014), emotional regulation (Simpson et al., 2010), and relationships (Mikulincer et al., 2010). This research demonstrates the importance of attachment bonds to a child's wellbeing. Thus, if a child suffers abuse at the hands of their caregiver, the ability of the child to meet these attachment needs may be greatly impaired. This is indicated in the empirical evidence regarding the impact of institutional child abuse. For example, Wolters (2008) points out that victims in institutional settings were less trusting, had a more negative outlook on life, and were also seen as

suspicious and mistrusting of authority. In addition, therapists working with victims of institutional abuse reported that the children abused in institutional settings had smaller social support networks compared to children abused in non-institutional settings (Wolters, 2008). This theory therefore highlights the importance of lack of secure attachment which, if applied to institutional abuse, may exacerbate the impacts of it.

In addition to accounting for the important role of the relationship between the child and the caregiver, positively, the Spaccarelli's (1994) model also accounts for potential sex differences in the impact of child abuse. Spaccarelli (1994) noted that the sex of the victim may affect the impact of the abuse experienced and this is supported in the empirical evidence. Whilst some similarities between the outcomes for adults who have reported childhood sexual abuse have been found for men and women (e.g., Vaillancourt-Morel et al., 2015), differences are equally acknowledged. For example, women may be more likely to use avoidance to deal with their experiences of sexual abuse when compared to men (McCallum et al., 2012). Spaccarelli's (1994) model also covers several key issues found to be relevant to child sexual abuse that may also be applied specifically to institutional abuse such as the importance of disclosure (Colton et al., 2002). It is also in line with key theories in this area, for example, Attachment Theory (Bowlby, 1973, 2005) through highlighting the importance of the childcare giver relationship. Whilst it acknowledges the importance of multiple influences in the outcome of child abuse, it is not made explicitly clear how certain situations result in the development and maintenance of abuse and its negative impact, which may be better explained in behavioural models of the impact of child abuse (Freeman & Morris, 2001) such as that of Hoier et al. (1992) discussed previously. Despite this, this model highlights a range of factors that may exacerbate the impacts of abuse such as negative

responses to disclosure and negative child-care giver relationship which as clearly applicable to institutional abuse (e.g., Colton et al., 2002).

3.5.2. Strength Factors

As can be seen from the literature presented so far in this chapter, there is variation in the type and severity of the outcomes following institutional child abuse. Of note, there has also been little focus in the literature and models relating to the importance of strength factors following abuse. However, relevant theory based in a more general setting may be applied. As captured earlier, resilience refers to an individual's ability to adapt to adversity or severe stress (American Psychological Association, 2016). Lueger-Schuster, Weindl, and Kantor, et al. (2014) found that a sense of optimism, fewer emotional responses invoked during disclosure, and task-orientated coping, were related to better mental health outcomes following institutional abuse. Pessimism showed the opposite pattern. Positively this research adds to the empirical evidence base by exploring the strength factors of individuals following institutional abuse, demonstrating the importance of optimism, task-orientated coping, and fewer emotional reaction during disclosure to be strength factors.

The notion of resilience factors is supported in psychological theory. However, it is noted that there is variability in the literature regarding the conceptualisation of resilience (Liu et al., 2017). Some view resilience as a product of adverse experience, with a u-shaped relationship, indicating that moderate adversity can result in resiliency (Rutter, 2012). In this case, little experience of adversity may be insufficient to generate resilience, whilst at the other end of the spectrum, suffering extreme adversity may be so psychologically overwhelming that resilience is unable to develop. Positively, this conceptualisation of resilience views it as a developmental process and allows for the interaction between the

individual and the environment to be acknowledged. However, it is noted that as resilience is seen to result from adversity, it can be difficult to distinguish between factors that influence the initial adversity and those that influence the resulting resilience (Liu et al., 2017). Moreover, research has not always found that individuals who have similar levels of adversity show similar levels of resilience (Seery & Quinton, 2016). Others, therefore, view resilience as a continuum from vulnerability to resilience, which incorporates several strength factors such as self-efficacy and interpersonal support (Fergusson et al., 2003). It is argued that the variation in resilience research described is underpinned by the multi-dimensional and multi-faceted nature of resilience (Liu et al., 2017).

To better understand the broad and complex nature of resilience, the *Multi-System Model of Resilience (MSMR)* has been developed (Liu et al., 2017). This integrative model includes three types of resilience: core, internal, and external. Core resilience refers to a trait like characteristic within individuals. Internal resilience refers to inter-personal factors. External resilience refers to contextual factors. Hence, resilience is not conditional to a specific event but is essentially a part of everyday functioning. Acknowledgement of the multi-dimensional nature of resilience is seen as beneficial by Lui et al. (2017) in terms of the predictive ability of the model. However, it is also noted that further research is needed to understand the weight of each of the model components and that due to the broad nature of the model, it may lack specificity (Liu et al., 2017). Despite this, a number of resilience factors noted in the literature in relation to institutional abuse such as task-oriented coping (e.g., Lueger-Schuster, Weindl, & Kantor et al., 2014) fit clearly into this model. More specifically Mc Gee et al. (2020) capture the importance of core, internal, and external resilience in a sample of 17 adult survivors of child maltreatment in an institutional setting supporting the applicability of this model to institutional child abuse.

However, these resilience factors relating to institutional abuse may fit equally well into other models of resilience. For example, the *Multidimensional Model of Psychological Resilience* (MMPR) has been developed by De Terte et al. (2014). This model indicated that cognition (e.g., optimism, adaptive coping), environment (e.g., social support), and physical behaviour (e.g., adaptive health practices) were important aspects of resilience. This model may therefore equally capture resilience factors following institutional abuse. Like Liu et al. (2017), De Terte et al. (2014) also used empirical evidence to inform their model, highlighting a strength of this model. However, limitations of this model must also be considered when applying it to institutional abuse. For example, measurement issues were noted in relation to low levels of reliability in the tools used to support the model. Therefore, further research is needed to both further support the model and to consider its applicability to institutional abuse in more depth.

An alternative approach to understanding resilience is outlined by *Differential Impact Theory* (DIT; Ungar, 2017) which stresses the importance of both the individual and the environment when considering recovery and/or growth in the face of adversity. It postulates that changes to the environment result in changes to the individual, and the extent of these changes is impacted by the level of resources (psychological, socio-cultural, and economic) in the environment and the level of risk faced by the individual (Ungar, 2017). For example, it is noted that a person's positive attitude may be protective in the face of lower-level risk, but that access to environmental resources such as intervention may be more important when the individual is in a higher-risk context (Ungar, 2017). This theory has been supported in later empirical literature (Wessells, 2018). A key strength of this theory is its move away from models that focus more solely on the individual to also capture the environment (Theron

& Ungar, 2018) a common strength of multi-dimension models. This is important when applying this theory to child abuse as according to Marriott et al. (2014), multiple factors influence resilience following sexual abuse, including inner factors, such as interpretation of experiences, coping skills and self-esteem, along with resources within the community, family, and friendship. However, an interesting consideration is the specifics of these environmental factors. While social support may be considered important in these multi-dimensional models and theories those who have reported childhood abuse are also less likely to feel they have social support (Vranceanu et al., 2007). Therefore, the perception of social support may also be important to consider. As noted in Chapter 1 social support was not always found to promote recovery following institutional abuse (Lueger-Schuster, Weindl, and Kantor, et al., 2014) highlighting the complexities in this area. Therefore, while an emerging theme in the literature is beginning to explore resilience factors following institutional abuse such as optimism and task orientated coping the empirical literature is yet to explore the broader range of factors that could be considered based on relevant theories of resilience.

3.6 Summary

Overall, many negative impacts of institutional child abuse have been outlined in this chapter, such as negative impact on future relationships, impact on the victim's views of themselves and the world around them, mental health issues, and an increase in challenging behaviours (e.g., Carr et al., 2010; Hermenau et al., 2011; Spröber et al., 2014; Villegas & Pecora, 2012; Wolfe et al., 2006). These impacts are in line with what has been found in models of the impact of child abuse, not specific to an institutional setting (e.g., Finkelhor & Browne, 1985). However, the literature calls for a clearer conceptualisation of child sexual

abuse (Mathews & Collin-Vézina, 2019). In addition, no current model of the impact of child abuse appears to encapsulate all the theoretical and empirical impacts specifically relating to institutional abuse, described in this chapter. For example, several factors found relevant in the empirical literature are not captured explicitly in the current models of the impact of child abuse, such as the impact of the institutional setting and increased isolation (Lueger-Schuster, Weindl, & Kantor et al., 2014). Moreover, the empirical literature has also supported the importance of the concept of resilience and strength factors to the future impact of institutional child abuse (e.g., Lueger-Schuster, Weindl, & Kantor et al., 2014). Literature exploring the impact of resilience is not a new concept (Block & Block, 1982) and it has become more visible in the literature over time. But there still is a lack of focus on resilience specifically in relation to institutional child abuse. As a result, it will be important to consider these factors in more depth when exploring the impact of institutional abuse and considering how they affect the later impacts of institutional child abuse. This has informed the research aims and hypotheses, which will be outlined in the ensuing chapter.

Chapter 4 – Addressing the Research Question

4.1 Structure of the chapter

This chapter will set out the aims and the rationale for the current PhD research. It will comprise an exploration of the need to focus on childhood institutional abuse as a specific form of abuse distinct from abuse occurring in a home setting. The identification of the need to account for environmental factors and strength factors that may affect the impact of institutional abuse will then be explored. Finally, how the research aims will be addressed is summarised.

4.2 The current research

This PhD aimed to explore childhood experiences of sexual, physical, emotional abuse and/or neglect in an institutional setting, providing an in-depth exploration of factors that may influence these outcomes, such as strength factors. These strength factors are currently less explored in the literature than the negative impact of institutional abuse. The research included a focus on factors important to the effects of institutional abuse, such as the role of the environment (Lueger-Schuster, Kantor, & Weindl et al., 2014[27]), the cumulative effect of numerous traumatic experiences (Havlicek, & Courtney, 2016) and resilience (Lueger-Schuster, Weindl, & Kantor et al., 2014). The ensuing sections will discuss in more depth the rationale for this research relating to the importance of three core factors: the

[27] Both Lueger-Schuster, Weindl, and Kantor et al. (2014) and Lueger-Schuster, Kantor, and Weindl et al. (2014) included a sub-sample of individuals who reported abuse in boarding schools. However, not all abuse reported is explicitly noted to have been experienced in a residential setting.

impact of poly-victimisation and cumulative trauma, the role of the environment, and the need for additional exploration of strength factors.

4.3 The importance of institutional child abuse as a distinct form of abuse and the cumulative impact of multiple traumas

As noted in Chapter 1, research has illustrated the potential for multiple experiences of trauma to have a more negative impact when compared to a single experience of trauma (Afifi et al., 2014). This is important when considering the impact of institutional abuse, as those who are placed in institutions may have experienced child abuse before the placement (Havlicek & Courtney, 2016). In addition, placement in an institution may itself have a detrimental impact on a child's wellbeing (e.g., MacLean, 2003; Johnson et al., 2006). Therefore, this indicates the need for research to explore the role of pre-existing traumatic experiences in more detail, specifically in relation to how they may exacerbate the impact of institutional abuse given the increased level of trauma symptoms reported following poly-victimisation (e.g., Finkelhor et al., 2006).

4.4. The need to understand the impact of the institutional environment on the later impacts of institutional child abuse.

Chapter 2 indicated the importance of considering the environment in which the institutional abuse occurred. This is an important issue to consider as the traumatic impact of institutional child abuse may also be exacerbated by the setting, which reduces disclosure and support for the victim (Blakemore et al., 2017). In addition, placement in care may lead to isolation (Green, 2001), which may increase the impact of institutional abuse. For example,

PTSD was higher in those who experienced more isolation and institutional abuse (Lueger-Schuster, Kantor, & Weindl et al., 2014). These factors must therefore be accounted for when exploring the impact of institutional child abuse.

4.5 The need for further empirical exploration into the impact of institutional child abuse specifically including strength factors.

It has been noted that there is limited research into the impact of institutional child abuse, with attention more commonly focused on religiously affiliated institutions. The existing research is also often dated (Darling et al., 2018[28]). On reviewing the literature in this area, it has also become clear that there is further need for research exploring the impact of physical and emotional abuse, and neglect in an institutional setting in order to up-date current research including non-religious facility and to better understand what may exacerbate and protect against these factors. This is important to allow for a clearer understanding of the complex relationship between institutional abuse, experiences prior to care, protective factor and future negative outcomes which will allow for a better understanding of how to target intervention to reduce these negative impacts. As a result, this research continued to build on the empirical literature and focused on a broader definition of institutional abuse as opposed to focusing narrowly on religiously affiliated abuse and included a key focus on strength factors.

[28] This article does not solely focus on residential institutions.

4.6 Research Aims

This PhD thus explored the detrimental impact of institutional abuse, whilst adding to the literature regarding how strength factors assist individuals who have suffered institutional abuse to overcome or manage these negative impacts. It is hoped that a better understanding of strength factors, the impact of the environment, and disclosure will be useful when working with survivors, to increase understanding of what works in aiding recovery. This knowledge was to be used to inform a preliminary conceptual model exploring environmental and individual factors promoting negative symptoms and strength factors following institutional abuse. The differences between those who have reported institutional abuse and those who have not was also explored.

Systematic review

A systematic review of the literature was first completed to allow for a clearer understanding of what is already known about the effects of institutional abuse. Five databases were searched (PsycINFO, Medline, Cochrane Library, ERIC and CINAHL complete) for relevant literature and the themes found within this were synthesised.

Research aim: To understand what is already known about the impacts of childhood institutional abuse in the current literature.

Study 1

Study 1a then used a Delphi method to capture the views of professionals working with individuals who had reported institutional child abuse. The Delphi method allowed access to a geographically diverse group of individuals (Sharkey & Sharples, 2001). Mead

and Moseley (2001) state that the Delphi method is valuable when there is a limited amount of previous research in the area, which is the case when exploring institutional abuse. The Delphi method was used to complement the systematic review to allow for both academic (i.e., literature) and professional views to be gathered and consensus gained.

Study 1b then examined the perspective of individuals who have reported institutional childhood abuse. It was felt important to use a qualitative approach to allow for in-depth information to be gathered (Jackson et al., 2007). A survey method was used to remove interview bias and the need for the researcher to respond to disclosure of abuse, as the way in which a disclosure is responded to has been noted to impact the individual and how they see themselves and interpret their abuse (Ullman, 2003).

Research aims:

- To examine the impacts of institutional abuse as perceived by those who have reported it and professionals who work with them.

The following predictions were made:

1a. Institutional abuse will have several negative impacts relating to mental health and wellbeing (e.g., Carr et al., 2010).

1b. Factors such as self-esteem and support will protect against the impacts of institutional abuse (e.g., Guy, 2011).

1c. Responses to disclosure will impact how an individual responds to their experiences of abuse (e.g., Wolfe et al., 2009).

Study 2

The aim of this study was to use serious case reviews to build on areas of interest from the systematic review and study 1 and where there is less previous literature and detail. A large amount of the available literature exploring institutional abuse has focused on the negative impacts of this form of abuse. Therefore, this study explored the role of disclosure in the impacts of institutional abuse and strength factors and coping.

Research aims:

- To better understand the role of disclosure of institutional abuse, how it occurs, and how this impacts recovery.
- To better understand coping strategies and factors that protect against the impacts of institutional abuse.

The following predictions were made:

2a. Unsupportive responses to disclosure will negatively impact those who have reported institutional abuse (e.g., Wolfe et al., 2009).

2b. Positive coping strategies (e.g., seeking support) will protect against the negative impacts of institutional abuse (e.g., Finlay, 2010).

Study 3

This study was conducted to allow for further exploration of the research aims, using quantitative methods and building on the earlier qualitative studies to examine specific factors determined to be of interest. It examines the impact of personality functioning, resilience, strength factors, who perpetrated the abuse, the care environment, and if abuse was disclosed, and how these factors influence PTSD (trauma) symptoms following institutional

abuse. This final study allows for a comparison of PTSD (trauma) symptoms between institutional abuse and non-institutional abuse.

Research aims:

- To explore the impact of disclosure, the care environment, and who perpetrates the abuse on later PTSD (trauma) symptoms reported following institutional abuse.
- To explore whether those who have reported institutional abuse will report higher levels of PTSD (trauma) symptoms in comparison to those who report no institutional abuse.
- To explore the potential mediating role of several factors raised earlier in the PhD studies concerning the relationship between experiencing institutional abuse and later PTSD (trauma) symptoms, relationships, and placement in secure care. These factors include personality functioning, resilience, and strength factors.

The following predictions were made:

3a. Those disclosing abuse will differ in their level of PTSD symptoms compared to those who do not disclose (e.g., Royal Commission into Institutional Responses to Child Abuse, V3, 2017). No direction was predicted due to the lack of previous research to inform the direction.

3b. Those reporting abuse perpetrated by a carer will report higher levels of PTSD symptoms when compared to those abused by someone else. This prediction is based on the premise of Betrayal Trauma Theory (e.g., Birrell & Freyd, 2006).

3c. Those who report abuse in an institutional setting will report higher levels of PTSD symptoms when compared to those who do not report institutional abuse (e.g., Lueger-Schuster et al., 2018).

3d. Those who report a more negative care environment will report higher levels of PTSD symptoms than those who report lower levels of a negative care environment (e.g., Lueger-Schuster, Kantor, & Weindl et al., 2014).

3e. Institutional abuse will be positively associated with PTSD symptoms (e.g., Lueger-Schuster, Kantor, & Weindl et al., 2014).

3f. Those who have reported institutional abuse will be less likely to be in a current relationship (e.g., due to the lack of trust in others; Wolters, 2008).

3g. Institutional abuse will be positively associated with current placement in a secure setting (e.g., due to the reported relationship to risk taking behaviour; Wolfe et al., 2006).

3h. Resilience will protect against the negative impact of institutional abuse (e.g., Lueger-Schuster, Weindl, & Kantor et al., 2014).

3i. Protective factors (such as secure attachment under the age of 18, and social support) will reduce the negative outcomes following institutional abuse (e.g., Carr et al., 2009).

3j. Challenges with personality functioning in the domain of self will exacerbate the negative impacts of institutional abuse (e.g., Murphy, 2009).

3k. Personality functioning impairment in the domain of interpersonal will exacerbate the negative impacts of institutional abuse (e.g., Murphy, 2009).

Chapter 5 – A Systematic Review of the literature exploring the impacts of institutional child abuse

5.1 Structure of the chapter

This chapter presents a systematic review of the literature. The method used to obtain and extract literature will be outlined and results will then be presented, focusing on the themes found. Finally, this chapter will end with a discussion of these findings.

5.2 Method

A systematic review of the literature was conducted, guided by The PRISMA guidelines (Prisma, 2009).

5.2.1 Procedure

Identification of keywords was carried out based on relevant guidelines including the selection of words relevant to the study aims and based on an initial literature review (Florida International University Libraries, 2016; Perestelo-Pérez, 2013; Petticrew & Roberts, 2006). The initial search terms included forms of abuse and names of institutions or various effects of abuse. Citation pearl growing was used to further develop the search terms. This is where a precise search is conducted to find a relevant citation. The index terms for that citation are then examined and new terms identified are added to the search strategy. It has been suggested that this method is a more robust way of gathering keywords than the building blocks method, although it is less well evidenced in practice (Booth, 2008). The building blocks method includes developing key terms for each aspect of the query (e.g., each element

to be explored) and then adding synonyms for each of these aspects which are then added together as a string of search terms using Boolean operators (e.g., AND, OR).

Following this, the building blocks method was used to extract literature. For this, the keywords were entered along with the Boolean operator "AND" and "OR", and the truncation * to allow for variations in the spelling and tense of the word to be included in this search. During this stage, the validity of the search terms was examined by collecting papers already identified by the initial literature review and ensuring they are returned by the search (O. Price, email message to author, March 4, 2016). Following an examination of the articles that were not included in the search, the search terms were altered to better return relevant result. These were then tested. Four papers in the initial literature review for this project were judged relevant to this review based on their examination of the impacts of institutional child abuse (Knefel et al., 2015; Lueger-Schuster et al., 2015; Lueger-Schuster, Kantor, & Weindl et al., 2014; Lueger-Schuster, Weindl, & Kantor et al., 2014). Of these, three papers were captured using the search terms. The excluded paper used very broad terms in the abstract and therefore was not captured.

This resulted in the final search terms: (Child* Abuse* OR Child* Maltreatment* OR Institutional* Abuse* OR Child* Physical* Abuse* OR Child* Sexual* Abuse* OR Child* Emotional* Abuse*) AND (Care OR Juvenile* Detention* OR Borstal* OR Institution* OR Church* OR School* OR Detention* Centres* OR Industrial* Schools* OR Out Of Home* OR Group Homes* OR Secure* Boarding* OR Authority* Care* OR In Care OR Institutional* OR Prison* OR Young* Offenders*). The search was limited to words that were included in the abstract. No date limits were set. Only study including human participants were explored.

A search of Google Scholar revealed the top results for the search 'systematic review child abuse'. These results were then used to gain an idea of databases used for similar research in this area (e.g., Barth et al., 2013; Chen et al., 2010; Maniglio, 2009; Mikton & Butchart, 2009; Norman et al., 2012). This was used to inform the databases included in this study. The following databases were included PsycINFO, Medline, Cochrane Library, ERIC and CINAHL complete. These databases cover several relevant topics such as psychology, education, behavioural science, mental health, and medicine. Additional references were identified based on reference lists of included papers.

5.2.2. Exclusion Criteria

Exclusion criteria were developed based on the aims of the study. These included:

1. The paper was a duplicate.
2. The research did not refer to the psychological effects of sexual, physical, or emotional abuse or neglect or disclosure of these experiences.
3. This abuse did not occur in an institutional residential setting[29].
4. The abuse occurred when the individuals were over the age of 18.
5. The research was not empirical evidence (i.e., primary research).
6. The paper was not written or accessible in English.

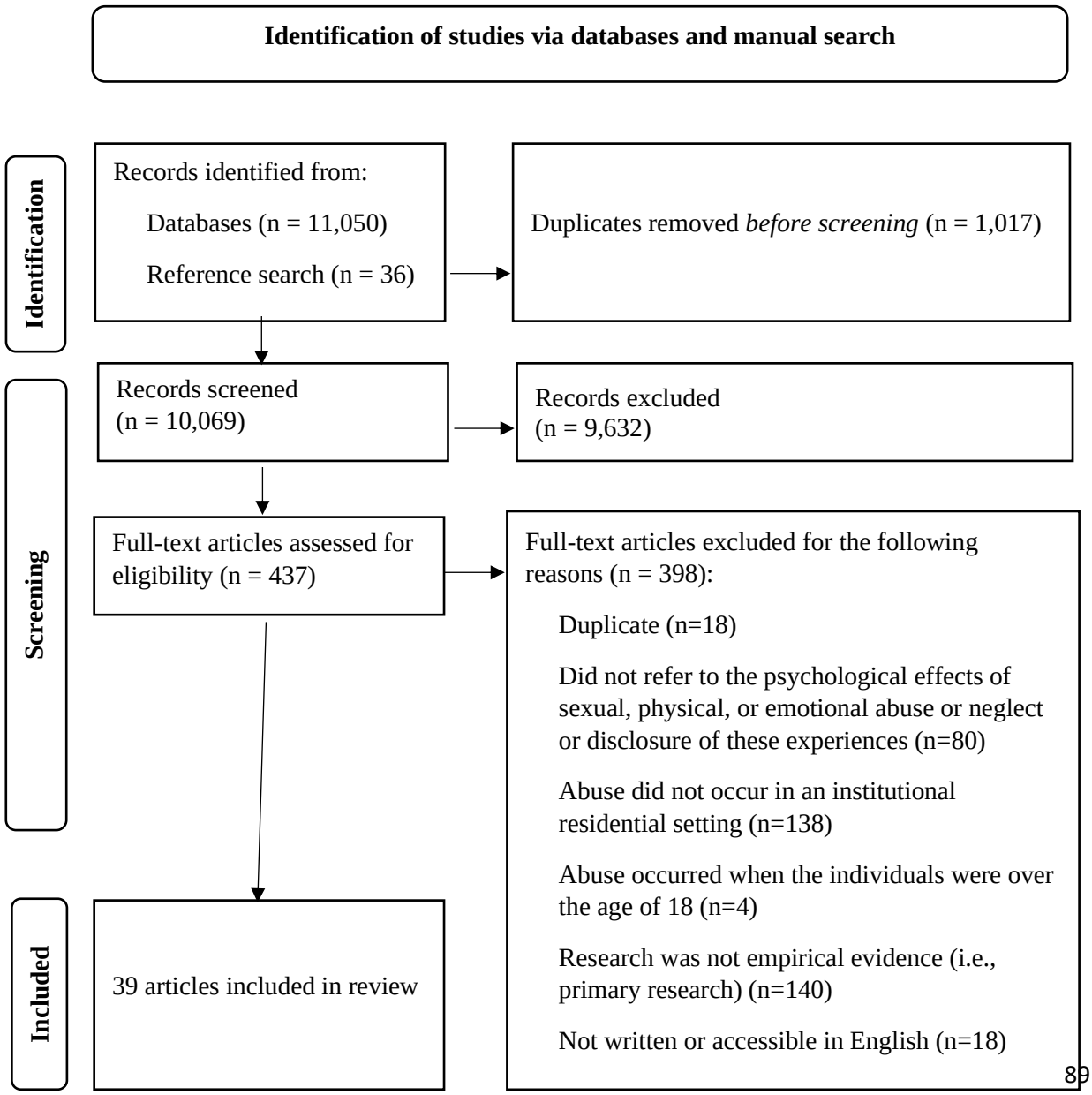
The search was conducted in 2016[30]. Abstracts were initially screened to examine whether they fitted the criteria. The full texts of those papers included were then examined.

[29] Studies were included if any of the sample included those who had experienced abuse in an institutional setting. Specific details of each study sample can be found in Appendix 2.
[30] The systematic review was updated in April 2022 to allow for an exploration of any recently published literature. A summary of this update can be found in Appendix 1. This update did not result in any alterations to the themes noted in this chapter.

The reason for exclusion was noted at each stage. In some cases, more than one exclusion criteria were relevant. In this case, the most obvious was recorded. Relevant papers were included in the final review. The number of included studies can be seen in Figure 5.1. Study information can be found in Appendix 2 (Table of information of studies included in the systematic review) and study findings in Appendix 3 (Table of findings of studies included in the systematic review).

Figure 5.1

PRISMA Flow chart of included studies



Reflexive Thematic Analysis was used to examine study findings (Braun et al., 2018; Braun & Clarke, 2019), which followed Braun and Clarke's (2006) six-step process. This approach to analysis was used due to its flexibility and usefulness when identifying key features of a large body of information whilst giving in depth descriptions of the information (Braun and Clarke, 2006). The six steps included becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining, and naming themes and finally writing these into a report. This was facilitated using the computer software NVivo. This allowed for the grouping of data into themes.

5.3 Results

5.3.1. Inter-rater reliability

A second rater reviewed 10% (n=43) of the returned papers and rated whether they should be included in the review. Agreement of 81%[31] was indicated, which was above the accepted level of agreement, 80% as proposed by Schlosser (2007). Braun and Clarke (2019) state that inter-rater reliability of themes development is not recommended for reflexive thematic analysis due to the accepted input of the researcher in theme generation. As a result, inter-rater reliability was not conducted on the themes, however, developed themes were reviewed via discussion with a colleague separate from the research to encourage reflection. Following this, the title of the superordinate theme relating to future life chances was expanded and clarified (e.g., relationship was changed to the negative impact on future

[31] Disagreements referred to abstracts where the author rated the paper to meet exclusion criteria 3 (This abuse did not occur in an institutional residential setting n=6) or the reviewer rated the abstract to be excluded due to criteria 2 (The research did not refer to the psychological effects of sexual, physical, or emotional abuse or neglect or disclosure of these experiences, but the author rated it as included n=2). The coding was discussed and that of the author was retained in each instance.

relationships and attachment), and the subordinate theme of survivor characteristics was altered to the impact of demographic variables on the impacts.

5.3.2. Quality assessment

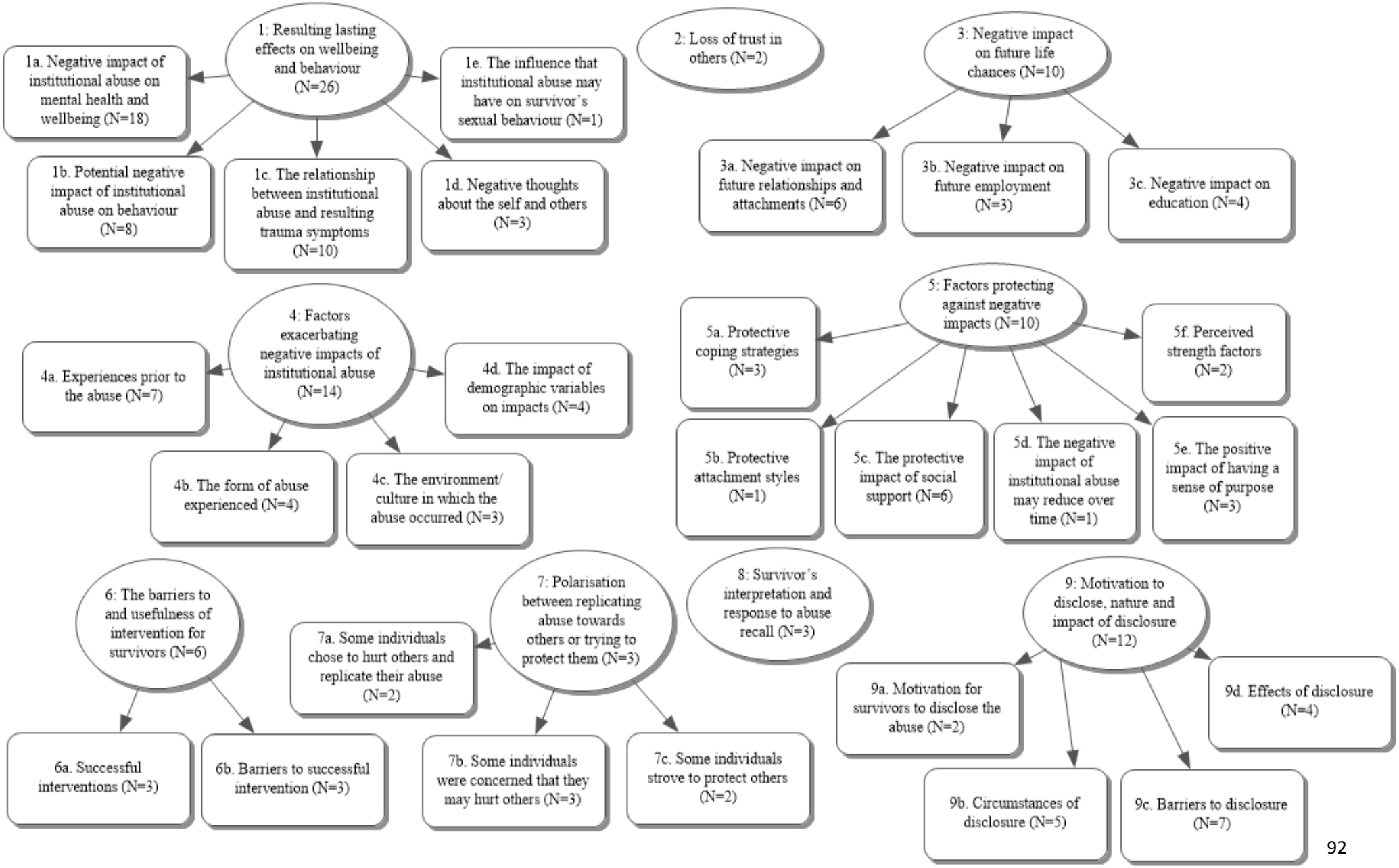
Following PRISMA (2009) guidelines, the risk of bias in included studies was examined. Ten included studies were case studies, so were not included in quality assessment. Due to a small body of research, they were still included in the final review. This is noted in Appendix 2 (Table of information of studies included in the systematic review), so they can be easily identified. Assessment criteria were based on the Newcastle-Ottawa Scale (NOS) for assessing study quality. Whilst many tools have been developed to explore the quality of studies (Sanderson et al., 2007), the NOS was chosen due to its reliability (Stang, 2010) and applicability to the included studies. This tool demonstrated some level of variety in the quality of these studies (see Appendix 4- Quality assessment of studies included in the systematic review). For example, the sample size was justified in only 10 studies and only 11 studies used validated measures of investigative reports to measure institutional abuse. Due to the limited number of studies in this area and as a result of the limited literature supporting the use of quality assessment to remove studies, all studies (n= 39) were included in the final analysis of themes.

5.3.3. Reflexive Thematic Analysis Results

Nine overall themes were identified in the current literature. These have been summarised in Figure 5.2.

Figure 5.2

Summary of superordinate themes and subordinate themes for the Systematic Review (and number of sources that included these themes)



Superordinate theme 1: Institutional abuse may result in lasting effects on wellbeing and behaviour. It has been noted that institutional abuse can have a range of negative impacts. This superordinate theme consisted of five subordinate themes. Research has supported the *negative impact of institutional abuse on mental health and wellbeing* (Benedict et al., 1996; Carr et al., 2010; Rassenhofer et al., 2015; Salazar et al., 2011) and that these impacts may be long lasting (Schaverien, 2011). Mental health impacts may include depression/depressive symptoms (Carlisle & Rofes, 2007; Hermenau et al., 2011; Spröber et al., 2014; Wolfe et al., 2006), anxiety (Carr et al., 2010), internalising/externalising behaviour (Hermenau et al., 2011; Hermenau et al., 2015), Obsessive-Compulsive Disorder (Carlisle & Rofes, 2007; Spröber et al., 2014), suicide ideation (Carlisle & Rofes, 2007), and self-injurious behaviour (Rusch et al., 1986). These impacts have also been reported to include feelings of powerlessness, helplessness, loneliness, isolation, low self-esteem, a feeling of being different to others, a 'self-sufficient' presentation, anger, distress, pain, shame, guilt, fear, and antisocial personality disorder (Bruskas, 2013; Carlisle & Rofes, 2007; Fitzpatrick et al., 2010; Meladze, 1999; Murphy, 2009; Schaverian, 2011; Wolters, 2008). In addition, those abused in an institutional setting demonstrated higher levels of hopelessness and had fewer coping resources (Wolters, 2008) and were more likely to report combined mental health issues when compared to those abused in a non-institutional setting (Villegas & Pecora, 2012).

Concerning the *potential negative impact of institutional abuse on behaviour*, behavioural changes such as increased aggression (Carlise & Rofes, 2007; Hermenau et al., 2011; Rusch et al., 1986), hostility towards therapists (Wolters, 2008), and reduced engagement in pleasurable activities (Cook et al., 1993) were noted. Within this theme, an increase in risky behaviours was also noted. For example, many adult survivors of

institutional abuse reported a history of crime (Wolfe et al., 2006) and substance misuse (Fitzpatrick et al., 2010). Abuse and institutionalisation were also common in the background of those engaged in prostitution (Nixon et al., 2002).

Research also supported *the relationship between institutional abuse and resulting trauma symptoms*. This included PTSD (Carr et al., 2010; Cook et al., 1993; Hermanau et al., 2011; Wolfe et al., 2006), C-PTSD (Flanagan-Howard et al., 2009), and individual symptoms of trauma. Specifically, 59.9% of those who reported institutional abuse had clinically significant levels of avoidance of reminders of early trauma, 46.2% had impaired self-reference, 44.1% had symptoms of dissociation, 41.7% had symptoms of depression, 38.5% had anxious arousal, 35.2% had maladaptive tension reduction, 35.2% experienced anger, 23.9% had sexual concerns and 12.6% had sexual dysfunction (Carr et al., 2010).

Another subordinate theme developed in relation to lasting effects to wellbeing was an impact on *negative thoughts about the self and others*. It was indicated that institutional abuse may impact the way individuals view and judge themselves. For example, this included the perception that their weaknesses should be punished (Carlise & Rofes, 2007), feeling they are not worthy of affection and warmth (Murphy, 2009), feeling alone, or that they are not good at recognising who is good and who is bad (Murphy, 2009).

A final subordinate theme was *the influence that institutional abuse may have on survivors' sexual behaviour*. For example, one in four men who reported institutional abuse reported a history of confusion concerning their sexuality and one in five were currently experiencing confusion or uncertainty (Wolfe et al., 2006). Over two-thirds of the sample experienced sexual problems in their relationships and nearly half were experiencing sexual

difficulties at the time of interview (e.g., hypersexuality, hyposexuality, feelings of inadequacy, and related difficulties; Wolfe et al., 2006). This also included confusion about sexual orientation in 27.5% of individuals who reported institutional abuse (Wolfe et al., 2006). Notably, this was not compared to a control group that had not reported institutional abuse, and the reason behind these outcomes was not explored.

Superordinate theme 2: Loss of trust in others. Another theme that was developed was the impact institutional abuse had on how survivors trust others. This included feeling a sense of betrayal and loss of trust (Wolters, 2008) extending beyond the interpersonal into loss of faith and devaluation of the church (Wolfe et al., 2006). This extended to suspicion and mistrust of authority (Wolters, 2008).

Superordinate theme 3: Negative impact on future life chances. This includes negative impacts on areas such as relationships, employment, and education. Specifically, this theme explores *the negative impact on future relationships and attachments*. This has included relationship problems (Rassenhofer et al., 2015), not knowing how to love (Benzola, 1997) sexual problems in relationships (Wolfe et al., 2006), use of aggression in relationships (Wolfe et al., 2006), and feeling emotionally distant from their partners (Schaverien, 2011). Intimate relationships may also act as a trigger for trauma symptoms (Murphy, 2009). However, it must be noted that this may be influenced by the nature of institutional care itself rather than the abuse alone. For example, learning to distance themselves from others when placed in care as a result of the frequent changes in those around them making it difficult to form bonds was a reported (Benzola, 1997). Importantly, not all individuals who experience institutional abuse reported problems and Schaverien (2011) highlights evidence of successful marriages. In addition, reports of these negative impacts may be influenced by the

source that is reporting them. For example, it was noted that psychosocial impact was higher in reports in government data when compared to church data (Rassenhofer et al., 2015).

Institutional abuse can also have *negative impacts on future employment*. For example, some survivors of institutional abuse reported hating employment and having many different jobs (Schaverien, 2011). In addition, those who had suffered institutional abuse were less likely to be in employment. When compared to children abused in a non-institutional setting, those abused in an institutional setting were less likely to be employed and were less resourceful in terms of employment (Wolters, 2008). However, it was reported that therapy may lead to positive changes in supporting these individuals to enter employment (Murphy, 2009).

A final subordinate theme explores the *negative impact on education*. This appeared to be for several reasons including, the individuals own feelings, situational factors, and the influence of other negative impacts such as mental health. For example, those who reported institutional abuse reported more adjustment problems in school compared to those who did not (Benedict et al., 1996). It was also felt, specifically by women, that this had an inter-generational impact on their children as they were less able to help them with schoolwork (Goldman & Bode, 2012). However, this thought was less common in men who more frequently reported that they felt encouraged to support their children in school, so they did not have the same negative experiences (Bode & Goldman, 2012). Education was also negatively impacted by feeling different from others (Benzola, 1997), feeling rebellious (Bode & Goldman, 2012), and lack of concentration (Goldman & Bode, 20102). Situational factors also played a role in impacting education. This included lack of opportunity in the institutional setting (Bode & Goldman, 2012; Goldman & Bode, 20102) as well as being told

they did not deserve education (Bode & Goldman, 2012). Thus, education may not only to be impacted by institutional abuse but also placement in an institutional setting itself. Finally, other negative impacts such as negative impacts on well-being also influenced education such as lack of trust in others and fear (Bode & Goldman, 2012), depression, anxiety, and fear of male authority in women (Goldman & Bode, 2012). Notably, some individuals who reported institutional abuse were able to complete education and some reported that their experiences of abuse gave them the drive to complete this (Bode & Goldman, 2012).

Superordinate theme 4: Factors exacerbating negative impacts of institutional abuse. Several factors were found to influence the extent to which a survivor of institutional child abuse experienced the full range of negative impacts. One such factor was the survivor's *experiences prior to the abuse.* The papers included in this review noted numerous negative childhood events before entry into the institution. For example, physical and emotional abuse (Saha et al., 2013), exposure to domestic violence (Saha et al., 2013), critical parenting (Carlisle & Rofes, 2007), being upset at being placed in care (Wolters, 2008), parental divorce (Wortham, 2000), parental imprisonment (Benedict et al., 1996), parental substance use (Benedict et al., 1996; Saha et al., 2013), and parental psychiatric problems (Benedict et al., 1996). These negative experiences may result in a cumulative effect, as total Trauma Symptom Inventory (TSI) scores were significantly higher in the group who had reported interfamilial abuse and institutional abuse when compared to those who had reported institutional abuse only. However, these groups did not differ with regards to their scores on current and lifetime psychological disorders and personality disorders (Carr et al., 2010). In addition to this, developmental problems before placement were higher in those who reported sexual abuse in foster care when compared to those who did not experience maltreatment in

foster care (Benedict et al., 1996). However, no difference was found concerning previous mental health issues (Benedict et al., 1996).

Results also showed that the negative impact may be dependent on *the form of abuse experienced*. This was noted specifically with regards to mental health problems, trauma symptoms, and negative impacts on relationships. It was indicated that institutional sexual abuse may lead to the most negative impact on mental health. For example, those who reported sexual abuse in an institutional setting reported more mental health problems, such as depression, when compared to those who reported physical abuse, or no abuse, in an institutional setting (Benedict et al., 1996). In addition, those who reported sexual abuse had the highest re-enactment scores when compared to those who reported severe physical and emotional abuse, meaning that they more frequently re-enacted their abuse on others (Fitzpatrick et al., 2010). However, the quality of long-term relationships was reported to be higher for those who reported sexual abuse in an institutional setting when compared to those who reported emotional or physical abuse (Fitzpatrick et al., 2010).

The impact of institutional abuse on trauma symptoms may also be influenced by the form of abuse reported as PTSD levels were highest in individuals who reported severe sexual abuse when compared to physical and emotional abuse (Fitzpatrick et al., 2010). In addition, the research suggested that C-PTSD was more common in individuals who reported institutional abuse for an extended period (Knefel & Lueger-Schuster, 2013). Those who reported PSTD following institutional abuse were more likely to have reported penetration when compared to other forms of sexual abuse and more likely to have also reported isolation. However, duration of perpetrator contact was not found to impact whether they experienced PTSD or did not (Lueger-Schuster, Weindl, & Kantor et al., 2014).

Regarding *the environment/culture in which the abuse occurred*, it was noted that survivors of institutional abuse commented on the environment of the institution in which this abuse occurred. For example, referring to it as a place where decisions are made for them (Wortham, 2000). The challenges of living in an institution and its negative impact on education were also noted (Feely, 2010). The time and setting of the abuse were also shown to be important. For example, shame about sexuality was higher in those individuals who suffered institutional abuse in the 1950s and 1960s when compared to the 1970s (Spröber et al., 2014). Furthermore, regarding the setting, those abused in a Protestant institution reported higher levels of psychosocial problems when compared to those abused in a Roman Catholic or secular institution (Spröber et al., 2014). Therefore, the environment and culture were seen to be important to survivors of institutional abuse.

The impact of demographic variables on impacts was noted as a subordinate theme. A sex difference was found in trauma symptoms of those who had reported institutional child abuse. Women were more likely to report C-PTSD when compared to men. However, no sex differences were found concerning later PTSD (Knefel et al., 2015). It was noted that gender effects were found for PTSD when using the ICD-10, in that PTSD was more common in women than men who had reported institutional abuse, however, that these were neutralised when using the ICD-11 (Knefel & Lueger-Schuster, 2013). Women who had reported institutional abuse had higher rates of a lifetime diagnosis of panic disorder with agoraphobia. However, men had significantly higher rates of lifetime diagnosis of alcohol dependence (Carr et al., 2010). Controls were not noted in this study as to whether these differences occur in the general population. The age of the victim did not appear to influence PTSD as the age of the first experience of institutional abuse was similar between those with no PTSD symptoms, mid-level symptoms, and the highest levels of PTSD (Lueger-Schuster, Kantor, &

Weindl, et al., 2014). However, the later negative impact of institutional abuse could also be influenced by the age at which the individual was placed into care. Interestingly, a relationship between institutional abuse and later aggression, and institutional abuse and depression was found only for those who entered the institution at a young age (in the first 4 years of life). This was not found for those who entered the institution above the age of four (Hermenau et al., 2014).

Superordinate theme 5: Factors protecting against negative impacts. Some factors can arguably protect survivors of institutional abuse from the range and severity of negative impacts following institutional abuse. For example, survivors reported the importance of positive attachments, having or being a mentor, self-reflective capacity, self-esteem, receiving help from foster care programmes, valuing education, and for some a sense of spirituality and faith (Guy, 2011). Overall, six main subordinate themes were developed concerning strength factors.

Regarding the subordinate theme of *protective coping strategies*, whilst survivors used a variety of coping strategies, some were more successful than others. Coping strategies included avoidant coping, turning to staff, 'getting tough', and complying (Finlay, 2010). The type of coping may influence the extent of the negative impact. For example, higher resilience, optimism, and task orientated coping were more likely to be found in those with no, or low, levels of PTSD symptoms after suffering institutional abuse when compared to those with higher levels of PTSD symptoms. However, emotional orientated coping and pessimism were lower in those with no or low levels of PTSD, rather than high levels of PTSD symptoms. No differences were found regarding using distraction as a form of coping

(Lueger-Schuster, Kantor, & Weindl, et al., 2014). Finally, avoidant coping was not found to be an effective coping strategy (Benzola, 1997).

Regarding *protective attachment styles*, a secure attachment was a protective factor when compared to other forms of attachment such as preoccupied, dismissive, or fearful. For example, those who had reported institutional abuse and had secure attachments were more likely to still be married to or cohabiting with their first partner when compared to those with other attachment styles (fearful, dismissive, or pre-occupied) (Carr et al., 2009). In addition, mental health issues such as current anxiety and mood disorders, personality disorders, trauma symptoms, and lifetime alcohol dependency were lower in individuals who had secure or dismissive attachments when compared to fearful or preoccupied attachments. Those with a secure attachment demonstrated the least negative impacts of institutional abuse (Carr et al., 2009).

The protective impact of social support protected against some of the negative impacts of institutional abuse. Several sources of support were noted: the social circle (Guy, 2011), staff (Finlay, 2010; Guy, 2011), therapists (Guy, 2011; Murphy, 2009), and religion (Guy, 2011). This also included support from others in terms of directing survivors to help organisations (Jackson, 2013). This support led to increased trust in others (Jackson, 2013) and self-esteem (Murphy, 2009) which also improved when survivors learnt about their talents from others (Guy, 2011). It was also noted that this relationship may be complex. For example, perceived social support did not differ between groups with no symptoms of PTSD and high levels of PTSD symptoms (Lueger-Schuster, Kantor, & Weindl et al., 2014). However, social support was found to partially mediate the relationship between institutional abuse and depressive symptoms. For those with low levels of social support, depressive

symptoms appeared to be constant regardless of the complexity of maltreatment. However, for those with higher levels of social support, lower levels of depressive symptoms were reported when maltreatment complexity was low and higher when complexity was higher (Salazar et al., 2011). This relationship may also be impacted by the quality of the support as inconsistent support was reported to be a risk factor for negative outcomes by four out of eight participants (Guy, 2011).

The negative impact of institutional abuse may reduce over time. For example, traumatisation and re-enactment decreased over time (Flanagan-Howard et al., 2009). However, spiritual disengagement increased. Positive coping also increased over time but coping by complying (e.g., by complying with the wishes of those in authority) and avoidant coping decreased (Flanagan-Howard et al., 2009).

Finally, *the positive impact of having a sense of purpose* can help survivors of institutional abuse to overcome some negative impacts of this. For example, having something consistent in their lives, such as sport (Jackson, 2013), becoming a parental figure (Guy, 2011) getting a part-time job (Benzola, 1997), and an education (Guy, 2011). This sense of purpose resulted in increased feelings of autonomy and increased self-esteem (Guy, 2011; Jackson, 2013).

A smaller but relevant subordinate theme was *perceived strength factors*, the notion that some survivors of institutional abuse reported having drawn strength from their experiences. For example, some survivors reported that difficulties experienced in care and the resultant lack of trust made them strong and resilient (Guy, 2011). However, they did not expand clearly on how this had taken place. In addition, a group of survivors of bullying in

institutional care noted that this gave them strengths they would not otherwise have had (Carlisle & Rofes, 2007).

Superordinate theme 6: The barriers to and usefulness of intervention for survivors. Research has begun to explore aspects of intervention that are useful when working with survivors of institutional abuse and the potential barriers to this. Evidence in support of *successful interventions* was found in three studies. For example, a drama workshop was reported to be useful in allowing survivors to gain insight into their relationships with themselves and others (Bundy, 2006). Another intervention in which therapists demonstrated empathetic understanding, active listening, congruency, and unconditional positive regard within this along with changes to the care environment, such as banning physical punishment, lead to reductions in PTSD symptoms. However, no reduction in depression or internalising and externalising problems was reported (Hermenau et al., 2011). Finally, a psychotherapeutic intervention was found to reduce behavioural problems as measured by the Child Behavioural Checklist in boys but did not reduce schizoid or obsessive subscales. In girls, this intervention was found to reduce behavioural problems as measured by the Child Behavioural Checklist, but not internal, anxious, schizoid, immature, somatic and delinquent subscales (Sullivan et al., 1992).

Possible *barriers to successful intervention* included issues in the formation of relationships with the therapist and lack of motivation. This included concern about therapy ending, the need to avoid dependency (Schaverien, 2011), and being more challenging to work with. For example, therapeutic alliance was harder to gain when compared to individuals abused not in an institutional setting, which therapists suggested may be a result of attachment difficulties. Those who reported institutional abuse were less autonomous in

their choice to seek therapy, showed slower therapeutic change, and impacted therapists more when compared to individuals abused outside of an institutional setting (Wolters, 2008). However, it is important to note that not all individuals abused in an institutional setting lack motivation to engage in therapy (Murphy, 2009).

Superordinate theme 7: Polarisation between hurting or protecting others. This theme included three subordinate themes, *some individuals chose to hurt others and replicate their abuse* such as bullying siblings or peers (Carlisle & Rofes, 2007; Schaverien, 2011), *some individuals were concerned that they may hurt others* (Schaverien, 2011), and *some individuals strove to protect others* for example by disclosing their abuse as a means of stopping further abuse (Colton et al., 2002). Those who chose to hurt others included bullying siblings or those considered defenceless after experiencing bullying in the institution themselves (Carlisle & Rofes, 2007; Schaverien, 2011). This could suggest that some individuals who have reported institutional abuse may go on to replicate their experiences towards others. However, it was reported that experiences of institutional abuse may lead to concern that survivors may themselves hurt others, despite their actions showing a desire to protect them (Schaverien, 2011). Alternatively, survivors may report hating those who abuse power (Schaverien, 2011), disclosing their abuse as a means of protecting others (Colton et al., 2002).

Superordinate theme 8: Survivor's interpretation and response to abuse recall. Several reflections on survivors' experiences of institutional abuse were noted here. For example, recognising the negative impact this had on them (Schaverien, 2011). Some expressed confusion about how someone could commit such abuse (Murphy 2009) and some avoided memories of abuse (Schaverien, 2011). The abuse led some individuals to consider

why this had happened to them and question why someone could commit such abuse (Benzola, 1997; Meladze, 1999). It is important to note that not all survivors initially identified their experiences as abuse (Schaverien, 2011).

Superordinate theme 9: Motivation to disclose, nature and impact of disclosure. This covered several subordinate themes related to the disclosure of institutional abuse. One subordinate theme developed explored *the motivation for survivors to disclose the abuse* they experienced in an institutional setting. Many reasons were given as the motivation to disclose institutional abuse. This included motivations that were to improve the survivors' future and those to protect others. Only 22% of individuals who suffered institutional abuse reported that compensation was a motivation (Rassenhofer et al., 2015). Other motivations included overcoming past trauma, for acknowledgement of harm, or to see justice brought to the perpetrator, not for themselves but the future protection of others (Colton et al., 2002).

Regarding the *circumstances of disclosure*, it was suggested that this often did not occur until years after the abuse (Colton et al., 2002), detail was often only given when asked (Schaverien, 2011), and was often limited (Guy, 2011). It was noted that in some instances there was little emotion associated with disclosure (Schaverien, 2011). However, at other times intense emotion was displayed (Murphy, 2009). Reluctance to talk and emotional reactions during disclosure were higher in those with PTSD symptoms but the urge to talk did not differ (Lueger-Schuster, Kantor, & Weindl et al., 2014).

Several *barriers to disclosure* were also noted. For example, those still in an institution had difficulties where the abuse of power was still present (Colton et al., 2002). Other barriers included not being taken seriously (Benzola, 1997), stigma, having no help,

punishment, being perceived as a potential abuser (Colton et al., 2002), and feeling the need to be independent (Schaverien, 2011). Some survivors' parents also felt they were not believed (Cooke et al., 1993). There were also some differences in the way in which disclosures were dealt with that may act as barriers to successful disclosure. For example, support diminished between disclosure and trial (Colton et al., 2002), some survivors experienced blaming following disclosure (Saha et al., 2013), and on occasion, no action was taken by parents (Carlise & Rofes, 2007) which reportedly acted as barriers to further disclosure. Despite this, some positive responses to disclosure were noted. For example, within an empathetic and unconditional therapeutic relationship (Murphy, 2009).

The subordinate theme of the *effects of disclosure* was also generated, although detailed studies were limited. Despite this, it was noted that disclosure may result in re-traumatisation, shock, and disorientation specifically when being approached by investigators exploring claims of abuse via letter. For some, negative life impacts such as suicide attempts or use of illicit substances were attributed to the stress of discussing their abuse during an investigation (Colton et al., 2002). It was also noted in one case study that there was a reduction in seizures following disclosure of institutional abuse (Nagamitsu et al., 2011). Impacts of institutional abuse were also found based on the responses to the abuse. Lack of respect to authority and a poor outlook on life attributed to silence and inaction following abuse (Wolfe et al., 2006), victimisation felt as a result of nothing being done (Colton et al., 2002) and anger at the lengthy process of making a claim (Wolfe et al., 2006).

5.4 Discussion

The developed themes illustrated the negative impacts of institutional child abuse on the victim including to their mental health and wellbeing, their trust in others, and the future life chances (e.g., Carr et al., 2010; Rassenhofer et al., 2015; Wolfe et al., 2006). It was also indicated that factors, such as the form of abuse and prior experiences before abuse, may exacerbate the impact of the abuse, whereas positive coping strategies and secure attachment may protect against these negative impacts (e.g., Carr et al., 2009; Carr et al., 2010; Lueger-Schuster, Kantor, & Weindl, et al., 2014). A small body of research has begun to explore the effectiveness of intervention and barriers to successful intervention such as challenges in building therapeutic rapport. Interestingly, it was noted that a small number of victims of institutional abuse went on to replicate their abuse toward others whereas others engaged in behaviour to protect others from experiencing this form of abuse such as protesting against it. The final theme explored the motivation for disclosure and barriers to this.

Several of these themes are in line with relevant theory. For example, when applying Attachment Theory (Bowlby, 2005) to the impact of institutional abuse, it may explain why institutional abuse may result in future problems in connections with others based on the severing of attachment bond. This was supported in the themes of *loss of trust in others*, *barriers to successful intervention*, and *negative impact on future relationships and attachments*. These themes indicate that institutional abuse may have negative impacts on the way survivors interact with others in the future. Attachment Theory (Bowlby, 2005) may also be linked to the subordinate theme of *protective attachment styles*, indicating the importance of secure attachment styles to protect against the negative impacts of institutional child abuse and to promote recovery.

A potential hostile attribution bias (Huesmann, 1998) was noted in the subordinate theme *Negative thoughts about the self and others* regarding victims feeling that they cannot tell who is good and who is bad (Murphy, 2009). However, this theme was based on a limited amount of detail and did not explain the underlying mechanism that caused these feelings or the impacts that they had in great depth. It would therefore be useful to explore in future research to what extent the survivor's view of the world is altered following institutional abuse.

When applying Social Learning Theory (Bandura, 1977), it could explain why those who have reported institutional abuse may re-enact this abuse on others, as noted in the theme *of polarisation between replicating abuse towards others or trying to protect them*, in which some individuals go on to hurt others. Despite this, others actively avoided this and made efforts to protect others from the same abuse they experienced indicating that an application of Social Learning Theory is insufficient on its own. The current literature base does not explain what underlies the polarisation in this theme.

The findings are also consistent with the expected negative impacts of institutional abuse based on models of child abuse; models not specific to an institutional setting. This can be seen when considering the *Transactional Model of Child Sexual Abuse* (Spaccarelli, 1994). This model explains the importance of abuse characteristics and disclosure to the negative impact of institutional abuse. This suggestion is consistent with the theme of *factors exacerbating negative impacts of institutional abuse* of institutional child abuse, which included the subordinate theme of *the form of abuse experienced*, and the superordinate

theme of *motivation to disclose, nature and impact of disclosure*, which included the impact that disclosure may have (Colton et al., 2002; Fitzpatrick et al., 2010).

Despite this, some superordinate themes and subordinate themes identified in the systematic review were not covered in previous models of the impact of sexual abuse, such as the impact on the environment. Whilst the *Transactional Model of Child Sexual Abuse* (Spaccarelli, 1994) does note the importance of the environment in determining the impact of abuse, it refers to the environment in terms of relational factors within the family as opposed to the setting of the abuse. It does not touch on issues specific to institutional abuse, such as lack of contact with biological parents. This element is therefore missing from current models that explore the impact of child abuse, which needs to be addressed if they are to be applied specifically to the impact of institutional abuse.

The systematic review was useful in identifying gaps in the literature. For example, whilst some interventions appear successful with survivors of institutional abuse, there was little research that explored the impact of interventions using control or comparison groups, such as those who have reported other forms of abuse (e.g., Bundy, 2006). Additional research to fill this gap in the future may be beneficial. Here it may be useful to develop a model of factors that mediate the negative influences of institutional abuse to enable interventions to be based on them. Similarly, research has begun to explore perceived strength factors (e.g., Guy, 2011). However, this systematic review has demonstrated that this theme is under-developed in the research when compared to the theme of lasting negative impact. Thus, it is not clear if these are genuine strengths or perceived strengths.

The review has highlighted some further implications for research. For example, whilst the importance of past experiences before placement in care was noted in the literature (e.g., Lueger-Schuster, Weindl, & Kantor et al., 2014), this review has identified the need for a clearer idea of how these pre-existing factors may play a *role* as the current literature is fragmented in that many studies focus on negative impacts or protective factors or disclosure, for example, rather than exploring both together in more depth. It has also identified the need to further explore the role that social support plays in recovering from institutional abuse as a result of the mixed findings.

A further implication of this review is related to future participant recruitment. As noted in the systematic review, the methods used to collect information regarding abuse may have a negative impact on survivors if they were contacted unexpectedly, such as via letter (Colton et al., 2002). As a result, the method used in the ensuing studies will aim to avoid contacting survivors in an unexpected way, where participants feel they are *required* to respond to the research. This method of approach was seen as more distressing when participants were asked about their experiences outside of circumstances where they would normally reflect on it (e.g., on support forums or in therapy). This will be specifically important for qualitative victim research focusing specifically on survivors of institutional abuse. In addition, the notion that responding to disclosure of abuse may impact the individual's perceptions of this abuse was also reinforced (e.g., Murphy, 2009). Thus, further substantiating the usefulness of a questionnaire-based approach for collecting qualitative responses in further work.

5.4.1 Limitations

There are several limitations to this review that should be considered. For example, due to the limited amount of available literature, the inclusion criteria allowed was broad and the quality of the research diverse. Whereas this allowed for a comprehensive overview of the area, the breadth is noted and more specificity would be welcome in future research.

Furthermore, the definition of maltreatment differed between papers and in the measures of maltreatment (See Appendix 2), which causes challenges when comparing findings across the literature. This indicates the importance of providing clear definitions of the focus of the research to potential participants. Finally, due to the complexity of the histories of these individuals, it can be difficult to establish the cause and effect of difficulties (e.g., Lueger-Schuster et al., 2014). It may therefore be important to control for pre-care experiences in future research, which will be explored within this PhD.

It is also noted that some themes such as "*Environment/culture in which the abuse occurred*" are based on a small number of sources. However, Braun and Clarke (2006) highlight the importance of flexibility in terms of what is classed as a theme and whether this is based on the prevalence of the theme across sources or how important the theme is to the research question. As the aim of this systematic review was to better understand the research area and identify areas where further research is needed, it was considered important to include themes based on their importance to the research aims rather than on prevalence alone. This is important as themes that are less prevalent in the current literature indicate an area that may need further development to fill in the gaps and build knowledge in this area.

5.4.2 Future Research

Further research is needed to add to what is known in the literature, which has allowed for an exploration of the academic knowledge in this area with the views of victims themselves and the professionals who work with them. Future research should aim to take advantage of the findings from this systematic review by exploring specifically the negative impacts of institutional abuse, and factors that give survivors strength to recover from these. It should adopt a qualitative approach to exploring the impacts of institutional abuse in victims to better understand the mechanisms of how impacts relate and why. This would, for example, allow for exploration of the polarisation between individuals who go on to replicate their abuse on others and those who instead try to protect others (e.g., Schaverien, 2011), the complex protective influence of social support (e.g. Lueger-Schuster, Kantor, & Weindl et al., 2014) and what, if any, role the environment (Wortham, 2000) and disclosure (Colton et al., 2002) play in exacerbating the negative impact of institutional abuse.

5.4.3 Concluding comments

There may be several factors that exacerbate these negative impacts of institutional abuse, such as experiences before entering the institution and the institutional environment itself. However, factors such as secure attachment and optimism may help protect against the negative impact of this abuse, as may interventions. Finally, research has shown the need for a greater understanding of the impact of disclosing abuse but has suggested that reactions to abuse may be important in how an individual then proceeds to cope with their abuse. The ensuing study will therefore explore the gaps in the literature noted, to further inform our understanding of the negative impacts and the strength factors following institutional abuse, by capturing views beyond published research in relation to exploring the views of

professionals working with victims of institutional abuse and the victims themselves in more depth.

Chapter 6 - Study 1a and 1b: The View of Professionals and Individuals Who Have Reported institutional abuse on the Negative Impacts and Relevant Strength Factors.

6.1 Structure of the chapter

This chapter presents Study 1a, a Delphi study, regarding the negative impacts of institutional abuse, with the expert group representing professionals working with survivors of institutional abuse. The aim was to capture the unpublished views of professionals working in the area of institutional child abuse, to reach a consensus view regarding four key areas chosen based on findings from the systematic review, negative impacts, pre-existing factors, strength factors, and disclosure. Firstly, the methods used to obtain and analyse the data are discussed. This is followed by the results of the Delphi. Next, this chapter will explore findings from Study 1b. Study 1b included collecting qualitative information from survivors of institutional abuse regarding what they believe the negative impacts were, what strength factors they found beneficial, and if they disclosed what their experience of disclosure was. The aim of this study was to better understand the impact of institutional abuse from the viewpoint of the victim. The methods for the research are discussed and the results are then presented.

Study 1a and 1b add to the systematic review by providing an alternative perspective to the academic viewpoint. The following predictions were made; 1a) Institutional abuse will have several negative impacts including to mental health and wellbeing (e.g., Carr et al., 2010), 1b) Factors such as self-esteem and support will protect against the impacts of institutional abuse (e.g., Guy, 2011), 1c) Responses to disclosure will impact how an individual responds to their experiences of abuse (e.g., Wolfe et al., 2009). The extent to which these predictions were met will be explored in the ensuing chapter.

6.2 Study 1a – Delphi study of professionals who work with those who have reported institutional child abuse

6.2.1 Method

Design. A mixed method Delphi approach was used in order to explore consensus between experts (Hsu & Sandford, 2007). With the first round being qualitative to allow for in-depth data to be collected to inform the items to be included in the later quantitative analysis used to explore consensus. This method includes using multiple stages of data collection, known as rounds, each round building on the previous one (McKenna, 1994). This included four rounds of data collection from a panel of experts. This Delphi method was designed following guidelines from Iqbal and Pipon-Young (2009).

Participants. Purposive sampling was used to recruit participants who had experience working with survivors of institutional abuse. The selection criteria included being a qualified Therapist (BPS/BABCP/EMDR), Social Worker, Personal Injury lawyer, or Psychologist and being a member of a professional body in your area. Participants were also required to have worked clinically with an individual and/or managed cases involving individuals who have reported institutional child abuse and feel confident in their professional opinion that they can discuss the effects of this abuse. Overall, 40 individuals responded to the initial research advert and requested to participate. Table 6.1 includes the participant information at each round. The includes the number of participants included in each round, the mean years of practice, the number of cases worked with, and how many individuals were currently working with an individual who has reported institutional abuse.

Table 6.1

Participant Information for Rounds One to Four.

Participants	Round 1	Round 2	Round 3	Round 4
Number of Participants	15	24 (10 from the original pool)	16	16
Percent of the sample retained from previous round	N/A	67% (from original sample)	67%	100%
Participant demographics				
Age	M=49.43, SD = 12.80 (Missing=1)	M=49.95, SD= (Missing=3)	M=51.92, SD = 11.76 (Missing=3)	M=51.92, SD = 11.76 (Missing=3)
Sex	Male = 7, Female = 7 (Missing=1)	Male=8 Female=13 (Missing=3)	Male = 5, Female = 8 (Missing=3)	Male = 5, Female = 8 (Missing=3)
Discipline				
Law	4	4	3	3
Social work	5	5	2	2

Therapy	2	7	6	6
Psychology	4	5	2	2
Not noted	0	3	3	3
Years of practise	M=23.07 SD=10.82	M=19.40, SD=11.34	M = 18.91, SD= 12.05	M = 18.91, SD= 12.05
Number of cases [32]	M=293.64 (1-2000)	M=219.89 (1-2000)	M = 154.67, (1-1000)	M = 179.00, (1-1000)
Number of cases for psychologists	M=26.00 (1-70)	M=23.50 (1-70)	M=4.00 (1-7)	M=4.00 (1-7)
Number of cases for social workers	M=5.66 (2-10)	M=193.33 (5-570)	M=570.00 (570[33])	M=570.00 (570[34])
Number of cases for solicitors	M=1033.33 (100-2000)	M=1033.33 (100-2000)	M=550.00 (100-1000)	M=550.00 (100-1000)
Number of cases for therapists	M=6.00 (6[35])	M=28.40 (6-60)	M=34.00 (6-60)	M=35.00 (20-50)
Currently working with a case	No = 6 Yes = 9	No=9 Yes=15	No = 5 Yes = 11	No = 5 Yes = 11

[32] Four participants in round 1, 3, and 4 and five participants in round 2 were not included in the means as their response was qualitative and simply indicated that they had worked with numerous cases.
[33] Only one social worker reported the number of cases for round 3 and 4
[34] Only one social worker reported the number of cases for round 3 and 4
[35] Two social workers were included in this round, the second gave a qualitative response noting there had been many cases.

Materials and Procedure. This study was ethically reviewed and approved by the University of Central Lancashire. An initial research advert was sent via email and social media to reach participants who may meet the criteria to allow them to express their interest in the research. The survey link for round 1 was then sent to individuals who expressed their interest in the research.

Round one of this research commenced with qualitative questions relevant to the aim of the research which were developed based on the findings of the systematic review (See Appendix 5 - Delphi round 1 survey):

1. What types of negative effects of institutional/in care abuse do you see in those who have experienced this form of abuse?
2. Does the type of abuse (e.g., sexual, physical, emotional) impact the type of negative effects and if so, how?
3. What pre-existing vulnerabilities, if any, do you feel influence the effects of institutional/ in care abuse?
4. Does the type of abuse (e.g., sexual, physical, emotional) impact the pre-existing vulnerabilities that influence the effects of institutional/in case abuse and if so, how?
5. What can promote recovery and resilience following institutional/In care abuse?
6. Does the type of abuse (e.g., sexual, physical, emotional) impact the factors that promote resilience following institutional/ in care abuse, and if so, how?
7. What role, if any, does disclosure play in the effects of institutional/in care abuse?
8. Does the type of abuse impact the role of disclosure following institutional/ in care abuse (e.g., sexual, physical, emotional) and if so, how?

These questions were initially piloted by asking two professionals working in the area to check for validity and understanding. Each factor captured in round one was included as an item in round two. This led to the creation of a list of items (See Table 6.2) which had been noted by professionals as important to each question. In the second round, the list of items was sent to the same individuals who completed round one. This round asked participants to rate their agreement on the importance of each item (strongly agree, agree, disagree, strongly disagree). Participants were also allowed to add any items to the list that they felt had not been covered to improve the validity of these results. Due to the small response rate (n=15), this round was also opened to new participants (See Table 6.1 for the number of participants at each round). It was felt this was also important to allow for any further attrition over the course of the study. It is expected that this had little impact on results as participants were still given the opportunity at this stage to include new items. Following this round, responses were analysed to explore the consensus reached for each item. Items that reached 80% were seen to have met consensus as suggested by Vosmer et al. (2009). In addition to this, the median (3.25 or higher) and standard deviation (less than 1) of each item were also explored to increase reliability where an item met each criterion to be included. The inclusion of standard deviation also reduced the impact of polarisation where mean and median may be misleading (Hsu & Sandford, 2007; Sharkey & Sharples, 2001).

In the third round, participants were asked to confirm that those items that had reached 80% should be included in the list and those that did not should be excluded. This round asked them to rate their agreement on the importance of each item (strongly agree, agree, disagree, strongly disagree). Items that remained above 80% in this round were included, those that did not were included in a final validation round.

The fourth round of this Delphi research acted as a validation round as agreement on some items had fluctuated over the course of the research. Items not reaching 80% consensus of agreement were included in the item list. Participants were asked whether they agreed this item was important to retain (yes/no). Those that did not reach 80% agreement in this final round were excluded from the final list of items. Agreement on excluded items ranged from 15-70% agreement (see Appendix 6 for % agreement of each item). Missing data were explored at each round. Data were found to be missing at random (e.g., $x^2(3715) = 00$, p=1.000). No difference in items included was found when inputting means using expectation maximisation to replace missing means.

6.2.2 Results

Thematic analysis. Overall, 177 items met the criteria for consensus (See Table 6.2; See also Appendix 6 for a full list of items generated during the process of the Delphi) by the final round, which were then condensed into themes using the reflexive thematic analysis. As noted in Chapter 5, the six steps of this analysis included becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining, and naming themes and finally writing these into a report. This was facilitated using the computer software NVivo. This allowed for the grouping of data into themes (see Figure 6.1).

Inter-rater reliability. Quantitative inter-rater reliability is not recommended for reflexive thematic analysis. However, for thoroughness, items and themes were reviewed by another researcher to generate discussion and reflection. Minor alterations were made based on feedback, specifically, an additional subordinate theme *impact to emotions* was added to the overall theme of lasting effects on wellbeing and some theme names were clarified (e.g., the

theme existing social support was expanded to capture that the social support was positive for subordinate theme 5c, see Figure 6.1). Following this, the reviewer re-examined the themes and agreement was gained.

Table 6.2

Items included in the Delphi Study which met over 80% consensus at the final round.

Item	% agreement at final round
Impacts of institutional abuse	
Increased anger	93%
Increased aggression	93%
Increased violence	80%
Increased use of violence to settle arguments	80%
Increased likelihood of criminality	88%
Increased delinquent behaviour	87%
Increased risk-taking behaviour	93%
Increased isolation	93%
Negative impacts on cognitive development	93%
Difficulty maintaining future life chances	80%
Not fulfilling full potential	87%
Low achievement	85%
A sense of mistrust	100%
Difficulty establishing relationships	100%
Difficulty maintaining relationships	100%
Fear of not being listened to	100%
Lack of understanding of inter-personal relationships	100%
Lack of closeness in relationships	100%
Seeing closeness even in those who may pose risk	86%
Parenting difficulties	87%
Difficulties with boundaries	93%

Anti-authoritarian attitudes	80%
Lack of trust in authority	100%
Insecure attachment styles	100%
Impacts to feeling of safety	93%
Difficulties with impulse control	93%
Emotional regulation difficulties	100%
Depression	93%
Anxiety	100%
Low self-esteem	100%
Self harm	87%
Maladaptive coping	93%
Shame	93%
Embarrassment	100%
Alcohol addiction	80%
Drug addiction	84%
Development of personality disorders	86%
Self blame	100%
Guilt	100%
Dissociation	93%
Flashbacks	87%
Post-traumatic stress disorder	80%
Rumination of past abuse	87%
Repeat victimisation	93%
There is cumulative impact of multiple negative experiences	100%
Vulnerability to grooming	93%
Negative impacts on sleep	93%
Sexual abuse cannot be isolated from the many other problems that these victims suffer	93%
It is hard to generalise, an individual approach should be used	100%
Mistrust of other people	100%
Poor problem-solving skills	81%*
Increased likelihood of later imprisonment	81%*

Whether the form of abuse effected the impacts

The form of abuse experienced (e.g., sexual/physical/emotional) impacts the negative effects of institutional abuse	87%
Sexual and physical abuse include a significant degree of emotional abuse	100%
The more serious the emotional impact of any of these forms of abuse, the more negative the outcome	100%
The victim's beliefs around the abuse are more important than the type of abuse	100%
It is hard to generalise, an individual approach should be used	100%
Sexual abuse may link more closely to effects of sexual nature (e.g., increased masturbation)	94%*
The response to the abuse is more important than the type of abuse	88%*

The importance of pre-existing factors

Being in the care system	100%
Lack of compassionate parenting	93%
Lack of affection as a child	93%
Lack of support	100%
Isolation from the outside world	100%
Previous trauma	100%
Previous abuse	100%
Poor attachments	100%
Child self-esteem (low self-esteem)	100%
Childs (poor) coping	92%
The importance of a cumulative effect	93%
It is hard to generalise, an individual approach should be used	100%
Pre-disposition to mental illness	88%*

Does the form of abuse impact which pre-existing factors are relevant?

The impact may be worse if the form of institutional abuse is the same as previous abuse in the home setting	92%
Lack of previous affection may lead to vulnerability to being groomed	100%
If a child has previously experienced extreme violence, they may not appreciate that the level of violence used in the institution is wrong.	93%

If a child has previously experienced sexual abuse, they may not appreciate that sexually inappropriate behaviour toward them in the institution is wrong.	100%
It is hard to generalise, an individual approach should be used	93%
Blaming themselves for being placed in care	100%

Strength factors

Access to specialist intervention	100%
Psychotherapy	85%
Cognitive affective processing	92%
Addressing attachment issues	93%
Work to increase self esteem	100%
Work to increase self efficacy	100%
Working with staff who are knowledgeable of abuse	100%
Continuity of main carer	100%
A key attachment figure	100%
Consistent boundaries	100%
Consistent routines	100%
Increasing safety	100%
Building on the child's strengths so they feel good about themselves	100%
A sense of connectedness in the world	100%
Peer support	100%
Work or education outside of the institution	100%
Being believed	100%
An understanding it was not their fault	100%
Empathetic responses to disclosure	100%
Feeling understood by others	100%
Being informed about outcomes of court procedures against abusers and institutions	100%
Successful conviction of the perpetrator	93%
An individual assessment/formulation	100%
It is hard to generalise, an individual approach should be used	93%
Safety	100%
Care	100%

Justice	100%
Acceptance and Commitment Therapy (and the adolescent variation that incorporates developmental information)	92%
Create Code of Conduct for the institution all co-workers including the directors	100%
Provide child protection training sessions	100%
Provide training session on child rights for staff members and children also	100%
Access to a helpline	93%
Being employed	93%

Does the form of abuse experienced impact which of these strength factors is most important to the survivor?

It is hard to generalise, an individual approach should be used	93%
Any form of abuse can be detrimental	100%

What role, if any, does disclosure play in the effects of institutional/in care abuse?

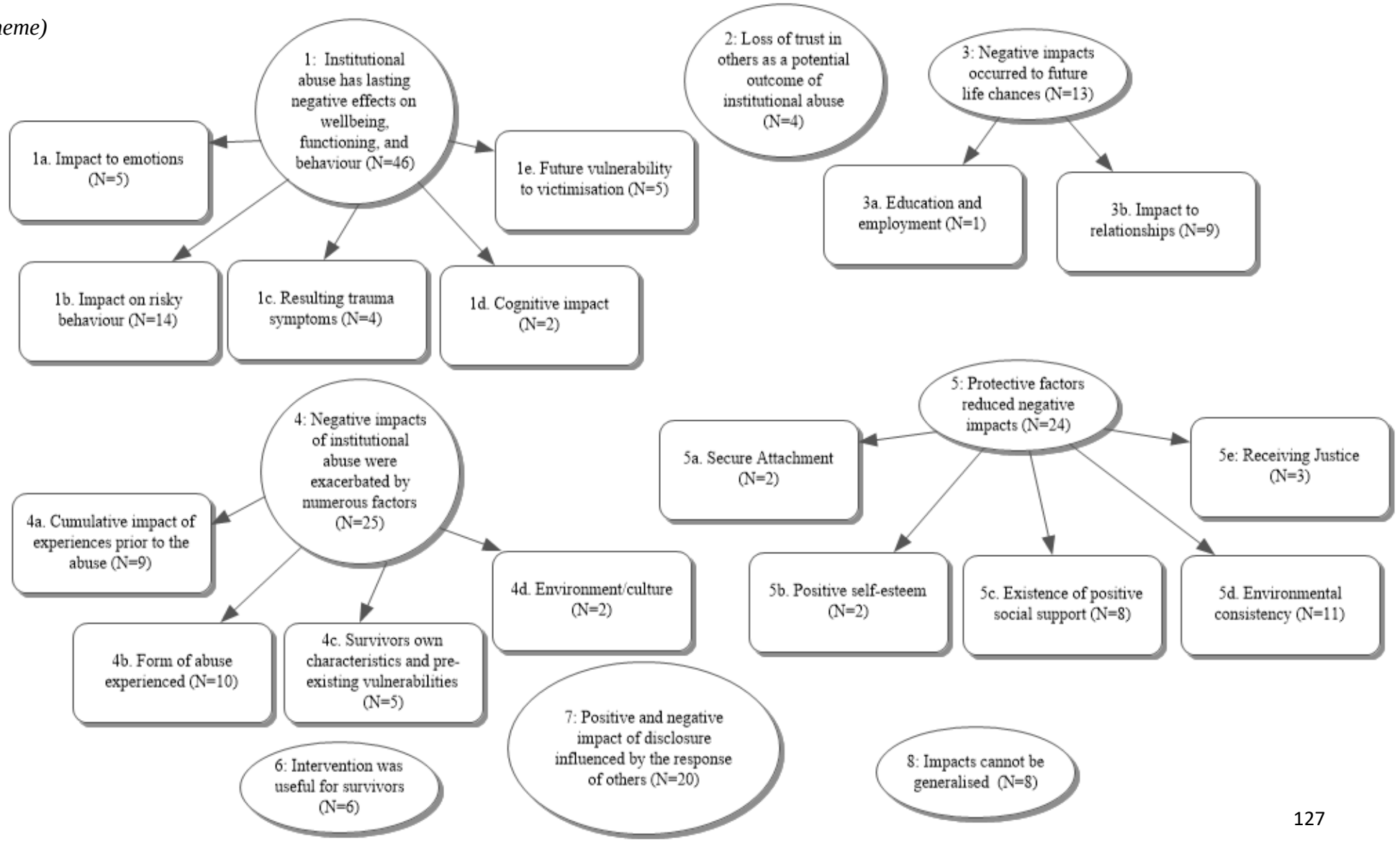
Action following disclosure may be impacted by the relationship between the alleged abuser and the individual who it is disclosed to	93%
Lack of criminal conviction can result in despondency (e.g., low spirits)	93%
It will be harmful if they are not believed.	100%
Lack of action can result in lack of faith in adults to keep them safe	100%
It will be harmful if they are told they are not a reliable witness	100%
When there are aggressive defence proceedings in court	93%
It is critical in building self esteem	93%
It may be empowering	100%
It can make a child feel heard	100%
Reinforce that it is not acceptable to be abused	100%
It can be positive for them to believe they are helping others	100%
Important that the child is offered support	100%
The impact of disclosure may be dependent on the response	100%
It is hard to generalise, an individual approach should be used	93%
During the child abuse cases, response of adults is very important	100%

An investigation should be undertaken when a child reports abuse to a manager	100%
The impact of disclosure will be dependent on the client's psychopathology	81%*
It can cause psychological harm	87%*
Does the form of abuse experienced impact the effects of disclosure?	
It is difficult to generalise	93%
Staff or responsible people should notice or take into account all abuse forms and respond	100%
Set rules should be set for abusers	86%
It may be more likely that information about physical abuse is passed on	81%*

Based on included items, several themes were developed and are presented in Figure 6.1.

Figure 6.1

Summary of Superordinate Themes and Subordinate Themes Generated From Professional Sample (and number of items included in each theme)



Superordinate theme 1: Institutional abuse has lasting negative effects on wellbeing, functioning, and behaviour. Mental health issues such as anxiety and depression and negative impacts to sleep and coping were noted to be potential outcomes following institutional child abuse. Within this theme, the subordinate theme of *impact to emotions* included challenges with emotional regulation difficulties and the development of negative emotions such as shame and anger. *Resulting trauma symptoms* also emerged as a subordinate theme capturing the trauma symptoms such as rumination of past abuse occurring following institutional abuse. *The impact on risky behaviour* was also noted, including changes in behaviour relating to increased us of aggression and violence, and substance misuse. The subordinate theme of *cognitive impact* indicated the potential detrimental impact of institutional abuse on cognitive development, for example, in leading to poor problem-solving skills. Finally, *future vulnerability to victimisation* was also noted as a subordinate theme. This subordinate theme highlighted that victims of institutional child abuse may be vulnerable to future victimisation as a result of the cumulative impacts of multiple traumas and difficulties in judging the character of others.

Superordinate theme 2: Loss of trust in others was a potential outcome of institutional abuse. This theme included items that captured the impact of institutional child abuse on trust. This included; a sense of mistrust; lack of trust in authority and mistrust of other people; and fear of not being listened to.

Superordinate theme 3: Negative impacts occurred to future life chances. This theme focuses on difficulty maintaining future life chances and not fulfilling full potential. The subordinate theme of impacts to *education and employment* was noted with the low achievement being highlighted as a potential consequence of institutional abuse. The

subordinate theme *impact to relationships* captured the negative impact that institutional child abuse could have on establishing and maintaining healthy relationships which was impacted by a lack of understanding of inter-personal relationships. Furthermore, overlap is noted with the superordinate theme *Institutional abuse has lasting negative effects on wellbeing, functioning, and behaviour* where issues such difficulties with boundaries may also impact future life chance.

Superordinate theme 4: Negative impacts of institutional abuse were exacerbated by numerous factors. Within this theme it is indicated that not all individuals will experience the same negative impacts and that there are several factors that may exacerbate these impacts. This included the subordinate theme of *the cumulative impact of experiences prior to the abuse* which include the impact that experiences prior to the institutional abuse, such as lack of previous affection and previous abuse, can have on the later impacts of this abuse. This also included the notion that these experiences may normalise abuse experiences. Another subordinate theme was *the form of abuse experienced*, in which it was noted that many forms of abuse co-occur and the severity of the abuse and response to the abuse may be more impactful than the specific form of abuse. The *survivors' own characteristics and pre-existing vulnerabilities* such as poor coping, self-blame, and low self-esteem were also noted to be important as these had the potential to increase the negative impacts of institutional child abuse. As part of the theme of factors exacerbating negative impact, it was also noted that the *environment/culture* may play a role, specifically, isolation from the outside world and lack of social support exacerbating the impacts.

Superordinate theme 5: Protective factors reduced negative impacts. Several factors were noted to reduce the negative impacts of institutional abuse. This included having a

secure attachment either through having a key attachment figure or through using intervention to address attachment issues. *Existence of positive social support* was also noted to be important to recovery. This highlighted the protective nature of a sense of belonging and access to support from those who are knowledgeable about abuse. *Environmental consistency* both in relation to consistent rules and boundaries as consistency of caregiver behaviour was also noted to be a protective factor. Finally, *Receiving justice* may also be an important strength factor specifically in relation to the perpetrator being held accountable by the justice system which was reported to be helpful for recovery.

Superordinate theme 6: Intervention was useful for survivors. This theme captured the benefits of effective psychological intervention on reducing the negative impacts of institutional abuse. Specifically, it was noted that interventions were noted as strength factors that helped individuals recover. Examples included Psychotherapy and Acceptance and Commitment Therapy. No further detail was given in relation to the delivery or effectiveness of these interventions.

Superordinate theme 7: Positive and negative impact of disclosure influenced by the response of others. A clear division was captured in this theme with disclosure being noted to have positive impacts in relation to supporting the victim to feel empowered and heard. However, it was noted in some instances to have negative impacts, and that the response to disclosure influences whether disclosure will be a positive or negative experience. For example, it was noted that it is important to offer support and be empathetic. In addition, inaction and disbelieving were noted to be harmful responses.

Superordinate theme 8: Impacts cannot be generalised. The importance of having an individual approach concerning understanding the negative impact of institutional abuse was captured in relation to the negative impacts, pre-existing factors, strength factors, the impact of disclosure, and whether the form of abuse impacted these outcomes.

6.3 Study 1b – Understanding the impact of institutional child abuse: A victim perspective

6.3.1 Method

Participants. The final sample consisted of 10 participants, six who currently resided in a secure setting and four from the general population. Initially, 29 participants responded to the research advert. Ten of these individuals currently resided in a secure setting and completed a paper-based questionnaire. The data from three participants were removed due to not meeting the inclusion criteria stated in the advert (e.g., abuse occurring in an institutional setting under the age of 18). A further participant's data was removed due to the consent form not being returned. Nineteen participants from the general population participated. Of the 16 participants who consented to engage in the research, only five completed information past the demographic questions. Of those responses, one participant's data was excluded as it did not meet the inclusion criteria. Participants ages ranged from 34-76 years old (M=49.06, SD=11.06). Eight of the participants were male and two were female. Five participants resided in residential care before the age of 18, three in boarding school, one in an orphanage, and one in a Young Offender's Institute. One participant reported sexual abuse, two reported physical and emotional, and seven participants reported sexual, physical, and emotional abuse.

Materials. Survey questions were developed for this study based on the aims of the research and the systematic review. A demographic sheet was used to capture age, sex, the type of abuse reported, the length of time the abuse occurred, age of initial abuse, age of abuser, sex of abuser, and relationship to the abuser. The survey then proceeded to a series of questions that requested a narrative of the victim's experience. This focused on pre-existing vulnerabilities, key impacts, factors aiding recovery, and disclosure experiences (See Appendix 7 - Qualitative victim survey). Figure 6.2 indicates the questions used.

Figure 6.2

Questions used to explore victim's experiences in study 1b.

1. Approximately how old were you when the abuse started?
2. Approximately how long did this abuse last for? (Days/Months/Years)
3. Was the individual(s) who abused you an adult or a child?
4. Please specify the relationship of the abuser(s) to you (e.g., carer, teacher, someone in care with you).
5. Was the abuser(s) Male, Female?
6. What impacts do you feel this abuse had on you?
7. What impacts do you feel this abuse has had on your life?
8. What factors, if any, were present before the abuse that you suffered that may have made the effects worse for you to cope with?
9. What factors, if any, helped you manage the effects of the abuse in the short term?
10. What factors, if any, helped you manage the effects of the abuse in the long term?
11. Have you disclosed this abuse?
12. Who did you disclose the abuse to (e.g., friend, partner etc.)?
13. When did you disclose?
14. Why did you disclose?
15. How did you feel after this disclosure?

Procedure. Participants were recruited through online forums and social network groups that aimed to offer support to survivors of child abuse. An advert for the research, including details of the aim of the research and information on how to participate was posted on these sites. This advert was also posted in a local newspaper in the northwest and a newspaper that is circulated in secure settings. The research advert was also circulated to personal injury lawyers, who were invited to pass the research information onto individuals who may be interested in engaging. Notably, this was restricted to closed legal cases to avoid their clients feeling pressure to engage. Participants were invited to complete a free narrative of their experiences and the impact this had on their lives, including the factors that had aided their recovery. This was completed via "eSurvey Creator". Paper copies of the survey were available for those who did not have access to the internet. This study was ethically reviewed and approved by the University of Central Lancashire.

6.3.2 Results

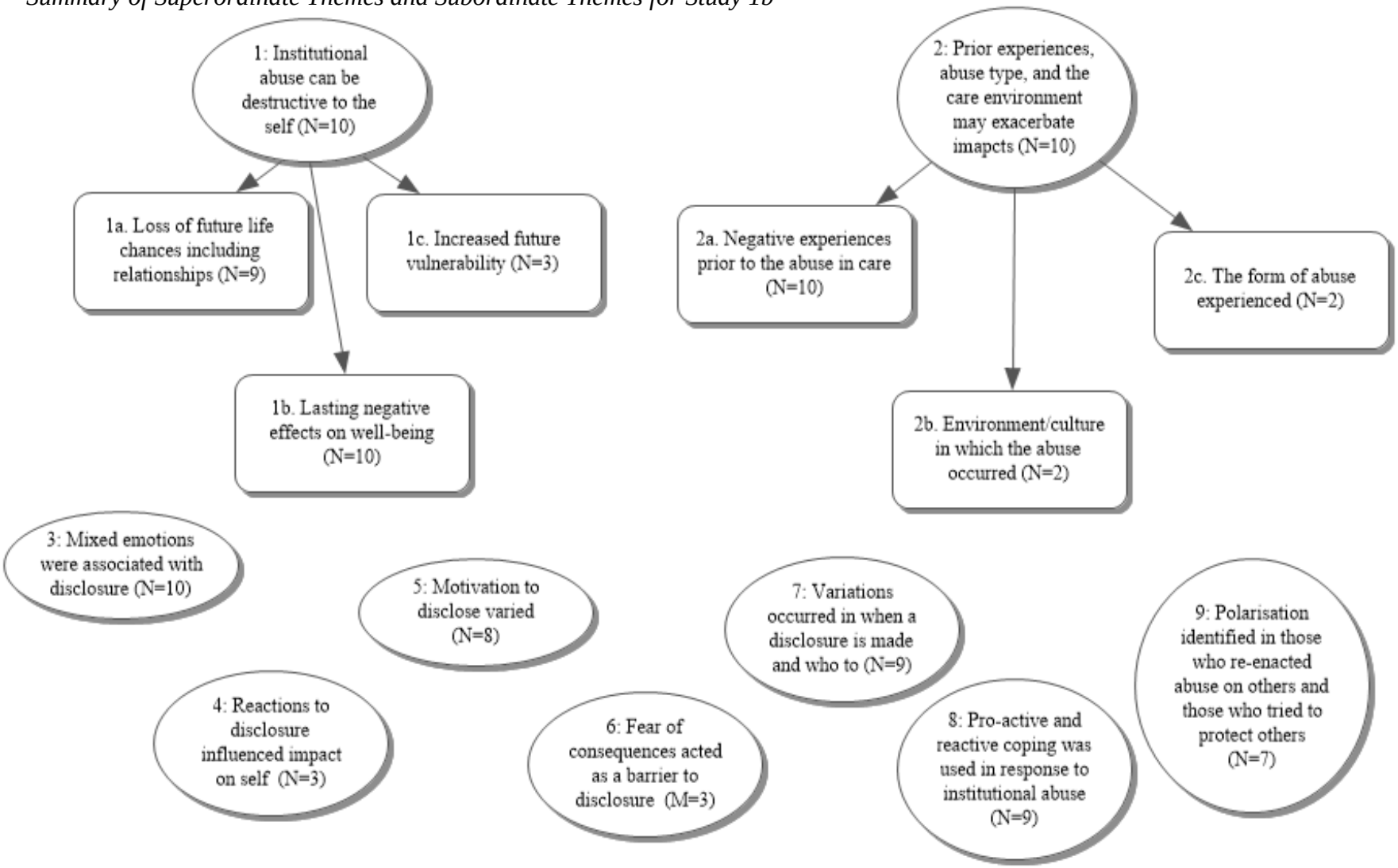
Reflexive Thematic Analysis was used to examine study findings using Braun and Clarke's (2006) six-step process, as outlined in section 5.2.2. A summary of resulting themes can be found in Figure 6.3.

Inter-rater reliability. As in study 1a items and themes were reviewed by another researcher to generate discussion and reflection. Final themes were agreed upon.

Thematic analysis.

Figure 6.3

Summary of Superordinate Themes and Subordinate Themes for Study 1b



Superordinate theme 1: Institutional abuse can be destructive to the self. This theme captured a range of potential negative impacts that institutional abuse had on victims. This included the subordinate theme of *loss of future life chances including relationships.* This included broad statements such as that institutional abuse *"thwarted my considerable potential",* as well as difficulty establishing and maintaining positive friendships and intimate relationships. This was often a result of the impact that the abuse had on the victim's ability to trust others (n=9). For example: *"I can't trust or get close to people and can't stand people touching or coming to close to me as they may restrain me".* (Participant 1). A further barrier to establishing and maintaining relationships was the impact of institutional abuse on the victim's interpersonal skills and ability to express emotions, "*Later in life, I continued to have problems in relationship. I was not able to express my feelings to a partner. I failed to speak of my problems. I failed to listen to others. My marriage ended due to this".* (Participant 4). It was noted that the negative impact of institutional abuse, such as increased anger, could become *"hard to hide"* impacting relationships. Despite these difficulties with intimacy, one participant focused on their strong desire for love, despite the fact they have not yet experienced it noting *"I do not think that I have truly loved anyone. I crave love above all else."* (Participant 3).

Institutional abuse was reported to result in *potential lasting negative effects on well-being*. Four individuals reported issues relating to mental health including anxiety, self-harm and suicide attempts, depression, PTSD, Antisocial Personality Disorder, drug abuse, and sleep disorders. This included the development of negative feelings and emotions. For example, feeling shame, confusion and powerless. Institutional abuse was also reported to impact the individual's sense of self. This included lack of confidence and negative feelings towards themselves, such as hating themselves. For example, Participant 5 noted *"hating*

myself for being such a failure meant I was at least trying to deal with negative emotions/energy". These feelings were reported by four participants to result in risky behaviours such as drug use and violence in order to cope *"took drugs to block things out started hitting out at people"* (Participant 2). On the contrary, participant 8 reported *"minimal"* negative impacts following the institutional sexual abuse. Two participants reported, however, feeling the abuse experienced had made them stronger for example noting *"I am calm in situations of violence as I know how to survive them*" (Participant 10), feeling stronger as they can protect themselves by *"trusting no one"* (Participant 3) and risk-taking behaviour stating, *"my fear has empowered a life of adventure - a willingness to take risks and see what happens."* (Participant 10). These perceptions of strength demonstrated interesting similarities with the negative impacts reported by some participants such as loss of trust and risk-taking.

Increased future vulnerability was highlighted as a further subordinate theme. This was seen to be a result of learning to be passive. For example, participant 5 reported that the institutional abuse *"cause[d] me to repeat the passive response to others seeking to subjugation me or exploit me or use me".* However, participant 10 reported to be vulnerable due to feeling strong and now able to "*call out bullies*" and felt this made them a target.

Superordinate theme 2: Prior experiences, abuse type, and the care environment may exacerbate impacts. It was noted that several factors may exacerbate the negative impacts of institutional abuse. One such factor was *negative experiences before the abuse in care* which were reported by all 10 participants. This included feeling a lack of love and connectedness, loss of attachment figure, feeling unloved due to placement in care, and feeling like an outsider, for example *"I was without love and affection at home I was*

subjected to violent beating – fear and emotional distress. So, I was more I suppose likely to be responsive to anyone who would show me kindness or affection/attention" (Participant 5). Participant 3 noted *"I had no father in my life and I didn't receive the love and affection that children normally received. I was bullied and abused before care and further abuse made life far worse and impossible to cope with".* (Participant 3). Eight participants reported to feel these experiences exacerbated the negative impacts of the institutional abuse that they reported.

The environment/culture in which the abuse occurred, including lack of love and lack of agency, was also reported to be an issue that may exacerbate the impacts of institutional abuse. For example, one institution was noted to be *"an alien place where we were expected to conform or else"* (Participant 5). This environment not only did not prepare individuals for the future *"– I lacked basic life experiences the ups and downs economic/ household issues"* (Participant 5) but also facilitated abuse *"For the first year I was not allowed to phone home…This wasn't because my parents were bad…Really it was so that staff including the head could sexually abuse us young ones who they picked out"* (Participant 1). For those in a secure setting it was noted that the environment of the setting in which the institutional abuse occurred was often mirrored by their current placement in relation to elements such as lack of autonomy.

The *form of abuse experienced* was also explored in relation to exacerbating the impacts of institutional child abuse. Both participant 7 and 8 reported greater impacts of physical abuse when compared to sexual abuse. For example, noting *"I am more concerned by the impact of the psychological and emotional abuse that took place"* (Participant 7) and reporting *"minimal"* impacts of sexual abuse (Participant 8).

Superordinate theme 3: Mixed emotions were associated with disclosure. Disclosure was noted to result in a range of impacts, some of which were negative and some positive. It was reported that there were *mixed emotions that were associated with disclosure*. This included solely positive responses reported by two participants such as relief *"Since my abuse it seemed that I have been carrying so much baggage on my shoulders that when I made that disclosure, I felt a weight had been taken off me."* (Participant 2). Two participants reported solely negative impacts which focused on negative emotions such as feeling *"Vulnerable, exposed"* (Participant 7). However, participant predominantly reported mixed emotions (n=6) that focused on relief and access to support alongside feeling upset and exposed, for example, *"I kind of feel that some weight has gone, but feel that a can of worms are now open and struggle at times as it is there at front of my mind. However, one thing I learnt is that I wasn't alone."* (Participant 1).

Superordinate theme 4: Reactions to disclosure influenced impact on self. This superordinate theme highlighted the notion that supportive responses have a positive impact on the victim. For example, it was reported that this allowed for a more in-depth disclosure to be made and support to be received, *"It was difficult at the beginning, but she is a lovely lady and over time I found it more easy to open up… She made me feel…safe and cared for with her kind words, her gentle smile and the way she did not pry."* (Participant 4). In contrast it was noted that a mocking response or lack of response could have negative impacts on the victim. This was captured by Participant 5:

> *"Being used and abused and passed from one lad to another makes you feel totally powerless and ultimately you lose faith in people. Especially when you inform the*

authorities, you are mocked and or blamed by the abuser and the staff believe the older boy. It has ruined everything my life is not recoverable." (Participant 5).

Superordinate theme 5: Motivation to disclose varied. A range of motivations to disclose institutional child abuse were reported including pro-active reasons, such as to progress with therapy, and more reactive reasons, such as no longer being able to cope *"I had a break down in group therapy after hearing someone talk about their abuse, and it put me back in my place and with the breakdown I disclosed it in a matter of minutes."* (Participant 2). A key motivation to report the abuse was to stop the abuse, either for themselves, or to protect others in the future. This was the case for Participant 7 *"To raise awareness and to seek an apology or acceptance from the perpetrators."* and Participant 8 *"I very much wanted to draw attention to the outcomes of emotional abuse."*

Superordinate theme 6: Fear of consequences acted as a barrier to disclosure. Barriers to disclosure centred around fear of the consequence of disclosure. This included physical consequences *"but still I couldn't tell anyone as I thought they would hurt me."* (Participant 1). However, this theme did not only focus on fear of consequences because of exposing the perpetrator, but also the consequential responses to the disclosure itself. For example, Participant 10 noted *"looking back I would say culturally I knew not to tell as there was a deep sense that you'd wouldn't be believed and may be blamed."*

Superordinate theme 7: Variations occurred in when a disclosure is made and who to. When an individual discloses their experiences varied. This could occur directly after the abuse, not until they were adults, or not at all. For example. Participant 4 noted *"I am now able to tell what went on all of those years ago"*. Disclosures were made to a variety of

individuals including health care professionals, support charities, police, staff (at children's homes or in prisons), religious leaders, during group therapy or to abuse inquiries friends, family, or partners. This highlights that no two disclosures may be the same.

Superordinate theme 8: Pro-active and reactive coping was used in response to institutional abuse. Nine participants reported factors that they felt helped them manage and cope with the negative impacts of institutional child abuse. This included drawing on positive past experiences and personal characteristics, *"Luckily I had a sunny happy disposition and was able to push on through my youth"* (Participant 5). Some coping strategies were more pro-active such as working to change abusive cultures, seeking social support, or attending therapy whereas other were more avoidant such as *"not telling people and putting it at the back of my head. Making myself busy all of the time"* (Participant 1). A number of these coping strategies are also linked to the negative impacts of institutional child abuse discussed in superordinate theme 1 relating to the negative impact of institutional abuse including substance misuse, self-harm, and aggression as coping.

Superordinate theme 9: Polarisation identified in those who re-enacted abuse on others and those who tried to protect others. The theme of hurting others reportedly as a result of their own experience of abuse, and the contrasting desire to protect others was also noted in participant responses. Five individuals discussed how their abuse had led them to hurt others including inappropriate sexual behaviour and bullying, for example, *"Trouble feeling empathy for male people…. The ability to…increase in the severity of committing crime without remorse"* (Participant 3). In contrast, three participants discussed a desire to avoid hurting others the way they had been hurt and being sensitive to the needs of others because of their own experiences. For example, noting *"In the positive, a greater*

appreciation of the need for compassion and insight into others fears has enabled a sense of meaning in relation to being kind to people." (Participant 10). Despite this, Participant 10 also reported that whilst he did not want to hurt others, that fear and anxiety sometimes resulted in defensive behaviours *"which could have felt like bullying to others"*.

6.4 Discussion

Overall, study 1a (experts) and 1b (victims) both highlight the potential negative impacts of institutional child abuse that may include loss of trust in others, mental health issues, and loss of future life chance. However, differences have also been noted in the focus of responses where experts gave a larger focus to factors that protect against the negative impacts with this being captured in the theme: *Protective factors reduced negative impacts*, whereas victims focused in more depth on coping strategies, regardless of whether they are seen as protective and effective strategies, and on disclose in relation to barrier and motivations to disclose, as captured in the themes: *Motivation to disclose varied; Fear of consequences acted as a barrier to disclosure; Pro-active and reactive coping was used in response to institutional abuse*. This demonstrates that while victims and professionals were asked to focus on similar aspects such as negative impacts and strengths factors different issues within these factors were important to professional and victims. This may be expected based on the differing roles and experiences these individuals take with professionals focusing on building protective factors in a therapeutic setting and victims focusing on day to day coping with their experiences.

Despite the difference in focus noted between victims (study 1b) and professionals (study 1a) both noted the potential negative impacts of institutional abuse on emotions,

including the development of shame and guilt and emotional regulation difficulties. This was captured to a greater extent by victims and included having a lack of confidence and negative feelings towards themselves. This is in line with the prediction that institutional abuse will have several negative impacts relating to mental health and wellbeing (Prediction 1a) and with previous literature that has supported the role of childhood trauma in an institutional setting in future emotional regulation difficulties (Weindl et al., 2018) thus this finding was expected. However, the important role of impacts to emotions is not explicitly captured in the current models of the impacts of child abuse (e.g., Information Processing of Trauma Model, Hartman & Burgess, 1993; The Traumagenic Dynamic Model, Finkelhor & Browne, 1985). Therefore, while an understanding of the importance of the impact of institutional abuse on emotions is developing, it is not yet being clearly captured in relevant models.

Mental health symptoms and trauma symptoms were identified by experts and victims as potential impacts following institutional abuse. This included issues such as PTSD, depression, and anxiety. This is consistent with previous literature and theory. Specifically, empirical evidence has previously indicated mental health symptoms and trauma symptoms as consequences of institutional child abuse (Benedict et al., 1996; Knefel, & Lueger-Schuster, 2013[36]). These consequences are captured in models of child abuse more generally such as the Information Processing of Trauma Model (Hartman & Burgess, 1993) that posit the role of processing in the development of trauma symptoms following a traumatic event. This also supports the application of this model to understanding the impacts of institutional child abuse when considering the effect on mental health and trauma symptoms. This finding therefore demonstrates some of the similarities between the impacts of institutional abuse and

[36] This research included those who reported abuse in a foster care setting or in a Catholic Church setting, though it was not specified that the church setting was residential.

abuse in a broader context with these models being easily applied to capture these impacts with a clear and consistent picture of possible impacts being developed.

Institutional abuse was reported not only to impact wellbeing but also behaviour. Increased risky behaviour was noted by professionals to be a potential negative impact of institutional abuse such as increased violence and substance use, and anti-authoritarian attitudes. Those who reported institutional abuse also identified these risky behaviours as a consequence of institutional abuse. However, this was contextualised in more detail by victims (study 1b) who reported that these behaviours may be used as coping mechanisms. In addition, these behaviours were present throughout other themes, such as the theme – *Polarisation identified in those who re-enacted abuse on others and those who tried to protect others*. In this theme, some individuals identified that they felt they had hurt others as a result of their abuse, but importantly, also indicated that not all of them had this experience. Others focused on protecting others and campaigning to protect others from experiencing institutional abuse. This finding is somewhat in accord with what would be expected based previous literature noting the increase in risky behaviours in those who experience abuse in a broader setting (e.g., Maniglio, 2009) and on the application of Social Learning Theory (Bandura, 1977) which indicates the importance of learned behaviour in future behaviour. However, the mechanisms underpinning the desire to protect others based on the experience of institutional abuse are less well understood based on the current literature base and must be examined further. Though this study does give an indicator that some of these risk related behaviours are being used as a coping response indicating the need for further exploration of coping responses following the experience of institutional abuse to explore if effective coping may underlie these differing responses.

Increased risk following institutional abuse was not only noted in relation to risk taking behaviour, but also increased future vulnerability noted by both experts and victims. In Study 1a exploring the view of experts, this focused on the impact of cumulative traumatic events and the notion that some individuals may see closeness in relationships that are risky for them. This links to previous literature concerning abuse that does not specifically occur in an institutional setting. Specifically, it was noted that child abuse perpetrated by a caregiver may result in insecure attachment styles and resistant attachment may increase vulnerability to revictimization (Alexander, 1992). This, therefore, supports similarities between child abuse more generally, and child abuse occurring specifically in an institutional setting as both have the potential to increase future vulnerability to victimisation, which is driven by an alteration in the way the individual's views relationships.

Additional information on the underlying cause of increased future vulnerability was highlighted in Study 1b focusing on the experience of victims where individuals reported being passive which may place them at risk, or *"calling out bullies"* which made them a target themselves. This is less well documented in the previous literature. Whilst previous literature has examined the potential for child abuse, such as sexual abuse, to be linked to increased risk-taking behaviour such as high-risk sexual behaviours and aggression (Maniglio, 2009), this does not explore the risk taken to support others. However, when taken together with the notion that child abuse may be linked to increased risk behaviours, and that it may also be linked to the desire to protect others from experiencing the same form of abuse (Colton et al., 2002), these findings are not unexpected.

The negative impact on future relationships was supported in both Study 1a (experts) and 1b (victims) with a focus on the impact of institutional abuse on these relationships. This

included difficulty in establishing and maintaining relationships and difficulties with parenting. This was expanded on in more detail by victims, for example, fear of physical contact or feeling guarded was identified as a factor that influenced some individuals' ability to form meaningful relationships. This is consistent with previous literature demonstrating the potential impact of abuse on attachment which can in turn impact the establishing and maintenance of future relationships (Alexander, 1992). Therefore, the findings in relation to loss of life chances in future relationships are compatible with previous theory. These findings build on previous theory and highlight that impacts to relationships may have also been impacted by a loss of trust cause by institutional abuse. For example, both studies have indicated the potential for loss of trust in others, including in authority, following institutional abuse. This was expected based on previous literature finding that institutional abuse was related to both loss of trust in interpersonal relationships and more broadly to a loss of faith (Wolfe et al., 2006). Thus, the current research substantiates the notion that institutional abuse can have a negative impact on future relationships which is impacted by loss of trust.

Further to the negative impact on relationships other negative impacts on future life chances were also noted. For example, both studies identified the negative impact on employment and education. This included that institutional abuse may lead to a low level of achievement noted in Study 1a (experts) and may result in an individual not for fulfilling their full potential indicated in Study 1b (victims). This is consistent with previous literature which indicates that institutional abuse has been reported to have a negative impact on education (Benzola, 1997; Goldman & Bode, 2012). However, previous literature has also noted that placement in an institutional setting during childhood may have a negative impact on education (Courtney & Dworsky, 2006; Stanley, 2017). This leads to challenges when identifying the cause of these negative impacts. The reason behind this negative impact has

been explored in previous literature including that institutional abuse made victims feel different from others (Benzola, 1997) thus impacting their ability to engage at school, that it impacted their concentrations (Goldman & Bode, 2012) and that there was a lack of opportunity for education in the institutional setting (Bode & Goldman, 2012). Study 1b specifically built on this understanding by capturing an additional influencing factor: risky behaviour. Risky behaviour was reported to be linked to the negative impact on employment and future life chance as it effected the individual's ability to engage positively in education and employment thereby demonstrating a range of potential mediating factors between the experience of institutional abuse and loss of future life chances in relation to education and employment.

This notion that there are factors that may mediate the relationship between institutional abuse and future negative outcomes was further demonstrated in study 1a and 1b. Specifically, several factors were reported in both studies, by experts and victims, to impact the extent to which institutional abuse resulted in the described negative impacts. This included the cumulative impact of negative experiences prior to the abuse where increased levels of prior traumatic experiences resulted in increased likelihood of negative impacts such as PTSD, as expected based on previous literature (e.g., Havlicek & Courtney, 2016). This is captured in general models of trauma such as the Information Processing of Trauma Model (Hartman & Burgess, 1993) that notes the important role of factors before the trauma such as social context in relation to how trauma is processed and consequently impacts the victim. However, Study 1b allowed for exploration of the notion that some individuals reported that they did not feel any experiences before their placement in care that influenced their response to experiencing institutional abuse. Therefore, the negative impacts they experienced could not be easily attributed to pre-care traumatic experiences. This further illustrates the

importance of understanding which reported impacts are a result of experiences before placement, and which are a specific result of the abuse.

In order to understand the factors that may influence the relationship between institutional abuse and negative outcomes, it was demonstrated in study 1a and 1b that the form of abuse becomes important to consider. Expert responses (Study 1a) focused on the fact that many forms of abuse often occur together, indicating that it can be challenging to separate differing impacts. It was noted that the individual's beliefs about the abuse and the response to the abuse were more important than the type of abuse reported. The role of the form of abuse was noted to a lesser extent by victims (Study 1b), though one individual did report being more concerned about the impact of physical and emotional abuse when compared to sexual abuse. This variation in response to the type of abuse is congruous with previous literature which reported that sexual abuse was related to a greater increase in depression but also higher quality long term relationships when compared to physical or emotional abuse (Benedict et al., 1996; Fitzpatrick et al., 2010). Study 1, therefore, builds on these findings illustrating that not only of the form of abuse but the individual's perceptions of the abuse can impact the future consequences, and that the most impactful form of abuse for one individual may differ from that of another.

It was illustrated that characteristics of the individual and the environment may influence the extent to which victims experienced several of negative outcomes, with experts focusing more on individual factors and victims giving more attention to the environment. Experts noted that self-blame, low self-esteem, poor coping, and poor attachment styles may increase the likelihood of negative outcomes. Individual factors were explored to a lesser extent by victims. These findings are expected based on previous literature which identified

the importance of individual coping styles on later PTSD (Lueger-Schuster, Weindl, & Kantor et al., 2014[37]) substantiating the importance of these characteristics in relation to understanding the potential impacts of institutional abuse. Expert responses (study 1a) also revealed that the institutional environment may exacerbate the outcome following institutional abuse. Specifically, lack of social support and isolation from the outside world. However, no further reflection on the environment was included. In contrast, victims (Study 1b) reflected in more depth on the environment. For example, participants noted the importance of isolation from the outside world and lack of social support, but also the impacts of growing up in an environment that felt "unnatural". This element has been captured to a less extent in previous literature. Research has shown the importance of a stable environment in allowing an individual to develop in a placement (Hawkins-Rodgers, 2007). However, the negative impact of the environment as an exacerbating factor in the impact of institutional abuse has been less well examined outside the impacts on disclosure, for example, if there were limited access to social support and impact of exposure to young people with significant adjustment problems (Carr et al., 2019; Collin-Vézina et al., 2015).

While a range of factors has been indicated to exacerbate negative impacts, several factors were also reported to support recovery. However, these varied between experts (study 1a) and victims (study 1b) and were limited in detail. Addressing attachment issues was reported in Study 1a to be important highlighting the importance of overcoming attachment difficulties to allow for positive future relationships. This indicated the importance of relationships which was also reported to some extent in Study 1b with the importance of social support being indicated. As noted earlier in this section, institutional abuse may have a

[37] This paper included a sub-sample of individuals who reported abuse in boarding school. However, not all abuse reported is explicitly noted to have been experienced in a residential setting.

negative impact on attachment that can underpin later negative outcomes (Alexander, 1992). Therefore, the findings from Study 1a regarding the importance of addressing these issues are congruous with previous research and the predictions made in the current study that factors such as self-esteem and support will protect against the impacts of institutional abuse (Predication 1b). Interestingly, whilst social support has been reported to play a role in recovery more generally (e.g., De Terte, Stephens, & Huddleston, 2014), it has not been found to play a role following institutional abuse in some studies (e.g., Lueger-Schuster, Weindl, & Kantor et al., 2014). This highlights some contradictions in the literature. It will therefore be important to explore strength factors in more detail in Study 2 to allow for further reflection on this.

Increasing self-esteem and developing a consistent environment was noted to be important by experts (study 1a) but was not commented on by victims (study 1b). In Study 1b, positive previous experiences such as being loved, being accepted, and being placed in a safe environment, and keeping busy were reported to be strength factors. However, limited detail was provided regarding how these were beneficial. Despite this, these findings are consistent with Attachment Theory (Bowlby, 1973, 2005) and Self-Determination Theory (Deci & Ryan, 2002) which note the importance of relatedness and secure attachment bonds on positive functioning. However, the range of strength factors reported such as a safe care environment and feeling loved have not been explored in the literature specifically relating to institutional abuse in depth, therefore it is not possible to explore them in relation to previous literature. As a result of the limited detail concerning strength factors, this must be explored further in Study 2.

While a range of factors were reported to exacerbate of protect against the negative impact of institutional abuse, disclosure reportedly had the potential to do both. Disclosure was reported by both experts (study 1a) and victims (study 1b) to have the potential for both positive and negative impacts. Furthermore, these consequences could be impacted by the response of others. This included the negative impact of lack of action or blame. This concurs with the prediction that responses to disclosure will impact how an individual responds to their experiences of abuse (Prediction 1c). This is also consistent with literature exploring the role of disclosure of institutional abuse, which has indicated the potential for such negative responses to disclosure (e.g., Colton et al., 2002) and provides further detail about the impacts of these responses. Study 1 also goes beyond Prediction 1c and adds to the previous literature by exploring the circumstances in which institutional abuse was disclosed. Specifically, the circumstances in which abuse was disclosed varied greatly in timeframe. Disclosures were made to several different individuals such as the police, counsellors, and family and friends. Such variations were also supported in previous literature (Colton et al., 2002; Guy, 2011; Murphy, 2009). However, this study builds on previous literature by demonstrating the importance of a supportive environment in which to disclose which has been less well explored in previous research. Study 1b also included reflections on motivations and barriers to disclosure. Motivations to disclose included having a more positive future, no longer being able to cope, stopping the abuse, and receiving an apology which have previously been identified to be important (e.g., Colton et al., 2002). Barriers to disclosure included fear of negative consequences, such as punishment or lack of belief, which again have previously been supported in the literature (e.g., Benzola, 1997; Schaverien, 2011). However, little detail was given as to how individuals overcame these barriers. Therefore, findings in relation to disclosure were supportive of previous research,

however, gaps in current knowledge were also identified. Disclosure will therefore be explored in more detail in Study 2 including the impact of the environment.

6.4.1. Limitations

A limitation of this study was the low number of participants. As a result of this additional participants were sought in the second round of Study 1a. This was also the case for Study 1b where there was a low level of engagement with the research. There are also challenges with the representativeness of the sample as 60% of the sample in 1b were currently in a prison setting. This limitation was outweighed by the depth of information provided by each participant as a result of using such qualitative methods that restricted the number of participants who engaged in the study, with the gathering of a depth of information taking president over increasing participant numbers. However, the final study in this thesis uses a quantitative method to ensure less effort is required by potential participants to increase participation and compliment study 1.

As a result of the method used for Study 1a, the Delphi method, polarisation may have skewed factors seen as important by the professionals. Specifically, if half of the sample thought it was important, but half did not, the factors would be unlikely to reach the agreed value for inclusion of 80%. However, standard deviation was also explored in order to try and overcome this limitation. In addition, this was also supported by Study 1b, where qualitative methods were used to allow for the exploration of polarisations and divergent cases.

Furthermore, this study will only include individuals who have chosen to disclose their experience of institutional abuse within an academic study. As this study has illustrated the importance of a supportive environment to disclosure, this may limit the number of

respondents who feel comfortable to disclose and will allow only for a sample of participants who feel comfortable to disclose their experiences in an anonymous survey that does not lead to increased support. Therefore, Study 2 will use serious case review to overcome this challenge, where it is possible that individuals may have more motivation to disclose to an investigative review rather than in a research setting. This is supported by the motivations for disclosure that have been reported such as to gain support and receive justice.

6.4.2. Concluding comments

Overall, this research has supported the notion that institutional abuse can have negative impacts on wellbeing and future life chances in line with previous research. This is beneficial as it will enable those working in research and practice to prioritise resources in areas where victims are likely to need support. This study has also identified factors such as the care environment that may exacerbate or social support that may protect against the negative impacts of institutional abuse. However, these factors are captured in much less detail when compared to the negative impacts and future research is needed to explore them further. Finally, this study indicated the important role of response to disclosure in recovery and how individuals may disclose their institutional abuse differently. A greater understanding of disclosure is needed, extending beyond only those who agree to participate in academic research, as this study has illustrated that individuals may prefer to disclose in a supportive environment. This may result in a limited sample of only those who feel comfortable disclosing in an online survey. In addition, disclosure is noted as a key step in allowing a victim to receive the support they need, so a clear understanding of how to support disclosure is vital. Therefore, the next study will explore disclosure in more depth using serious case reviews.

Chapter 7 – Study 2: Qualitative Analysis of Serious Case Reviews and Online Reports to Explore Disclosure and Strength Factors.

7.1 Structure of the chapter

This chapter presents a Rapid Evidence Assessment (REA) of serious case reviews and online reports. The need for this review was identified in Study 1a and 1b, research with victims and experts, where it was identified that the view of these populations is not fully captured in the academic literature. Therefore, a review of serious case reviews was considered an important addition to the programme of research. The chapter will commence with details of the method used and findings from a Reflexive Thematic Analysis of included sources. The findings are presented separately for issues relating to disclosure and issues relating to coping responses and strength factors to allow for the exploration of these two separate issues in depth. These findings will then be discussed in relation to previous literature and address the following predictions that were made in relation to the REA: 2a) Unsupportive responses to disclosure will negatively impact those who have reported institutional abuse (e.g., Wolfe et al., 2009), 2b) Positive coping strategies (e.g., seeking support) will protect against the negative impacts of institutional abuse (e.g., Finlay, 2010).

7.2 Method

7.2.1 Procedure

A REA was conducted in December 2020. The National Society for the Prevention of Cruelty to Children (NSPCC) National case review repository was searched with the keywords “Institutional Abuse”. This database was chosen as it is the “most comprehensive collection of case reviews in the UK” (NSPCC, 2022). A REA uses systematic methods to

explore what is already known about a policy or practice, in a short time frame (Grant & Booth, 2009). The search was limited to online reports and case reviews. Each article returned was examined to explore if it met the exclusion criteria.

7.2.2. Exclusion criteria

The following exclusion criteria were used when screening sources:

1. The paper was a duplicate.

2. The work did not refer to aspects of institutional abuse, specifically, disclosure or coping and strength factors.

3. This abuse did not occur in an institutional residential setting[38].

4. The abuse occurred when the individual/s were over the age of 18.

7.2.3. Data Extraction

Reflexive Thematic Analysis was conducted on included sources as outlined by Braun and Clarke (2006), also using NVivo software, a qualitative data analysis software. This was conducted separately for information relating to disclosure and coping and strength factors to fully explore the aims of the study. Themes were discussed with a colleague separate from the research to encourage deeper reflection and clarification on each theme. No changes were made following this discussion.

7.3 Results

7.3.1. Included sources

[38] Sources were included if they made any reference to disclosure and strength factors following institutional abuse in residential settings. Therefore, some sources included both abuse reported in residential settings and non-residential settings.

Fifty-six sources were originally included. In each case, the full texts were reviewed as abstracts were often not detailed. Twenty-one sources were excluded as they met exclusion criteria two (i.e., the work does not refer to aspects of institutional abuse, specifically, disclosure or coping and strength factors). One article was excluded as it met exclusion criteria three. This resulted in a final sample of 34 sources included. It should be noted that some case reviews include both institutional and non-institutional abuse and not all sources outline the number of participants included as some are review articles for example. Further information about the included reviews can be found in Table 7.1

Table 7.1

The source, number of pages, and sample of included sources

Source (no of pages)	**Sample included**
Brown (2014) (116)	Case study at a music school
Carmi (2014) (60)	Abuse by a religious official (not clear if this included residential care settings)
Child Exploitation and Online Protection (CEOP) Centre (2013) (32)	Both residential and non-residential institutions (varied and indistinguishable)
Child Rights International Network (CRIN) (2014) (48)	Abuse by a religious official (not clear if this included residential care settings)
Conway (2012) (4)	Residential childcare
Darling et al. (2020) (85)	Custodial Institutions (so residential)
Gibb (2017) (81)	Abuse by a religious official (not clear if this included residential care settings)
Harrington and Whyte (2015) (71)	School that included boarders
Hart et al. (2017) (36 Chapters)	Residential Homes
Independent Inquiry Into Child Sexual Abuse (IICSA) (2017) (154)	Both residential and non-residential institutions (varied and indistinguishable)

Independent Inquiry Into Child Sexual Abuse (IICSA) (2018) (174)	Child migration programmes
Independent Inquiry Into Child Sexual Abuse (IICSA) (2019a) (172)	Children in the care of local authority with case studies of residential care homes and foster care
Independent Inquiry Into Child Sexual Abuse (IICSA) (2019b) (125)	Custodial Institutions
Jay et al. (2020) (154)	The Roman Catholic Church (Not solely residential)
Jillings (2012) (175)	Childcare setting s
Johnstone et al. (2015) (358)	Included abuse of adults and children. Information was only included if it referred to a child who if in hospital was staying overnight
Kaufman and Erooga (2016) (133)	Both residential and non-residential institutions (varied and indistinguishable)
Kirkup and Marshall (2014) (139)	Included abuse in secure hospital, only included in analysis if under the age of 18
McNeish et al. (2018) (12)	Both residential and non-residential institutions (varied and indistinguishable)
Mendez Sayer et al. (2018) (162)	Custodial Institutions
Munn et al. (2014) (16)	Specific section on Institutional Abuse but not specific only to residential
O'Riordan and Arensman (2007) (54)	Institutional abuse, not specified to be residential
Royal Commission into Institutional Responses to Child Abuse (2017) (17 volumes)	Both residential and non-residential institutions (varied and indistinguishable)
Scottish Child Abuse Inquiry (2018) (73)	Residential care
Scott-Moncrieff and Morris, (2015) (136)	Hospital including overnight stays
Smellie et al. (2020) (61)	Schools (both residential and non-residential)
Soares et al. (2019) (117)	Children’s homes and residential care (so residential)
Truth Project (2019a) (7)	Both residential and non-residential institutions (varied and indistinguishable)
Truth Project (2019b) (7)	Both residential and non-residential institutions (varied and indistinguishable)

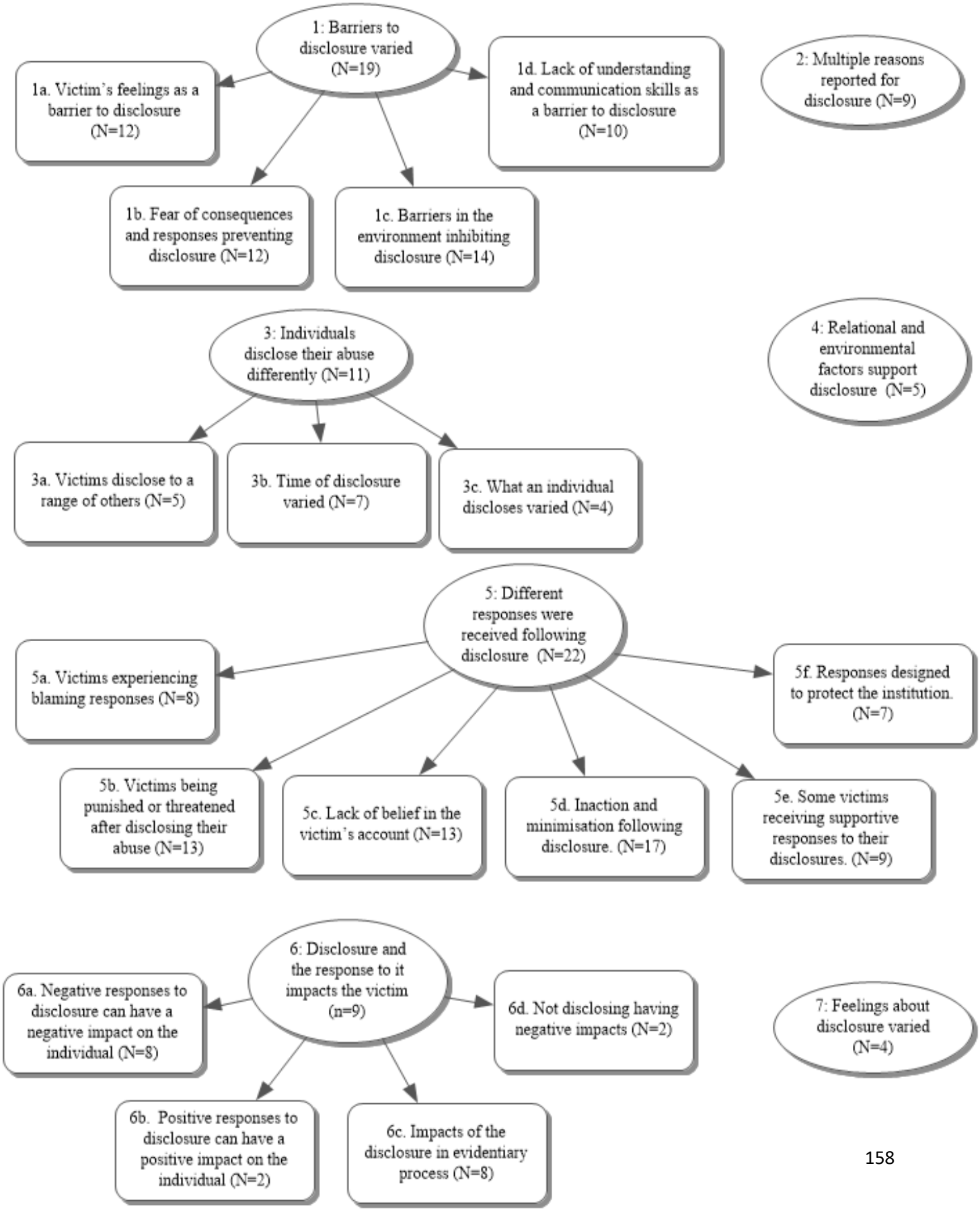
Truth Project (2020a) (7)	Both residential and non-residential institutions (varied and indistinguishable)
Walters and Medway Safeguarding Children Board (2019) (67)	Secure Training Facility
Ward et al. (2018) (54)	Residential Schools

7.3.2. Thematic analysis part 1: Disclosure

Disclosure is important to identify abuse (Ward et al., 2018). It starts the process of addressing the impacts of the abuse, holding the perpetrator accountable, and allowing institutions to make changes to avoid further abuse (Royal Commission into Institutional Responses to Child Abuse, V4, 2017). The superordinate and subordinate themes related to disclosure are outlined in Figure 7.1. The number of sources referring to this theme are also noted. As sources did not consistently include the number of participants expressing each opinion it is not possible to establish the number of individuals captured in each theme.

Figure 7.1

Superordinate Themes and Subordinate Themes Relating to Disclosure and from the REA



Superordinate theme 1: Barriers to disclosure varied. Survivors faced numerous barriers to disclosure, however, each experience of disclosure is unique (Royal Commission into Institutional Responses to Child Abuse, V4, 2017). This superordinate theme included four subordinate themes. *Subordinate theme 1a: Victim's feelings as a barrier to disclosure.* A range of feelings were reported to hinder disclosure. This included humiliation, anger, and disgust (Darling et al., 2020; Independent Inquiry Into Child Sexual Abuse, 2018; Royal Commission into Institutional Responses to Child Abuse, V4, 2017; Smellie et al., 2020). In addition, to these feelings, guilt and shame were reported to be strong barriers to disclosure: *"I still have at the back of my mind that I was the guilty person, that I was the one who said 'Yes I will masturbate you because I'm sick of getting belted'"* (Royal Commission into Institutional Responses to Child Abuse, V4, 2017), *"by now my whole personality was built on me being a tough guy so I was too ashamed to tell anyone"* (Independent Inquiry into Child Sexual Abuse, 2019a). Not only feelings towards the self, but also positive feelings, such as affection or gratitude, towards the institution or perpetrator were seen as a potential barrier to disclosure. This was especially important if previous abuse and neglect had led to attachment difficulties (Independent Inquiry into Child Sexual Abuse, 2019a). It was not always clear from the included sources if issues discussed referred to barriers during childhood or adulthood.

Subordinate theme 1b: Fear of consequences and responses preventing disclosure. Fear of what the response of others may be was found to be important including lack of confidentiality, stigma, not being believed, and lack of action (Darling et al., 2020; Hart et al., 2017; Independent Inquiry Into Child Sexual Abuse, 2019b) *"I felt that my complaints would not have been heeded or even looked into in any depth"* (Hart et al., VC26, 2017). Fear of consequences also included fear of physical or retribution punishment (Child Exploitation

and Online Protection Centre, 2013; Hart et al., 2017; Smellie et al., 2020): "*I knew I would get a beating if I reported it".* This resulted in an aversion to *"grassing"* [reporting their abuse] (Darling et al., 2020; Mendez et al., 2018). More practical concerns included fear of being moved to another placement and separated from siblings (Independent Inquiry Into Child Sexual Abuse, 2019a; Royal Commission into Institutional Responses to Child Abuse, V4, 2017). Not all fear was related to consequences to themselves, this also included concern for the possible consequences to others (Darling et al., 2020; Kirkup & Marshall, 2014; Mendez et al., 2018) such as fear of effects to their family in material and or reputation (Smellie et al., 2020) or to the institution, "*I also felt that if I reported the matter, I would be betraying my school. I had a strong sense of loyalty to [school]"* (Royal Commission into Institutional Responses to Child Abuse, V4, 2017).

Subordinate theme 1c: Barriers in the environment inhibiting disclosure. It was reported that lack of opportunity to report the abuse was a barrier, influenced by lack of access to the outside world and lack of assess to trusted adults (Child Exploitation and Online Protection (CEOP) Centre, 2013; Darling et al., 2020; Scottish Child Abuse Inquiry, 2018). This was impacted by changes in placement and high staff turnover (Hart et al., V10, 2017; Independent Inquiry Into Child Sexual Abuse, 2019a) and was more commonly reported as a barrier for those who disclosed as children rather than adults (Royal Commission into Institutional Responses to Child Abuse, V4, 2017). The culture of the organisation was also noted to play a role in hindering disclosure. An environment where there was a power imbalance between staff and children, where abuse was normalised and disclosures of others ignored, or where there was an atmosphere of fear hindered disclosure acted as barriers to disclosure (Darling et al., 2020; Hart et al., C5, 2017; Munn et al., 2014; Royal Commission into Institutional Responses to Child Abuse, V4, 2017). Religious elements of the

environment were also reported to act as a barrier to disclosure. For example, it was reported to be against the rule of the religious organisation, in some cases, to disclose the abuse and damage their reputation (Royal Commission into Institutional Responses to Child Abuse, V4, 2017).

Subordinate theme 1d: Lack of understanding and communication skills as a barrier to disclosure. Not knowing how to describe what was happening was reported to be barriers to disclosure (Independent Inquiry into Child Sexual Abuse, 2019b; Smellie et al., 2020). This could be a result of lack of the necessary communications skills or lack of understanding that the experience was abusive (Harrington & Whyte, 2015; Independent Inquiry Into Child Sexual Abuse, 2019a; Royal Commission into Institutional Responses to Child Abuse, V4, 2017): *"The main reason that I didn't report the abuse was that I didn't realise it was wrong*" (Hart et al., C8, 2017). This may be a result of age, developmental stage, or cognitive impairment (Royal Commission into Institutional Responses to Child Abuse, V4, 2017). Lack of knowledge about how to disclose abuse was also noted as a barrier (Hart, Lane, Doherty, & Historical Institutional Abuse Inquiry, C15, 2017). However, it was suggested elsewhere that most children knew how to make a complaint (Walters & Medway Safeguarding Children Board, 2019).

Superordinate theme 2: Multiple reasons reported for disclosure. Many reasons for disclosure have been indicated by those who have reported institutional child abuse. For example, Hart et al. (2017, V10) explored these in both males and females and for both, the most commonly reported reasons were *"to tell my story"*, *"to record the abuse"* and *"to help others/prevent abuse"*. In relation to helping others, this included empowering others to come forward or protect them from further abuse (Brown, 2014; Hart et al., C5, 2017; Royal

Commission into Institutional Responses to Child Abuse, V3, V4, 2017; Soares et al., 2019). An alternative motivation was to be acknowledged and for an apology (Jay et al., 2020) and to support their own recovery: feeling they could no longer cope or because they could no longer carry the burden of secrecy (Royal Commission into Institutional Responses to Child Abuse, V4, 2017). Disclosure was not always a thought-out decision, but sometimes triggered by a specific life event. Such events included seeing another disclose, finding out about another avenue for disclosure, or having contact with the perpetrator (Royal Commission into Institutional Responses to Child Abuse, V4, 2017). Receiving redress and compensation (Hart et al., VC26, 2017) was also noted as a motivation. However, for some, compensation brought anger that their experiences were reduced to monetary terms (Royal Commission into Institutional Responses to Child Abuse, V3, 2017).

Superordinate theme 3: Individuals disclose their abuse differently. This theme captures the notion that victims disclose their abuse in different ways. *Subordinate theme 3a: Victims disclose to a range of others.* The person an individual discloses to may differ, this may include an employer (Soares et al., 2019), a partner, a therapist or counsellor, the police or a representative of the criminal justice system, the Royal Commission, a parent, a person in authority at the institution (Royal Commission into Institutional Responses to Child Abuse, V4, 2017), or solicitors (Hart et al., C11, 2017). It was noted that the age of the individual may impact who they are more likely to disclose to, with children being more likely to disclose to a parent or someone in authority within the institution, adolescents being more likely to disclose to their friends and adults being most likely to disclose to friends or partners (Royal Commission into Institutional Responses to Child Abuse, V4, 2017).

Subordinate theme 3b: Time of disclosure varied. Not all individuals disclosed their experiences of institutional child abuse at all, and those who did disclose did not always disclose during childhood (Hart et al., C17, 2017) and many disclosures were later redacted (Independent Inquiry Into Child Sexual Abuse, 2019b). Those who disclosed during adulthood took on average 31.9 years to disclose. On average it was reported that it took individuals an average of 23.9 years to disclose their abuse (25.7 years for men and 20.6 years for women) (Royal Commission into Institutional Responses to Child Abuse, V4, 2017).

Subordinate theme 3c: What an individual discloses varied. The level of detail in disclosure differed between individuals. This ranged from disclosing in full all at once (Royal Commission into Institutional Responses to Child Abuse, V4, 2017) to making a partial disclosure and revealing some information over time. More limited disclosure may be to gauge the response to their disclosure before giving more detail (Royal Commission into Institutional Responses to Child Abuse, V4, 2017).

Superordinate theme 4: Relational and environmental factors support disclosure. For an individual to feel able to disclose, several key issues were noted to be important. This included the need for a safe and private space, with access to an individual outside of the institution (Independent Inquiry Into Child Sexual Abuse, 2019b; Mendez et al., 2018). Those who develop a secure relationship with a carer were more likely to disclose (Kaufman & Erooga, 2016) particularly in institutions where there is a common language about what is and what is not appropriate (Kaufman & Erooga, 2016).

Superordinate theme 5: Different responses were received following disclosure.

A range of responses to disclosure were experienced by victims. *Subordinate theme 5a: Victims experiencing blaming responses.* Disclosures were often met with concealment, and victim blame (Darling et al., 2020; Royal Commission into Institutional Responses to Child Abuse, V3, V4 2017; Smellie et al., 2020; Soares et al., 2019). This blaming was noted to be part of the culture in some institutions (Independent Inquiry into Child Sexual Abuse, 2019a).

Subordinate theme 5b: Victims being punished or threatened after disclosing their abuse. This could include being alienated, humiliated, stigmatised, rejected, threatened, and ostracised by the institution or community (Child Exploitation and Online Protection (CEOP) Centre, 2013; Royal Commission into Institutional Responses to Child Abuse, V3, V4 2017). Punishment could also include physical punishment and abuse (Hart et al., 2017; Independent Inquiry into Child Sexual Abuse, 2019a; Independent Inquiry into Child Sexual Abuse, 2019b). To some, it was perceived that aggressive treatment was an attempt to silence them (Independent Inquiry into Child Sexual Abuse, 2018). Overall, 5.3 % reported being threatened by the perpetrator (Royal Commission into Institutional Responses to Child Abuse, V4, 2017).

Subordinate theme 5c: Lack of belief in the victim's account. Many individuals reported not being believed after their disclosure (Hart et al., 2017; Royal Commission into Institutional Responses to Child Abuse, V4, 2017). This included some individuals being called liars (Hart et al., C21, 2017; Independent Inquiry Into Child Sexual Abuse, 2019a) and being told not to make false allegations or *"things will get bad for you"* (Hart et al., V10, 2017).

Subordinate theme 5d: Inaction and minimisation following disclosure. A reported response following disclosure was that no or minimal action being taken (Brown, 2014; Child Exploitation and Online Protection (CEOP) Centre, 2013; Darling et al., 2020; Johnstone et al., 2015). Lack of action, or inappropriate action, included a perception by the institution that the offence should be handled internally leading to the appropriate authorities not being told (Child Exploitation and Online Protection (CEOP) Centre, 2013). Many individuals also reported their abuse being minimised (Jay et al., 2020; Soares et al., 2019). For example, they were told to avoid the perpetrator (Hart, Lane, Doherty, & Historical Institutional Abuse Inquiry, C10, 2017) or the abuse was trivialised (Child Rights International Network, 2014) or referred to as a homosexual relationship (Soares et al., 2019).

Subordinate theme 5e: Some victims receiving supportive responses to their disclosures. This included feeling the complaint was dealt will well (Independent Inquiry into Child Sexual Abuse, 2018; Walters & Medway Safeguarding Children Board, 2019). For example, one individual reported disclosing to the police and principal of his old school helpful (Royal Commission into Institutional Responses to Child Abuse, V3, 2017). A range of response that were seen as supportive were highlighted, these included compassion, transparency, accountability, focusing on the victim, listening, staying calm, and discussing what would happen next (Royal Commission into Institutional Responses to Child Abuse, V3, V4, 2017).

Subordinate theme 5f: Responses designed to protect the institution. A possible response to disclosure was that institutions and members of those institutions focused on protecting the perpetrator and the institution. This included not notifying the parents or children and focusing on the reputation of the organisation (Royal Commission into

Institutional Responses to Child Abuse, V3, 2017). In some instances, individuals were told not to report the abuse to protect the perpetrator (Scottish Child Abuse Inquiry, 2018). In other examples, the perpetrator was dismissed but due to bringing the home into disrepute rather than their interactions with the children (Hart et al., C11, 2017).

Superordinate theme 6: Disclosure and the response to it impacts the victim.

Disclosure is noted to impact the victim, with a specific focus on the evidentiary process. In addition, the varying responses discussed in superordinate theme 5: Different responses to disclosure had differing impacts on the individual disclosing. *Subordinate theme 6a: Negative responses to disclosure can have a negative impact on the individual.* Negative responses such as disbelief, minimisation, and blaming were reported to have a negative impact on the victim. This included humiliation, re-traumatisation, lack of trust in others including authority, feelings of betrayal, and self-blame (Hart et al., C8, 2017; Royal Commission into Institutional Responses to Child Abuse, V3, V4, 2017). *"When I look back now it makes me feel physically sick that everyone knew this was going on including the workers and did nothing."* (Soares et al., 2019). These negative impacts could inhibit the support afforded to the victims and inhibit future disclosure. For some this resulted in the use of alternative methods of coping such as running away (Royal Commission into Institutional Responses to Child Abuse, V3, 2017).

Subordinate theme 6b: Positive responses to disclosure can have a positive impact on the individual. It was indicated that positive responses, including an apology, allowed victims to feel *"a weight had been lifted"*. It was seen as *"validating"* when the authorities confirmed that the individual's experience was a crime (Royal Commission into Institutional Responses to Child Abuse, V4, 2017) and reassuring when staff did not try to deny the

disclosure or distance themselves from it (Royal Commission into Institutional Responses to Child Abuse, V3, 2017).

Subordinate theme 6c: Impacts of disclosure in the evidentiary process. It was noted that the legal process could be lengthy, frustrating, and emotional (Independent Inquiry into Child Sexual Abuse, 2018; Soares et al., 2019). Negative elements of this process included lack of support during the process, financial strain limiting access to experienced legal representation, and unexpected contact from the police that could be re-triggering (Darling et al., 2020; Soares et al., 2019). Negative experiences also extended to concern about potential outcomes. For example, the thought of the perpetrator being found not guilty triggered suicidal behaviour for some individuals (Brown, 2014). Feelings of blame could also be induced by intense questioning with an accusatory tone during disclosure and investigation (Darling et al., 2020). Furthermore, some individuals felt penalised for processing civil claims for compensation at the same time as going through the criminal investigation (Soares et al., 2019). However, some aspects of the process were reported to make the experience easier including being kept informed and working with experienced police officers (Soares et al., 2019).

Subordinate theme 6d: Not disclosing having negative impacts. Whilst responses to disclosure may have led to negative impacts for some individuals, not disclosing abuse also may have led to negative impacts such as experiencing the negative impacts of child abuse alone (Royal Commission into Institutional Responses to Child Abuse, V4, 2017). Individuals who did not disclose, did not receive support, or if they did receive support, it may not have been appropriate support that takes their trauma into account (Royal

Commission into Institutional Responses to Child Abuse, V4, 2017). *"I was very isolated not being able to talk of the abuse"* (Hart et al., V10, 2017).

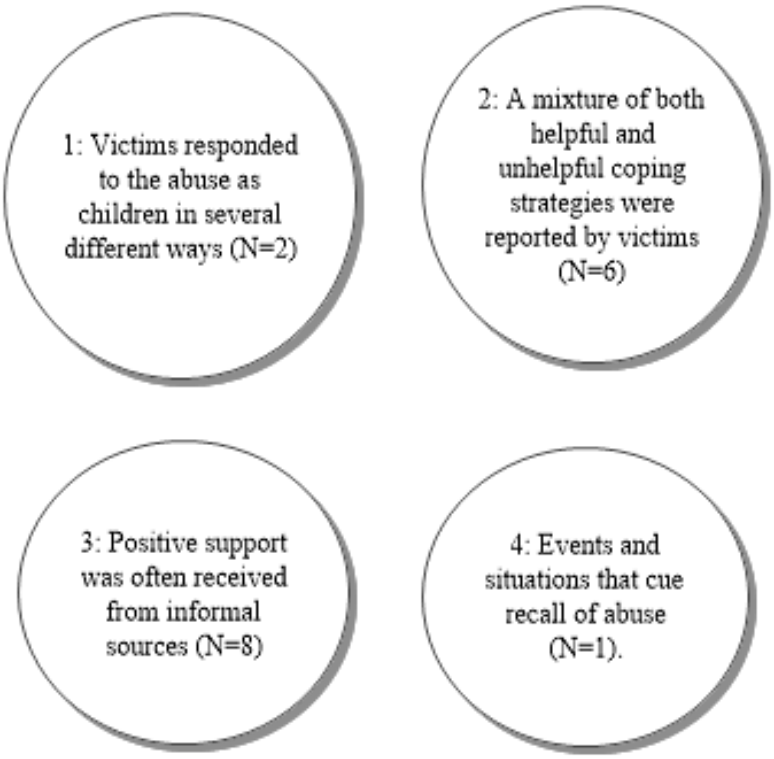
Superordinate theme 7: Feelings about disclosure varied. It was noted that individuals may feel differently about disclosure, with some feeling emotional or finding it hard to discuss (Hart et al., V10, 2017; Soares et al., 2019) and reporting it to be a distressing experience *"If I knew how hard it was going to be to face these issues of abuse after all these years, I may not have done it.".* This fear could last into adulthood *"Even now, I find the disclosure of the abuse horrendously difficult to tell."* (Royal Commission into Institutional Responses to Child Abuse, V4, 2017). However, it could also be seen as a positive experience after they were finally able to open up (Darling et al., 2020). This included feelings of relief, happiness, and closure (Hart et al., V10, 2017; Royal Commission into Institutional Responses to Child Abuse, V3, 2017). These feelings were impacted by the reaction to disclosure as noted in superordinate theme 6 exploring the impact of disclosure and responses to disclosure, but also by the circumstances. For example, it was noted that being in a room with the abuser whilst trying to disclose was very distressing (Royal Commission into Institutional Responses to Child Abuse, V3, 2017). In addition, some felt a feeling of guilt, especially if the disclosure causes disharmony with the family or community (Royal Commission into Institutional Responses to Child Abuse, V4, 2017).

7.3.3. Thematic Analysis part 2: Coping Responses and Strength Factors

It was indicated that individuals who reported institutional abuse showed varying rates of resilience and recovery (Darling et al., 2020; McNeish et al., 2018; Hart et al., V10, 2017). Superordinate themes relating to coping responses and strength factors are outlined in Figure 7.2, no subordinate themes were developed based on the included sources.

Figure 7.2

Superordinate Themes Relating to Coping Responses Strength Factors from the REA



Superordinate theme 1: Victims responded to the abuse as children in several different ways. Responses included accepting the abuse, withdrawal, and avoiding the perpetrator (Hart et al., V10, 2017; Soares et al., 2019). Others reported an active approach to responding to the abuse such as fighting back, putting weight on so they could defend themselves, or "rebelling" against the abuse (Hart et al., V10, 2017; Soares et al., 2019). An alternative approach taken was to focus on trying to help others out (Hart et al., V10, 2017). Responses for males and females were explored, with males most commonly reporting accepting the abuse as normal, not knowing what to do, and experiencing fear. Females most commonly reported accepting the abuse as normal, withdrawing, and not knowing what to do (Hart et al., V10, 2017).

Superordinate theme 2: A mixture of both helpful and unhelpful coping strategies were reported by victims. Behavioural and physical coping strategies were noted. For example, avoiding thoughts of the abuse, accepting it as normal, running away, self-harm, substance misuse, and gambling (Darling et al., 2020; Walters & Medway Safeguarding Children Board, 2019). It was noted that men are more likely to use drugs to cope than women (Conway, 2012). More negative coping mechanisms were less successful and in the long term (Darling et al., 2020). For example, coping such as drug use and criminal behaviour may have exacerbated negative impacts of abuse and limited the ability to engage in social and work activities impacting the development of self-esteem and sense of purpose (Conway, 2012). However, some strategies were reported to be helpful to support recovery (Darling et al., 2020; O'Riordan & Arensman, 2007): appropriate counselling (Darling et al., 2020), using supportive relationships (Hart et al., V10, 2017; Soares et al., 2019) building self-esteem and confidence, and finding creative outlets such as writing, journaling, music, and crafts had also been helpful to recovery (Darling et al., 2020).

Superordinate theme 3: Positive support was often received from informal sources. Experiences of perceived support varied with some participants reporting a lack of options for support and others feeling supported by healthcare professionals (Darling et al., 2020; Soares et al., 2019). While support may include support from formal counselling and be seen as beneficial some victims report it to be of limited use (Hart et al., V10, 2017). Poor experiences of counselling were related to poor welcome at the initial session, sessions not meeting their expectations, and the way individual counsellors delivered sessions. Positive support was more commonly attributed to informal support from other survivors, friends, families, and colleagues (Soares et al., 2019). The most helpful source of support was reported to be meeting other victims and their families (Carmi, 2014) and survivors reported

a positive experience when connecting with other victims (Darling et al., 2020). Some described good support from family and friends and other informal organisations, whereas others had very little (Darling et al., 2020).

Superordinate theme 4: Events and situations may retrigger abuse. It was noted that situations and events could retrigger the trauma. This included life events such as bereavement or argument with someone, receiving an unexpected phone call from the police, seeing someone who lived in the same home, or seeing content in the media related to child abuse could be retriggering (Soares et al., 2019).

7.4. Discussion

The inclusion of online reports and serious case reviews in Study 2 added important reflections on the role of disclosure. Study 2 indicated the important role of disclosure by exploring the impacts of not disclosing abuse, where previous literature has focused only on the negative impacts of when abuse is disclosed (e.g., Colton et al., 2002). Those who reported institutional abuse noted that while disclosure may have some negative impacts not disclosing the abuse at all may also have a negative impact, for example on reducing the support available to the individual. The impact of not disclosing abuse has not been explored in the previous literature and therefore this study adds valuable understanding of the complexities of disclosure, and lack of disclosure. This indicates a need to understand what underlies the relationships between both disclosure and non-disclosure and future negative outcomes.

One factors that was clearly identified to impact negative outcomes following disclosure was the response given to the disclosure. This impacted how individuals interpreted and understood their abuse, with un-supportive responses having the potential to result in re-traumatisation. This is in line with the prediction that unsupportive responses to disclosure will negatively impact those who have reported institutional abuse (Prediction 2a). Whilst previous literature has noted that lack of action as a result of the disclosure can result in an individual feeling victimised, having a poor outlook on life, and anger (Colton et al., 2002; Wolfe et al., 2006; Wolfe et al., 2009), Study 2 has provided a more in-depth understanding of several responses less well explored in the literature in relation to institutional abuse, such as punishment and the severe negative impact this may have on a victim. It is important to note that some individuals did receive supportive responses such as an apology and offering practical and psychological support. This is consistent with previous literature (Murphy, 2009). However, Study 2 added to previous literature by noting that, for some, disclosure of institutional abuse was positive and led to feelings of relief and happiness. Therefore, it may be suggested that whether disclosure is viewed as positive or negative is impacted by the support and responses of the institution and trusted others, before, during and after the disclosure. Further research is needed to explore how these variations in feelings during disclosure may be related to the overall impact of institutional child abuse.

This study also resulted in the identification of several barriers to disclosure, some of which, such as negative feelings and negative responses to disclosure, have been identified in previous literature (e.g., Benzola, 1997; Colton et al., 2002). However, Study 2 added to previous literature by providing a more in-depth understanding of the role of the environment and the child's understanding of abuse as barriers to disclosure. This has been captured in previous literature noting the important role of abuse of power for those disclosing in an

institutional setting (Colton et al., 2002). However, the sources included in Study 2 have given a more in-depth understanding of a wider range of environmental issues including the lack of access to a trusted adult and the impact of cultures, such as cultures of abuse where abuse is seen as the norm, in inhibiting disclosure. Therefore, the role of the environment as a barrier to disclosure is clearly demonstrated. Study 2 has also more clearly indicated the important impact of lack of understanding of abuse on disclosure, with those who are not able understand or articulate their experiences being unable to disclose, which has important implications as noted disclosure is a key step in identifying that institutional abuse has occurred (Royal Commission into Institutional Responses to Child Abuse, V4, 2017) which is important to provide the correct support for individuals to allow for future recovery.

While an understanding of the barriers to disclosure is key to support future disclosure, this study also identified several reasons for disclosure which are also important to understand in order to support further disclosure. These findings add a more in-depth knowledge to the currently developing knowledge of the motivations for disclosure following institutional abuse. For example, previously identified motivations include protecting others, seeking justice, and overcoming trauma (see Colton et al., 2002). Study 2 built on this by providing a more in-depth understanding of these factors, including giving examples of specific triggers that may encourage disclosures such as upcoming contact with the perpetrator. Furthermore, Study 2 captured the conflicting feelings individuals may feel in relation to compensation. While previous literature has noted that compensation was a motivating factor for a small number (22%) of victims (Rassenhofer et al., 2015[39]). This was explored in more depth with the inclusion of Serious Case Reviews capturing that not only are not all victims motivated by compensation, but for some it is actively upsetting and felt to

[39] Not all the participants in this study reported that their institutional abuse occurred in a residential setting.

minimise their experiences. This finding in relation to conflicted feelings about disclosure links closely to the finding that how the abuse is viewed by the individual and others impacts whether disclosure is viewed as positive or negative with the notion that monetary compensation may be seen to minimise the abuse being reported in study 2 and therefore being unwanted. This finding substantiates further the important role of responses to disclosure in whether disclosure is seen as positive or negative and adds an understanding of the key role of the victim's perception of what that response means to them.

Individuals whose views were captured in these reports indicated variation in the way in which they disclosed their abuse. This ranged from reporting at the time of the abuse to not reporting until years later, consistent with previous literature (Colton et al., 2002). It was also noted that the level of detail may vary between disclosures. For some this disclosure was years after the experience which may impact memory, and some wanted to avoid thinking about the specific details of the abuse. This knowledge again builds on previous literature that highlights such variation (e.g., Colton et al., 2002; Guy, 2011; Schaverien, 2011). However, Study 2 added to previously published literature by allowing a more in-depth understanding of who individuals are likely to disclose to, capturing the notion that children are more likely to disclose to adults, whereas adolescents are more likely to disclose to peers. This study therefore indicates that the situation in which an individual may feel comfortable to disclose varies from person to person. Despite this, the importance of privacy and feelings of safety in order to facilitate disclosure was consistently noted. Previous literature has focused more specifically on barriers to disclosure and motivations to disclosure. Therefore, Study 2 has allowed for a more in-depth understanding of factors that those who have reported institutional abuse and professionals working with them have found important to supporting disclosure. These findings, however, are consistent with expectations based on an

understanding of barriers to disclosure such as stigma or punishment (Colton et al., 2002) as they offer the opposite approach in responding.

Overall, this review has also allowed for a better understanding of coping strategies and factors that protect against the impacts of institutional abuse. Specifically, this study illustrated that there are several responses that may be used by victims to deal with the abuse during childhood. Findings are in line with previous literature which has explored coping and identified that emotional orientated coping and pessimism (Lueger-Schuster, Kantor, & Weindl et al., 2014[40]) were less helpful coping strategies in that they were related to increased PTSD levels. However, Study 2 added to this by exploring other less helpful coping strategies such as substance use. This study also highlighted the negative impact these coping strategies can have on recovery through the detrimental impact they have on protective factors such as social support which was reportedly impacted by coping strategies such as substance misuse impacting the ability to form positive supportive relationships with others.

While some coping strategies were seen to be un-effective, helpful strategies included receiving positive personal support, and appropriate counselling. This is congruent with previous literature that has indicated the benefits of successful intervention (Bundy, 2006). This is consistent with the prediction that positive coping strategies (e.g., seeking support) will protect against the negative impacts of institutional abuse (Prediction 2b). Feeling supported was also an important aspect of recovery, the support experienced varied. These variations in level and source of social support have been identified in previous literature (Finlay, 2010; Guy, 2011; Murphy, 2009) noting that a variety of sources of support were

[40]This study included a sub-sample of individuals who report abuse in boarding schools. However, not all abuse reported is explicitly noted to have been experienced in a residential setting.

used, but that not all individuals reported to have social support. Social support was not found in previous literature to be associated with reduced trauma symptoms (Lueger-Schuster, Kantor, & Weindl et al., 2014). However, positive social support is important to survivors when discussing strength factors found in Study 2. This demonstrates that complexities when examining the importance of protective factors, specifically social support which may be impacted by the variety and availability of support noted by victims.

7.4.1. Limitations

While the inclusion of Serious Case Reviews has been valuable in order to allow a more in depth understanding of key issues in relation to disclosure and strength factors, their inclusion is not without its limitations. For example, less detail is often provided, when compared to scientific research, in relation to data collection methods and sample characteristic, such as the number of individuals providing information to the review and their age. Thus, adding challenges when contextualising the information and conclusions. In addition, not all sources only included those who had reported institutional abuse in a residential setting. Therefore, it was not always possible to conclude whether the experiences described were specifically related to institutional abuse in a residential setting.

7.4.2. Concluding comments

The qualitative exploration of serious case reviews has allowed for a greater depth of understanding of the role of disclosure and potential barriers to this. Furthermore, it has added to previous literature by highlighting the potential impact of the care environment as a barrier to disclosure. This study has also led to a better understanding of the coping strategies used by victims in response to their experiences of institutional abuse. Future research is needed to explore the impact of not disclosing abuse in more detail. In addition, the impact of

the strength factors discussed on later negative impacts needs to be explored in more depth to understand if there is a significant impact of these factor in reducing negative impacts. Future research will also aim to explore the role of the care environment to differentiate the impacts of environment from the impact of the abuse. These issues will be explored in Study 3.

Chapter 8 – Study 3: Exploring the Role of Influencing Factors in The Outcome of PTSD symptoms Following Institutional Abuse.

8.1. Structure of the chapter

Study 3 built on the findings that emerged from earlier studies such as the important role of disclosure, the cumulative impact of pre-existing experiences prior to institutional abuse (such as abuse in the home setting), and the exacerbating impact of a negative care environment. PTSD symptoms were chosen as the negative outcome of focus due to its consistent presence as a key outcome to consider noted in previous studies in this programme of research. This chapter will first present the findings of this study before exploring these findings in relation to previous literature and the following predictions: Those disclosing abuse will differ in their level of PTSD symptoms compared to those who do not disclose (3a); Those reporting abuse perpetrated by a carer will report higher levels of PTSD symptoms when compared to those abused by someone else. This prediction is based on the premise of Betrayal Trauma Theory (3b); Those who report abuse in an institutional setting will report higher levels of PTSD symptoms when compared to those who do not report institutional abuse (3c); Those who report a more negative care environment will report higher levels of PTSD symptoms than those who report lower levels of a negative care environment (3d).

Findings in relation to the following predictions will also be explored: Institutional abuse will be positively associated with PTSD symptoms (3e); Those who have reported institutional abuse will be less likely to be in a current relationship (3f); Institutional abuse will be positively associated with current placement in a secure setting (3g); Resilience will

protect against the negative impact of institutional abuse (3h); Protective factors (such as secure attachment under the age of 18, and social support) will reduce the negative outcomes following institutional abuse (3i); Challenges with personality functioning will exacerbate the negative impacts of institutional abuse (3j); Personality functioning impairment in the domain of interpersonal will exacerbate the negative impacts of institutional abuse (3k).

8.2. Method

8.2.1. Participants

Inclusion criteria for participation in Study 3 included being over the age of 18 years old and able to read and comprehend the English language. The sample originally consisted of n=409. Three participants were removed as they were under the age of 18. Those who did not complete further than the demographic questions were also removed, resulting in a final sample of n=384. Overall, 24.2% (n=93) reported experiencing institutional abuse and were aged between 18 and 35 years old (M= 33.58, SD=9.33). A further 49.7% (n=191) of participants reported abuse only in a home setting and were aged between 18 and 74 years old (M=37.71, SD=11.80). Finally, 26.0% of participants (n=100) did not report experiencing any abuse and were aged between 18 and 72 years old (M=40.03, SD=14.57).

8.2.2. Measures

Demographic information was collected in relation to age, sex, country of residence, level of education, employment, and placement in an institution during childhood, and placement in a secure facility during adulthood, was developed with multiple-choice responses.

The following measures were employed (See Appendix 7 - Study materials):

Childhood Experiences of Abuse Checklist. This checklist captures the presence of child abuse experiences, specifically emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. This was developed based on previous studies which indicated the need to capture the form of abuse in a way that required minimal abuse detail from victims. Childhood experiences of abuse are measured with a dichotomous response to reduce distress to participants by not asking for further abuse details. Participants are asked to report if they have experienced each form of abuse and whether this was experienced in a home setting, in care, or in secure care and by a carer or someone else. Instructions to participants are as follows, "Please indicate (with a tick) if you feel you have experienced any of the below, before the age of 18 by ticking the appropriate box".

Strength factors Checklist. This checklist captures the presence of potential strength factors against the impact of institutional abuse specifically, social support, coping, leisure activities and future goals. Items for inclusion in the checklist were developed based on strength factors found relevant based on relevant literature (e.g., de Vogel et al., 2009; Lueger-Schuster, Weindl, & Kantor et al., 2014) and studies included in this programme of research. These questions were reviewed by an individual external to the research who confirmed key strength factors were captured. Participants are asked to rate how true each statement was for them on a scale of 1 – very false or often false to 4 – very true or often true. Items include "Prior to the age of 18, I had a strong positive relationship with a parent or caregiver" and "Other people think I cope positively with stress".

Negative Experiences of the Care Environment Checklist. This checklist aims to capture the nature of experiences during placement in care. Items for inclusion in the checklist were developed based on earlier studies in this programme of research and were reviewed by an individual external to the research who confirmed that factors noted in these studies relating to how the care environment was experienced were included. Participants are asked to rate 10 items exploring their experience of institutional care on a scale of 1 – very false to 4 very true. Items include "Decisions were made for me" and "I had negative feelings about being placed into care".

Experiences of Disclosure Checklist. This checklist aims to explore how individuals felt following the disclosure of abuse. Checklist items were developed based on findings from earlier studies in this programme of research and an individual external to the research reviewed them and confirmed that the checklist captured possible feelings about disclosure noted in these studies. Participants are asked how true the statements are of their disclosure experience which is rated from 1 – very false or often false – 4 – very true or often true and 12 items are reverse coded. Items include “satisfied” and “Like I was helping others”.

The Post Traumatic Stress Disorder Checklist – Civilian (PCL- C) (Weathers, Litz, Huska, & Keane, 1994). This is a 17-item measure that asks participants to report to what extent the items reflect their experiences in the last month rated from 1 - not at all, to 5 - extremely. Higher scores indicate higher levels of PTSD symptoms (though not a diagnosis of PTSD). Total trauma symptom severity scores can be calculated by summing scores from each item. Items include “Feeling very upset when something reminded you of a stressful experience from the past?” and “Feeling distant or cut off from other people?”. This scale was found to be well validated (Blevins, Weathers, Davis, Witte, & Domino, 2015) with

good internal reliability. Specifically, in non-clinical samples α=.92-.94 (Conybeare et al., 2012).

The Brief Resiliency Scale (Smith et al., 2008). This scale explores participants' levels of resiliency. This is a six-item scale rated from 1 - strongly disagree, to 5 - strongly agree. A higher score is representative of higher levels of resilience. Items 2, 4, and 6 are reverse coded. Items include “I tend to bounce back quickly after hard times” and “It does not take me long to recover from a stressful event”. This is noted to be among one of the best-validated resilience measures based on a review of the psychometric properties of measures of resilience where scores were given for properties such as internal consistency and construct validity (Windle, Bennett, & Noyes, 2011). For example, this measure showed good internal consistency ranging from α=.80–.91 (Smith et al., 2008).

Level of Personality Functioning Scale–Brief Form 2.0 (Weekers et al., 2019). This scale examines personality functioning focusing on the interpretation of self and interpersonal functioning. This is a 12-item questionnaire and participants are asked to rate each item from 1 – very false or often false, to 4 – very true or often true. Items include "My emotions change without me having a grip on them" and "I often find it hard to stand it when others have a different opinion". This scale has been reported to have acceptable to good (Field, 2009) internal consistency for the total scale (α = .82), and the subscales self-functioning (α = .79), and interpersonal functioning (α = .71).

8.2.3. Procedure

To recruit a general population sample, a research advert was posted on social media and online forums, including those dedicated to survivors of institutional abuse and care

leavers. In addition, a sample of individuals who had previously resided in prison was collected using Prolific. Prolific is a participant recruitment platform that allows researchers to share their research study to participants who are provided payment for their participation. This website allows the researcher to restrict who can view the questionnaire through a range of filter questions that ensure a relevant sample. To collect this sample, the filter question "Have you ever been in prison for committing a crime?" was applied, and only those who answered 'yes' to this question were eligible to complete the questionnaire.

Those who chose to engage in the research first viewed an information sheet before accessing the study measures. Only participants who reported placement in care were asked to complete the Negative Experiences of the Care Environment Checklist and only those who reported experiences of child abuse were asked to complete the Experiences of Disclosure Checklist. After the completion of the measures, they were able to view a debrief sheet. Due to the sensitive nature of the research, a link to the debrief sheet was included on each page to support any participants who did not wish to finish the questionnaire. Prior to analysis, data were screened for missing data, outliers, and normality.

8.2.4. Ethics

Ethical approval was granted by the University of Central Lancashire Ethics Committee.

8.3. Results

8.3.1. Data Screening

Data was found to be missing at random (Little's MCAR test: x^2 (16) = 10.611, p=.833). No univariate outliers were identified. Overall, five multivariate outliers were identified using Mahalanobis Distance. As transformation would be unlikely to rectify true multivariate outliers (due to the nature of the problem being across more than one variable) the outliers were deleted (see Tabachnick & Fidell, 2014). All scales were normally distributed except the PCL-C (KS (21) =.191, p=.043). However, the PCL-C was noted to be normally distributed (KS (36) =.120, p>.200) after multivariate outliers were removed.

8.3.2. Sample characteristics

Table 8.1 outlines the sample characteristics concerning sex, placement in care, placement in secure care as an adult, and recruitment method.

Table 8.1

Demographics of Participants Split by Group Indicating the Number (and %) of Participants in Each Group.

Variable	No abuse was reported (%)	Experience of abuse at home (%)	Experience of abuse in care/ care and home (%)	No response	Overall
Sex					
Male	70 (70.7)	97 (50.8)	51 (54.8)	0 (0)	218 (56.7)
Female	29 (29.3)	92 (48.2)	40 (43.0)	1 (100.0)	162 (42.2)
Intersex	0 (0)	1 (0.5)	0 (0)	0 (0)	1 (0.3)
No response	0 (0)	1 (0.5)	2 (2.2)	0 (0)	3 (0.8)
Placement in care as a child					
Yes	7 (7.1)	22 (11.5)	36 (38.7)	0 (0)	65 (16.9)
No	92 (92.9)	169 (88.5)	57 (61.3)	1.00 (100.0)	319 (83.1)
Missing	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Secure care as an adult					
Yes	42 (42.4)	93 (48.7)	54 (58.1)	0 (0)	189 (49.2)
No	56 (56.6)	96 (50.3)	38 (40.9)	1 (100.0)	191 (49.7)
No response	1 (1.0)	2 (1.1)	1 (1.1)	0 (0)	4 (0.0)

Of those abused in a home setting, 53.4% (n=101) reported disclosing their abuse and 46.6% (n=88) did not report that they had disclosed their abuse. For those who reported experiencing abuse in an institutional setting, 48.4% (n=47) reported disclosing their abuse and 48.4% (n=44) did not report this. The number of participants (and %) reporting each form of abuse in each setting can be found in Table 8.2.

Table 8.2

The Number of Participants Reporting Each Form of Abuse in Each Setting

	Emotional Abuse (%)	Physical Abuse (%)	Sexual Abuse (%)	Emotional Neglect (%)	Physical Neglect (%)
Never	143 (37.2)	200 (52.1)	265 (69.0)	171 (44.5)	270 (70.3)
At home by a carer	154 (40.1)	117 (30.5)	24 (6.3)	144 (37.5)	65 (16.9)
At home by someone else	81 (21.1)	57 (14.8)	70 (18.2)	60 (15.6)	34 (8.9)
In care by a caregiver	22 (5.7)	17 (4.4)	8 (2.1)	23 (6.0)	13 (3.4)
In care by someone else	22 (5.7)	11 (2.9)	17 (4.4)	16 (4.2)	7 (1.8)
In a secure unit by a caregiver	21 (5.5)	9 (2.3)	3 (0.8)	14 (3.7)	10 (2.6)
In a secure unit by someone else	19 (5.0)	11 (2.9)	10 (2.6)	12 (3.1)	8 (2.1)

8.3.3. Descriptive Statistics

Means, standard deviation, and Cronbach's alpha were calculated for each scale. These were also calculated for each type of abuse group; those who reported institutional abuse, those who report abuse in a home setting only, and those who did not disclose abuse in this research (See Table 8.3).

Table 8.3

Descriptive statistics for all measures

Measure	Abuse Type	N	Means	SD	Observed Range	Potential range	α
Strength factors checklist	Total	379	15.63	4.07	8-24	6-24	.74
	Institutional Abuse	91	14.99	4.49	6-23	6-24	.78
	Abuse in a home setting	189	14.68	3.71	5*-23	6-24	.67
	No abuse reported	98	18.02	3.35	8-24	6-24	.71
Negative experiences of the care environment checklist	Total	63	31.65	5.91	18-40	10-40	.83
	Institutional Abuse	35	33.57	5.33	19-40	10-40	.87
	Abuse in a home setting	21	30.52	4.99	19-39	10-40	.79
	No abuse reported	7	25.43	6.73	18-36	10-40	.86
Experiences of disclosure checklist	Total	151	47.38	13.74	10*-79	26-104	.90
	Institutional Abuse	47	50.45	11.80	18*-74	26-104	.85
	Abuse in a home setting	101	46.31	14.29	10*-79	26-104	.91
	No abuse reported	3	35.67	16.29	17*-47	26-104	N/A

Experiences of disclosure checklist -Negative emotion after disclosure	Total	149	11.70	3.08	4-16	4-16	.81
	Institutional Abuse	46	12.11	2.57	5-16	4-16	.69
	Abuse in a home setting	100	11.55	3.25	4-16	4-16	.83
	No abuse reported	3	10.67	5.13	5-15	4-16	N/A
Experiences of disclosure checklist - Positive emotion after disclosure	Total	145	21.19	6.71	10-40	10-40	.90
	Institutional Abuse	46	21.35	6.62	11-34	10-40	.88
	Abuse in a home setting	96	20.91	6.64	10-40	10-40	.90
	No abuse reported	3	27.67	9.81	22-39	10-40	N/A
Experiences of disclosure checklist - Negative response to disclosure	Total	144	22.28	6.90	9-36	9-36	.88
	Institutional Abuse	46	24.46	5.91	11-36	9-36	.83
	Abuse in a home setting	95	21.39	7.15	9-36	9-36	.90
	No abuse reported	3	17.00	5.20	11-20	9-36	N/A
The Post Traumatic Stress Disorder Checklist – Civilian (PCL- C)	Total	379	42.19	16.25	17-85	17-85	.95
	Institutional Abuse	91	50.88	13.64	21-78	17-85	.91
	Abuse in a home setting	189	44.37	16.21	17-85	17-85	.94
	No abuse reported	98	29.95	10.71	17-66	17-85	.91
PCL-C – Cluster B	Total	379	11.68	5.14	5-25	5-25	.90
	Institutional Abuse	91	14.32	4.83	5-24	5-25	.88

	Abuse in a home setting	189	12.24	5.07	5-25	5-25	.88
	No abuse reported	98	8.18	3.41	5-20	5-25	.86
PCL-C – Cluster C	Total	379	17.77	7.36	7-35	7-35	.89
	Institutional Abuse	91	21.33	6.42	7-34	7-35	.81
	Abuse in a home setting	189	18.69	7.50	7-35	7-35	.89
	No abuse reported	98	12.72	4.90	7-31	7-35	.81
PCL-C– Cluster D	Total	379	12.75	5.26	4-25	5-25	.84
	Institutional Abuse	91	15.23	4.48	5-25	5-25	.73
	Abuse in a home setting	189	13.44	5.32	4-25	5-25	.84
	No abuse reported	98	9.04	3.69	5-19	5-25	.78
The Brief Resiliency Scale	Total	379	18.54	5.70	7-30	6-30	.90
	Institutional Abuse	91	17.81	5.48	6-30	6-30	.84
	Abuse in a home setting	189	17.46	5.85	7-30	6-30	.92
	No abuse reported	98	21.27	4.68	7-30	6-30	.87
Level of Personality	Total	374	26.76	8.52	12-48	12-48	.90
Functioning Scale–Brief	Institutional Abuse	88	29.58	7.47	12-48	12-48	.85
Form 2.0 = – Total	Abuse in a home setting	187	28.64	8.26	12-48	12-48	.90

	No abuse reported	98	20.57	6.72	12-48	12-48	.88
LPFS-Self	Total	377	14.36	4.95	6-24	6-24	.87
	Institutional Abuse	89	15.47	4.40	6-24	6-24	.81
	Abuse in a home setting	189	15.59	4.80	6-24	6-24	.87
	No abuse reported	98	10.91	4.02	6-24	6-24	.84
LPFS- Interpersonal	Total	375	12.40	4.36	6-24	6-24	.83
	Institutional Abuse	89	14.07	4.11	6-24	6-24	.77
	Abuse in a home setting	187	15.59	4.32	6-24	6-24	.83
	No abuse reported	98	9.66	3.35	6-18	6-24	.79

NB: *Below potential range due to missing data. Missing data excluded from subscale analysis for disclosure scales.

8.3.4. The Impact of Disclosure and Perpetrator Relationship

This analysis captured the following prediction: That those disclosing abuse will differ in their level of PTSD symptoms compared to those who do not disclose (Prediction 3a) and that those reporting abuse perpetrated by a carer will report higher levels of PTSD symptoms when compared to those abused by someone else. (Prediction 3b). This was explored using a Factorial ANOVA to explore potential differences in levels of PTSD between those who reported disclosing their experiences and those who did not and those who reported experiencing abuse perpetrated by a carer compared to someone else. Levene's test of equal variance was not significant ($F(3,87) = .23$, $p = .876$). Means and standard deviations can be found in Table 8.4.

Table 8.4

Means (and SD) for PTSD Symptoms by whether disclosure occurred and who the perpetrator of abuse was

	Perpetrator of abuse					
	Carer (N/SD)		Someone else only (N/SD)		Total (N/SD)	
Disclosure not reported	48.68	(37/ 13.48)	36.57	(7/ 12.70)	46.75	(44/ 13.95)
Disclosure reported	55.12	(41/ 12.58)	52.17	(6/ 10.53)	54.74	(47/ 12.27)
Total	52.06	(78/ 13.33)	43.77	(13/ 13.87)	50.88	(91/ 13.64)

A significant main effect of disclosure was found ($F(1,87) = 38.14$, $\eta^2 = .09$, $p = .005$). Means indicated that those who reported disclosure of their abuse reported higher levels of

PTSD symptoms. A non-significant main effect of perpetrator type was found (F (1,87) =3.80, η^2 =.04, p=.055). This indicates that individuals who reported abuse perpetrated by a carer did not report higher PTSD symptoms when compared to those reporting abuse by someone else. No interaction effect of disclosure and perpetrator type was noted (F (1,87) =.1.40, η^2=.02, p=.240) therefore disclosure and perpetrator of abuse did not interact together to influence PTSD symptoms.

To explore the impacts individual sub-scales of the Experiences of Disclosure Checklist on trauma symptoms, a regression analysis was conducted. A correlation matrix of experience of disclosure subscales (See Appendix 9 - Principal Component Analysis results) and total trauma symptom severity can be found in Table 8.5. As can be seen in Table 8.5 positive emotion after disclosure did not correlate significantly with total symptom severity. Therefore, it was not included in the regression analysis as it was not expected to be related.

Table 8.5

Correlation Matrix of Experience of Disclosure Subscales and Total Trauma Symptom Severity

	PCL-C Total	Negative emotion after disclosure	Positive emotion after disclosure
Negative emotion after disclosure	0.37*		
Positive emotion after disclosure	-0.07	-0.32*	
Negative response to disclosure	0.28*	0.57**	-0.03*

*** Correlation is significant at the 0.01 level (2-tailed), * Correlation is significant at the 0.05 level (2-tailed), N=46*

The overall model significantly predicted overall trauma symptom severity (F (2,43) =3.53, MSE=138.22, p=.038). The model accounted for 10% of the variance in trauma symptom severity (r^2=.14, Adjustedr^2=.10). However, neither of the subscales (negative emotion after disclosure β=.31, t=1.79, p=.081; negative response to disclosure β=.11, t=.61, p=.543) independently predicted trauma symptom severity. Therefore, negative emotion after disclosure and negative response to disclosure were not individually predictive of PTSD symptoms.

8.3.5. The Impact of the Care Environment

This captures the following predictions: Those who report abuse in an institutional setting will report higher levels of PTSD symptoms when compared to those who do not report institutional abuse (Predication 3c) and that those who report a more negative care environment will report higher levels of PTSD symptoms than those who report lower levels of a negative care environment (Prediction 3d). These predictions were explored using a Factorial ANOVA. This analysis was conducted using a subsample of only those who had reported placement in care during childhood and rated their experiences (n=60). It is noted that despite the small sample size, the assumption of the equality of variance was not found to be violated based on Levene's test (F (4,54) =1.75, p=.153).

Means (and standard deviation) of PCL-C for the type of abuse and experience of care can be found in Table 8.6.

Table 8.6

Means (and SD) of PTSD symptoms for Type of Abuse and Experience of Care

	Low reported negative experiences (N/SD)	High reported negative experiences (N/SD)	Total (N/SD)
No abuse	33.83 (6/11.67)	17.00 (1/0.00)	31.49 (7/12.41)
Abuse at home	42.97 (14/16.89)	61.83 (6/12.45)	48.00 (20/17.95)
Abuse in care	50.55 (11/13.00)	48.27 (22/14.93)	49.03 (33/13.54)
Total	43.48 (31/15.51)	50.00 (29/15.70)	46.63 (60/15.81)

A significant main effect of abuse type on total trauma symptom severity was identified (F (2,54)5.34, η^2 =1.16, p=.010). Bonferroni post hoc tests revealed a significant difference in PTSD symptoms between those who reported no abuse, and those who reported it in a home setting (MD=-16.57, p=.032), as well as those who experience no abuse and those who experience abuse in an institutional setting (MD=-17.60, p=.013). This indicates that those who experience no abuse reported fewer PTSD symptoms when compared to those who experience abuse in a home or institutional setting. No significant difference in trauma symptom levels was found between those who experience abuse in a home setting, and those who experience abuse in an institutional setting (MD=1.03, p=1.000). No significant main effect of negative care environment on PTSD symptoms was identified (F (1,54) <.01, η^2 <.01, p=971).

A significant interaction between abuse type and negative experience of care was identified. Therefore, several t-tests were completed with the data split by abuse type to explore where this significance lay. Due to the Bonferroni adjustment, an alpha value of .017

was used (to reduce type 1 error). The results for the home group equality of variance was not assumed so the equality of variance not assumed column was used (Levene's test: f=5.17, p=.035). A significant difference in PTSD symptoms between those who had a negative experience of care and those who had a less negative experience of care was found in those who reported abuse in a home setting (t (12.91) =-2.91, p=.012). Mean values indicated that those who reported higher negative experiences of care also reported higher levels of PTSD symptoms. No significant effect of negative care environment on PTSD symptoms was found in those who did not report abuse (t (5) =1.34, p=239) or the institutional abuse group t (31) =.45, p=.657).

To further explore the significant interaction effect a one-way ANOVA was completed with the data split by negative experience levels. Results indicated a significant main effect of abuse type on trauma symptom levels in the group who reported higher levels of negative care environment (F (2,28) =5.28, p=.012). No significant main effect of abuse type on trauma symptom levels in the low negative care environment group was reported (F (2,28) =2.62, p=.091). It should be noted that, for this group, equal variance was not assumed (Levene's test f (2) =3.66, p=.039). This indicates that for individuals who reported high levels of negative care environment, but not those who reported low negative care environment, there is a significant impact of the type of trauma on the level of PTSD symptoms experienced. To explore where this difference lay three t-tests were conducted using only individuals in the high levels of negative care environment groups, alpha adjusted to .016 to reduce type 1 error when conducting three t-tests. Using only the high levels of negative care environment group, despite the significant interaction noted, no significant difference in trauma symptom levels between those who reported abuse at home and those who reported no abuse (t (5) =-3.33, p=.021), or those who reported no abuse and those who

reported abuse in an institutional setting (t (21) =-2.18, p=.041). Furthermore, no significant difference in PTSD symptoms levels was found between those who reported abuse at home and those who reported abuse in an institutional setting (t (26) =2.14, p=.042) after adjusting for the alpha value. This indicates that for those in the higher levels of negative care environment group PTSD symptoms do not differ significantly between those abused in an institutional setting and those in a home setting or who reported no abuse or those who reported abuse in a home setting versus those who reported no abuse.

8.3.6 The Role of Personality functioning, Resilience, and Strength Factors on the Impacts of Institutional Abuse

Structural Equation Modelling (SEM) was applied to explore whether personality functioning, resilience, and strength factors mediated the relationship between the experience of institutional abuse and symptoms of PTSD, currently being in a relationship, and having ever been placed in a secure facility as an adult (Prediction 3e-3k). This was conducted using IBM SPSS Amos 28 using Maximisation Likelihood parameter estimates. See Table 8.7 for a correlation matrix of these variables.

The model (See Figure 8.1) initially had poor fit (GFI=.66; CFI=.29; RMSEA=.52; x2(9) =928.24, p<.001). Consistent with modification indices, the covariation between disturbance terms for LPF-self, LPF-Interpersonal, resilience, and strength factors was added to the model. This is also consistent with the theoretical understanding of the expected covariation between these variables (e.g., Amani & Khosroshahi, 2020; Weekers et al., 2019). This improved the model to a good fit (GFI=.99; CFI=.99; RMSEA=.10; x2(3) =14.12, p<.003; see Blunch, 2013; Schreiber et al., 2006).

Table 8.7

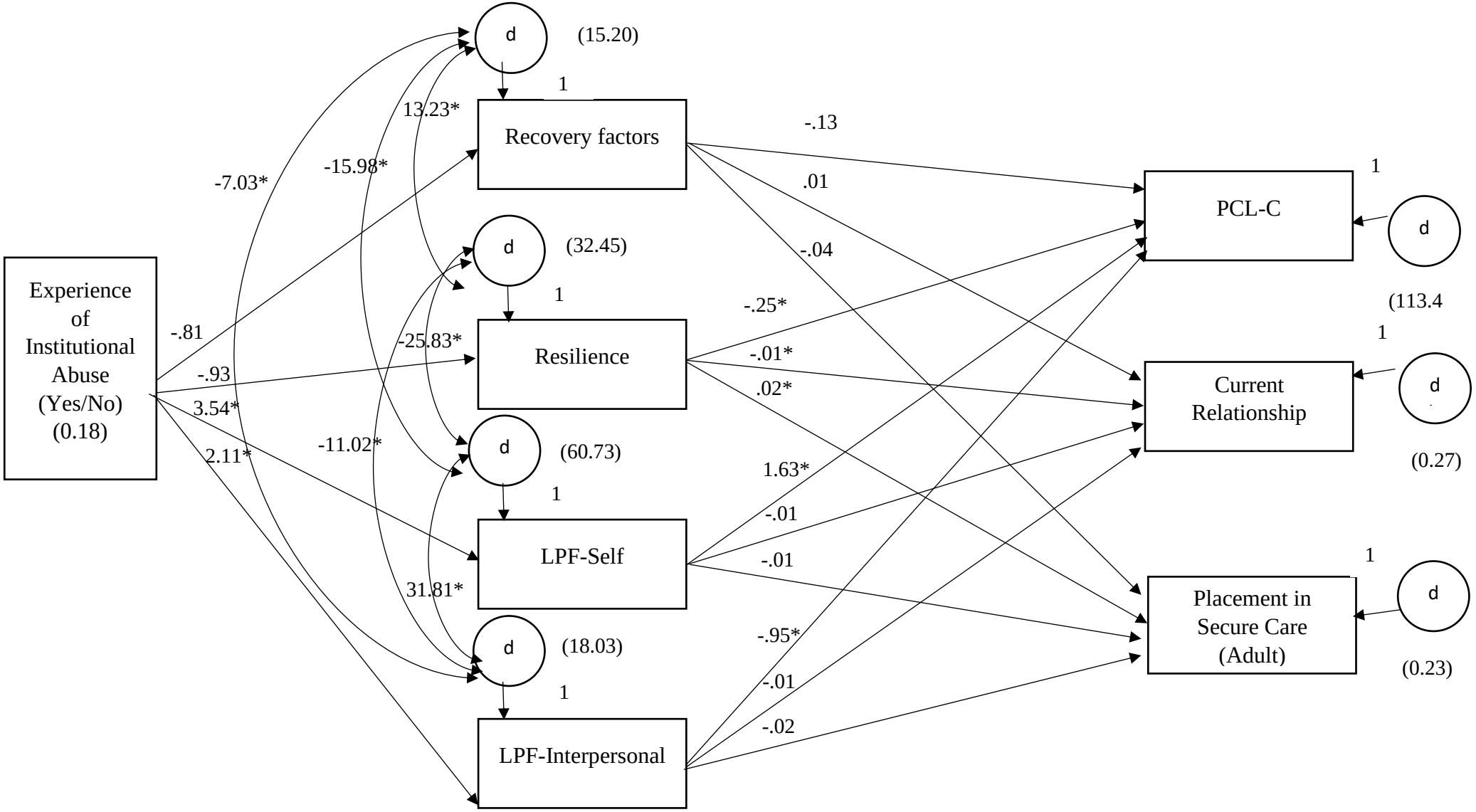
Correlation Matrix of Factors Included in the SEM.

	PTSD Symptoms	LPFS-Self	LPFS-Interpersonal	Resilience	Strength factors	Experience of Institutional Abuse	Placement in Secure Care as an Adult
LPFS- Self	.72**						
LPFS- Interpersonal	.61**	.90**					
Resilience	-.47**	-.55**	-.46**				
Strength factors	-.40**	-.48**	-.41**	.57**			
Experience of Institutional Abuse	.30**	.18**	.21**	-0.1	-0.1		
Placement in Secure Care as an adult	-0.02	0.06	0.09	0	-.21**	0.1	
Currently in a relationship	-0.01	-.14**	-.14**	-0.02	0.06	-0.02	-.12*

*** Correlation is significant at the 0.01 level (2-tailed), * Correlation is significant at the 0.05 level (2-tailed), N=374*

Figure 8.1

*Estimated SEM with Unstandardised Path Coefficients (and R^2). *=p<.05*



Results indicated that institutional abuse had a direct positive association with PTSD symptoms (B=7.36, β=.19, S. E=1.32, p<.001). This indicates that the experience of institutional abuse is associated with an increased likelihood of higher levels of PTSD symptoms. However, experience of institutional abuse was not significantly associated with an increased likelihood of being in a current relationship (B=.02, β=.01, S. E=.06, p=.790) or having ever been placed in a secure hospital or prison setting (B=.09, β=.08, S. E=.06 p=.12).

The indirect effect of institutional abuse on PTSD symptoms via increased levels of personality functioning impairment in the domain of self (LPFS-self) was significant. Specifically, the experience of institutional abuse was positively associated with increase personality functioning impairment (domain: self) (B=3.54, β=.18, S. E=1.01, p<001) and increase personality functioning impairment (domain: self) was positively associated with PTSD symptoms (B=1.63, β=.85, S. E=.16, p<.001). This indicates that institutional abuse may result in higher levels of PTSD symptoms through its impact on personality functioning impairment, with institutional abuse increasing impairment in the domain of self, which in turn increases PTSD symptoms. However, the association between personality functioning impairment (domain: self) and currently being in a relationship (B=-.01, β=-.15, S. E=.01, p=.224), as well as placement in secure care as an adult (B=-.01, β=1.16, S. E=.01, p=.202), were not significant.

The indirect effect of institutional abuse on PTSD symptoms via increased levels of personality functioning impairment in the domain of interpersonal (LPFS-interpersonal) was significant. Specifically, the experience of institutional abuse was positively associated with impairment in personality functioning (domain: interpersonal) (B=2.11, β=.21, S. E=0.51, p<.001) and this impairment was negatively associated with PTSD symptoms (B=-.95, β=-

.25, S. E=.30, p=.001). This indicates that institutional abuse may result in higher levels of PTSD symptoms through its impact on impairment in personality functioning (domain: interpersonal), with institutional abuse increasing impairment in personality functioning (domain: interpersonal) which in turn decreases PTSD symptoms. However, the association between personality functioning impairment (domain: interpersonal) and both currently being in a relationship (B=-.01, β=-.05, S. E=.01, p=.671), and placement in secure care as an adult (B=-.02, β=.17, S. E=.01, p=.140) were not significant, thus indicating no indirect effect of institutional abuse on these outcomes via personality functioning impairment (domain: interpersonal).

The indirect effects of institutional abuse on PTSD Symptoms, currently being in a relationship, and placement in secure care as an adult via resilience and via strength factors were not significant as institutional abuse was not significantly associated with resilience (B=-.934, β=.-.07, S. E=.69. p=.176) or strength factors (B=-.81, β=-.09, S. E=.49, p=.101). However, resilience was positively associated with placement in secure care during adulthood (B=.02, β=.17, S. E=.01, p=.008). Resilience was also negatively associated with currently being in a relationship (B=.01, β=-.16, S. E=.07, p=.022) and with PTSD symptoms (B=-.25, β=-.09, S. E=.13, p=.047). This indicates that increased levels of resilience are significantly positively associated with placement in secure care as an adult and negatively associated with currently being in a relationship and PTSD symptoms.

Strength factors were significantly and negatively associated with placement in secure care during adulthood (B=-.04, β=-.30, S. E=.01, p<.001). This indicates that increased levels of strength factors are significantly associated with a reduced likelihood of being placed in secure care during adulthood. The associations between strength factors and both PTSD

symptoms (B=-.13, β=-.03, S. E=.17; p=.432), and positively associated with currently being in a relationship (B=.01, β=.06, S. E=.01 p=.359) were not significant. This indicates that there are no significant relationships between strength factors and PTSD symptoms and currently being in a relationship.

8.4. Discussion

This study added to previous work by exploring the role of disclosure, who perpetrates the abuse, and the care environment in relation to the negative impacts of institutional abuse in more detail. It was indicated that those who had disclosed their abuse reported higher levels of PTSD symptoms when compared to those who did not indicate that they had reported their experiences. This is consistent with prediction 3a, that disclosing abuse will differ in their level of PTSD symptoms compared to those who do not disclose. Notably mixed findings have been reported in previous literature (McTavish et al., 2019) with some studies noting disclosure may be required to allow for appropriate support, however, noting it may also lead to negative feelings (e.g., Colton et al., 2002; Ward et al., 2018), though previous research was largely qualitative. Therefore, this study adds to previous literature by providing further quantitative evidence that disclosing institutional abuse can be related to increased trauma symptoms.

While trauma symptoms in those who reported institutional abuse were impacted by disclosure, they were not impacted by who perpetrated that abuse. Furthermore, there was no interaction effect between the perpetrator of the abuse and whether or not a disclosure was made in relation to PTSD symptoms. Based on previous literature it was expected that those abused by a carer would experience increased PTSD symptoms (e.g., Prediction 3b). For example, this is highlighted in Betrayal Trauma Theory (Freyd, 1994) where it is noted that a

key element of the trauma is the social betrayal by an individual or institution who had a duty of care. The finding of Study 3 concerning the role of the perpetrator is therefore not line with previous literature. However, it should be noted that the difference between PTSD symptoms in those abused by a carer versus someone else was approaching significance. It should also be explored further the relationship to those who were not considered as a carer to examine whether any betrayal may have been experienced if a positive relationship was expected with the perpetrator. It is possible that the line between carer versus not carer may become more blurred in an institutional setting with the level of connection to the child varying even between those who are in a position of care (e.g., key worker versus support worker). However, overall, when only the categories of perpetrator as carer versus someone else were considered no significant difference was found in PTSD symptoms suggesting impacts were not worse when the abuse was perpetrated by a carer.

Not only did the perpetrator of the abuse not appear to impact trauma symptoms, neither did the setting of the abuse (institutional versus home). In relation to the setting of abuse, individuals who reported institutional abuse reported higher levels of PTSD symptoms when compared to those who did not report any abuse. However, no significant difference in PTSD symptoms were found between individuals who reported institutional abuse and those who reported abuse in a home setting. Therefore, prediction 3c, those who report abuse in an institutional setting will report higher levels of PTSD symptoms when compared to those who do not report institutional abuse, was only partially supported. This was unexpected as Lueger-Schuster et al. (2018) found that individuals who reported abuse in an institutional setting (foster care) reported higher levels of child maltreatment and higher levels of lifetime and current PTSD. As Lueger-Schuster et al. (2018) noted that the institutional abuse group had higher levels of maltreatment experiences overall, it is possible that these prior-

experiences underpin the differences in findings with the amount of abuse not being controlled for in the current study as this was not possible (See section 8.4.1).

Further to the exploration of setting, specifically examining the care environment within the setting, there was no significant difference in PTSD symptoms in those who reported a high level of negative care experiences when compared to those who reported a low level, thus Prediction 3d was not supported. However, a significant interaction between abuse type and negative experience of care was identified. Specifically, in individuals who had reported abuse in a home setting, those who reported higher negative experiences of care reported higher levels of PTSD symptoms though no significant effect of the care environment on PTSD symptoms was found for those who reported no abuse or abuse in a care setting. While previous literature has highlighted the potential for the care environment of those who experience institutional abuse to be negative (Wortham, 2000), the care environment has not previously been explored concerning the extent to which this related PTSD symptoms in those who had reported institutional abuse. This is therefore a novel finding that while the experience of care (outside of the abuse experienced) may be reported to be negative by some victims this does not necessarily result in increased trauma for those who experience abuse in an institutional setting.

While the care environment does not appear to be a key factor in outcomes (specifically PTSD symptoms) following institutional abuse, other possible mediating factors were also explored. In order to explore factors that exacerbate or protect against the impacts of institutional abuse, the following factors were explored: personality functioning, resilience, and strength factors. As would be predicted based on previous literature (Prediction 3e; Carr et al., 2010; Cook et al., 1993; Hermanau et al., 2011; Wolfe et al., 2006) institutional abuse

was positively and directly associated with PTSD symptoms. Furthermore, this relationship was mediated by personality functioning impairment (domain: self) congruent with previous literature. For example, qualitative research has indicated that issues relating to self-functioning, such as how individuals see themselves, can be challenging for individuals who have reported institutional abuse (Murphy, 2009). This study, therefore, builds on this by highlighting the importance of the influence of abuse on self-functioning and how this relates to the development of PTSD symptoms using quantitative methods.

Institutional abuse also increased impairment in personality functioning in relation to the domain interpersonal, as may be expected based on previous literature illustrating the impact of institutional abuse on interpersonal relationships such as victims feeling they are not worthy of affection, feeling alone (Murphy, 2009), and loss of trust in other (Wolfe et al., 2006). However, it was expected that personality functioning in the domain of interpersonal would then predict increased levels of PTSD symptoms as personality functioning impairment was found to be related to insecure attachment (Roche et al., 2018), for example, which is also related to increased negative impacts following institutional abuse such as negative impacts to mental health (Carr et al., 2009). However, this was not the case and personality functioning in the domain of interpersonal was negatively associated with PTSD symptoms indicating that increased problems with interpersonal functioning resulted in reduced PTSD symptoms. Thus, prediction 3k, that challenges with personality functioning in the domain of interpersonal will exacerbate the negative impacts of institutional abuse, was not supported for PTSD symptoms. One possibility is that until the trauma is resolved, relationships may act as a trigger for trauma (see Murphy, 2009) and those with higher levels of challenges with interpersonal functioning may avoid relationships and therefore be less likely to experience this trigger. However, whilst the relationship between personality

functioning in the domain of interpersonal and currently being in a relationship is negative, it was not significant. This highlights the complex relationship between institutional abuse, interpersonal functioning, and the role they play in the development of PTSD symptoms.

The relationship between institutional abuse and PTSD symptoms was not mediated by resilience. However, increased resilience was negatively associated with PTSD symptoms, thus partially supporting prediction 3h, resilience will protect against the negative impact of institutional abuse, as while institutional abuse did not alter resilience levels, resilience did result in lower trauma symptoms for the overall sample. This is in line with the work of Lueger-Schuster, Weindl, and Kantor, et al. (2014)[41] who found that concepts related to resilience such as optimism (e.g. De Terte et al., 2014) were linked to lower levels of PTSD symptoms in individuals who had reported institutional abuse. This study therefore substantiated and strengthened previous research concerning the importance of resilience and expands on this to suggest that institutional abuse does not impact resilience, but that those who have higher levels of resilience may have reduced levels of PTSD symptoms.

Despite the key role of resilience in reducing PTSD symptoms, the same was not found for strength factors. Strength factors were not associated with reduced PTSD symptoms, thus prediction 3i, protective factors (such as secure attachment under the age of 18, and social support) will reduce the negative outcomes following institutional abuse was not supported in relation to the negative impact of PTSD symptoms. This was an unexpected finding based on both theory and literature which have illustrated the negative relationship between PTSD symptoms and higher levels of strength factors (e.g., Carr et al., 2009;

[41] This study included a sub-sample of individuals who reported abuse in boarding schools. However, not all abuse reported is explicitly noted to have been experienced in a residential setting.

Lueger-Schuster, Weindl, & Kantor et al., 2014). Strength factors were not found to be related to decreased PTSD symptoms in this sample of individuals who have reported institutional abuse, therefore differing from previous findings. However, previous research has explored these factors (e.g., social support, attachment) individually. The current study explored strength factors as an overall concept. It should also be noted that this is a complex area with some research not finding an impact of some strength factors captured in this study such as social support (Lueger-Schuster, Weindl, & Kantor et al., 2014) to lead to reduced PTSD symptoms. Thus, clustering of these strength factors together is one possible avenue of explanation for these findings that needs to be explored. This study, therefore, adds to the literature by highlighting the complex relationship between institutional abuse, strength factors and PTSD symptoms which will be discussed in more detail in Chapter 9.

While institutional abuse was related to higher personality functioning in the domain of interpersonal, it was not associated with whether the individual is likely to currently be in a relationship, therefore prediction 3f, that those who have reported institutional abuse will be less likely to be in a current relationship, was not supported. Previous research has indicated the potential for institutional abuse to negatively impact future relationships, such as increasing the use of aggression in relationships (Wolfe et al., 2006) and being emotionally distant (Schaverien, 2011). However, the likelihood of individuals choosing to enter a relationship, despite these challenges, is less well explored. This research, therefore, adds to the current literature base and indicates that whilst relationships may pose challenges for individuals who have reported institutional abuse, they are not less likely to currently be in a relationship.

Institutional abuse was not directly or indirectly related to placement in secure care as an adult, indicating the prediction 3g, that institutional abuse will be positively associated with current placement in a secure setting, was not supported. This is a novel finding of this study as there has been minimal exploration of this in previous literature. However, based on General Strain Theory (Agnew, 2001) a relationship may be expected. In addition, previous research has indicated that institutional abuse may result in increased risky behaviours such as aggression and alcohol and substance use (Fitzpatrick et al., 2010). However, it appears that, based on the current research, this may not translate to placement in a secure setting[42].

8.4.1. Limitations

Several limitations must be considered when interpreting the findings from this study. Due to the number of participants in each group, it was not feasible to explore the impacts of different types of abuse (sexual, physical, emotional, and/or neglect), or compare those who reported one form of abuse experiences compared to those who explored multiple forms as no individuals who reported abuse in an institutional setting reported only one form of abuse. This is important as the type of abuse and number of differing abuse experiences is important when considering the impact of institutional abuse (e.g., Benedict et al., 1996).

In addition, it is noted that PTSD symptoms were the only negative outcome examined in this study. This was to reduce the number of questions participants were asked to respond to, to reduce fatigue effects. However, previous research has identified challenges in addition to PTSD symptoms such as depression (Wolfe et al., 2006) and self-injurious

[42] As currently being in a relationship and placement in secure care were not indicated to be a result of institutional child abuse, they were not considered to be negative impacts of institutional abuse. Therefore, they were not explored further in relation to predictions 3h-3k that predicted that resilience and strength factors will protect against the negative impacts of institutional abuse and impairment in personality functioning will exacerbate them.

behaviour (Rusch et al., 1986). Furthermore, strength factors were explored as a unidimensional variable and measured with only six items, again, to reduce fatigue effects. This may have resulted in a lack of sensitivity in the analysis as individual strength factors such as social support and secure attachment were not explored in depth individually. It is possible that individual strength factors may have differing impacts. For example, while secure attachment is consistently found to be a protective factor against the negative impacts of institutional child abuse (Carr et al., 2009) social support is less well supported (Lueger-Schuster, Kantor, & Weindl et al., 2014)[43].

8.4.2. Concluding comments

Overall, the findings of study 3 indicate that institutional abuse is significantly and directly associated with higher levels of PTSD symptoms but not the likelihood of currently being in a relationship or placement in a secure facility as an adult. The relationship between institutional abuse and PTSD symptoms is also mediated by LPF-self and LPF-interpersonal, but not resilience or strength factors. Those who had negative care experiences did report higher levels of trauma but only when the abuse occurred in a home setting. Finally, individuals who disclosed their abuse reported higher levels of trauma however, no significant difference in PTSD symptoms was found between those abused by a carer versus those abused by someone else.

[43] This study used the same sample as Lueger-Schuster, Weindl, and Kantor, et al. (2014).

Chapter 9 – General Discussion

Several key findings have been identified in the current PhD research programme. For example, while several negative impacts have been noted as potential outcomes of institutional abuse, the key role of exacerbating (e.g., negative pre-care experiences and challenges with personality functioning concerning the self) and strength factors (e.g., resilience, effective coping, and acceptance) has been identified. It has been demonstrated that the combination of exacerbating and strength factors help to account for the variation in possible impacts following institutional abuse. In addition to this, the key role that disclosure plays following institutional abuse has been reinforced in this research and expanded to give a more in-depth understanding of how responses to disclosure, whether they be positive or negative, influence future outcomes for the victim. These findings will be explored in-depth and in relation to previous literature in this chapter.

The current set of studies has demonstrated that institutional child abuse has the potential to result in a vast range of negative impacts. For example, a consistent finding from the current research was the potential for institutional child abuse to result in PTSD symptoms. This is consistent with previous literature exploring the impacts of institutional abuse (Carr et al., 2010; Cook et al., 1993; Hermanau et al., 2011; Wolfe et al., 2006) as well as literature exploring the impact of child abuse more generally and not specifically in an institutional setting (e.g., Maniglio, 2009). This emphasises the role of institutional abuse in the development of PTSD symptoms as well as the similarities between institutional abuse and abuse in other settings where both may result in PTSD symptoms.

However, while all studies in this programme of research identified the role of institutional abuse in later PTSD symptoms, it is noted that no difference in the level of PTSD symptoms was supported in the current study between those abused in an institutional setting and those abused in a home setting. A distinction was predicted based on the expected cumulative impact of pre-existing traumatic experiences, such as placement in an institutional setting and the later institutional abuse (Afifi et al., 2014; MacLean, 2003; Havlicek & Courtney, 2016; Johnson et al., 2006). The importance of the cumulative impact of multiple negative experiences and poly-victimisation has been highlighted in previous theories including Life Course Theory (Laub & Sampson, 1993), which postulates that cumulative disadvantages during childhood can limit an individual's future opportunities for development. If an individual has experienced both placement in an institutional setting and institutional abuse, it was expected that this would result in cumulative negative impacts (e.g., MacLean, 2003; Johnson et al., 2006; Havlicek & Courtney, 2016) more so when compared to an individual who experiences abuse in a home setting who has not experienced placement into care. However, as noted, no difference in trauma symptom levels was found between these groups and while PTSD was also captured in earlier studies in this programme of research (study 1a and 1b) it was not specifically noted that these symptoms were expected to be greater when compared to those who experienced this form of abuse in a home setting.

For studies 1a and 1b, the lack of focus on the extent of impacts for those who experienced institutional abuse when compared to abuse in a home setting may have been impacted by the nature of the questions where the focus was solely on the impact of institutional abuse. The lack of difference in these groups found in study 3 may be impacted by levels of previous trauma that were not controlled for in this study (see section 9.2.). Specifically, several experiences before abuse may also result in cumulative impacts of

trauma such as exposure to domestic violence (Saha et al., 2013) or parental divorce (Wortham, 2000) not only placement in care. Therefore, variations in these experiences before abuse that have not been captured may explain the inconsistencies in the research with regards to whether institutional child abuse or child abuse occurring in a home setting is more likely to result in higher levels of trauma symptoms. A further consideration here is whether the experience was recognised as abuse. It was highlighted in study 2 for example that environments where abuse is normalised can be present in institutional settings. Therefore, it is possible that the full extent of PTSD symptoms following institutional abuse may not be captured, if not all individuals who experience it recognise it, they may not report that they have experienced institutional abuse and may therefore not be captured in the institutional abuse group in the analysis.

While PTSD symptoms were a commonly reported consequence of institutional abuse, other negative mental health impacts in addition to trauma-related symptoms were also shown in the current research to be potential outcomes following institutional abuse. These were captured by both victims of institutional abuse (e.g., Study 1b and Study 2) and those working with survivors of institutional abuse (Study 1a) and included depression, anxiety, and impacts on emotions more generally as expected based on previous literature (e.g. Bruskas, 2013; Carlisle & Rofes, 2007; Carr et al., 2010; Fitzpatrick et al., 2010; Hermenau et al., 2011). This included the development of shame, guilt, fear, sadness, negative feelings about oneself, and lack of confidence, along with impairments to emotional regulation. The identification of emotional regulation is important as it supports the potential applicability of Complex PTSD (C-PTSD) to the developing understanding of the impacts of institutional child abuse, as C-PTSD is noted to be related to difficulties in affect regulation (Ford & Courtios, 2009) and has also been supported in empirical literature to be a potential outcome

of institutional child abuse (Knefel, & Lueger-Schuster, 2013[44]). The current PhD research has therefore highlighted and substantiated the range of possible negative outcomes concerning mental health and wellbeing that are often reported and is consistent with previous literature.

However, impacts on mental health and wellbeing are not the only possible negative impacts of institutional abuse. This form of abuse has also been found, in this research, to impact future relationships. Specifically, the quality of future social relationships can be impacted by a loss of trust in others, a sense of betrayal, and the possibility that intimate relationships may be triggering for an individual who has reported institutional abuse. This is consistent with previous literature (Wolfe et al., 2006) and indicates the applicability of Betrayal Trauma Theory (Freyd, 1994) to understanding the impacts of institutional child abuse as it captures the impact that the betrayal caused by the experience of institutional abuse, and the response to this, can have on victims as is captured d in Betrayal Trauma Theory (Freyd, 1994). Therefore, it is clear that it is not the abuse alone that impacts relationships, but the betrayal experienced where the perpetrator is expected to act in the position of a carer and betrays the victim. This PhD research demonstrates that this can result in a lack of trust in future relationships. Though as illustrated in the final study, institutional child abuse did not reduce the likelihood that an individual would be in a romantic relationship. This builds on previous literature in identifying that institutional abuse may affect the quality of relationships, but potentially not their presence.

[44] This research included those who reported abuse in a foster care setting or in a Catholic Church setting, though it was not specified that the church setting was residential.

This PhD research has indicated potential connections between the negative impacts of institutional child abuse. Specifically, the impact on interpersonal relationships may also be influenced by the impact institutional abuse may have on behaviour, as the potential for institutional abuse to result in the use of aggression to solve conflicts in future relationships was also noted in this programme of research. In turn, the use of aggression to solve conflicts had a negative impact on relationships as would be expected. This was one of several behavioural impacts noted in the current PhD research. Other impacts included the potential for increased aggression more generally (e.g., not specific to romantic relationships), substance use, and withdrawal (e.g., isolating themselves from others). While these findings are in line with previous literature (Carlise & Rofes, 2007; Cook et al., 1993; Hermenau et al., 2011; Rusch et al., 1986), the current research expanded more explicitly on the increase in these behaviours in terms of the functions they serve, noting that these behaviours may act as a coping strategy to manage other negative impacts, such as trauma symptoms and impacts to mental health and wellbeing.

It was also reported in this programme of research, in terms of impact on behaviour, that institutional abuse may result in the perpetration of abuse towards others. This may be explained through the lens of Social Learning Theory (Bandura, 1977), which proposed that children may learn behaviours from observing those around them, specifically if this behaviour is seen as rewarded. Therefore, it may be speculated that, if applied to institutional abuse, individuals who have reported institutional abuse may learn to replicate this abuse if they view the perpetrator as being rewarded and also feel a connection to the perpetrator. This impact was captured more specifically in study 1b where several victims reported this replication of the abuse they experienced towards others. Though it must be noted that a large proportion of individuals in Study 1b currently resided in a prison setting (N=6 out of 10),

therefore, it is expected that the impacts of institutional abuse that relate to more challenging behaviours would be more common in this group as they have been convicted of a criminal act.

Despite this possible influence on victims re-enacting their abuse on others, an important polarisation was noted, where some individuals specifically reported not hurting others, but going on to behave in a way to protect them. So not only not replicating their abuse but going above and beyond to help others. This differing outcome was captured individually in previous literature noting that individuals may replicate their abuse on others (Carlisle & Rofes, 2007; Schaverien, 2011), or that they may behave in a way to protect others (Colton et al., 2002). However, previous research has not drawn together this contrast of hurting others versus protecting others and captured the polarisation between the two as has been captured in the current PhD research. This is important as considering both outcomes (hurting or protecting others) in the same study is important to allow for exploration of the underlying mechanisms that result in these differing impacts following institutional abuse. Highlighting this distinction is also crucial as victims of institutional abuse (study 1b) indicated the negative impact of stigma relating to fears they will be considered a potential abuser due to their own experiences. Therefore, this finding that many victims go on to behave in a way to protect others (e.g., protesting against institutional abuse, disclosing to protect others from the person that abused them) challenges this stigma, identifying that victim frequently went on to try and protect others and did not replicate their abuse.

Negative impacts on future life chances following institutional abuse were not limited to the impacts on future relationships and behaviour. Both victims of institutional abuse and

professionals who have worked with them indicated the impact of institutional abuse on education and employment, such as through the impacts on mental health impacting job stability. Therefore, the current programme of research captured the potential for institutional abuse to negatively impact education and employment. However, this relationship between institutional abuse and education/employment may not be straightforward as research has also illustrated that institutionalisation itself may impact education such as institutional settings offering a lack of access to education (Courtney & Dworsky, 2006; Stanley, 2017). This, therefore, makes establishing causation challenging as it cannot be easily established from this research whether it is the abuse or the institutionalisation that has impacted education, and there is a need to compare those who reside in an institutional setting but do not experience institutional abuse, to those who reside in an institutional setting and do experience abuse[45]. Despite this complexity, in-depth qualitative analysis as part of this PhD programme has allowed for the conclusion to be drawn that institutional abuse does have a negative impact on education for some individuals, especially when the perpetrator of the abuse has a key role in the education of the victim. Therefore, institutional abuse may have a direct effect on education in addition to any impact of placement in an institutional setting alone.

While several negative impacts of institutional abuse have been identified. It is clear from both the current PhD research and previous literature (e.g., Carr et al., 2019; Lueger-Schuster, Kantor, & Weindl, et al., 2014[46]) that not all individuals will experience all the negative outcomes discussed. For example, it was demonstrated that individuals can

[45] This was not explored quantitatively as only 7 out of 65 participants who reported placement in an institutional setting did not report any experience of abuse.
[46] Both Lueger-Schuster, Weindl, and Kantor et al. (2014) and Lueger-Schuster, Kantor, and Weindl et al. (2014) included a sub-sample of individuals who reported abuse in boarding schools. However, not all abuse reported is explicitly noted to have been experienced in a residential setting.

experience institutional abuse, have positive relationships with others, and experience gainful employment. Therefore, it is important to consider the factors that exacerbate or protect against the negative impacts of institutional child abuse. One such factor identified in the current programme of research was the type of abuse reported. However, contradictions were noted regarding which form of abuse results in the most negative impacts. Sexual abuse was generally reported to lead to the most negative outcomes in the systematic review, however, in Study 1b exploring the perspective of victims this issue was only explored by two participants, reporting that emotional and physical abuse were more impactful than sexual abuse. The findings of studies 1a and 1b indicated overall that it is the beliefs about the abuse (such as self-blame and betrayal) that are more important than the type of abuse according to victims and professionals. The Rapid Evidence Assessment (REA) supported this notion in relation to survivors' interpretation and response to abuse recall. Therefore, in each study in the current programme of research in which the form of abuse was explored, it was indicated that it is the victim's interpretation of the abuse is a key consideration concerning how the form of abuse relates to future impacts not just the form of abuse itself. Thus, this programme of research highlighted that it is not only important to consider the type of abuse, but more specifically the victim's interpretation of which form of abuse has resulted in more challenges for them.

Further to the perception of abuse, experiences before institutional abuse were also important to the later outcomes following institutional abuse. This included parental loss and child abuse in the home. This illustrated the importance of the cumulative effect of multiple experiences of trauma that these prior experiences may lead to, including based on the experience of poly-victimisation. This finding was expected based on previous literature where similar pre-care experiences have been reported to impact the effect of institutional

abuse (Benedict et al., 1996; Carr et al., 2010; Saha et al., 2013; Wolters, 2008). Several individual differences were also noted that were potentially related to increased negative impacts of institutional child abuse. This included insecure attachment, poor coping, and low self-esteem. While the impact of these individual differences was expected based on their similarity to exacerbating factors captured in previous research (e.g., Benzola, 1997; Carr et al., 2009; Lueger-Schuster, Kantor, & Weindl, et al., 2014), the role of personality functioning in mediating the relationship between trauma symptoms in those who had reported institutional abuse, where institutional abuse exacerbated challenges with personality functioning which in turn resulted in increased PTSD symptoms, was a novel finding of this programme of research. This finding, however, was consistent with what was expected based on previous literature such as that illustrating the impact of institutional abuse on the victim's thoughts about themselves (Murphy, 2009). This is also congruent with the Information Processing of Trauma Model (Hartman & Burgess, 1993) which highlights the important role of the victim's thoughts and how this information is stored in relation to the impacts of trauma in that previous experiences impact how the world and the self are viewed. When applied to institutional abuse it could be expected that the experience of institutional abuse will have a negative impact on the way the self and the world are viewed which in turn results in more negative outcomes for the victim. This was supported in the current research and indicates the importance of supporting victims of institutional abuse in terms of their personality functioning.

A further novel finding in this research programme was the impact of the institutional environment on the social support and disclosure experience of those who have reported institutional abuse. Specifically, it was noted that institutional settings may be seen as an unnatural environment where there is a lack of agency, consistent with previous literature

(e.g., Wortham, 2000). However, this PhD research built on previous research to capture the extremely negative effect this environment may have on the availability of support and suppression of disclosure. This notion was supported by victims, professionals, and the REA. However, it is important to note that the final study showed no difference in trauma symptoms in those who reported higher negative experiences of care compared to those who reported fewer negative experiences of care. So, it can be concluded that whilst the environment has been reported to impact support available and the likelihood of disclosure following institutional abuse, this may not translate to increased trauma symptoms.

While some factors exacerbated the negative impacts of institutional abuse, other factors were reported to support recovery following institutional abuse and were seen to protect against the negative impacts of institutional abuse. These strength factors identified included task-oriented coping, optimism, secure attachment, consistency in the environment, and previous love and acceptance. Furthermore, these findings are supported by previous literature (e.g., Carr et al., 2009; Lueger-Schuster, Kantor, & Weindl, et al., 2014; Sheridan & Carr 2020) also highlighting these factors as protective. However, it was noted that questions developed to explore secure attachment, positive coping, and future goals were not predictive of reduced trauma symptoms in the final study. This is surprising given the findings of earlier studies in this programme of research indicating that each of these variables was an important protective factor against negative outcomes following institutional abuse. Limitations in measurement offer a potential explanation for this finding (see section 9.2) as these elements are otherwise consistently found to be strength factors elsewhere in this program of research and relevant literature (e.g., Carr et al., 2009). This lack of significant findings concerning the role of these protective factors in reducing PTSD symptoms following institutional abuse may also have been impacted by the inclusion of social support in the overall measure of

protective factors. This is important as mixed findings in the protective role of social support following institutional abuse have been noted and will now be discussed.

The research included in the systematic review and more recent research noted that perceived social support did not protect against PTSD following institutional abuse (Lueger-Schuster, Kantor, Weindl, et al., 2014; Moore et al., 2019). However, evidence from experts and victims (Study 1) illustrated the protective nature of social support. One possible explanation for the variation in the role of social support is the quality of social support that the victim receives. For example, the REA (Study 2) captured variations in how much social support was available to individuals in institutional care and how they perceived their social support. Furthermore, the systematic review and study 1 capture the potential for elements of social relationships to trigger trauma symptoms for some individuals based on their abuse experiences, such as physical touch. It would therefore be expected that the extent to which social support can be protective will also be impacted by the extent to which relationships are seen as triggering. Therefore, it is concluded from the current thesis that social support is likely required to be available, positive, and not re-triggering to be a protective factor.

A final element of institutional abuse explored in this PhD programme of research was disclosure. It was demonstrated that disclosure can result in both positive and negative feelings and that the response to the disclosure could greatly impact whether the experience was positive or negative. Specifically, a supportive response was more likely to evoke positive feelings and a judgmental response was more likely to evoke a negative response. Response to disclosure could also impact how the abuse was later understood, such as whether the victim blamed themselves, which is in line with previous literature (Wolfe et al., 2006). This is also consistent with previous models of the impacts of trauma more generally,

again capturing similarities between institutional abuse and other forms of trauma. For example, it is noted in the Information Processing of Trauma Model (Huesmann, 1998) that disclosure of trauma may have a positive or negative impact depending on how it is responded to by the family and community. Interestingly, the REA (study 2) also built on previous literature and demonstrated the potential negative impacts of not disclosing, with a focus on the barrier this may cause to receiving support. It was noted that those who do not disclose may therefore not be able to receive appropriate trauma-related support. Nevertheless, the final study showed that individuals who did disclose their abuse were in the group of individuals with higher levels of trauma suggesting the disclosure was not protective in this study. One possible explanation for these mixed findings is that if disclosure is seen as challenging in the short term based on the anxiety related to sharing the information, but beneficial in the long term due to access to the correct support, this may have impacted the results of Study 3 where time since disclosure was not captured (See section 9.2). A further potential explanation for the finding that disclosure was more common in those with higher levels of trauma symptoms may be that individuals who had disclosed their abuse did so due to the increased levels of trauma resulting in a greater need to ask for help. This interpretation is also supported in the REA (study 2) which highlighted the need for support and the inability to cope as a potential motivation for disclosure.

Several barriers to disclosure were also noted, across the thesis findings, which included fear of the consequences, negative feelings such as shame, the culture of the environment (e.g., a culture accepting of abuse), and lack of communication skills that inhibit disclosure. These findings are compatible with previous research (e.g., Benzola, 1997; Colton et al., 2002; Schaverien, 2011). The thesis also builds on previous literature by providing a greater level of detail in relation to the barriers and motivations for disclosure. For example,

the current PhD research identified that disclosure may be made to raise awareness and help others, to receive support, to start the healing process or receive an apology. They may occur at the time of the abuse, years later, or not at all. Disclosures may vary in detail due to retrospective memory and avoidance of recalling abuse details as captured in the view of professionals and the REA. Importantly, the current PhD programme indicated that disclosures may be made to several individuals. For example, children more often disclosed to parents or authority figures, adolescents to friends, and adults to friends, partners, or authority. This is an important finding of the current research regarding supporting individuals to disclose their abuse in clinical settings.

9.1. A Preliminary Model of Factors Promoting Negative Symptoms and Strength Factors Following Institutional Child Abuse

The findings of this thesis have been used to develop a preliminary conceptual model that integrates the negative impacts of institutional child abuse and the factors influencing the extent to which these impacts are experienced see Figure 9.1. Such a model is not available in the current literature; this is important as research has identified that professionals working with individuals who have reported institutional abuse report this to be challenging and complex (e.g., Wolters, 2008). It is therefore hoped that a model of the factors that influence the impacts of institutional child abuse will help to provide structure to this complex issue.

While some key factors identified as being important in the current research programme have been included in models exploring the impacts of abuse more generally, such as the potential for trauma symptoms (The Traumagenic Dynamic Model, Finkelhor & Browne, 1985; Information Processing Model of Trauma, Hartman & Burgess, 1993), the role of the nature of abuse (The Transactional Model of Child Sexual Abuse, Spaccarelli,

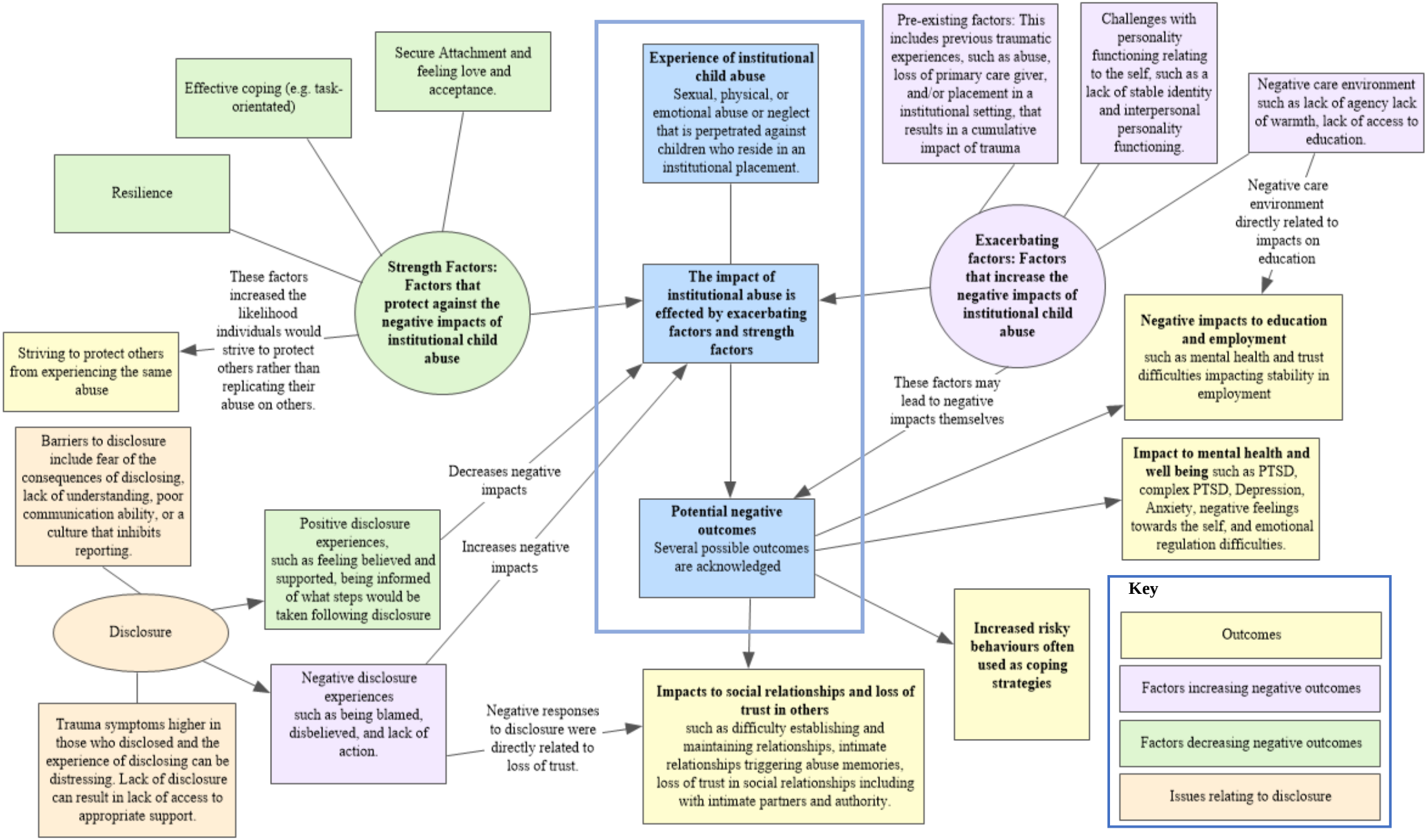
1994) and the impact of experiences prior to the trauma (Information Processing of Trauma Model Hartman & Burgess, 1993), the current programme of research has indicated that there are elements of the impacts of institutional abuse that are not captured fully by current models of abuse which have focused on that occurring in a home setting. This includes emotional regulation difficulties, resilience, and the impact of the institutional environment. Whilst the Transactional Model of Child Sexual Abuse (Spaccarelli, 1994) does capture the impact of the environment this is concerning family factors not the actual setting of the abuse, which the current research notes is of particular importance. In addition, the potential for differentiation in those who go on to replicate their abuse and those who instead strive to protect others is missing from previous models. Identifying this polarisation is important as the concern that those who had reported institutional abuse had about being stigmatised as an abuser because of their experiences had been identified in this PhD programme.

The model presented in Figure 9.1 outlines the relationship between experiences of institutional child abuse and potential negative outcomes of this including the possible impacts to mental health and wellbeing, education and employment, risky behaviours, and social relationships. A key element of the model is that it captures the key role of variables that impact the relationship between institutional child abuse and these possible outcomes. Therefore, key strength factors such as resilience, effective coping, and secure attachment are highlighted. These factors reduce the negative impacts of institutional child abuse and help victims to manages these impacts. In addition, factors that may increase the likelihood of negative impacts are also captured. These include pre-existing factors which are those that were present before the abuse including abuse in the home setting and negative responses to placement in care. Furthermore, it is noted in the model that challenges with personality

functioning and negative care environments (such as lack of warmth) can exacerbate negative impacts.

This model allows for some of the complexities in the relationships between negative impacts, strength factors, and exacerbating factors to be captured. For example, it is noted that the negative care environment may both exacerbate the negative impacts of institutional abuse including reducing access to support and directly impact the individual's education and employment. This model has also allowed for the important role of disclosure to be included. Specifically, it is noted that negative responses to disclosure can exacerbate the negative impacts of institutional abuse whereas positive responses can protect against them.

Figure 9.1 – *A model of the factors that influence the impacts of institutional child abuse*



9.2 Limitations

Whilst the nature of the research was exploratory, supporting the initial cross-sectional design, this has made it challenging to establish cause and effect (Hayes, 2018) and has resulted in reliance on retrospective accounts. Longitudinal research would support the exploration of cause and effect and reduce the role of retrospective memory. This would also allow for a more in-depth exploration of the role of pre-existing factors and whether they mediate or moderate the impacts of institutional abuse. This would allow for a more in depth understanding of the importance of key variables identified in the research to date. For example, this would better allow for an exploration of disclosure in relation to how trauma symptoms may change overtime following a disclosure of institutional child abuse.

It is also important to note that definition of institutional abuse used in this study was broad. This was a result of the exploratory nature of this research and the need to capture a broad range of issues in order to develop an initial understanding. The definition of an institutional setting was, therefore, specifically broad. This is important because how institutional abuse is defined and what is captured in the understanding of institutional settings may impact results. For example, previous literature has demonstrated that the type of setting impacts the prevalence rates of institutional abuse (Euser et al., 2014: Euser et al., 2013) and the amount of abuse that occurs (e.g., Lueger-Schuster et al., 2018) which may in turn effect the level of negative impacts experienced. It was therefore not possible to capture these nuances in the current research programme given the broad definition of institutional abuse used that included any institutional setting such as residential care centres, schools, churches, reformatories, and recreational facilities managed by secular or religious organisations (Gallagher, 1999) with the limitation that they must be residential.

The broad nature of the exploration of strength factors is a further limitation of this study. In earlier qualitative studies broad questions were used to explore which factors both victims and professionals felt were important to recovery (e.g., "What factors, if any, helped you manage the effects of the abuse in the short term?" and "What factors, if any, helped you manage the effects of the abuse in the long term?"). This broad approach was also taken in the final quantitative study with an overall measure of strength factors being generated from earlier studies and consisting of 6 items (See Appendix 8 for study 3 materials). This broad approach was a beneficial starting point to research in this area allowing for several important factors, such as secure attachment, positive coping, and social support to be highlighted. However, it does not allow for a more in-depth understanding of these strength factors individually.

A further limitation of this research comes from the participant recruitment method. While study 1b was also advertised in a local newspaper in the northwest of England and a newspaper that is circulated in secure settings, the main recruitment method for participants in this research programme was via online platforms such as social media and Prolific. This did allow for a range of participant to be reached regardless of geographical location for example, however, this also impacts the applicability of these findings to individuals who do not use social media or who do not access the internet. This is important as individuals who do and do not use the internet have not been found to be a homogenous group (Kim & Jeong, 2015).

9.3 Future Research

A key focus of future research should be to continue to test the developed model (See Figure 9.1). A specific area that requires further attention is the role of strength factors. This

should include an in-depth exploration of the role of social support starting with a qualitative exploration of the benefits of social support in protecting against the negative impacts of institutional child abuse, including questions about the nature and availability of this support and any barriers to receiving this support, such as relationships acting as triggers for previous trauma. This should then be followed up with quantitative exploration of the mediating role of social support (the nature and availability) in protecting against the impacts of institutional abuse in order to increase the generalisability of the finding. This would be beneficial to help to better understand the currently complex findings in the literature (e.g., Lueger-Schuster, Kantor, & Weindl et al., 2014).

A further focus of future research should be to better understand the impact of the care environment on the individual and how this may exacerbate the impacts of institutional abuse. The current thesis identified that the negative care environment appeared to impact availability of social support and trusted others and acted as a barrier to disclosure, but this did not result in increased trauma symptoms. It would be beneficial for future research to explore the potential relationship between the negative care environment, barriers to disclosure and social support, and how this effects other negative impacts of institutional abuse (e.g., depression and anxiety). This would be beneficial to allow for a better understanding of changes to the institutional setting that could be made to support victims of institutional abuse in developing secure supportive relationship and disclosing their abuse in order to receive appropriate professional support as needed.

Future research should aim to continue to explore how this model applies to specific population samples such as those in secure care. This is noted to be a useful consideration as qualitative research with victims highlighted the high proportion of participants choosing to

engage in the research who were based on a secure setting (10 out of 29 participants). These participants indicated that elements of their current environment replicated that of the institution which they resided during childhood along with the betrayal they experienced when disclosing abuse during adulthood in the secure setting and feeling that they were not supported. In order to do this, quantitative research should explore this using similar measure to that of Study 3 (See Appendix 8) with the addition of the Institutional Betrayal Questionnaire Version 2 (IBQ.2; Smith & Freyd, 2017) in order to explore the potential exacerbating impact of this betrayal on later outcomes following institutional child abuse.

9.4 Implications

This research has both practical and research implications. In relation to research implication, it offers a structure to the current knowledge of the impacts of institutional abuse and highlights areas for future research. This will be important to support the continued development of research in this area by providing a guide to future research needs (See section 9.3). In addition to this, it has allowed for a greater understanding of how best to approach participants for engagement in research based on a greater understanding of the impact of how individuals are asked questions about their experiences. For examples the REA demonstrates the importance of avoiding repeated questioning, being transparent, and providing clear lines of access to support.

In relation to the practical implications, the development of a model of the impacts of institutional abuse allows for a structure to be provided when working with individuals who have reported this form of abuse. It is hoped that as the model is developed it will be beneficial in guiding intervention and identifying areas of need as well as providing a structure to support the formulation of the impacts of institutional abuse. For example, this

research has captured the importance of considering the cumulative impact of multiple traumas in those who experience institutional abuse.

The findings of the research and the model are useful for developing practical guidance when working with individuals who have reported intuitional abuse. This includes guidance on how to respond to a disclosure of institutional abuse specifically that responses must be non-judgmental, non-blaming, and allow the individual to give the information as and when they are ready. This is already supported in relation to abuse in a home setting, and this research supports its application to those who have reported institutional abuse and extends if further to emphasise the great importance of avoiding stigma during disclosure. This thesis has demonstrated that negative impacts that stigma may have on the victims such as discouraging them from disclosing and also impacting future relationships due to fear of stigma.

Understanding factors that exacerbate the negative impacts of institutional abuse is another important implication of this research. Specifically, the novel findings of this research that impairments in personality functioning in relation to the domain self exacerbate PTSD symptoms following institutional abuse, this therefore reveals a key area for intervention to focus on in addressing personality functioning, where applicable, in those who have reported institutional abuse. Furthermore, the need to address the potential for relationships to act as a trigger from trauma has been noted. This is important as social support is often considered a protective factor, so this demonstrates the need for an individualised assessment of needed and difficulties in this area.

9.5 Concluding comments

This research allowed for a better understanding of the complex relationship between institutional abuse and negative outcomes and allowed for the development of a preliminary conceptual model of the negative impacts of institutional child abuse, and factors that influence the extent to which these impacts are experienced which captured these complexities. It has indicated that several factors exacerbating the impact of institutional abuse may also lead to negative outcomes themselves thus resulting in a potential cumulative impact of trauma as a result of previous traumatic experience commonly reported prior to placement in an institutional setting. Furthermore, it has been demonstrated how disclosure can be a challenging time for victims and may be related to increase trauma symptoms, thus illustrating the importance of a positive and supportive response to disclosure.

It is hoped that the findings from this research and the preliminary model will guide future practice when researching and working with survivors of institutional child abuse. For example, it has captured the importance of individual assessment when working with victims of institutional abuse to understand the complexities of institutional abuse such as exploring how the individual may benefit for social support and if there are any barriers to this such as relationships acting as a trigger to traumatic memories. Overall, a clear theme throughout the thesis is the importance of how an individual understand and interprets their experiences and how this impacts their view of themselves and others. This has clear practical implications such as the need to address personality functioning impairment in the domain of the self when working with individuals who experience institutional abuse who show challenges in this area.

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10. Appendices

Appendix 1: Summary of Systematic Review Update

Figure 10.1

PRISMA Flow chart of included studies for the updated systematic review.

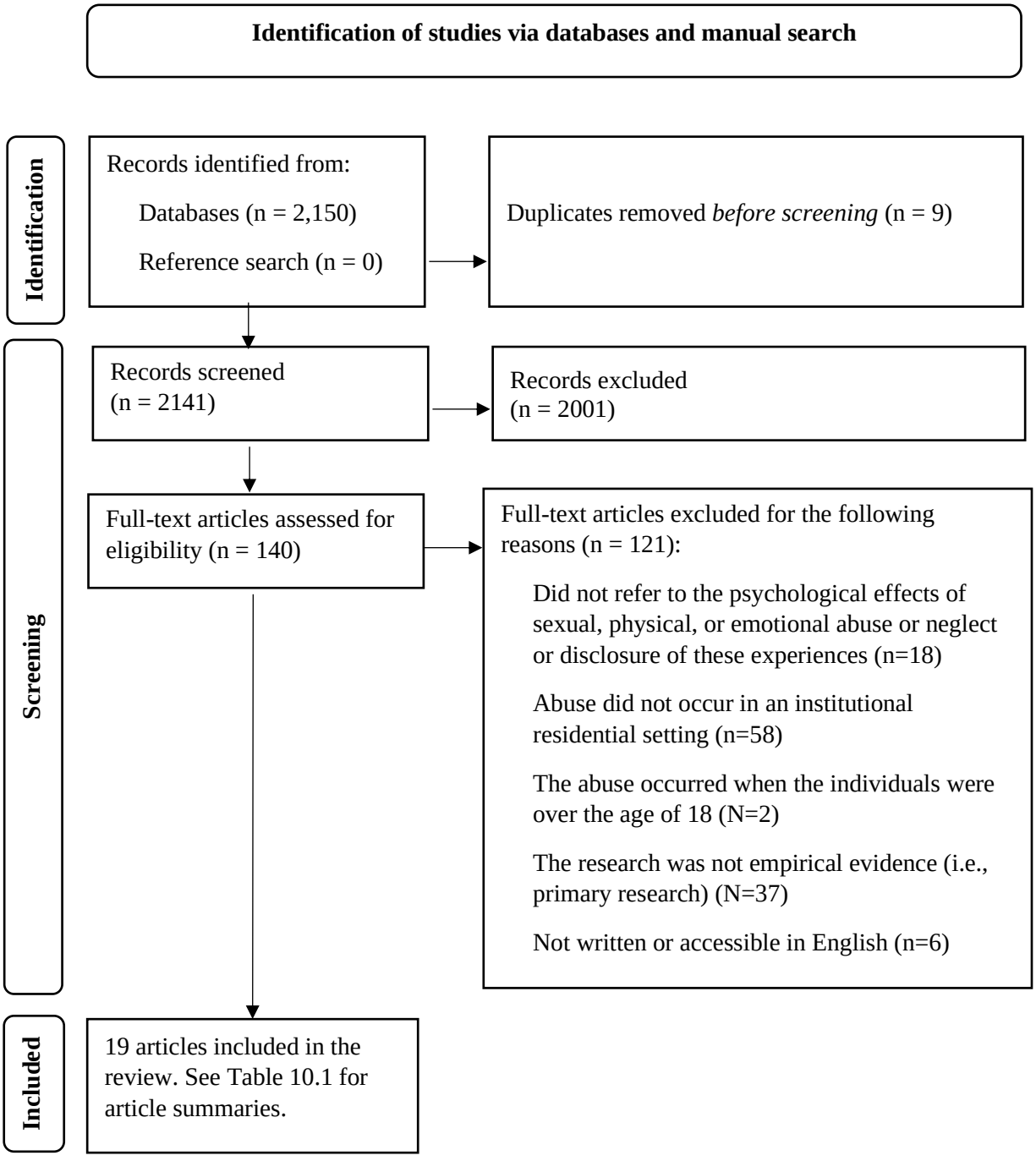

Table 10.1

Articles summaries for studies published since the Systematic Review was conducted (2016-2022)

Study	Participants	Key findings	Themes identified
Black, C., Frederico, M., & Bamblett, M. (2019). Healing through Connection: An Aboriginal Community Designed, Developed and Delivered Cultural Healing Program for Aboriginal Survivors of Institutional Child Sexual Abuse. *The British Journal of Social Work*, 49(4), 1059–1080. https://doi.org/10.1093/bjsw/bcz059	"Aboriginal survivors of institutional child sexual abuse who had also experienced cultural abuse" in being removed from their home and culture. Information was gathered from survivors (surveys and interviews) and facilitators, and an iterative action research approach was used. The number of participants was not noted. (The sample included individuals who were removed from family care)	This article focused on describing the findings of a "Cultural Healing Program (CHP) designed, developed and delivered by an Aboriginal Community Controlled Organisation". The programme included aspects relating to self-care, exploration of identity, and cultural activities. Fear, low self-esteem, lack of trust, lack of knowledge of culture, cultural load (e.g., obligations to the community), disconnection with family, and trauma acted as barriers to effective intervention. Engagement in the programme was reported to create a feeling of safety and a positive impact of connecting with others and developing a sense of belonging was noted. The importance of visiting significant cultural sites and empowerment by elders was also noted.	The barriers to and usefulness of intervention for survivors.
Carr, A., Nearchou, F., Duff, H., Ní Mhaoileoin, D., Cullen, K., O'Dowd, A., & Battigelli, L. (2019). Survivors of institutional	Survivors of historical institutional abuse in Scotland (N=225) who reported to The Scottish Child Abuse Inquiry.	Negative outcomes were reported to include: "psychosocial adjustment (96%), mental health (84%), and physical health (43%)". It was noted that the impact of institutional abuse on future outcomes relating to	Resulting lasting effects on wellbeing and behaviour.

abuse in long-term child care in Scotland. *Child Abuse & Neglect*, 93, 38–54. https://doi.org/10.1016/j.chiabu.2019.04.018	(Individuals who were placed in care during their childhood)	psychosocial impacts was mediated by risk (e.g., number of care placements, negative factors in the childcare environment, number of birth family adversities, and number of neuro-developmental disorders) and protective factors (e.g., supportive relationships, constructive coping, useful skills such as academic or sporting, effective coping, and effective legal actions). The relationship between institutional abuse and mental health was mediated by risk factors only. The relationship between institutional abuse and physical health was not mediated by risk or protective factors.	Factors exacerbating negative impacts of institutional abuse. Factors protecting against negative impacts.
Fernandez, E., & Lee, J.-S. (2017). Experiences and outcomes of adults who endured maltreatment as children in care in Australia in the twentieth century. In A. V. Rus, S. R. Parris, & E. Stativa (Eds.), *Child maltreatment in residential care: History, research, and current practice.* (pp. 419–460). Springer International Publishing. https://doi.org/10.1007/978-3-319-57990-0_20	Surveys completed by 669 individuals who were previously in out-of-home-care alongside interviews with 92 participants, and 20 focus groups with 77 participants.	Abuse was experienced from peer and adults. Negative impacts of abuse in care lasted into adulthood. Those who experienced all form of abuse reported more negative outcomes.	Resulting lasting effects on wellbeing and behaviour. Factors exacerbating negative impacts of institutional abuse.

Glück, T. M., Knefel, M., & Lueger-Schuster, B. (2017). A network analysis of anger, shame, proposed ICD-11 post-traumatic stress disorder, and different types of childhood trauma in foster care settings in a sample of adult survivors. *European Journal of Psychotraumatology, 8*, https://doi.org/10.1080/20008198.2017.1372543	Adult survivors of child abuse in a foster care setting (N=220).	Anger rumination was found to be important in the relationship between PTSD symptoms and anger in this sample. Trait anger was not directly connected to any form of maltreatment.	Resulting lasting effects on wellbeing and behaviour.
Graves. S. L. (2015). *Clergy-perpetrated child sexual abuse: Perceived effects based on archival reports of adult survivors who pursued litigation against the Catholic Church.* ProQuest Dissertations Publishing.	Claimant questionnaires from plaintiff attorneys of 47 cases. One defendant was a Chaplin at a children's residential care facility (*not all abuse was in a residential setting).	It was noted that survivors of clergy-perpetrated abuse reported being afraid to disclose, the delay before disclosure and person the abuse was disclosure to varied. Long term impacts included anxiety and depression, trauma related symptoms, loss of faith, substance abuse, and sexual problems.	Resulting lasting effects on wellbeing and behaviour. Motivation to disclose, nature and impact of disclosure.
Kantor, V., Knefel, M., & Lueger-Schuster, B. (2017). Investigating institutional abuse survivors' help-	Survivors of institutional child abuse (N=220). (Foster care).	A three-factor structure of Inventory of Attitudes towards Seeking Mental Health Services was supported in this sample. The PTSD-intrusion	Resulting lasting effects on wellbeing and behaviour.

seeking attitudes with the Inventory of Attitudes towards Seeking Mental Health Services. *European Journal of Psychotraumatology, 8*(1), https://doi.org/10.1080/20008198.2017.1377528		scale and the depression scale significantly predicted mental health service use.	The barriers to and usefulness of intervention for survivors (*more specifically help seeking*)
Liebenberg, & Moore, J. C. (2016). A Social Ecological Measure of Resilience for Adults: The RRC-ARM. *Social Indicators Research, 136*(1), 1–19. https://doi.org/10.1007/s11205-016-1523-y	Adult survivors of clerical institutional childhood abuse (N=105). Nine of these participants also completed qualitative interviews. (The type of institution is not explicitly noted in the 'Sample' section, though reformatories and industrial schools are explored throughout the introduction).	Exploratory Factor Analysis indicated five components of the RRC-ARM in this sample: social/community, family attachment and supports; spirituality; national and cultural identity; and personal skills and competencies. Qualitative analysis captured the impact of this form of abuse on spirituality, such as participants no longer going to church. Participants also reported a strong cultural identity. Strong correlations were found between resilience and mental wellbeing in this sample.	Factors protecting against negative impacts. Resulting lasting effects on wellbeing and behaviour.
Lueger-Schuster, B., Knefel, M., Glück, T. M., Jagsch, R., Kantor, V., & Weindl, D. (2018). Child abuse and neglect in institutional settings,	A group of adult survivors of institutional child abuse (physical, sexual, emotional abuse and neglect) who had been placed in foster care in Vienna during childhood	Those in the foster care group reported higher levels of all forms of maltreatment, also reporting higher rates of depression, alcohol, and substance use dependency, anxiety, PTSD, and avoidant, compulsive, paranoid, borderline and anti-social personality disorders. Those in the foster care	Resulting lasting effects on wellbeing and behaviour.

cumulative lifetime traumatization, and psychopathological long-term correlates in adult survivors: The Vienna Institutional Abuse Study. *Child Abuse & Neglect*, 76, 488–501. https://doi.org/10.1016/j.chiabu.2017.12.009	(n=220) and a general population comparison group exposed to maltreatment by their families (n=234).	group also had higher levels of familial abuse prior to placement in foster care.	
Mc Gee, S. L., Maercker, A., Carr, A., & Thoma, M. V. (2020). "Some call it resilience": A profile of dynamic resilience-related factors in older adult survivors of childhood institutional adversity and maltreatment. *Child Abuse & Neglect*, 107, 104565–104565. https://doi.org/10.1016/j.chiabu.2020.104565	Adult survivors of childhood/adolescent adversity and maltreatment in institutional settings (N=17). (Residential welfare settings).	Qualitative analysis resulted in the development of theme relating to future adversity including abuse and neglect, harsh regimes, detrimental perceptions and interactions (e.g. stigma), re-exposure and reminders, failure of system and society, and the cycle of abuse (e.g. difficulty obtaining record, conflicted sense of identity, trans-generational). Themes relating to resilience included core resilience factors such as individual characteristics (e.g. emotional development as a result of aging, health behaviours such as health sleep behaviours), internal resilience such as personality characteristics (e.g. persistence), social support, goal attainment, adaptive belief systems (e.g. spirituality, general life beliefs), processing (e.g. reflection and perspective taking) and external factors included influential events and	Factors exacerbating negative impacts of institutional abuse Factors protecting against negative impacts.

		experiences such as those providing a sense of meaning, recognition and collective identity and access to services.	
Moore, J., Flynn, M., & Morgan, M. (2019). Social Ecological Resilience and Mental Wellbeing of Irish Emigrant Survivors of Clerical Institutional Childhood Abuse. *Child Abuse Review (Chichester, England : 1992),* 28(1), 52–68. https://doi.org/10.1002/car.2548	105 adult survivors of institutional child abuse in ireland (quantitative phase) 56 of whom have emigrated to the UK by the time of the study. Nine participants who had experienced institutional abuse and were reported by practitioners to have adjusted well to the adversity of the abuse experiences (qualitative phase). (Institutional care).	Several factors (e.g., problem focused coping, altruism, defiance, and social and community inclusion) contributed to mental wellbeing in this sample, though family support and spirituality did not in the quantitative analysis though spirituality was captured by 3 sources in the qualitative analysis.	Factors protecting against negative impacts.
Moore, T., McArthur, M., & Death, J. (2020). Brutal Bullies and Protective Peers: How Young People Help or Hinder Each Other's Safety in Residential Care. *Residential Treatment for Children & Youth,* 37(2), 108–135.	Individuals who lived in residential care during childhood (N=27). It was noted that not all had experience abuse by an adult in care (the prevalence rate was not noted).	Qualitative analysis revealed that peer victimisation in residential care resulted in hypervigilance. The consequences of peer victimisation were reported to be long lasting. It was noted that problems with identification of problematic behaviour impacted disclosure of peer abuse in relation to sexual harassment while feeling there was not access to trusted others impacted disclosure of adult abuse.	Resulting lasting effects on wellbeing and behaviour. Motivation to disclose, nature, and impact of disclosure.

https://doi.org/10.1080/0886571X.2019.1682487			
Moore, J., Thornton, C., & Hughes, M. (2017). On the Road to Resilience: The Help-Seeking Experiences of Irish Emigrant Survivors of Institutional Abuse. *Child Abuse Review,* 26(5), 375–387. https://doi.org/10.1002/car.2415	Survivors of institutional child abuse in industrial schools or reformatories in Ireland (N=22).	Semi-structured interviews were used and qualitative analysis revealed that survivors reported negative initial help seeking experiences in Ireland. This led to self-management of impacts. Indication of impacts related to depression, nightmares, and flashbacks were noted. Giving evidence to the Residential Institutions Redress Board (RIRB) was described by participants as distressing. Motivation to help children and family financially was a motivation for this disclosure. The participants chose to disclose to a range of different professionals including solicitors and psychologists. Other sought support from parents and others in the community at the time of the abuse. Specific events and experiences such as illness, needs of children, bereavement, and family problems were important in triggering help-seeking behaviour. Peer support was reported to be important in terms of signposting to formal intervention. Barriers to help seeking included insensitivity of professionals and lack of clear boundaries.	Resulting lasting effects on wellbeing and behaviour. The barriers to and usefulness of intervention for survivors. Motivation to disclose, nature, and impact of disclosure.

Sheridan, G., & Carr, A. (2020). Survivors' lived experiences of posttraumatic growth after institutional childhood abuse: An interpretative phenomenological analysis. *Child Abuse & Neglect*, 103, 104430–13. https://doi.org/10.1016/j.chiabu.2020.104430	Survivors of historical institutional abuse in Ireland (N=9) (a range of residential institutions)	Qualitative analysis was used to develop two subordinate themes: Survivor identity and Engendering growth. In relation to survivor identity, it was noted that stigmatising attitudes of society impacted participants sense of self. Self-identity was also impacted by interactions with other survivors and the ability to develop meaningful relationships in safe group contexts. A sense of missed opportunity was noted specifically in relation to educational disadvantages. Participants also captured the sense of rejection of their survivorship by others. Finally, the sense of positive self-impressions was noted through the change in societal attitudes and de-stigmatisation. In relation to engendered growth, it was noted that temporal changes such as entering parenthood or specific events such as abuse disclosure promoted positive change. Cognitive insights such as prior positive memories and rejection of responsibility for the experience were also seen as important for future growth. Improved relationships with others and meaningful activity were noted to be important for positive development. Survivors described a feeling of personal strength such as feeling determined as well as positive qualities such as being honest and caring. The avoidance of conflict in interpersonal exchanges was highlighted as a result of conditioned fear.	Resulting lasting effects on wellbeing and behaviour. Negative impact on future life chances. Factors protecting against negative impacts. Survivors interpretation and responses to abuse. Motivation to disclose, nature, and impact of disclosure.

		Continued distress was also reported and included future vulnerability to intimate partner violence and other stressful life events.	
Stewart, D. L. (2016). *Fragmented Lives: A Qualitative Study of the Experiences of Black Youth Who Have Aged Out of the Foster Care System.* ProQuest Dissertations Publishing.	Individuals formerly in foster care (N=8). Themes relating to abuse in foster care were captured in five of the participants.	One participant reported disclosing their abuse at the time to a Foster Care Worker but frequent changes in workers made it difficult to establish trust. None of the workers reportedly investigated the participants claims. Abuse in foster care reportedly had a lasting impact on self-worth and self-esteem. One participant reported making a joke of name calling to cope with it and was reluctant to identify this as abuse. Another participant reported keeping emotions and expectations on the periphery to avoid being hurt following their abuse and being fearful of being vulnerable to strangers.	Resulting lasting effects on wellbeing and behaviour. Motivation to disclose, nature and impact of disclosure.
Sutinah, & Aminah, S. (2018). Child abuse and neglect in orphanages in EAST JAVA Province (Study on forms of child abuse, anticipatory efforts developed children and the role of the orphanage). *Children and Youth Services Review, 93*, 24–29.	Children who currently reside in orphanages (N=500) and 2-3 caregivers from each of the 5 orphanages included.	It was noted that those who were subject to abuse in the institutional setting used a range of approaches to try and avoid further abuse including keeping quiet, avoiding the perpetrator, and trying not to break the rules.	Motivation to disclose, nature and impact of disclosure. *This paper also more explicitly captures the response to the abuse at the time.*

https://doi.org/10.1016/j.childyouth.2018.07.002			
Weindl, D., Knefel, M., Glück, T., & Lueger-Schuster, B. (2020). Emotion regulation strategies, self-esteem, and anger in adult survivors of childhood maltreatment in foster care settings. *European Journal of Trauma & Dissociation, 4*(4). https://doi.org/10.1016/j.ejtd.2020.100163	An Austrian sample of 220 participants who reported childhood abuse in foster homes.	Self-esteem mediated that impact of emotional regulation on trait anger and on anger rumination.	Resulting lasting effects on wellbeing and behaviour. Factors protecting against negative impacts.
Weindl, D. Knefel, M., Glück, T. M., Tran, U. S., & Lueger-Schuster, B. (2018). Motivational capacities after prolonged interpersonal childhood trauma in institutional settings in a sample of Austrian adult survivors. *Child Abuse & Neglect*, 76,	A sample of 220 participants in Vienna who reported childhood trauma in an institutional setting. (Foster care)	Prolonged childhood trauma was associated with reduce self-efficacy and self-esteem and difficulties in emotional regulation.	Resulting lasting effects on wellbeing and behaviour.

194–203. https://doi.org/10.1016/j.chiabu.2017.11.001			
Weindl, D., & Lueger-Schuster, B. (2018). Coming to terms with oneself: A mixed methods approach to perceived self-esteem of adult survivors of childhood maltreatment in foster care settings. *BMC Psychology*, 6(1), 47–47. https://doi.org/10.1186/s40359-018-0259-7	46 survivors of maltreatment in foster care settings in Vienna.	Using mix-method approach it was found that lower emotional self-esteem (e.g., self- related associations and emotions and self-acceptance) was found in the population compared to a norm sample. A range of positive and negative attitudes towards the self were noted in the qualitative analysis. Events such as childbirth were related to positive attitudes for one participant for example. The analysis also captured the maintenance of self-confidence during placement. Others reported more negative attitudes towards themselves. More positive attitudes about ones-self and emotions were noted in those with higher levels of emotional self-esteem and more negative attitudes noted in those with lower emotional self-esteem.	Resulting lasting effects on wellbeing and behaviour. Factors protecting against negative impacts.
Wissink, I. B., van Vugt, E. S., Smits, I. A. M., Moonen, X. M. H., & Stams, G.-J. J. M. (2018). Reports of sexual abuse of children in state care: A comparison between children with and without intellectual	Case files of children with reported abuse (N=176), 128 of whom had reported intellectual disability. In this study around 25% of reported the perpetrator was reported to be a step/foster parent	The focus of this article is the nature of abuse. However, reference to disclosure is made in this article which is relevant to the current study. It was noted that 66% of abused children disclosed their abuse by telling someone (rather than it being identified by others through abuse indicators).	Motivation to disclose, nature and impact of disclosure.

disability. *Journal of Intellectual & Developmental Disability, 43*(2), 152–163. https://doi.org/10.3109/13668250.2016.1269881

Appendix 2: Table of information of studies included in the systematic review

Table 10.2

Information of studies included in the systematic review

Study	Setting	Design	Setting of abuse	Measure of abuse	Measures used for other factors	Analysis
Benedict et al. (1996).	US	Case-control study	Family Foster Care	Substantiated maltreatment where "the injury or risk of injury to a child is the result of an action by the caretaker, or when there is evidence to suggest that the caretaker has neglected a child or failed to protect that child from maltreatment".	Information was collected from social service records. This included information about health history, development, and behaviour before and during foster care.	Analysis consisted of exploring percentages and conducting multinomial logistic regression.
Benzola (1997).	USA	Case-study	Foster Care and	Self-report account	Self-report account	No formal analysis of the relationship.
Bode and Goldman (2012)	Australia	Cross-sectional	Residential care between 1950-1975.	Interview focusing on key variables. Child sexual abuse is defined as "any contact or non-contact sexual experience perpetrated on a child who is under the legal age of sexual consent, which, in Australia, is 16 years".	Interview focusing on key variables (e.g., education, specifically educational development, and opportunities).	One on one interviews presented in condensed narratives on which conclusions were based.

Bruskas (2013).	US	Cross-sectional	Measured 'before' or 'while in' care	Adverse Childhood Experiences (ACEs) Questionnaire with the addition of question 'before' or 'while in care' *note not all items on this scale refer to abuse.	The 13-item Sense of Coherence (SOC) and the 12-item General Health (GHQ) Questionnaires.	Correlation and regression analyses.
Bundy (2006).	Australia	Case study write up	State and church run orphanages	Based on feedback and discussion with participants.	Based on feedback and discussion with participants.	Based on feedback and discussion with participants.
Carlisle and Rofes (2007).	UK and US	Cross-sectional	Boarding school	A 12-item qualitative questionnaire. This included the nature of the bullying.	Other questions involved what the child was like before the bullying, and what effects this bullying had.	Survey responses were analysed using the guidelines of Glesne and Webb's (1993) suggestions for coding, to explore the themes.
Carr et al. (2010).	Ireland	Cross-sectional	Industrial schools and reformatories	The Childhood Trauma Questionnaire (Bernstein & Fink, 1998; Scher, Stein, Asmundson, McCreary, & Forde, 2001).	Modules from the Structured Clinical Interview for Axis I Disorders of DSM IV (SCID I, First et al., 1996; Zanarini et al., 2000) and the Structured Clinical Interview for DSM IV Personality Disorders (SCID II, First	Pearson product-moment correlations and t-test and chi squared analysis.

					et al., 1997; Zanarini et al., 2000), the Trauma Symptom Inventory (TSI, Briere, 1996), and the Experiences in Close Relationships Inventory (ECRI, Brennan, Clark, & Shaver, 1998).	
Carr et al. (2009).	Ireland and UK	Cross-sectional	Religiously affiliated residential reformatories and industrial schools	This was gathered as part of an interview	Experiences in Close Relationships scale (ECR), Structured Clinical Interview for Axis I Disorders of DSM IV (SCID I), Structured Clinical Interview for DSM IV Personality Disorders (SCID II), Trauma Symptom Inventory (TSI), World Health Organization Quality of Life Scale 100 UK (WHOQOL 100 UK), Global Assessment of Functioning Scale (GAF) and Kansas Marital and Parenting Satisfaction Scales (KMS).	Correlations, chi-squared tests and ANOVA. Where ANOVA was use Sceffes post-hocs were conducted where necessary.
Cook et al. (1993).	USA	Case Study	A residential school	Self-report of the individual and others who also reported similar abuse	Autism was diagnosed	No formal analysis of the relationship

Feely (2010).	Ireland	Ethnographic research	Industrial Schools	Semi-structured interview and follow-up focus groups. Information was triangulated with tutors, councillors, and legal representative who have worked with the individuals.	Semi-structured interview and follow-up focus groups.	Ethnographic research
Finlay (2010).	Canada	Cross-sectional	Secure setting	13 dichotomised questions measuring experience of violence. This included sexual harassment and assault.	Feeling of safety was explored using dichotomous responses. Interviews explored previous history with the criminal justice system, family structure, coping, and staff relationships.	Information coded from interview data using triangulation design and quantitative results generated by grouping variables to validate qualitative results.
Fitzpatrick et al. (2010).	Ireland and UK	Cross-sectional	Institutional setting (residential)	A structured interview which included Childhood Trauma Questionnaire (CTQ) (Bernstein and Fink, 1998; Scher et al., 2001). Cases were classified based on the abuse the individuals reported to be their worst.	Institutional Child Abuse Processes and Coping Inventory (Flanagan-Howard et al., 2009), TSI (Briere, 1996), Life Problem Checklist (LPC). ECRI (Brennan et al., 1998), Kansas Marital Satisfaction Scale (KMS) (Schumm et al., 1986), Structured	ANOVAs and Scheffes post-hoc tests (or Dunnett's test where the assumption of homogeneity was not met).

					Clinical Interview for Axis I Disorders of the Diagnostic and Statistical Manual of Mental Disorders IV (SCID I, DSM IV), Structured Clinical Interview for DSM IV Personality Disorders (SCID II) (First et al., 1997).	MANCOVAs were used for scales where no meaningful total score was available.
Flanagan-Howard et al. (2009).	Ireland and UK	Cross-sectional (tool validation study)	Institution (unspecified)	Institutional and family versions of the Childhood Trauma Questionnaire (CTQ, Bernstein & Fink, 1998) and descriptions of participants worst experience of abuse.	Institutional Child Abuse Processes and Coping Inventory, the anxiety, mood and substance use modules of the Structured Clinical Interview for Axis I Disorders of DSM IV (SCID I, First, Spitzer, Gibbon, & Williams, 1996); the antisocial, borderline, avoidant and dependent personality disorder modules of the Structured Clinical Interview for DSM IV Personality Disorders (SCID II, First, Spitzer, Gibbon, &Williams, 1997); the Trauma symptom Inventory (TSI, Briere, 1996); the Global	Principal component analysis and confirmatory factor analysis were used to explore the factor structure. Correlations were examined when testing discriminative validity. A series of ANOVAs were used to explore differences between

					Assessment of Functioning Scale (GAF, Luborsky, 1962); and the UK version of the 100 item World Health Organization Quality of Life Scale 100 (WHOQOL, Skevington, 2005) along with demographic information.	the types of abuse reported.
Goldman and Bode (2012).	Australia	Cross-sectional	Orphanage between 1940 and 1970	Child sexual abuse was defined as "any contact or non-contact sexual experience perpetrated on a child under the age of consent, which, in Australia is 16 years".	Information was gathered based on interview	One on one interviews, presented in condensed narratives on which conclusions were based.
Guy (2011).	US	Cross-sectional	Foster care system (some kinship)	Information was gathered during interview.	Information was gathered during interview including questions around resilience and attachment.	Thematic Analysis
Hermenau et al. (2014).	Tanzania	Case Control	Institutional care (orphanages)	The Maltreatment and Abuse Chronology Of Exposure-Paediatric Interview (pedMACE; Isele et al., 2013) Completed during structured interview.	Children's Depression Inventory, the Reactive-Proactive Questionnaire (RPQ; Raine et al., 2006) and the Strengths and Difficulties Questionnaire (SDQ; Goodman,	The analysis included exploration of correlation using Pearson's correlation,

					Meltzer, & Bailey, 1998) completed during structured interview.	MANOVA and ANOVA
Hermenau et al. (2011).	Germany (Researchers) Africa (Participants)	Longitudinal	Home, school and orphanages	Stressful and traumatic experiences (physical, psychological and sexual violence as well as neglect and witnessed violence) was measured using interview.	Information was gained via interview, this included sociodemographic data, physical health, mental health including the Strengths and Difficulties Questionnaire (SDQ) for internalising and externalising behaviour, The UCLA PTSD Index for Children DSM IV was used to screen for exposure to traumatic events and for symptoms of PTSD. Depression and suicidality were assessed with the Mini-International Neuropsychiatric Interview kid for children and adolescents (M.I.N.I.;Section A and C), Aggressive behaviour was assessed at t2 with the Reactive-Proactive Questionnaire.	T2 was six months after T1. In between this time all physical punishment was banned and KIDNET - Narrative Exposure Therapy for Children was delivered Correlation analysis was used.

Hermenau et al. (2015).	Tanzania	longitudinal study	Orphanage	Physical maltreatment was defined as being spanked or beaten and emotional maltreatment was defined as being yelled or screamed at. The Maltreatment and Abuse Chronology or Exposure - Paediatric interview (items relating to physical and emotional abuse from caregivers).	Interview at three time points (to explore mental health before and after training). All measures were translated into Swahili. Measures included The Children's Depression Inventory (CDI), The Strengths and Difficulties Questionnaire (SDQ; Goodman etal.,1998), and the Reactive Proactive Questionnaire (RPQ)(Raine et al., 2006) (adapted).	ANOVAs and t-test used as post-hoc. As abuse was dichotomous, Cochran's Q was used where there were three time points and McNermar for those with two time points and as post hocs. T0= 20 month before intervention, T1= 1-4weeks before intervention and T3= three months after the intervention.
Jackson (2013).	Australia	Case Study	A catholic run orphanage	A series of one-hour interviews over a two-year period	A series of one-hour interviews over a two-year period	Written in the form of a biography. Note this was created as a cinematic narrative

Knefel and Lueger-Schuster (2013).	Austria	Cross-sectional	Institutional abuse (foster care and Catholic church settings, it was not noted if these were residential)	Concerns regarding abuse were assessed by a clinical psychologist. The reports commission judged the reports credibility.	The criteria for PTSD and CPTSD taken from Posttraumatic Stress Disorder Checklist _ Civilian Version (PCL-C) and the Brief Symptom Inventory (BSI) scales was used.	This research explored the prevalence of conditions and then confirmatory factor analysis was conducted.
Lueger-Schuster, Kantor, and Weindl, et al. (2014).	Austria	Cross-sectional	81.7% perpetrated in residential settings, 14.4% occurred in other clerical	Information was gathered using reports, this explored violence that participants experienced, where this took place and how long for. Based on these reports the Austrian Victims' Protection commission decided who will receive help and treatment.	Information about pre-abuse living condition and psychological outcomes was also collected and included in 'clearing reports'. Active participants also filled in the Posttraumatic Stress Disorder Checklist (PCL-C) (Weathers, Litz, Herman, Huska, & Keane, 1993) and the Brief Symptom Inventory (BSI) (Derogatis &	Chi squared tests and t-tests or u-tests if data were continuous.

			settings. * This was grouped in the analysis.		Melisaratos, 1983; Franke & Derogatis, 2000).	
Lueger-Schuster, Weindl, and Kantor et al. (2014).	Austria	Cross-sectional	81.7% perpetrated in residential settings, 14.4% occurred in other clerical settings. * This was grouped in the analysis.	Information was gathered using reports, this explored violence that participants experienced, where this took place and how long for. Based on these reports the Austrian Victim's Protection commission decides who will receive help and treatment.	The PTSD Checklist-Civilian Version (PCL-C;Weathers, Litz, Herman, Huska, & Keane, 1991), The Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1990), The Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), The 10-item Connor Davidson Resilience Scale (CD-RISC; Campbell-Sills & Stein, 2007), The Life Orientation Test (LOT; Scheier&Carver, 1985), The Recalled Perceived Social Support Questionnaire (RPSSQ) developed by the research team to measure perceived social support after institutional abuse.	Participants were split into three groups based on the severity of their symptoms. ANOVAs were then used to explore group differences. Helmert contrasts were used for subgroup analysis.

Colton et al. (2002).	Wales	Cross-sectional	Residential homes	An interview including topics such as the disclosure of abuse.	An interview including topics such as the impact of participation in the investigation of this abuse.	Exploring interviews for themes.
Knefel et al. (2015).	Australia	Cross-sectional	Catholic Church (not explicitly residential) and a federal organization for foster children	It was noted that all participants had reported at least one form of institutional abuse (physical, sexual, and emotional).	Items from the PTSD Checklist Civilian Version (PCL-C;Weathers, Litz, Herman, Huska, & Keane, 1991) and the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) were used.	Latent profile analysis was used.
Meladze (1999).	Former Soviet Union	Case-Study	State-run foster homes	The individual's account which included reference to 'humiliating stripping and demoralisation'. This included being threatened with physical violence to induce fear and stress and these threats being carried out on occasion. This	The individuals account.	No formal analysis of the relationship.

				included physical and psychological violence in a number of institutions.		
Murphy (2009).	UK	Case-Study	Physical, sexual, and emotional abuse in care.	He reported physical, sexual, and emotional abuse, both in orphanages and schools he attended, by both staff and other pupils including a female member of the clergy.	His case history includes numerous removals and reuniting with siblings.	This study used phenomological inquiry on data taken from case notes from therapy.
Nagamitsu et al. (2011)	Japan	Case-Study	Residential care facility - abuse by a male peer	Based on a care-givers report.	Based on a care-givers report.	No formal analysis of the relationship.
Nixon et al. (2002).	Canada	Cross-sectional	Numerous places, including within the family or within foster care	Information was gathered through semi-structured interview. Notable questions about violence and abuse were not asked, but this information was given in response to the question “How did you become involved in prostitution?” and “What services and resources did you find helpful or not helpful?”	Semi-structured interviews included questions relating to how individuals became engaged in prostitution and impacts of involvement.	Qualitative analysis.

Rassenhofer et al. (2015).	Germany	Cross-sectional	15% boarding school 18.2% children's home 66.8% congressional settings * This was grouped in the analysis	Using letters emails and calls participants could provide any information they wanted to.	Using letters emails and calls participants could provide any information they wanted to.	Descriptive statistics were examined and Mann–Whitney U-Test were used to compare the two services.
Rusch et al. (1986).	USA	Cross-sectional study	A residential institution	Substantiated cases of abuse in the institution, written reports and documented findings of investigations were used to identify these individuals as being abuse on at least one occasion, where there were eyewitness accounts and corroborating evidence.	Based on medical and programme records of individuals e.g., self-injurious behaviour.	T-tests and ANOVA were used, followed by a discriminant analysis.

Saha et al. (2013).	India	Case-Study	Boarding school	Case-Study.	Case-Study.	Case description.
Salazar et al. (2011).	US	Secondary analysis of a longitudinal panel study	'Out-of-home care'	The Lifetime Experience Questionnaire (Rose, Abramson & Kaupie, 2000). Summary scores were calculated of the number of affirmative abuse cases before entering care and during care. Pre-care abuse data was collected at time 1 (except sexual abuse due to age restrictions so this was collected at time 2). During care abuse was collected at time 2.	Social support was measured using the Medical Outcome Study Social Support Survey (Sherbourne & Stewart, 1991). This was measured at time 2. Depressive symptomology was measured as a count of depressive symptoms participants reported in the past 12 months (as part of the Composite International Diagnostic Interview, Core Version 2.1, 21 Month Version (World Health Organisation, 1997), this was measured at time 3.	Negative binomial regression (as a result of skewed data).
Schaverien (2011).	UK	Case-Study	Boarding school	Case-Study.	Case-Study.	Case description.
Spröber et al. (2014).	Germany	Cross-sectional	265 abused in schools,	Abuse was recorded during the interaction; a template was used to record key detail where participants agreed. This	The template also included details on the prevalence and nature of current	Descriptive statistics and frequencies were examined. A series

			351 abused in residential care and 434 abused in unspecified institutions. * This grouped in the analysis.	included detail such as when the abuse had occurred, the frequency of abuse and whether it was still ongoing.	mental health disorders and issues with psychological functioning.	of non-parametric analysis were completed.
Sullivan et al. (1992).	USA	Cross-sectional study	Residential school	All children included provided evidence that they were sexually abused on more than one occasion by dormitory staff or older students.	The child behaviour checklist was used to measure children's behaviour. The psychotherapy was undertaken by three individuals with master's degrees in counselling, a clinical psychologist, and a supervising psychiatrist.	Boys and girl's data was analyses separately as the child behaviour checklist was normed separately for boys and girls. T-

						tests and ANOVAs were used.
Villegas and Pecora (2012).	US	Cross-sectional	In care	Researchers categorised data from the CNAS data.	Researchers categorised data from the CNAS data, outcome measures were: The Composite International Diagnostic Interview(CIDI) and the Mental Health Component Summary Scale score (SF-12MCS)	Variable were transformed into dichotomous or trichotomous formats for consistency. Logistic regression was used to explore the effect of variables on the outcome of mental health.
Wolfe et al. (2006).	Canada	Cross-sectional	Religiously affiliated residential institution	The assessment was conducted as part of a court settlement. Clinical notes and record were accessed.	Semi structured interviews were conducted assessing variables such as family and social relationships, criminal history and employment. The Trauma Symptom Inventory (TSI; Briere, 1996), The Personality Assessment Inventory (PAI; Morey, 1991), and The Structured Clinical	Descriptive statistics of means and standard deviations.

					Interview for DSM-IV, Clinician Version (SCID-CV;First, Spitzer, Gibbon, &Williams, 1996) were also used.	
Wolters (2008).	Ireland	Cross-sectional	Institution (unspecified)	No specific measure.	Experts were asked numerous questions during interview such as; "What is your experience/perception of counselling clients who have reported abuse in institutional settings?" And "Do you think that in your experience there is anything significantly similar in working with someone who was abused as a child in an institutional setting compared with clients who were abused in non-institutional settings?"	Qualitative methodology based on phenomological and person-centred principles. Specifically, the Duquesne phenomenological method (McLeod, 2001)
Wortham (2000).	US	Case Study	Boarding school	Analysis of autobiographical narrative.	Analysis of autobiographical narrative.	Analysis of autobiographical narrative.

*Some definitions and descriptions in this table are taken verbatim from the original paper.

Appendix 3: Table of findings of studies included in the systematic review

Table 10.3

Table of findings of studies included in the systematic review

Study	Participants	Key findings
Benedict et al. (1996).	78 children with substantiated maltreatment between 1984 and 1988 and 229 non-maltreated controls.	Children sexually abused in care were more likely to have mental health and developmental problems identified. Physical abuse and neglect were not related to child health and functioning. It was suggested that maltreatment in foster care was associated with probable exasperation of existing problems or creation of new problems, specifically for those who were sexually abused.
Benzola (1997).	An individual who spent the majority of his childhood in the foster care system.	The individual described the emotional abuse he experienced by his foster father and how this made him feel 'different' and he later experienced difficulties in education and relationships.
Bode and Goldman (2012).	10 male participants aged between 46 and 66 years old.	Nine out of the ten participants reported to feel that child sex abuse (experienced in residential care) had a negative impact on their educational development, opportunities, and achievements.
Bruskas (2013).	101 women who had been in foster care. Mean age 36.38 years (8-71).	ACE Total correlated negatively with SOC and positively with GHQ. ACEs before foster care were significantly associated with SOC and GHQ. When adding ACEs during foster care and number of placements into each model, only ACEs before care continued to be significantly associated with these variables.

Bundy (2006).	Participants who reported institutional abuse in Australia.	Participants completed meetings and workshops with counsellors and eight 3-hour drama workshops with former residence themselves. Taking part in a drama workshop exploring their experiences reportedly allowed them to act differently towards themselves and gain insight into their relationship with themselves and others.
Carlisle and Rofes (2007).	Six participants, bullied at boarding school (out of a non-probability sample of 15 men bullied at school, aged 27-57 years).	Each individual described being bullied as having a significant impact. Other results were not distinguished between boarding and non-boarding school bullying. Case examples of experiences of boarding school bullying were included. One reported enjoying company prior to the bullying, but after becoming introverted, reporting symptoms of obsessive-compulsive disorder, and bullying a defenceless boy. He is now married with one child and works as an acupuncturist. He reported high levels of anxiety and nightmares about being back in boarding school. Another reported telling his parents and a teacher. He reportedly took to bullying his brother and another pupil but reported this was not much as he knew how it felt. He reported being scared, isolated, depressed and very quiet.
Carr et al. (2010).	247 adult survivors of institutional abuse. Mean age = 60, 54.7% were male.	The rate of psychological disorders was over 80%. This was noted to be higher than in the general population. Anxiety, mood, and substance use disorders were most common. These individuals also experienced elevated rates of trauma symptoms and insecure adult attachment style, and these were worse for those who experience both institutional and intra-family abuse
Carr et al. (2009).	247 adult survivors of institutional abuse. 54.7% male. The mean age was 60 years old (40-83), (Also	Results revealed that the most positive profile in relation to the outcomes measured was found in those with a secure attachment style, with the dismissive group having a similar profile. The most negative profile was found in those with a fearful attachment, with those having a pre-occupied attachment having a similar profile.

	used by Fizpatrick *et al*, 2010).	
Cook et al. (1993).	An individual with Autism who experienced physical abuse in a residential school	The individual initially resisted returning to the school after family visits and lost a large amount of weight before disclosing that a teacher had hit, slapped, and punched him. This resulted in changes in behaviour such as increased anger and experiencing symptoms of trauma.
Feely (2010).	28 survivors aged between 45 and 60.	15 individuals left school with their literacy needs met or partially met. 13 left with little or no literacy. It was suggested that a caring relationship played a pivotal role in the development of literacy skills.
Finlay (2010).	93 male and female youths sentenced to custody between the ages of 16 and 17.	Coping strategies used to deal with peer aggression were aligned with adaptive responses of individuals who have experienced child maltreatment or exposure to domestic violence. Protective features of the institutional environment and the role of staff mediated the impact of peer aggression.
Fitzpatrick et al. (2010).	247 adult survivors of institutional abuse. 54.7% male. The mean age was 60 years old (40-83).	Those who had experienced sexual abuse had experienced the most forms of abuse and had the highest PTSD scores along with alcohol, substance use and antisocial personality disorder and life problems. Following this individual who suffered physical abuse were the group with the second highest level of difficulties and emotional abused individuals were the best adjusted.
Flanagan-Howard et al. (2009).	247 assault survivors of institutional abuse recruited through CICA. 54.7% were male. The samples mean age was 60 years old.	Factors of the Institutional Child Abuse Processes and Coping Inventory were; Traumatisation, Re-enactment, Spiritual disengagement, Positive Coping and Avoidant coping. The total abuse score of the institutional version of the CQT had significant correlations with traumatisation and re-enactment scales of the past version of the Institutional Child Abuse Processes and Coping Inventory and with the traumatisation scale of the present version. Individuals who reported sexual abuse as their worst form of abuse reported higher levels of re-enactment in childhood compared to those reporting physical or

		emotional abuse. Individuals who reported physical abuse as their worst experiences reported higher levels of coping by complying in adulthood when compared to other forms of abuse. Traumatisation, re-enactment, coping by complying and avoidant coping decreased from past to present. Spiritual disengagement and positive coping increased.
Goldman and Bode (2012).	10 female volunteers aged between 44 and 72 years, found using purposive sampling.	These individuals perceived the abuse, specifically sexual abuse, to have had negative impacts on their educational achievement, development, and opportunity. They also reported that this had an impact on their own children. They also felt that this had consequential impacts on their self-esteem, wellbeing, and success.
Guy (2011).	8 former foster youths 20-24 years old at the time of interview.	All 8 participants were abused whilst they were in the care system. They talked in detail in relation to other aspects of the interview. However, responses were 'succinct' and 'without reflection' when discussing their abuse. Relationships were important strength factors, though not necessarily with adults, but with peers and siblings for example. It was also found that resiliency was helped by their ability to reflect on painful experiences.
Hermena u et al. (2014).	35 children placed in institutional care in their first 4 years of life and 35 place in institutional care after the age of four matched on age and sex. Mean age was 10.53 years (8-15). Each group	Results suggested that individuals who were institutionalised earlier in life experienced greater adverse experiences whilst in institutional settings and had a greater variety of mental health issues when compared to those institutionalised later in life.

	consisted of 19 males and 16 females.	
Hermena u et al. (2011).	38 (with a mean age of 8.64) children living in orphanages in Tanzania who were either orphaned or reported abuse or neglect at home.	Study 1: At time one, violence in the orphanage was a stronger correlate of ill-mental health when compared to violence experienced in a former home school or neighbourhood. This form of violence also was positively related to aggression at time 2. Study 2: Following psychotherapeutic treatment of PTSD and intervention to reduce violence in the home a reduction in experiences of violence and PTSD was found. Little effect was found on depressive symptoms and internalizing and externalizing problems.
Hermena u et al. (2015).	28 Children from institutions whose carers participated in a training workshop aimed at improving care quality and reducing maltreatment. Average age at interview was 9.76 years. Fifty percent were female.	In relation to physical maltreatment, this reduced from 50% (t1) to 18% (t3), there was significantly less physical maltreatment at point t3 when compared to and t1. They were also lower at t1 compared to t0. No significant difference was found in relation to emotional abuse at time points (61% at t0, 32% at t1 and 79% and t3). In relation to depression, this changed significantly over time, with a significant decrease between t3 and t1 and t3 and t0. No difference was found between t0 and t1. In addition, lower internalising and externalising scored (measured with the SDQ) were found at t3 compared to t1 and t0. They were also lower at t1 than t0. The same pattern was found for aggressive behaviour (measured by RPQ).
Jackson (2013).	Male survivor of institutional abuse.	The story of a man who left school illiterate, but later became an expert rugby player and was reunited with his mother. He went on to fight for the rights of children.
Knefel and	229 individuals who had appealed to the commission	Overall, 52.8% participants met the criteria for PTSD according to ICD-10 when compared to the ICD-11 proposal (17% for PTSD only; 38.4% for PTSD and complex PTSD). In the updated version of PTSD,

Lueger-Schuster (2013).	of the Catholic Church or the commission of the federal organization for foster children following abuse. The average age was 55.8 years, 177 men (77.3%) and 52 women (22.7%).	gender effects were neutralised. Rates of CPTSD were 21.4% (women 40.4% and men 15.8%). Those survivors who were diagnosed with CPTSD reported institutional abuse for a longer time.
Lueger-Schuster, Kantor, and Weindl, et al. (2014).	448 survivors. 75.7% were male. Mean age of 55 years old (25-80). 185 participants completed additional questionnaires.	The prevalence of PTSD was 48.6%. Overall, 84.9% of participants experienced clinically relevant symptoms in at least one domain. No specific factor pre-institutional abuse was found to affect the development of PTSD in later life (e.g., poverty, domestic violence). However, those with PTSD did report more family related risk factors.
Lueger-Schuster, Weindl, and Kantor et	448 survivors. 75.7% were male. Mean age of 55 years old (25-80). 185 participants completed additional questionnaires.	Previously known strength factors (education, social support, age) were not associated with mental health in this sample. The majority of the sample had mental health related issues. Fewer emotional reactions during disclosure, task-oriented coping, and optimism were related to better mental health.

al. (2014).		
Colton et al. (2002).	24 self-selecting survivors of abuse (two of these individuals were female)	Themes included the factors: motivation for disclosure, the effectiveness of help, and support and issues of power and gender. In relation to disclosure, it was suggested that financial compensation was not the primary motivation, and victims had a strong desire to see the perpetrators held accountable not just for themselves but for future potential victims. Some individuals did not disclose and had led a reasonable life and did not wish to revisit this abuse, others thought about their abuse constantly. Participants frequently reported that they did not wish to be known as victims due to fear of responses for family and friends and due to concerns around the perceived victim/perpetrator cycle.
Knefel et al. (2015).	Participants were those used by Knefel and Lueger-Schuster (2013). 229 adult survivors of childhood institutional abuse. Mean age 55.8 years (24-80 years). 77.3% were male.	Four distinct groups were revealed; those with elevated symptoms of PTSD and disturbances in self-organisation (labelled as complex PTSD), elevated PTSD symptoms and low disturbances in self-organisation. Elevated disturbances in self-organisation and some elevated symptoms of PTSD and those with low symptoms.
Meladze (1999).	An individual who grew up in the former soviet union	The individual reports sexual confusion, anger, anxiety, and effects on self-esteem.
Murphy (2009).	A “middle aged” white male.	It is reported that the individual experienced fear, anger, and constant threat as a result of the constant abuse. He expressed difficulty knowing who he was and found it difficult to establish interpersonal relationships. He had a large family but had no contact with them. He drank regularly and smoked

		cannabis to manage physical and psychological pain. He also expressed fear of going to the GP and feared the institutional structure of statutory institutions. He attended therapy in order to be free for this fear. It is reported that this client-centred therapy was related to a reduction in post-traumatic distress and the client began to develop a small number of non-abusive relationships improving the quality of life.
Nagamitsu et al. (2011).	A six-year-old girl living in residential care as a result of sexual abuse at home.	The individual experienced seizures. These seizures continued for 2 years and reportedly stopped following the disclose of sexual abuse perpetrated by a boy at the residential home.
Nixon et al. (2002).	47 females aged 18-36 years old.	These women reported 'considerable' childhood sexual abuse by family members or cares whilst they were in foster care. They were also victimised by others such as "pimps, other prostitutes and intimate-partners".
Rassenhofer et al. (2015).	927 victims of church related abuse. 571 individuals recruited through church related services and 356 through government related services. The mean age was 53.5 years old. 65% were males.	Greater levels of abuse were reported in the church data set when compared to children's homes or schools. 45% of individuals reported some form of psycho-social problems resulting from their abuse. Only 22% raised the issue of compensation. Level of abuse reported differed between reports to the two services.
Rusch et al. (1986).	160 residents of the Murdoch centre. 80 of whom had experienced	Those who were abused demonstrated higher levels of self-injurious behaviour and non-verbal behaviour compared to the non-abused group. In a discriminant analysis aggression was a strong differentiating factor between the groups.

	physical abuse in this setting. 80 were not abused here and were used as a comparison group.	
Saha et al. (2013).	A 15-year-old boy.	This individual was abused both at home and at boarding school. The incident at boarding school consisted of an attempted strangulation by an older pupil after the individual had reported the older student for smoking. Following this the individual was reportedly traumatised and refused to stay in the boarding school. He has since received counselling and is now dividing time between work, studies, and playing with friends.
Salazar et al. (2011).	513 participants aged 17 and above who had been in out-of-home care recruited using a systematic sampling procedure (281 females, 232 male).	Pre and during care maltreatment were predictive of depressive symptoms. Maltreatment was associated with lower levels of social support. A significant partial mediating effect was found on the effects of pre and during care maltreatment on depressive symptoms. It was also found to be a moderator and with significant social support x maltreatment interactions. Social support had a protective relationship with depressive symptoms for those who had few pre-maltreatment experiences. For during care maltreatment depressive symptoms were lower at higher levels of maltreatment for those with low versus moderate to high social support.
Schaveri en (2011).	One male individual and one female.	The female individual reported a negative experience referred to as an ‘initiation’. She reportedly mentioned this with no emotion and would not have expanded on the detail if she were not asked more about it. It is reported that she had not considered sending her own children to boarding school and after talking about her experiences began to understand why. She maintained a positive attitude to life and was successful. The male individual was reported to be clinically depressed, but not wanting medication. His

		wife had identified his emotional isolation. He too had experienced negative incidents at boarding school. He had not reported this to anyone before he was middle aged.
Spröber et al. (2014).	Analysis was based on information gathered from phone calls, letters and emails to a support line staffed by therapists and councillors. 1050 callers were victims of institutional abuse. Average age at time of contact was 52 years old (12-89 years). 614 respondents were males, 412 females.	This study explored the differences between institutional abuse in roman catholic, protestant and non-religiously affiliated institutions. It was found that the level of psychiatric diagnosis was similar between groups. However, more psychological problems were found in those abused in a protestant institution.
Sullivan et al. (1992).	72 hearing impaired individuals between the age of 12 and 16 who attended a residential school for the deaf (51 boys and 21 girls) who then received psychotherapy. A control	Those who received therapy demonstrated fewer behavioural problems than those who did not. For boys there was a reduction in: Total, Internal, External, Somatic, Uncommunicative, Immature, Hostile, Delinquent, Aggressive, and Hyperactive. There were no differences on the Schizoid and Obsessive scales (CBC scales) when compared to non-treatment group. For girls who received treatment there were lower scores on: Total, External, Depressed, Aggressive, and Cruel when compared to no treatment group. No differences were found on the Internal, Anxious, Schizoid, Immature, Somatic, and Delinquent scales

	group was also included (30 boys and 7 girls) who did not receive therapy.	
Villegas and Pecora (2012).	This study used the Casey National Alumni Study (CNAS) data set (Pecora *et al*., 2003). 1068 participants were included age raged from age 20 to 49 at the date of interview who have previously been in foster care.	It was found that ethnicity did not predict adult mental health whereas gender, mothers mental health, age of entrance into child welfare, number of placements, maltreatment whilst in car, and preparedness for leaving care were predictive of adult mental health
Wolfe et al. (2006).	76 men (aged 23-54, M=39.17) who had been placed in care due to their parent's inability to care for them with substantiated claims of multiple and sever sexual, physical and/or emotional child abuse.	Overall, 59.2% of participants presented with a current Axis 1 disorder and 88.2% have had an Axis 1 disorder at some point. PTSD, Alcohol Disorder and Major Depressive Disorder were most frequent. 31.6% of men were removed from the PAI analysis for significant elevation in the Negative Impression or Inconsistencies scales. This resulted in fewer PAI scales scores. Anxiety related disorders and borderline remained significantly elevated. 84% of the TSI profiles were valid. Significant elevations on the Depression, Intrusive Experiences, Defensive Avoidance, and Dissociation scales, and the Trauma and Dysphoria factor scales were noted. 27.5% of these men had experienced confusion about their sexual orientation in late teens and early 20s and 21.7% were currently experiences this. 4.1% met the criteria for homosexual paedophilia. 66.2% reported a history of sexual problems in their personal relationships.

		Many reported a history of criminal involvement. In addition, almost all individuals expressed a sense of betrayal and loss of trust extending beyond the inter-personal into loss of faith and devaluation of the church.
Wolters (2008).	10 qualified and practising therapists with three to five years working with individuals who have suffered institutional abuse and those who have suffered non-institutional abuse. Six were female and four were male. Participants were aged between 26 and 54 years old.	Both similarities and differences were found in these two groups. It was reported that individuals who had reported institutional abuse were harder to work with, more ‘damaged’, were less trusting, and had higher shame.
Wortham (2000).	Analyses the autobiographical narrative of a woman in her 50s who was interviewed in 1992.	This article reflected on the interactional positioning accomplished when telling an auto biographical narrative. It is observed, for example, that when discussing abuse in boarding school, the participant is said to 'position' themselves as vulnerable and in need of support in this case.

*Some definitions and descriptions in this table are taken verbatim from the original paper.

Appendix 4: Quality assessment of studies included in the systematic review

- Was experiencing abuse in care part of the recruitment criteria? This was the case for 21 studies but not for 8 of them.
- Representativeness of the sample (children abused in a residential institution): One study included a systematic sampling procedure, one was somewhat representative of the average in the target population, this included random sampling but from a select population. A select population was included in 27 studies.
- Sample Size: The sample size was justified, but not statistically in 10 studies. No justification was given in 19 studies.
- Non-respondents: Six studies justified non-respondents but did not conduct any statistical analysis to explore differences. In 23 studies no description was given, this is usually where samples were volunteer.
- Ascertainment of the exposure (to the risk factor institutional abuse): In 11 studies cases were substantiated using validated measures or investigative reports. In five studies the tools were not validated but were described or available in the paper. In 13 studies the description of the measure of institutional abuse was not made clear.
- Confounding factors are controlled (e.g., age, gender, type of abuse): Thirteen studies controlled for at least one relevant variable. Nine included no control variables, and seven were qualitative studies.
- Assessment of the outcome (e.g., the impacts of the abuse): This was based on self-report via validated measure or psychological report in 20 studies. Nine were self-report measures that were not validated.

- Analysis appropriate and described: this was the case in 25 studies, in four studies the analysis was not clearly described or not systematic.
- Ten included studies were case studies so were not included in quality assessment. Due to a small body of research, they were still included in the final review.

For case-control studies only (3 studies)

- Selection of controls: all three studies used institutional based controls.
- Definition of controls: all three studies used controls with no history of abuse.
- Comparability of cases: In all three studies the control group randomly selected from the same population.
- Same method of ascertainment for controls? This was the case in all three studies.

For Longitudinal studies (3 only):

- Was the number of participants at each stage/wave specified? This was done in two studies but not in one.
- Reasons for loss to follow-up at each stage: the description of this was limited in all three studies.

Appendix 5: Delphi round 1 survey lay out (Study 1a)

Aims of the research: Thank you for taking the time to read the participant information relating to my study. I am Rebecca Ozanne, a PhD student from the University of Central Lancashire and Forensic Psychologist in Training. My aim is to explore factors promoting negative symptoms and strength factors following institutional/ in care abuse. Ethics for the study have been granted by the University of Central Lancashire.

Institutional/In Care Abuse will be discussed in this study as sexual, physical or emotional abuse that occurred to children under the age of 18. This can refer to abuse by adults or peers for the purpose of this study. The abuse will have occurred in a setting where the child is under the care of the institution or a single authority and the institution serves the children in the community. This can include residential care, secure care and schools (e.g. boarding schools/ industrial schools).

What you will be asked to do: Participants in this study will be asked to complete multiple rounds of a Delphi study, it is expected that three rounds will be required. This will include responding to three separate emails, containing a link to a survey. The first will ask for a response to a broad open ended question regarding factors seen to be important following institutional/ in care abuse. The second and third emails will be used to consolidate the factors returned in the first round, with the aim of reaching 80% consensus rate on the factors involved. The time taken to complete the first round will depend on the level of depth given. The second and third round will take approximately 5 to 10 minutes to complete but may vary depending on the number of factors retuned from the first round.

Consent to participate will be indicated following the selection of the appropriate box on the second page of the study link. You must be over 18 years old to take part in this study.

The Study Criteria:

• Being a qualified Therapist (BPS/BABCP/EMDR), Social Worker and Personal Injury lawyer or Psychologist and be a member of a professional body in your area.

• Having worked clinically with an individual and/or managed cases involving experienced institutional/ in care abuse and feel confident in your professional opinion that they can discuss the effects of this abuse.

The right to withdraw: Participation is voluntary and you are free to discontinue at any time simply by not following the link presented in the email. Once responses have been sent they can no longer be withdrawn as they will have been mixed with other responses and used to inform further rounds and analysis.

What will happen to the responses (privacy notice): While group data is the primary focus of this study individual's data may be used in the context of quotations to evidence a point made during the write up. Please do not refer to information that could be used to identify an individual in your responses (other than your name in the designated box). Data will be downloaded for the survey cite and saved (password protected) on the university network. Names will be used by the researcher to keep track of which individual to involve in future rounds; they will not be accessible to other participants. The responses (including individual names) will only be stored on the university network, and will also be accessible on the survey creating database. In addition, emails will be stored on my email account, which are password protected but my not be considered as secure). The data is being collected as part of a PhD

project carried out at the University of Central Lancashire. Data will be reported in the final PhD thesis and may also be used in peer reviewed journals, conference presentations, written feedback to research participants, or presentations.

Thank you for your time.

Please contact either myself or my director of studies if you have any further questions regarding the study:

Rebecca Ozanne: rlozanne@uclan.ac.uk

Director of Studies: Professor Jane Ireland jlireland1@uclan.ac.uk

2nd Supervisor Dr Abigail Thornton athornton4@uclan.ac.uk

2nd Supervisor Dr Carol Ireland caireland@uclan.ac.uk

If you wish to contact someone independent of the research regarding this study, please contact the University Officer for Ethics:

OfficerForEthics@uclan.ac.uk

If you still wish to participate and are happy to consent to the study please select the box below and then select next *

Yes/ No

Name:

Email address:

Profession:

Speciality:

Age:

Sex:

Years of practise:

How many cases relating to institutional/in care abuse have you worked with?

How many cases, approximately, of this nature do you work with in an average year?

Are you currently working with a case of this nature?

If not, when was the last case of this nature you worked with?

Guidance: For the purpose of this study, Institutional/In Care Abuse will be defined as sexual, physical or emotional abuse that occurred to children under the age of 18. This can refer to abuse by adults or peers for the purpose of this study. The abuse will have occurred in a setting where the child is under the care of the institution or a single authority and the institution serves the children in the community. This can include residential care, secure care and schools (e.g. boarding schools/ industrial schools).

Please answer the following questions:

1. **What types of negative effects of institutional/in care abuse do you see in those who have experienced this form of abuse?**
2. **Does the type of abuse (e.g. sexual, physical, emotional) impact the type of negative effects and if so, how?**
3. **What pre-existing vulnerabilities, if any, do you feel influence the effects of institutional/ in care abuse?**
4. **Does the type of abuse (e.g. sexual, physical, emotional) impact the pre-existing vulnerabilities that influence the effects of institutional/in case abuse and if so, how?**
5. **What can promote recovery and resilience following institutional/In care abuse?**
6. **Does the type of abuse (e.g. sexual, physical, emotional) impact the factors that promote resilience following institutional/ in care abuse, and if so, how?**

7. **What role, if any, does disclosure play in the effects of institutional/in care abuse?**
8. **Does the type of abuse impact the role of disclosure following institutional/ in care abuse (e.g. sexual, physical, emotional) and if so, how?**

Thank you for taking time to complete round one of this Delphi study, following the analysis of result for the second round you will be

sent an email asking if you wish to be included in the second round.

If you are happy with this please select Yes, if you select no, you will not be contacted for the second round, but may still request a results summary *

Yes/No/ No but I would like a summary of the result

Thank you for taking part in this research. If you feel you would like additional support or information following the completion of this research please feel free to contact me (Rebecca Ozanne - rlozanne@uclan.ac.uk).

Rebecca Ozanne: rlozanne@uclan.ac.uk

Director of Studies: Professor Jane Ireland jlireland1@uclan.ac.uk

2nd Supervisor Dr Abigail Thornton athornton4@uclan.ac.uk

2nd Supervisor Dr Carol Ireland caireland@uclan.ac.uk'

Appendix 6: Items generated in the Delphi study with the panel of experts

Item	Percentage agreement		
	Round 2 [47]	Round 3	Round 4
Impacts of institutional abuse			
Increased anger	100%	93%	
Increased aggression	88%	93%	
Increased violence	83%	80%	
Increased use of violence to settle arguments	83%	80%	
Increased likelihood of criminality	92%	67%	88%
Increased delinquent behaviour	96%	87%	
Increased risk-taking behaviour	100%	93%	
Increased isolation	92%	93%	
Negative impacts on cognitive development	100%	93%	
Difficulty maintaining future life chances	92%	80%	
Not fulfilling full potential	96%	87%	
Low achievement	83%	85%	
A sense of mistrust	100%	100%	
Difficulty establishing relationships	92%	100%	

[47] This table commences at round 2, as round 1 was a qualitive round as outlined in the previous section.

Difficulty maintaining relationships	88%	100%
Fear of not being listened to	92%	100%
Lack of understanding of inter-personal relationships	92%	100%
Lack of closeness in relationships	96%	100%
Seeing closeness even in those who may pose risk	88%	86%
Parenting difficulties	96%	87%
Difficulties with boundaries	88%	93%
Anti-authoritarian attitudes	92%	80%
Lack of trust in authority	100%	100%
Insecure attachment styles	100%	100%
Impacts to feeling of safety	96%	93%
Difficulties with impulse control	88%	93%
Emotional regulation difficulties	96%	100%
Depression	92%	93%
Anxiety	92%	100%
Low self-esteem	96%	100%
Self harm	92%	87%
Maladaptive coping	96%	93%
Shame	96%	93%
Embarrassment	96%	100%
Alcohol addiction	92%	80%

Drug addiction	88%	73%	84%
Development of personality disorders	92%	86%	
Self blame	87%	100%	
Guilt	87%	100%	
Dissociation	96%	93%	
Flashbacks	96%	87%	
Post-traumatic stress disorder	100%	80%	
Rumination of past abuse	96%	87%	
Repeat victimisation	96%	93%	
There is cumulative impact of multiple negative experiences	100%	100%	
Vulnerability to grooming	88%	93%	
Negative impacts on sleep	88%	93%	
Sexual abuse cannot be isolated from the many other problems that these victims suffer	Added at round 2	93%	
It is hard to generalise, an individual approach should be used	Added at round 2	100%	
Mistrust of other people	Added at round 2	100%	
Poor problem-solving skills	78%	81%*	
Increased likelihood of later imprisonment	79%	63%*	81%
Sexualising relationships	83%	64%	75%
Paranoia	87%	79%	69%
Increased likelihood of becoming a perpetrator themselves	64%	63%*	75%
Increased obsessive behaviour	70%	60%*	50%

Physical complaints (e.g., auto immune issues such as Chronic Fatigue, Fibromyalgia, IBS, Skin complaints, alopecia, or Functional Neurological Disorder non- epileptic seizures)	Added at round 2	69%	56%
Most of them become opportunists	Added at round 2	21%	19%
Inability to work with others	70%	60%*	56%
Indiscriminate sexual behaviour	74%	56%*	50%
Overprotective attitudes of children	65%	38%*	44%
Staff splitting	48%	27%*	38%
Suicide ideation	78%	75%*	69%
Suicide	74%	64%*	50%
Sex addiction	46%	20%*	
Fear of becoming an abuser	67%	75%*	63%
Dependency on instructional lifestyle	57%	47%*	69%
Weak immune system	57%	40%*	25%
Lack of desire to self-care	79%	73%*	50%

Whether the form of abuse effected the impacts

The form of abuse experienced (e.g., sexual/physical/emotional) impacts the negative effects of institutional abuse	Yes 87% agreement, No 36%	87%
Sexual and physical abuse include a significant degree of emotional abuse	100%	100%

The more serious the emotional impact of any of these forms of abuse, the more negative the outcome	88%	100%	
The victim's beliefs around the abuse are more important than the type of abuse	83%	100%	
It is hard to generalise, an individual approach should be used	Added at round 2	100%	
Sexual abuse may link more closely to effects of sexual nature (e.g., increased masturbation)	76%	67%*	94%
The response to the abuse is more important than the type of abuse	71%	67%*	88%
Afterwards abused children start abuse other children who are new to the institution	Added at round 2	15%	44%
During the reunification they hate their biological parents	Added at round 2	27%	38%
Physical abuse may contribute more to anger, aggression, and offending compared to other forms of abuse	60%	60%*	63%
Sexual abuse causes greater adverse effects	60%	56%*	63%
Sexual abuse always has severe impacts	76%	63%*	63%
The impacts of physical and emotional abuse are more dependent on the setting	36%	33%*	31%
Emotional abuse may contribute more to low self esteem	60%	27%*	69%
The severity and duration are more important than the form of abuse	28%	53%*	50%
The importance of pre-existing factors			
Being in the care system	96%	100%	
Lack of compassionate parenting	92%	93%	
Lack of affection as a child	92%	93%	

Lack of support	96%	100%	
Isolation from the outside world	92%	100%	
Previous trauma	92%	100%	
Previous abuse	100%	100%	
Poor attachments	96%	100%	
Child self-esteem (low self-esteem)	92%	100%	
Childs (poor) coping	91%	92%	
The importance of a cumulative effect	96%	93%	
It is hard to generalise, an individual approach should be used	Added at round 2	100%	
Pre-disposition to mental illness	79%	87%*	88%
Early marriage	Added at round 2	23%	25%
Lack of parental skills	Added at round 2	62%	69%
Previous failed education	71%	50%*	50%
Younger age	61%	47%*	63%
Childhood poverty	60%	75%*	69%
Disability	64%	75%*	56%

Does the form of abuse impact which pre-existing factors are relevant?

The impact may be worse if the form of institutional abuse is the same as previous abuse in the home setting	88%	92%	
Lack of previous affection may lead to vulnerability to being groomed	92%	100%	

If a child has previously experienced extreme violence, they may not appreciate that the level of violence used in the institution is wrong.	100%	93%	
If a child has previously experienced sexual abuse, they may not appreciate that sexually inappropriate behaviour toward them in the institution is wrong.	96%	100%	
It is hard to generalise, an individual approach should be used	Added at round 2	93%	
Blaming themselves for being placed in care	Added at round 2	100%	
The form of abuse experienced (e.g., sexual/physical/emotional) impacts which of these pre-existing factors has the most effect	Yes 73% agreement, No 73%	54%	50%
Strength factors			
Access to specialist intervention	96%	100%	
Psychotherapy	100%	85%	
Cognitive affective processing	100%	92%	
Addressing attachment issues	96%	93%	
Work to increase self esteem	96%	100%	
Work to increase self efficacy	96%	100%	
Working with staff who are knowledgeable of abuse	100%	100%	
Continuity of main carer	91%	100%	
A key attachment figure	87%	100%	
Consistent boundaries	96%	100%	
Consistent routines	92%	100%	

Increasing safety	96%	100%
Building on the child's strengths so they feel good about themselves	100%	100%
A sense of connectedness in the world	100%	100%
Peer support	96%	100%
Work or education outside of the institution	96%	100%
Being believed	100%	100%
An understanding it was not their fault	100%	100%
Empathetic responses to disclosure	100%	100%
Feeling understood by others	96%	100%
Being informed about outcomes of court procedures against abusers and institutions	96%	100%
Successful conviction of the perpetrator	96%	93%
An individual assessment/formulation	Added at round 2	100%
It is hard to generalise, an individual approach should be used	Added at round 2	93%
Safety	Added at round 2	100%
Care	Added at round 2	100%
Justice	Added at round 2	100%
Acceptance and Commitment Therapy (and the adolescent variation that incorporates developmental information)	Added at round 2	92%
Create Code of Conduct for the institution all co-workers including the directors	Added at round 2	100%
Provide child protection training sessions	Added at round 2	100%
Provide training session on child rights for staff members and children also	Added at round 2	100%

Access to a helpline	Added at round 2	93%	
Being employed	Added at round 2	93%	
Acceptance from the perpetrator that the abuse was wrong	80%	79%	69%
Open ended therapy	68%	56%*	50%
Resilience is not a useful term in this context	55%	38%*	38%
Does the form of abuse experienced impact which of these strength factors is most important to the survivor?			
It is hard to generalise, an individual approach should be used	Added at round 2	93%	
Any form of abuse can be detrimental	Added at round 2	100%	
Physical and emotional abuse is easier to help with when compared to sexual abuse	17%	44%*	19%
The form of abuse experienced (e.g., sexual/physical/emotional) impacts which of these strength factors is most important to the survivor	Yes 47% agreement, No 68%	50%	25%
What role, if any, does disclosure play in the effects of institutional/in care abuse?			
Action following disclosure may be impacted by the relationship between the alleged abuser and the individual who it is disclosed to	88%	93%	
Lack of criminal conviction can result in despondency (e.g., low spirits)	92%	93%	
It will be harmful if they are not believed.	100%	100%	
Lack of action can result in lack of faith in adults to keep them safe	100%	100%	
It will be harmful if they are told they are not a reliable witness	100%	100%	

When there are aggressive defence proceedings in court	100%	93%	
It is critical in building self esteem	83%	93%	
It may be empowering	100%	100%	
It can make a child feel heard	100%	100%	
Reinforce that it is not acceptable to be abused	96%	100%	
It can be positive for them to believe they are helping others	96%	100%	
Important that the child is offered support	100%	100%	
The impact of disclosure may be dependent on the response	100%	100%	
It is hard to generalise, an individual approach should be used	Added at round 2	93%	
During the child abuse cases, response of adults is very important	Added at round 2	100%	
An investigation should be undertaken when a child reports abuse to a manager	Added at round 2	100%	
The impact of disclosure will be dependent on the client's psychopathology	75%	63%*	81%
It can cause psychological harm	71%	87%*	
If this disclosure is passed on to others it may break the child's trust	68%	69%*	63%
It is critical in building resilience	79%	56%*	56%
Disclosure may be less likely if the child thinks staff are inexperienced	56%	50%*	44%
Generally, it may be helpful, but for a small number it may be better to never disclose	35%	31%*	38%

Does the form of abuse experienced impact the effects of disclosure?

It is difficult to generalise	Added at round 2	93%

Staff or responsible people should notice or take into account all abuse forms and respond	Added at round 2	100%	
Set rules should be set for abusers	Added at round 2	86%	
It may be more likely that information about physical abuse is passed on	73%	75%*	81%
The form of abuse experienced (e.g., sexual/physical/emotional) impacts the effects of disclosure	Yes, 76% agreement, No 56%	64%	38%

Appendix 7: Qualitative victim survey (study 1b)

1. How old are you (in years)?
2. What sex are you?
3. Tick for where you live currently: England/ Northern Ireland/ Scotland/ Wales/ Other (please specify)
4. Are you: Unemployed/ Retired/ Working in a manual job/ Working in a professional job/ Other (please specify)
5. Are you: Single/ Married/ Cohabiting/ Divorced/ Widowed
6. How old were you when you were placed into care?
7. What type of care were you in? Borstal/ Prison/Youth Offenders Institute/ Boarding School/ Residential Care/ Industrial School/ Other Secure Care (please specify)
8. How has being placed in this institution/in care affected you?
9. Are there any negative experiences you feel have impacted on your life prior to being placed in an institution/ in care?
10. Are there any positive experiences you feel have impacted on your life prior to being placed in an institution/ in care?
11. Which form of abuse did you experience whilst in these locations? (Please tick as appropriate)
12. Which of these abuses had the most impact on you? Please rank them by placing a number next to each (e.g. 1 most impact, you can give them all a 1 if you wish).

If you experienced sexual abuse in any of the locations noted earlier please answer the following questions or tick 'not-applicable'

13. Approximately how old were you when the abuse started?
14. Approximately how long did this abuse last for? (Days/Months/Years)

15. Was the individual(s) who abused you an adult or a child?
16. Please specify the relationship of the abuser(s) to you (e.g. carer, teacher, someone in care with you).
17. Was the abuser(s) Male, Female?
18. What impacts do you feel this abuse had on you?
19. What impacts do you feel this abuse has had on your life?
20. What factors, if any, were present before the abuse that you suffered that may have made the effects worse for you to cope with?
21. What factors, if any, helped you manage the effects of the abuse in the short term?
22. What factors, if any, helped you manage the effects of the abuse in the long term?
23. Have you disclosed this abuse?
24. Who did you disclose the abuse to (e.g. friend, partner etc.)?
25. When did you disclose?
26. Why did you disclose?
27. How did you feel after this disclosure?

Questions 13-27 repeated for physical abuse and emotional abuse.

Final questions

1. What do you think is the best way to refer to those who have experienced abuse? Survivor/ Victim/ Other word you prefer? Please specify……
2. Some academics have used the term 'post traumatic growth' to describe how abuse can have some positive impacts on an individual's life. What do you think of this?
3. If you had a message to give to other victims, what would that be?
4. Are there any comments you would like to add that we have not addressed and/or you think is important for research to look at?

Appendix 8: Study materials (study 3)

Research Title: Adverse childhood experiences and future recovery

(Protocol: Version 3 28.10.2019)

Section 1: Demographic information

1	**How old are you (in years)?**	
2	**What sex are you?**	
3	**Please circle where you live currently:**	England/ Northern Ireland/ Scotland/ Wales; Other (please specify)_____
4	**When were you last in employment?** **What was this employment?**	_____ Working in a manual job/ Working in a professional job/ Other (please specify)_____
5	**Are you (please circle):**	Single / Married / Cohabiting (living together in a romantic relationship, unmarried) / Divorced Widowed
6	**What is your highest level of education?**	Primary School/ High school/ College/ Sixth form Apprenticeship/ Undergraduate degree/ Master's degree or higher
7	**As an adult, have you ever been placed in a secure facility (specifically prison or a secure hospital)**	I currently reside in a prison setting I currently reside in a secure hospital I have previously resided in a prison setting I have previously resided in a secure hospital

		I have never been in a secure facility
8	**As a child (under the age of 18) were you ever placed in institutional care?**	Yes/No Note: this refers to a setting where you were under the care of the institution or a single authority. This can include residential care, secure care and schools e.g. boarding schools/ industrial schools
8a	**If so, what type of care were you in (please circle)? (please do not give identifiable details of people or institutions)**	Borstal / Prison/Youth Offenders Institute Boarding School/ Residential Care/ Industrial School Foster care/ Other Care (please specify)_____
8b	**If so, please rate the following as to whether you feel they are true for the institutional setting you were in (under the age of 18).** **1 = Very false** **2 = Somewhat false** **3= Somewhat true** **4= Very true**	Decisions were made for me _____ I was isolated _____ I did not have social support _____ I did not experience affection _____ It was an unfamiliar place _____ It was an unrealistic environment when compared to the real world ____ I did not feel I was in control of my own future ____ I had negative feelings about being placed into care_____ Being in this institution had a negative impact on my education_____ I did not prepare me for a future outside of the institution_____

Section 2: My childhood experiences

Please indicate (with a tick) if you feel you have experienced any of the below, before the age of 18 by ticking the appropriate box.

		Never experienced this abuse	In home, by a caregiver(s)	In home, by someone else	In care, by a caregiver(s)	In care, by someone else	In a secure unit, by a caregiver(s)	In a secure unit, by someone else.
1	Emotional							
2	Physical							
3	Sexual							
4	Emotional							
5	Physical							

Section 3: How I respond to stressful experiences

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Indicate ***how much you have been bothered by each problem <u>in the last month</u>*** *by writing a number in the box.*

1	**2**	**3**	**4**	**5**
not at all	*a little bit*	*moderately*	*quite a bit*	*extremely*

write response

1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	
2	Repeated, disturbing dreams of a stressful experience from the past?	
3	Suddenly acting or feeling as if a stressful experience were happening again (as	
4	Feeling very upset when something reminded you of a stressful experience from the past?	
5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating)	
6	Avoid thinking about or talking about a stressful experience from the past or	
7	Avoid activities or situations because they remind you of a stressful experience from the past?	
8	Trouble remembering important parts of a stressful experience from the past?	
9	Loss of interest in things that you used to enjoy?	
10	Feeling distant or cut off from other people?	
11	Feeling emotionally numb or being unable to have loving feelings for those	
12	Feeling as if your future will somehow be cut short?	
13	Trouble falling or staying asleep?	
14	Feeling irritable or having angry outbursts?	
15	Having difficulty concentrating?	
16	Being “super alert” or watchful on guard?	
17	Feeling jumpy or easily startled?	

Section 4: My views on myself and others

Please rate the following based on how true they are for you.

0	**1**	**2**	**3**
Very false or often false	*Sometimes of somewhat false*	*Sometimes or somewhat true*	*Very true or often true*

Write response

1	I often do not know who I really am	
2	I often think very negatively about myself	
3	My emotions change without me having a grip on them	
4	I have no sense of where I want to go in my life	
5	I often do not understand my own thoughts and feelings	
6	I often make unrealistic demands on myself	
7	I often have difficulty understanding the thoughts and feelings of others	
8	I often find it hard to stand it when others have a different opinion	
9	I often do not fully understand why my behaviour has a certain effect on others	
10	My relationships and friendships never last long	
11	I often feel very vulnerable when relations become more personal	
12	I often do not succeed in cooperating with others in a mutually satisfactory way	

Section 5: Strength factors

These questions aim to explore if any of these factors are present for you. Please rate each question in terms of how much you agree or disagree with it.

0	**1**	**2**	**3**
Very false or often false	*Sometimes of somewhat false*	*Sometimes or somewhat true*	*Very true or often true*

write response

1	Prior to the age of 18, I had a strong positive relationship with a parent or	
2	I have a strong social support network	
3	I am able to cope well with stressful situations	
3a	Other people think I cope positively with stress	
4	I take part in structured leisure activities	
5	I have clear goals for my future	

Section 6: How I respond to stressful events

Please rate how much you agree or disagree with each of the items by writing a number in the box.

1	**2**	**3**	**4**	**5**
strongly disagree	*disagree*	*neutral*	*agree*	*strongly agree*

write response

1	I tend to bounce back quickly after hard times	
2	I have a hard time making it through stressful events	
3	It does not take me long to recover from a stressful event	
4	It is hard for me to snap back when something bad happens	
5	I usually come through difficult times with little trouble	
6	I tend to take a long time to get over set-backs in my life	

The final questions relate specifically to those who have experienced childhood abuse. If you have *not* experienced this, please indicate this by checking this box and move to the debrief sheet

□

If you have experienced child abuse, have you received any intervention to support you with this? Please tick as appropriate

□ Cognitive Behavioural Therapy (CBT)

□ Eye Movement Desensitization and Reprocessing (EMDR)

□ Other _____

Section 7: How I view my experiences

Please rate the following based on how true they are for you, regarding how experiencing abuse has impacted on you.

0	**1**	**2**	**3**
Very false or often false	*Sometimes or somewhat false*	*Sometimes or somewhat true*	*Very true or often true*

write response

1	I am calm in situations of violence as I know how to survive them	
2	I gained a sense of toughness from experiencing abuse	
3	Experiencing abuse empowered me for a life of risk taking and adventure	
4	Trusting no-one makes me stronger	
5	Pushing thoughts to the back of my head makes me stronger	
6	Drug and alcohol have been useful coping tools	
7	Self-harm has been a useful coping tool	
8	Aggression (towards objects or others) is a useful form of coping	

Section 8: Disclosure

These questions explore how you felt after disclosing the abuse you experienced, and how others reacted to this disclosure. If you did not disclose your abuse, please tick 'Not applicable' and move to the debrief.

Not applicable as I did not disclose my experiences of abuse

Please rate to statements below in relation to how much you agree they are true of your disclosure experience.

0	**1**	**2**	**3**
Very false or often false	*Sometimes or somewhat false*	*Sometimes or somewhat true*	*Very true or often true*

After I disclosed my abuse experiences I felt:

1	Positive emotions		14	Upset	
2	Negative emotions		15	Depressed	
3	Mixed emotions		16	Trapped	
4	Exposed		17	Like I was not believed	
5	Relieved		18	Blamed	
6	Satisfied		19	Like no action was taken	
7	Happy		20	Mocked	
8	Determined		21	Like the abuse got worse	
8	Like I was not alone		22	Supported	
10	Vulnerable		23	Like the response was empathetic	
11	Freed		24	Like I received Justice	
12	Like I was helping others		25	I was believed	
13	Ashamed		26	The person I disclosed to was	

Appendix 9: Principal Component Analysis results

As noted, several questions were developed for this study: Strength Factors Checklist; Negative Experiences of the Care Environment Checklist; Experiences of Disclosure Checklist. Principal Component Analysis (PCA) was, therefore, conducted to examine the factor structure of these tools. Results were explored for singularity and multi-collinearity and neither were found between the items in each scale. PCA is one of the preferred methods where the analysis aims to explore the data and can be used when the findings are not to be extrapolated beyond the sample (Field, 2009). Therefore, PCA was considered appropriate. Direct oblimin rotation was used as factors were expected to be related (Field, 2009). For the Strength Factors Checklist and the Negative Experiences of the Care Environment Checklist, the reproduced correlation matrix indicated that the rotated model was not significantly different from the original model. Therefore, no further analysis was conducted.

For the Experiences of Disclosure Checklist, a five-factor solution was chosen based on the scree plot which begins to flatten after five factors and Kaiser's criterion. Specifically, five factors had an eigenvalue greater than one, therefore, meeting Kaiser's criteria. This was considered an appropriate cut-off score as the analysis included less than 30 variables and Kaiser's criteria is therefore applicable (Field, 2009). Examining the items in each component, three clear subscales were noted: Negative response to disclosure, positive emotion after disclosure, and negative emotion after disclosure. Factor 4 and 5 had one and two items, respectively and did not have any logical grouping based on Study 1, Study 2, and Study 3 so were discarded from the analysis. As a result of the potential subthemes for the Experiences of Disclosure Checklist, a further exploratory analysis was conducted to examine if the subscales independently predicted trauma symptom levels in individuals who had reported institutional abuse.

Figure 10.2

Scree Plot of Principal Component Analysis for Experiences of Disclosure Scale

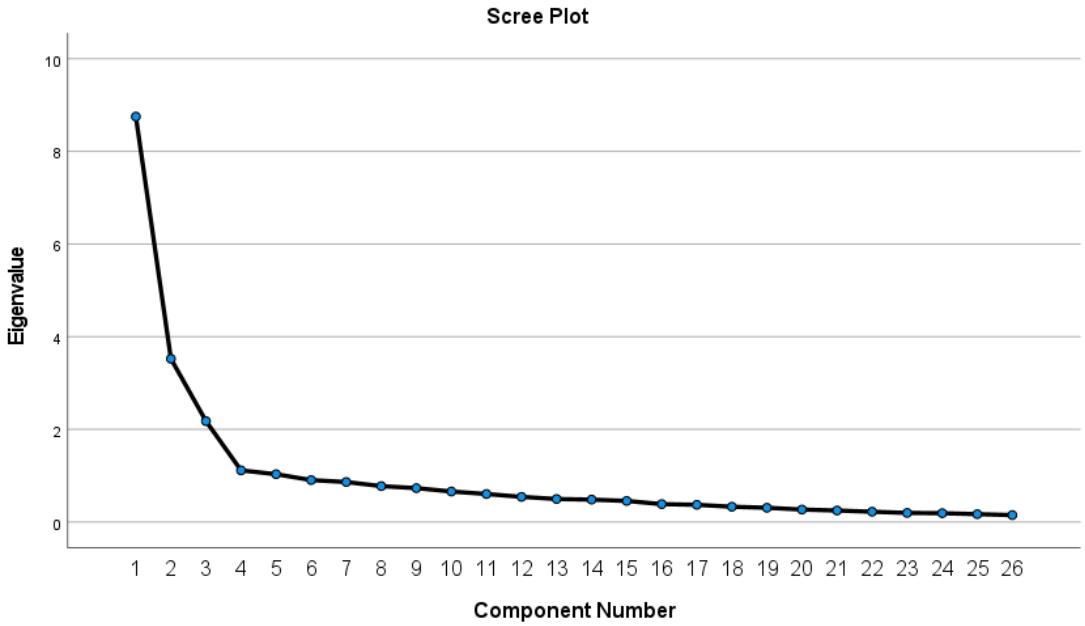

Table 10.4

PCA Item Loadings

Item		Component				
		1	2	3	4	5
1	Positive emotions	**0.76**	-0.13	0.04	0.05	0.14
2	Negative emotions	**-0.48**	0.21	0.22	0.17	-0.34
3	Mixed emotions	0.01	0.07	0.18	**0.81**	0.08
4	Exposed	-0.11	0.04	**0.67**	-0.04	-0.21
5	Relieved	**0.58**	-0.13	-0.08	0.44	-0.13
6	Satisfied	**0.82**	-0.05	-0.06	0.07	0.00
7	Happy	**0.83**	0.02	-0.18	0.00	0.10
8	Determined	**0.65**	0.12	-0.07	-0.08	-0.30
9	Like I was not alone	0.27	-0.31	-0.19	0.36	**-0.44**
10	Vulnerable	-0.07	0.07	**0.69**	0.16	0.02
11	Freed	**0.77**	0.00	0.03	0.11	0.01
12	Like I was helping others	**0.66**	0.12	-0.23	0.19	-0.07
13	Ashamed	-0.08	0.24	**0.72**	0.01	0.00
14	Upset	-0.12	0.41	**0.52**	0.18	-0.13
15	Depressed	-0.17	**0.54**	0.29	0.17	0.12
16	Trapped	0.08	**0.78**	0.19	-0.07	0.06
17	Like I was not believed	0.09	**0.84**	0.08	-0.03	0.18
18	Blamed	0.10	**0.80**	0.15	0.00	-0.05
19	Like no action was taken	-0.18	**0.53**	0.17	0.05	-0.10
20	Mocked	0.07	**0.79**	0.05	0.00	-0.12
21	Like the abuse got worse	-0.02	**0.78**	-0.18	0.03	-0.27
22	Supported	**0.54**	-0.45	0.27	-0.05	-0.10
23	Like the response was empathetic	0.46	**-0.48**	0.43	0.04	0.05
24	Like I received Justice	**0.72**	0.14	0.06	-0.24	-0.10
25	I was believed	0.31	**-0.55**	0.25	-0.10	-0.41
26	The person I disclosed to was distressed	-0.02	0.10	0.15	-0.05	**-0.77**