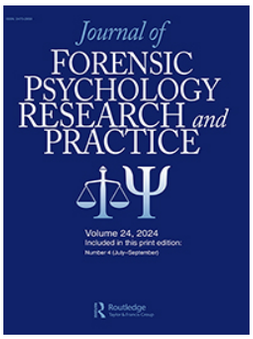

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Institutional Child Abuse: The Role of Disclosure, Risk, and Protective Factors in Understanding Trauma Responses

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ABSTRACT

The research examined impacts and recovery from institutional child abuse. There were three linked studies; a survey of 10 institutional abuse victims, a Rapid Evidence Assessment of 26 UK-based institutional child abuse case reviews, and a quantitative study of 384 adults reporting either institutional child abuse ($n = 93$), at home abuse ($n = 191$) or no abuse ($n = 100$). Collectively there was evidence for a focus on negative impacts and disclosure. There was an indirect effect of institutional abuse on PTSD symptoms mediated by personality dysfunction but not strength factors or resilience. The research highlighted the importance of disclosure and integrates findings into a preliminary conceptual model, the Integrated Model of Institutional Child Abuse impacts (IMICA).

KEYWORDS

Institutional child abuse; sex abuse; PTSD; trauma impacts; resilience; IMICA

Introduction

While the impact of child abuse has been widely researched, most focuses on abuse from family members, acquaintances, and strangers rather than institutional abuse (Lueger-Schuster et al., 2018; Lueger-Schuster, Kantor, et al., 2014). The current research defines institutions as settings under direct supervision of a formal body (e.g., a Local Authority or Church), or individuals under direct management of an institution (e.g., a foster carer), and includes overnight stays without family supervision.

Studies conducted with those exposed to institutional child abuse (sexual, physical, and emotional) noted high prevalence rates, with estimates of abuse falling between 50% and 93% (Sherr et al., 2017). Long-term consequences of institutional abuse include low self-esteem/self-worth, depression, aggression toward others (Auslander et al., 2016; Benedict et al., 1996; Forde, 1999), Post-Traumatic Stress Disorder (PTSD), trauma symptoms (Lueger-Schuster,

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Kantor, et al., 2014), and/or complex PTSD (Knefel et al., 2015). Research in this area is limited compared to non-institutional settings.

Many children in institutions have experienced prior abuse, which can contribute to cumulative trauma (e.g., Carr et al., 2010; Lueger-Schuster et al., 2018; Lueger-Schuster, Kantor, et al., 2014). Havlicek and Courtney (2016) found 70.9% of individuals in foster care experienced prior abuse, of which 19.3% experienced three types of abuse (physical, sexual, neglect). Estimates were higher using official records. Therefore, institutionalized children are vulnerable and can experience poly-victimization (Afifi et al., 2014).

Institutionalization alone can negatively impact children (Johnson et al., 2006), associating with attachment problems (Garcia Quiroga & Hamilton-Giachritsis, 2016), conduct problems, hyperactivity, substance use, depression (Hunter, 2001) mental health diagnoses (Mutiso et al., 2017; Zeanah et al., 2009), and exposure to others with significant adjustment problems (Carr et al., 2019). The mechanism by which negative impacts emerge is unclear, and institutionalization does not always lead to poor outcomes (MacLean, 2003), suggesting issues of complexity and needing to compare those abused in institutions with those abused solely elsewhere, which research has not yet considered.

Despite the prevalence of institutional abuse, no existing model explains the *impact* of institutional abuse and factors likely to exacerbate or protect against enduring impacts, though existing models could explain the association between institutional abuse and subsequent symptom expression. For example, the *Theoretical Model of Maltreatment in Out-of-Home Care* (TMM, Nunno, 1997) notes four factors: child's characteristics; carer's characteristics; facility environment; and external factors. Child characteristics capture individual differences, including requiring support because of needs and/or behavioral challenges (Nunno, 1997). Several staff/carer and environment/culture factors were considered important to institutional abuse perpetration. For external factors, maltreatment was reportedly highest at the beginning and end of the school year and when staff "layoffs" were threatened. Although this model is descriptive and focuses on the broader concept of "maltreatment," it includes factors relevant to institutions, including external and environmental factors, shifting explanations from a narrow focus on individual factors.

Focusing on factors external to the individual is, however, necessary for understanding abuse, including those which could aid recovery. Protective factors need considering, since not all institutional abuse victims suffer the full range of negative effects (Lueger-Schuster, Weindl, et al., 2014; Sheridan & Carr, 2020). Resilience is one protective factor (Mota et al., 2016), defined best as where an individual functions despite significant hardship (Jaffee et al., 2007). Lueger-Schuster, Weindl, et al. (2014), for example, considered resilience factors in adult institutional abuse survivors, finding optimism and task-

orientated coping led to better mental health outcomes, and not factors such as social support.

The *Three-Part Model of Psychological Resilience* (De Terte et al., 2014) supplements the TMM (Nunno, 1997), and suggests that cognition (e.g., optimism, adaptive coping), environment (e.g., social support), and physical behavior (e.g., adaptive health practices) are required for resilience. The environment may be particularly challenging in institutions and may limit resilience development, arguably promoting any emerging negative outcomes connected to abuse.

A further protective factor is the disclosure of institutional abuse (Lueger-Schuster et al., 2015; McTavish et al., 2019). Lueger-Schuster, Weindl, et al. (2014) found that institutional abuse victims with perceived higher social support demonstrated fewer negative emotional reactions from disclosing the abuse than those perceiving lower levels of social support. *Lack* of response following disclosure can lead to feeling re-victimized and a loss of respect for authority (Colton, 2002), with impacts exacerbated by a reduced potential for *safe* disclosure (Blakemore et al., 2017). Empirical evidence supports this. For example, Colton (2002) examined institutional sexual abuse survivor experiences ($n = 24$) and found most reported having no help, were not taken seriously, and/or were punished for disclosing, thereby impacting on the potential to disclose safely. However, more research is required.

The current research explored the negative impacts of institutional abuse, whilst adding to the literature regarding factors aiding recovery. It examined disclosure, resilience, strength factors, and individual characteristics (e.g., personality functioning) and builds to offer a preliminary conceptual model for understanding the impacts of institutional abuse – the Integrated Model of Institutional Child Abuse impacts (IMICA). The program of research explored the lived experience perspectives of institutional child abuse victims, conducted a Rapid Evidence Assessment of institutional child abuse case reviews, and compared experiences of child abuse in different settings. Predictions were:

(1) Institutional abuse would be positively associated with PTSD symptoms (e.g., Lueger-Schuster, Kantor, et al., 2014).
(2) Institutional abuse victims would report higher PTSD symptoms compared to victims abused in other settings, because of increased complexity in experience (e.g., Afifi et al., 2014; Mutiso et al., 2017; Zeanah et al., 2009).
(3) Factors such as resilience and support would protect against enduring impacts of institutional abuse (e.g., De Terte et al., 2014; Lueger-Schuster, Weindl, et al., 2014).

Study one: impact of institutional child abuse: a victim perspective

Method

Participants

Twenty-nine participants responded to the research advert, with ten taking part (eight males and two females), six of which currently resided in a secure setting with four from the general population (age range 34–76 years, $M = 49.06$, $SD = 11.06$). Five resided in residential care before age 18, three in a residential school, one in an orphanage, and one in a Young Offender's Institute. One reported sexual abuse, two reported physical and emotional abuse, and seven reported sexual, physical, and emotional abuse. To assist with protecting the anonymity of participants no detail on their location was obtained.

Materials

Demographic questions captured age, sex, and type of abuse. Survey questions requested free narrative responses, focusing on preexisting vulnerabilities, key impacts, factors aiding recovery, and disclosure. Questions included, "What factors, if any, helped you manage the effects of the abuse in the long term?"

Procedure

A research advert was posted in a local newspaper, a newspaper circulated in secure settings, and online forums and social network groups offering support to child abuse survivors. The advert was also circulated to personal injury lawyers for distribution to survivors from concluded legal cases. Ethical approval was granted by the University of Central Lancashire.

Results

Reflexive Thematic Analysis was used to examine the findings, following the Braun and Clarke (2006, 2019) method. Themes were reviewed by another researcher. Seven themes emerged (see Figure 1):

Superordinate theme 1: institutional abuse can negatively impact the self and life choices

Comprising three subordinate themes 1) *Loss of future life chances, including relationships*, e.g., "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" (P1); 2) *Negative effects on well-being and perspectives*, including mental health impacts, substance use, avoidance, desensitization to violence and risk-taking, e.g., "took drugs to block things out started hitting out at people" (P2); "not telling people and putting it at the back of my head. Making myself busy all of the time" (P1); 3) *Dictating future vulnerability* through learning to be passive, e.g.,

Superordinate themes	Subordinate themes
1.) Institutional abuse can negatively impact the self and life choices	1.1. Loss of future life chances, including relationships 1.2. Negative effects on well-being and perspectives 1.3. Dictating future vulnerability
2.) Factors contributing to negative impacts	2.1. Negative experiences before institutional abuse 2.2. The environment promoting challenges and abuse
3.) Varied motivations to disclose	
4.) Responses to disclosure	4.1. Mixed victim emotions 4.2. Mixed responses of others
5.) Fear as a barrier to disclosure	
6.) Developing resilience to impacts of institutional abuse	
7.) Changed responding to others	7.1. Hurting others because of abuse experiences 7.2. Developed desire to protect and be mindful of others

Figure 1. Themes generated from victim perspectives.

"[institutional abuse] cause[d] me to repeat the passive response to others seeking to subjugate me or exploit me or use me" (P5), or focusing on responding proactively to injustice, which could make them a target, e.g., "now able to call out bullies" (P10).

Superordinate theme 2: factors contributing to negative impacts

Comprising two subordinate themes; 1) N*egative experiences before institutional abuse*, reported by all participants, where eight explicitly indicated these exacerbated impacts of institutional abuse. These included feeling a lack of love and connectedness, loss of attachment figure, feeling unloved due to institutionalization, and feeling like an outsider, e.g., "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" (P5); 2) *The environment promoting challenges and abuse*, e.g., "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" (P1).

Superordinate theme 3: varied motivations to disclose

Covering pro-active reasons, including to progress with therapy, and reactive reasons, including no longer coping, e.g., "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." (P2), and wanting to highlight or remedy the abuse, e.g., "To raise awareness and to seek an apology or acceptance from the perpetrators." (P7).

Superordinate theme 4: responses to disclosure

Two subordinate themes emerged, 1.) *Mixed victim emotions*, including positive and negative impacts. Positive impacts included relief, e.g., "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." (P2). Negative impacts included feeling "Vulnerable, exposed" (P7). Predominately, emotions were mixed ($n = 6$), e.g., "I kind of feel that some weight has gone but feel that a can of worms are now open and [I] struggle at times as it is there at front of my mind. However, one thing I learnt is that I wasn't alone." (P1); 2.) *Mixed responses of others*, which could be supportive and facilitate disclosure, e.g., "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." (P4). However, responses could involve mocking and/or not being believed, e.g., "Being used and abused . . . 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." (P5).

Superordinate theme 5: fear as a barrier to disclosure

This centered on fear of the consequences, e.g., "I couldn't tell anyone as I thought they would hurt me." (P1), "I knew not to tell as there was a deep sense that you wouldn't be believed and may be blamed." (P10).

Superordinate theme 6: developing resilience to impacts of institutuional abuse

Most participants reported factors that helped them cope with the negative impacts of institutional abuse, including drawing on positive past experiences and personal characteristics, "Luckily I had a sunny happy disposition and was able to push on through my youth" (P5). Resilience also included using coping strategies, such as working to change abusive cultures, seeking social support, and/or attending therapy.

Superordinate theme 7: changed responding to others

This comprised two subordinate themes; 1.) *Hurting others because of abuse experiences*, with participants indicating their abuse led to them hurting others via dulled emotions, e.g., "Trouble feeling empathy for male people," "increase in the severity of committing crime without remorse" (P3) or via defensive behaviors, e.g., "which could have felt like bullying to others" (P10); 2.) *Developed desire to protect and be mindful of others*, e.g., "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." (P10).

Summary

Although limited by the number of participants, findings illustrated diversity in victim responses and also captured a role for disclosure. Negative impacts dominated the themes, with outcomes including PTSD, depression, and anxiety. This was consistent with previous literature (e.g., Benedict et al., 1996; Forde, 1999; Knefel et al., 2015; Lueger-Schuster, Kantor, et al., 2014) and captured challenges with individual coping and dulled emotions. However, there was evidence for an enhancement of emotions, such as wanting to protect and be kind to others, which represented a positive feature not captured in the literature. Abuse experiences prior to institutionalization, however, aggravated the negative impacts of abuse (e.g., Havlicek & Courtney, 2016). The mechanism raising a victim's vulnerability to future abuse is unclear, but findings highlight raised vulnerability as a reaction to abuse. Evidence emerged of also wanting to develop resilience, which is not captured extensively in the literature (De Terte et al., 2014; Lueger-Schuster, Weindl, et al., 2014). The role of the environment, including the link to disclosure, further featured, thereby contributing to an under-researched area in the literature.

Results overall also showed diverse negative and positive impacts, along with disclosure being particularly relevant. These findings formed the basis for the ensuing Rapid Evidence Assessment.

Study two: serious case reviews: Rapid Evidence Assessment of disclosure and strength factors

A Rapid Evidence Assessment (REA) of UK case reviews extended Study One by studying disclosure and strength factors further, using a wider sample. The REA examined the impact of responses following disclosure and how strength factors (e.g., positive coping strategies, seeking support) affect negative impacts of institutional abuse.

Method

The National Society for the Prevention of Cruelty to Children (NSPCC) national case review repository was searched using "Institutional Abuse." This database was chosen as is considered the most comprehensive collection of case reviews in the UK (NSPCC, 2022). Documents were excluded if they were duplicates, did not refer to institutional abuse, or did not include disclosure or coping/strength factors.

Fifty-four sources were identified. Full texts were reviewed, with 28 excluded (e.g., those not including disclosure or coping/strength factors, or not focusing on institutional abuse or indicating relevance). This resulted in a final sample of 26 (see Table 1).

Reflexive Thematic Analysis was conducted with NVivo using the Braun and Clarke (2019) method. Disclosure and coping/strength factors were analyzed separately to fully explore the aims. Themes were discussed with an independent researcher.

Results

Ten themes emerged regarding disclosure and three regarding coping/strength factors, summarized in Figure 2.

Thematic analysis: disclosure

Superordinate theme 1: Barriers to disclosure varied. Five subordinate themes emerged; 1) *Victim's negative feelings as a barrier*, including humiliation, anger, disgust (Darling et al., 2020; IICSA, 2018; Smellie et al., 2020), guilt, and shame (IICSA, 2019a); 2) *Misplaced positive feelings*, with victims reporting affection or gratitude toward the institution or perpetrator as a potential barrier. 3) *Fear of consequences preventing disclosure*, including lack of confidentiality, stigma, not being believed, and lack of action (Darling et al., 2020; Hart et al., 2017; IICSA, 2019b). Fear of consequences also included fear of retribution or physical punishment (CEOP, 2013; Hart et al., 2017; Smellie et al., 2020), fear of being moved to another institution and of being separated from siblings (IICSA, 2019a). Not all fear was related to personal consequences, there was concern for negative consequences to others (Darling et al., 2020; Kirkup & Marshall, 2014; Mendez Sayer et al., 2018; Smellie et al., 2020); 4) *The environment inhibiting disclosure*. Most commonly reported for childhood than adulthood disclosure. This included a lack of opportunity to report abuse, influenced by limited access to the outside world and trusted adults (CEOP, 2013; Darling et al., 2020; Scottish Child Abuse Inquiry, 2018), and impacted by changes in placement and high staff turnover (Hart et al., 2017; IICSA, 2019a). Organization culture also contributed, such as an atmosphere of fear or an environment where abuse had become

Table 1. REA sources and samples.

Source (no of pages)	UK Location	Sample
Brown (2014) (116)	Surrey	Case study at a music school
Child Exploitation and Online Protection (CEOP) Centre, 2013) (32)	Not indicated	Residential and nonresidential institutions (varied and indistinguishable)
Conway (2012) (4)	Scotland	Literature review but included reference to Scottish Case reviews in Residential childcare
Darling et al. (2020) (85)	England and Wales	Custodial Institutions
Harrington and Whyte (2015) (71)	Hampshire	School that included boarders
Hart et al. (2017) (36 Chapters)	Northern Ireland	Residential Homes
Independent Inquiry into Child Sexual Abuse (IICSA, 2017) (154)	England and Wales	Residential and nonresidential institutions (varied and indistinguishable)
Independent Inquiry into Child Sexual Abuse (IICSA, 2018) (174)	England and Wales	Child migration programmes
Independent Inquiry into Child Sexual Abuse (IICSA, 2019a) (172)	Nottinghamshire	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)	England and Wales	Custodial Institutions
Jay et al. (2020) (154)	England and Wales	The Roman Catholic Church (Not solely residential)
Jillings (2012) (175)	North Wales	Childcare settings
Johnstone et al. (2015) (358)	Buckinghamshire	Included abuse of adults and children. Information was only included if it referred to a child who, if in hospital, was staying overnight
Kirkup and Marshall (2014) (139)	West London	Included abuse in secure hospital, only included in analysis if under age 18
McNeish et al. (2018) (12)	Unknown but refers to UK reports within the review	Residential and nonresidential institutions (varied and indistinguishable)
Mendez Sayer et al. (2018) (162)	England and Wales	Custodial Institutions
Munn and Child Protection All Party Parliamentary Group, and NSPCC (2014) (16)	Unknown	Specific section on Institutional Abuse but not specific only to residential
Scottish Child Abuse Inquiry (2018) (73)	Scotland	Residential care
Scott-Moncrieff and Morris (2015) (136)	Cambridge	Hospital including overnight stays
Smellie et al. (2020) (61)	Includes England and Wales and those designated UK as part of the sample.	Schools (residential and nonresidential)
Soares et al. (2019) (117)	England and Wales	Children's homes and residential care
Truth Project (2019a) (7)	England and Wales	Residential and nonresidential institutions (varied and indistinguishable)
Truth Project (2019b) (7)	England and Wales	Residential and nonresidential institutions (varied and indistinguishable)
Truth Project (2020) (7)	England and Wales	Residential and nonresidential institutions (varied and indistinguishable)
Walters and Medway Safeguarding Children Board (2019) (67)	Rochester	Secure Training Facility
Ward et al. (2018) (54)	England and Wales	Residential Schools

Disclosure factors: Superordinate and Subordinate themes

1. Barriers to disclosure varied.
1.1. Victim's negative feelings as a barrier
1.2. Misplaced positive feelings
1.3. Fear of consequences preventing disclosure
1.4. The environment inhibiting disclosure
1.5. Challenges in understanding and communicating the abuse

2. Varied reasons reported for disclosure

3. Varied nature and timing of disclosure
3.1. Victims disclose to several others
3.2. When disclosure occurs
3.3. Amount of disclosure

4. Factors external to the individual that support disclosure

5. Negative responses to disclosure
5.1. Victims experiencing blaming responses
5.2. Victims being punished, excluded or threatened following disclosure
5.3. Not being believed
5.4. Inaction, minimisation and inappropriate action following disclosure
5.5. Responses designed to protect the institution and/or perpetrator

6. Positive responses to disclosure

7. Impact of disclosure on victims
*7.1.*Negative responses to disclosure negatively impact victims
*7.2.*Positive responses to disclosure can positively impact victims

8. Not disclosing can have negative impacts

9. The evidentiary process connected to disclosure impacting negatively

10. Varied feelings about disclosure

Strength/coping factors: Superordinate themes

1. Varied negative coping responses
2. Strategies supporting recovery reported by victims
3. Differing levels of support received, with a preference for informal

Figure 2. Themes generated from victim perspectives from the REA.

normalized (Darling et al., 2020; Hart et al., 2017; Munn & Child Protection All Party Parliamentary Group, & NSPCC, 2014); 5) *Challenges in understanding and communicating the abuse*. Not knowing how to describe/disclose what was happening was a barrier (Hart et al., 2017; IICSA, 2019b; Smellie et al., 2020) including not understanding the experience was abusive (Harrington & Whyte, 2015; Hart et al., 2017; IICSA, 2019a)

Superordinate theme 2: Varied reasons reported for disclosure. Many distinct reasons emerged, commonly representing a need to "tell my story," "record the abuse" and "help others/prevent abuse" (Brown, 2014; Hart et al., 2017; Soares et al., 2019). Victims' motivations included needing acknowledgment

and obtaining an apology (Jay et al., 2020) and receiving redress and compensation (Hart et al., 2017).

Superordinate theme 3: Varied nature and timing of disclosure. This comprised three subordinate themes: 1) *Victims disclose to several others*, including partners, parents, therapists, or counselors, someone in authority at the institution, employers, solicitors, police, or representatives of the criminal justice system (Hart et al., 2017; Soares et al., 2019); 2) *When disclosure occurs*. Not everyone disclosed and those who did did not always disclose during childhood (Hart et al., 2017), with many later retracting (IICSA, 2019b). Disclosure was not always a considered decision and could be triggered by an event and occur years later (IICSA, 2017, 2018); 3) *Amount of disclosure* ranged from full disclosure all at once to partial disclosures over time (e.g., IICSA, 2017, 2018).

Superordinate theme 4: Factors external to the individual that support disclosure. Factors included a safe and private space for disclosure, with access to someone outside the institution (IICSA, 2019b; Mendez Sayer et al., 2018).

Superordinate theme 5: Negative responses to disclosure. This comprised five subordinate themes: 1) *Victims experiencing blaming responses*. Disclosures could be met with concealment and victim blame (Darling et al., 2020; Smellie et al., 2020; Soares et al., 2019), which could be part of the culture (IICSA, 2019a); 2) *Victims being punished, excluded, or threatened following disclosure*, including being alienated, humiliated, stigmatized, rejected, threatened, and ostracized by the institution or community (CEOP, 2013; Hart et al., 2017) and/or physically punished (Hart et al., 2017; IICSA, 2019a, 2019b); 3) *Not being believed* (Hart et al., 2017); 4) *Inaction, minimization, and inappropriate action following disclosure* were commonly reported (Brown, 2014; CEOP, 2013; Darling et al., 2020; Jay et al., 2020; Johnstone et al., 2015; Soares et al., 2019). This comprised lack of action, or inappropriate action, including the institution perceiving the offense should be handled internally leading to appropriate authorities not being told (CEOP, 2013), victims being told to avoid the perpetrator (Hart et al., 2017) or, with same sex abuse, being referred to as a homosexual relationship (Soares et al., 2019); 5) *Responses designed to protect the institution and/or perpetrator*, including not notifying parents or other children and focusing instead on the organization's reputation. Sometimes individuals were told not to disclose to protect the perpetrator (Scottish Child Abuse Inquiry, 2018), or the perpetrator was dismissed for bringing the institution into disrepute rather than their abuse toward children (Hart et al., 2017).

Superordinate theme 6: Positive responses to disclosure. This included victims feeling their disclosure was dealt with well (IICSA, 2018; Walters & Medway Safeguarding Children Board, 2019).

Superordinate theme 7: Impact of disclosure on victims. This comprised two subordinate themes; 1) *Negative responses to disclosure negatively impact victims*, including humiliation, re-traumatization, lack of trust in others including authority figures, feelings of betrayal, self-blame (Hart et al., 2017; IICSA, 2017, 2018); *2) Positive responses to disclosure can positively impact victims*. Receiving an apology was described positively by victims, where this was validating of their abuse and confirmed a crime had occurred (e.g., IICSA, 2017, 2018).

Superordinate theme 8: Not disclosing can have negative impacts. This included victims feeling isolated and unable to receive support (Hart et al., 2017).

Superordinate theme 9: The evidentiary process connected to disclosure impacting negatively. The legal process connected to disclosure and pursuing a case against the perpetrator(s) was described as lengthy, frustrating, and emotional (IICSA, 2018; Soares et al., 2019). Negative elements included lack of support during the process, financial strain, and unexpected police contact triggering recall and/or trauma (Darling et al., 2020; Soares et al., 2019). Negative experiences extended to concern about potential outcomes of the legal process, such as the perpetrator being found not guilty, triggering suicidal behavior for some (Brown, 2014). Feelings of blame also resulted from intense and accusatory questioning during disclosure and investigation (Darling et al., 2020), with some feeling penalized for processing civil claims for compensation simultaneously to the criminal investigation (Soares et al., 2019).

Superordinate theme 10: Varied feelings about disclosure. Disclosure was described as emotional, hard, and/or distressing (Hart et al., 2017; Soares et al., 2019). Disclosure could also be viewed positively as victims were able to open up (Darling et al., 2020; Hart et al., 2017).

Thematic analysis: coping responses and strength factors

Superordinate theme 1: Varied negative coping responses. This included accepting the abuse, withdrawal, avoidance, fighting back, putting weight on, rebelling (Hart et al., 2017; Soares et al., 2019), self-harming, running away, and gambling (Conway, 2012; Darling et al., 2020; Walters & Medway Safeguarding Children Board, 2019). Men and women commonly reported accepting the abuse as normal and not knowing what to do, with men also reporting fear, and more substance use, with women more likely to withdraw.

Superordinate theme 2: Strategies supporting recovery reported by victims. Helpful strategies included accessing supportive relationships (Hart et al., 2017; Soares et al., 2019) building self-esteem and confidence, trying to help others (Hart et al., 2017), counseling and finding creative outlets (Darling et al., 2020).

Superordinate theme 3: Differing levels of support received, with a preference for informal. Some reported limited support options (Darling et al., 2020), whereas others felt supported by healthcare professionals (Darling et al., 2020; Soares et al., 2019). Support included formal counseling, although some victims considered this of limited use (Hart et al., 2017). Positive support was commonly attributed to informal support from friends, families, colleagues, and other survivors (Darling et al., 2020; Soares et al., 2019).

Summary

Examining case reviews demonstrated the diversity of disclosure and how this presented as a *process*. Barriers to disclosure were varied and included the institutional environment, further highlighting the complexity of this issue (Colton, 2002; Rush et al., 2014), and the importance of not considering disclosure as a static concept that should occur immediately following abuse or as it is developing. Abuse generally develops as part of a process, commonly referred to as "grooming," with the REA suggesting equal recognition should be attached to disclosure as a process and the associated barriers and facilitators that are linked to this. This includes any internal conflict victims experience. Indeed, supporting victims to articulate their experiences was highlighted as an essential, with safe and supported disclosure part of the recovery process (Blakemore et al., 2017) rather than solely a means of pursuing an evidentiary basis for a legal response.

The REA also captured an array of coping strategies and factors that could aid recovery from institutional abuse, with the review highlighting how emotional-orientated coping and pessimism were not helpful in managing trauma symptoms. The REA extended this by exploring negative coping strategies (e.g., substance use) and the detrimental impact these can have on protective factors (e.g., social support) and recovery. In addition, good quality support was highlighted as particularly important and this appeared to focus on informal rather than formal sources. Feeling supported and heard was beneficial to victims, representing a strength factor that could aid recovery, with variations in the level and source of social support identified in the review. Thus, there was some support for the prediction that factors such as support would protect against negative impacts of institutional abuse, although the nature of the support appears important.

The REA was, however, a limited qualitative review of already collated victims' views and unable to examine relationships between variables of interest. The ensuing study aimed to address this by extending the data collected thus far to examine directly with victims the interplay between positive and negative internal and external factors, and the role of disclosure in understanding impacts of institutional child abuse. It aimed to empirically capture resilience and strength factors, which as demonstrated by the earlier components of this research continue to be less well represented in the emerging data.

Study three: factors influencing trauma following institutional abuse

Building on the importance of disclosure and a role for supportive factors and the environment highlighted in the earlier components, this element examined what factors impact trauma associated with institutional abuse compared to non-institutional abuse.

Method

Participants

All were adults, with 406 initially participating. However, 22 were removed due to submitting no data beyond demographics, leaving 384. Of these, 24.2% (n = 93) reported institutional abuse (Age M = 33.58, SD = 9.33; Range 18 to 35), 49.7% (n = 191) reported abuse at home (Age M = 37.71, SD = 11.80; Range 18 to 73) and 26.0% (n = 100) reported no abuse (Age M = 40.03, SD = 14.57; Range 18 to 72). To assist with protecting the anonymity of participants, no detail on their location was obtained.

Materials

Demographic questions captured age, sex, institutionalization during childhood, institutionalization in secure care during adulthood (see Table 2) and being in a relationship (an indicator of immediate available support). The following measures were used:

Post-Traumatic Stress Disorder Checklist – Civilian Version (PCL-C) (Weathers et al., 1994)

Comprised 17-items, including "Feeling very upset when something reminded you of a stressful experience from the past?" Participants rated to what extent items reflected their experiences in the last month, from 1 (not at all) to 5 (extremely). Higher scores indicated higher current trauma symptoms. The measure does not diagnose PTSD. The scale has very good internal reliability (e.g., α = .92–.94, Conybeare et al., 2012).

Table 2. Participant demographics and abuse experiences.

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

Nature of abuse across setting

	Emotional (%)	Physical (%)	Sexual (%)	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)

Brief resiliency scale (Smith et al., 2008)

Comprised six-items, including "I tend to bounce back quickly after hard times." Participants rated items from 1 (strongly disagree) to 5 (strongly agree). Higher scores represented higher resilience levels. Good psychometric properties have been reported (e.g., $\alpha = .80–.91$, Smith et al., 2008).

Childhood experiences of abuse checklist

Comprised five-items, capturing the presence of child abuse (emotional, physical, sexual abuse; emotional, physical neglect), and measured using a dichotomous response to reduce distress to participants by not requesting details. Participants reported if they had experienced each form of abuse and whether that was at home, in care, in secure care, and by a carer or someone else.

Strength factors checklist

Comprised six-items capturing potential strength factors, specifically social support, coping, leisure activities, and future goals. Items were developed from the strength factor literature (e.g., Lueger-Schuster, Weindl, et al., 2014) and findings from the earlier studies. Participants rated how true each statement was from 1 (very false/often false) to 4 (very true/often true), e.g., "I am able to cope well with stressful situations."

Negative experiences of the care environment checklist

Comprised 10-items capturing experiences during placement, including "I was isolated" and "I did not have social support." Items were developed based on the earlier studies. Participants rated items from 1 (very false) to 4 (very true).

Experiences of disclosure checklist

This 26-item checklist explored how individuals felt following disclosure. Items were developed based on the earlier studies. Participants rated how true the statements were (e.g., "Like I was helping others") from 1 (very false/often false) to 4 (very true/often true).

Level of Personality Functioning Scale-brief form 2.00

Comprised 12-items measuring self and interpersonal personality functioning. Participants rated items from 1 (very false/often false) to 4 (very true/often true), including "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." Acceptable to good internal reliability has been reported (Weekers et al, 2019; self, $\alpha = .79$; interpersonal, $\alpha = .71$).

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. A sample of individuals who had resided in prison was collected using Prolific (a paid research recruitment platform). Participants viewed an information sheet before accessing the study measures. Only participants who reported institutionalization completed the Negative Experiences of the Care Environment Checklist and only those who reported child abuse completed the Experiences of Disclosure Checklist. All were provided with a debrief sheet. Ethical approval was granted by the University of Central Lancashire.

Results

Data screening

No univariate outliers were identified. Five multivariate outliers were identified using Mahalanobis Distance and were removed from the dataset, leaving 379 participants. All scales were subsequently normally distributed. Descriptive statistics are in Table 3.

Disclosure of abuse

Of those abused at home, 53.4% ($n = 101$) disclosed their abuse. For institutional abuse victims, 48.4% ($n = 47$) disclosed their abuse. A significant main

Table 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	91	14.99	4.49	6–23	6–24	.78
	Abuse	189	14.68	3.71	5*-23	6–24	.67
	Abuse at home	98	18.02	3.35	8–24	6–24	.71
	No abuse reported						
Negative experiences of the care environment checklist	Total	63	31.65	5.91	18–40	10–40	.83
	Institutional	35	33.57	5.33	19–40	10–40	.87
	Abuse	21	30.52	4.99	19–39	10–40	.79
	Abuse at home	7	25.43	6.73	18–36	10–40	.86
	No abuse reported						
Experiences of disclosure checklist	Total	151	47.38	13.74	10*-79	26–104	.90
	Institutional	47	50.45	11.80	18*-74	26–104	.85
	Abuse	101	46.31	14.29	10*-79	26–104	.91
	Abuse at home	3	35.67	16.29	17*-47	26–104	N/A
	No abuse reported						
Experiences of disclosure checklist - Negative emotion after disclosure	Total	149	11.70	3.08	4–16	4–16	.81
	Institutional	46	12.11	2.57	5–16	4–16	.69
	Abuse	100	11.55	3.25	4–16	4–16	.83
	Abuse at home	3	10.67	5.13	5–15	4–16	N/A
	No abuse reported						
Experiences of disclosure checklist - Positive emotion after disclosure	Total	145	21.19	6.71	10–40	10–40	.90
	Institutional	46	21.35	6.62	11–34	10–40	.88
	Abuse	96	20.91	6.64	10–40	10–40	.90
	Abuse at home	3	27.67	9.81	22–39	10–40	N/A
	No abuse reported						
Experiences of disclosure checklist - Negative response to disclosure	Total	144	22.28	6.90	9–36	9–36	.88
	Institutional	46	24.46	5.91	11–36	9–36	.83
	Abuse	95	21.39	7.15	9–36	9–36	.90
	Abuse at home	3	17.00	5.20	11–20	9–36	N/A
	No abuse reported						
Post-Traumatic Stress Disorder Checklist – Civilian (PCL- C)	Total	379	42.19	16.25	17–85	17–85	.95
	Institutional	91	50.88	13.64	21–78	17–85	.91
	Abuse	189	44.37	16.21	17–85	17–85	.94
	Abuse at home	98	29.95	10.71	17–66	17–85	.91
	No abuse reported						
Brief Resiliency Scale	Total	379	18.54	5.70	7–30	6–30	.90
	Institutional	91	17.81	5.48	6–30	6–30	.84
	Abuse	189	17.46	5.85	7–30	6–30	.92
	Abuse at home	98	21.27	4.68	7–30	6–30	.87
	No abuse reported						
LPFS-Self	Total	377	14.36	4.95	6–24	6–24	.87
	Institutional	89	15.47	4.40	6–24	6–24	.81
	Abuse	189	15.59	4.80	6–24	6–24	.87
	Abuse at home	98	10.91	4.02	6–24	6–24	.84

(*Continued*)

Table 3. (Continued).

Measure	Abuse Type	N	Means	SD	Observed Range	Potential range	α
	No abuse reported						
LPFS-Interpersonal	Total	375	12.40	4.36	6–24	6–24	.83
	Institutional	89	14.07	4.11	6–24	6–24	.77
	Abuse	187	15.59	4.32	6–24	6–24	.83
	Abuse at home	98	9.66	3.35	6–18	6–24	.79
	No abuse reported						

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

effect of disclosure was found (F (1,87) = 38.14, η^2=.09, p = .005); those who disclosed their abuse had higher PTSD symptoms than those who did not disclose.

Impact of the care environment

Considering only those who reported institutionalization during childhood, a significant main effect of abuse type on PTSD symptom severity was identified (F (2,54)5.34, η^2 = 1.16, p =.010). Bonferroni post hoc tests revealed significantly fewer PTSD symptoms for those reporting no abuse compared to victims abused at home (MD = −16.57, p =.03) or in an institution (MD = −17.60, p =.01). No significant difference in PTSD symptoms was found between victims abused in an institution or at home (MD = 1.03, p = 1.000).

Factors mediating the impacts of institutional abuse

Structural Equation Modeling (SEM) was used to explore whether resilience, strength factors, and/or personality functioning mediated the relationship between experiencing institutional abuse and PTSD symptoms. Being in a relationship and being institutionalized in secure care as an adult was also investigated. The analysis used Maximization Likelihood parameter estimates.

The model (see Figure 3) initially had poor fit (GFI = .66; CFI = .29; RMSEA = .52; $_X^2$(9) = 928.24, p < .001). Consistent with modification indices, and the theoretical understanding of expected covariation between variables (e.g., Weekers et al., 2019), the covariation between disturbance terms for LPFS-self, LPFS-interpersonal, resilience, and strength factors was added to the model, improving the model to a good fit (GFI = .99; CFI = .99; RMSEA = .10; $_x^2$(3) = 14.12, p < .003).

Results indicated institutional abuse was directly positively associated with higher PTSD symptoms (B = 7.36, β = .19, SE = 1.32, p < .001). Institutional abuse was not significantly associated with being in a relationship (B = .02, β

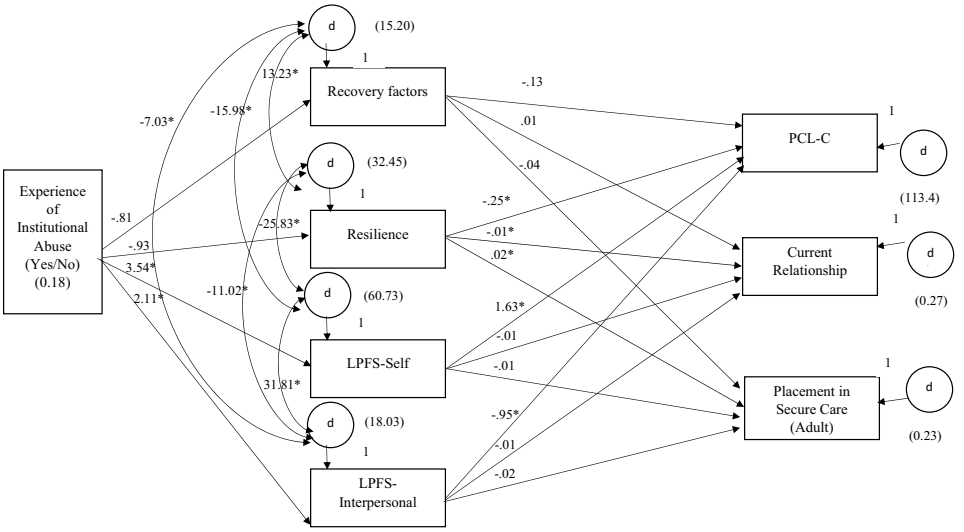

Figure 3. Estimated SEM with unstandardised path coefficients (and R^2). * = p < .05.

= .01, SE = .06, p = .790) or placement secure care (B = .09, β = .08, SE = .06, p = .12).

The indirect effect of institutional abuse on PTSD symptoms via increased self-personality dysfunction was significant, with institutional abuse positively associated with increased self-personality dysfunction (B = 3.54, β = .18, SE = 1.01, p < .001), and increased self-personality dysfunction positively associated with increased PTSD symptoms (B = 1.63, β = .85, SE = .16, p < .001). Indicating institutional abuse was associated with higher PTSD symptoms through its impact on increased self-personality dysfunction.

The indirect effect of institutional abuse on PTSD symptoms via increased interpersonal personality dysfunction was also significant, with institutional abuse positively associated with interpersonal personality dysfunction (B = 2.11, β = .21, SE = 0.51, p < .001) but with this impairment *negatively* associated with PTSD symptoms (B = −.95, β = -.25, SE = .30, p < .001). This indicates that institutional abuse may be associated with higher PTSD symptoms via interpersonal personality dysfunction, with institutional abuse increasing interpersonal personality dysfunction that in turn *decreases* PTSD symptoms.

Resilience was positively associated with institutionalization in secure care during adulthood (B = .02, β = .17, S. E = .01, p = .008). Resilience was negatively associated with 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). Strength factors were significantly negatively associated with institutionalization in secure care during adulthood (B=−.04, β=-.30, S. E = .01, p < .001) but not with being in a relationship or PTSD symptoms (all $p \geq .36$ns).

Summary

The findings highlighted the importance of disclosure in understanding trauma and suggested a complicated relationship between disclosure and distress, in that engaging others in trauma recall and/or recovery cannot automatically be assumed to confer benefits. Interestingly, the abuse environment did not impact PTSD symptoms, refuting the prediction that institutional abuse victims would report higher PTSD symptoms than those abused at home (Afifi et al., 2014; Lueger-Schuster et al., 2018; Mutiso et al., 2017; Zeanah et al., 2009). This was a speculative prediction, with research in this area limited. Findings could suggest that individual factors are of greater importance, beyond the abuse environment. As predicted, and consistent with previous literature, this final study demonstrated that institutional abuse was positively and directly associated with PTSD symptoms (e.g., Lueger-Schuster, Kantor, et al., 2014), mediated by self-personality dysfunction. Increased self-personality dysfunction increased PTSD symptoms, suggesting how individuals see themselves can be challenging for institutional abuse victims (Murphy, 2009). Current findings extend this by highlighting the importance of self-functioning and how this mediates PTSD symptoms for institutional abuse victims.

Institutional abuse was associated with increased interpersonal personality dysfunction, illustrating the impact of institutional abuse on interpersonal relationships, including loss of trust in others (Murphy, 2009). However, interpersonal personality dysfunction was associated with *decreased* PTSD symptoms, suggesting avoidance of interpersonal relationships and healthy connections with others protects against *manifestation* of trauma symptoms. Avoiding others may prevent behavioral expressions of trauma and allow for avoidance of engagements that could trigger recall (e.g., engagements with others, behavioral manifestations of challenges with trust). This is speculative but offers an explanation worthy of future research. One possibility is, until trauma is resolved, relationships may trigger trauma.

Interestingly, resilience did not mediate the relationship between institutional abuse and PTSD symptoms in this final study. Resilience was negatively associated with PTSD symptoms, supporting the prediction that resilience would protect against negative impacts of institutional abuse, and supporting the importance of resilience in understanding trauma responses (e.g., De Terte et al., 2014; Lueger-Schuster, Kantor, et al., 2014). The study expands previous research to suggest how institutional abuse does not impact resilience, but those with higher resilience may have reduced PTSD symptoms. Strength factors were not associated with PTSD symptoms, which were unexpected and inconsistent with prior, albeit limited, research (e.g., Carr et al., 2009; Lueger-Schuster, Weindl, et al., 2014).

Discussion

This multi-study highlights complexities in this research area and the range of impacts associated with institutional abuse victims. The importance of disclosure represented a recurrent theme, alongside a persistent limited articulation of strength factors. Individual characteristics, including resilience and personality functioning, were of value. Researching personality functioning demonstrated a role for individual characteristics in understanding the abuse-current trauma association. Self-personality dysfunction aggravated PTSD symptoms, whereas interpersonal-personality dysfunction reduced current trauma. Collectively, this offers some support for the Theoretical Model of Maltreatment in Out-of-Home Care (TMM, Nunno, 1997) demonstrating individual characteristics as a core feature. The environment was not significant, with no differences in PTSD symptoms between those abused in an institution or at home. The *process* that occurs following abuse, such as disclosure, appears to impact more on trauma symptoms. The current study did not control for abuse experiences prior to institutionalization or address the culture of institutions. Thus, external and preceding factors captured by the TMM were not explicitly addressed, although the literature suggests pre-existing trauma is a common feature of those institutionalized (e.g., Carr et al., 2010; Havlicek & Courtney, 2016; Lueger-Schuster et al., 2018; Lueger-Schuster, Kantor, et al., 2014). Nevertheless, results indicated a role for individual characteristics in understanding impacts of abuse, supporting this TMM element.

Resilience was a feature for institutional abuse victims and likely lessened reporting of trauma symptoms (Lueger-Schuster, Weindl, et al., 2014). This could be an artifact of reporting, with those with increased resilience more likely to cope with impacts of the abuse across time and to engage with a process of research/evaluation. Without judgment toward those not coping adaptively, this merely identifies a differing process following abuse that may lessen the manifestation of trauma symptoms, across time. Resilience presented as important to foster and was more important than strength factors in the final study, suggesting resilience should be considered distinctly from strength factors. Fostering resilience could represent a key factor beyond the presence/absence of strength factors. Resilience was conceptualized as a trait aligned to good coping, supporting the cognitive (e.g., adaptive coping) aspect of the Three-Part Model of Psychological Resilience (De Terte et al., 2014), whereas the environmental aspects of this model (e.g., social support – a strength factor) were comparatively less well evidenced. Beliefs that underpin resilience development are not well-understood, including their association with other protective factors. How resilience links to other variables (e.g., disclosure) to reduce exacerbation of trauma symptoms is another direction for future research.

PTSD symptoms did not differ between institutional abuse victims and those abused at home, suggesting that abuse, regardless of location, associates equally with reports of trauma in adulthood (Carr et al., 2010). This is of interest since a distinction was predicted based on the expected *cumulative* impact of pre-existing trauma for those institutionalized, including institutionalization itself (Afifi et al., 2014; Havlicek & Courtney, 2016; Johnson et al., 2006). The cumulative impact of negative experiences and poly-victimization was highlighted, but institutionalization does not necessarily confer increased PTSD symptoms. Trauma symptoms were higher for both abuse groups than those not reporting abuse, confirming *any* childhood abuse is likely associated with increased trauma reporting in adulthood.

The role of the institutional environment should not be discounted based on the limited findings of this research. Institutions are unnatural environments, with an increased lack of agency, and victims in Study One and the REA acknowledged negative impacts of these environments on disclosure and support acquisition. Although the final study showed no difference in trauma symptoms between environments, this may only relate to *reporting* trauma symptoms in adulthood and may not reflect impacts periodically close to the abuse. Disclosure, resilience, and personality functioning appear key to trauma symptoms in institutional abuse victims, whereas strength factors are not, but the mechanisms through which this occurs are unclear. The research found associations between variables and individual factors that influence trauma in institutional abuse victims. These individual factors, namely self personality dysfunction, are negative impacts of the disclosed abuse that may maintain trauma symptoms.

The collective findings from this research and associated literature can be used to propose a preliminary conceptual model of factors promoting negative symptoms and potential protective factors, following institutional child abuse, the *Integrated Model of Institutional Child Abuse impacts* (IMICA: see Figure 4).

The IMICA broadly captures some relationships between institutional child abuse and negative outcomes, including impacts beyond mental health. The model includes variables that appear important or cannot yet be discounted, including resilience, coping, and secure attachment. Factors that may increase the likelihood of negative impacts are also captured, including pre-existing negative factors, negative responses to placement, personality dysfunction, and challenges with disclosure. A recurrent theme was negative responses to disclosure exacerbating negative impacts of institutional abuse, whereas positive responses can protect against them.

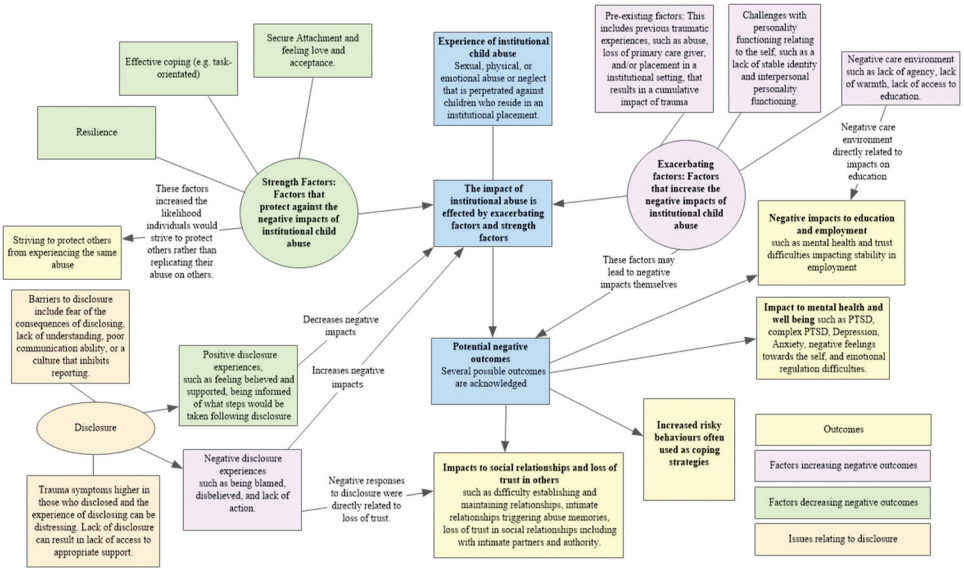

Figure 4. Integrated Model of Institutional Child Abuse impacts (IMICA): A conceptual model.

Limitations

The current research has limitations. This population is hard-to-reach, demonstrated via the diverse recruitment methods employed. Engaging participants in this sensitive research is challenging, considering the negative impact disclosing abuse engenders. This also ensures that attributing demographics to individual quotes is challenging, particularly with the qualitative elements where the risk of identifying participants via their direct quotes becomes raised. Providing participants with additional assurances of anonymity becomes essential for their engagement. It was also not possible to track trauma symptoms from the point of abuse, to examine potential trajectories of change, to capture intervening traumas, or determine if participants attributed their current presentation to past experiences. Thus, the earlier studies relied on retrospective recall and the final study on associations between PTSD symptoms and childhood experiences. Retrospective accounts and correlations mean cause and effect cannot be established. Longitudinal research would allow for exploration of cause and effect, reduce the role of retrospective memory, and allow for further exploration of pre-existing factors and whether they mediate or moderate impacts of institutional abuse. This would allow for a better exploration of how trauma symptoms may change over time following disclosure of institutional child abuse.

Conclusion

The program of research presented here clarifies the complex relationship between institutional abuse and negative outcomes, with the IMICA proposed to capture some of these complexities. Further highlighted is a limited understanding of strength factors and the important role of disclosure in the abuse-trauma symptom relationship. By demonstrating how disclosure can be challenging for victims and may relate to increased trauma symptoms, the research illustrated the importance of considering disclosure as a process that can be aggravated by negative responses. Developing resilience in an individual may also present as a protective feature. Connected to this is the role of the self and how impairment in this adds complexity and can aggravate trauma symptoms. This, coupled with a wider understanding of more enduring factors (e.g., resilience, personality, belief systems), could help with understanding the mechanisms whereby psychological recovery from trauma can be facilitated and/or minimized. This is, undoubtedly, an important avenue for future research.

Disclosure statement

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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