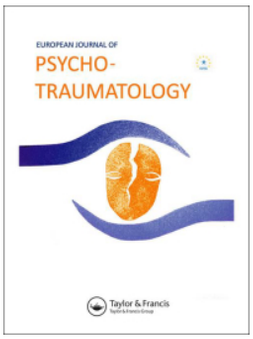

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BASIC RESEARCH ARTICLE

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'Sometimes I cry with that child': experiences and views of adult survivors of childhood sexual abuse on psychosocial treatment and support in India*

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ABSTRACT

Background: The high prevalence of childhood sexual abuse (CSA) in India is a cause for concern. Survivors of CSA often experience psychosocial difficulties in their adult lives. Whilst their difficulties are partly recognised in India, there is a need for further exploration on the availability and access to support.

Objectives: We explored the views and experiences of adult survivors of CSA in India on different types of treatment and support.

Method: We conducted semi-structured interviews with adults who were sexually abused before the age of 18. The data were analysed using reflexive thematic analysis, followed by narrative analysis of two transcripts.

Results: We interviewed 10 adult survivors of CSA in India. All participants were female with formal education. We conceptualised their recovery beginning with initial introspection and reliance, for example, on artistic and animal-assisted avenues. This is followed by seeking informal support, and, for some, seeking more formal support. Some also sought help through public figures, social media and Government initiatives and/or from their faith communities. We have further presented two narrative summaries explaining the genre, tone and core narrative of participants' experiences.

Conclusion: Our findings suggest that these adult female survivors of CSA in India predominantly relied on their own coping strategies in the absence of holistic support. This was pronounced due to the dearth of mental health and social care for those who have experienced CSA in India. Future research needs to focus on understanding the meaning and language of CSA to enable the development of culturally tailored interventions.

"A veces lloro con esa niña": experiencias y perspectivas de sobrevivientes adultas de abuso sexual infantil sobre el tratamiento y apoyo psicosocial en India

Introducción: La elevada prevalencia del abuso sexual infantil (CSA por sus siglas en ingles) en India constituye un motivo de preocupación significativa en salud pública. Las personas sobrevivientes de CSA suelen enfrentar dificultades psicosociales persistentes en la adultez. Aunque dichas dificultades han comenzado a ser reconocidas en el contexto indio, aún es necesario profundizar en la comprensión de las fuentes de apoyo disponibles para esta población y en su grado de accesibilidad.

Objetivos: Explorar las experiencias y opiniones de las adultas sobrevivientes de CSA en India y los tipos de tratamiento y apoyo.

Método: Se realizaron entrevistas semiestructuradas con personas adultas que fueron víctimas de abuso sexual antes de los 18 años. El análisis de los datos se llevó a cabo mediante análisis temático reflexivo, complementado con análisis narrativo en dos de las transcripciones.

Resultados: Se entrevistó a 10 sobrevivientes adultas de CSA, todas mujeres con educación formal. El proceso de recuperación fue conceptualizado en torno a cuatro fuentes generales. Inicialmente, las participantes recurrieron a la introspección y la confianza, como actividades artísticas o con asistencia animal. Posteriormente, muchas buscaron apoyo informal, y algunas accedieron a apoyo profesional. También se identificaron otras vías de ayuda, como el seguimiento de figuras públicas, redes sociales e iniciativas gubernamentales o de lideres y miembros de sus comunidades religiosas. Asimismo, se presentan dos narrativas que ilustran el género, tono y estructura central de las experiencias relatadas por las participantes.

ARTICLE HISTORY

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KEYWORDS

Childhood sexual abuse; child sexual abuse; adult survivors of childhood sexual abuse; sexual violence; sexual abuse; complex post-traumatic stress disorder; qualitative study; reflexive thematic analysis; narrative analysis; India

PALABRAS CLAVE

Abuso sexual infantil; CSA; sobrevivientes adultas de abuso sexual infantil; violencia sexual; abuso sexual; trastorno de estrés postraumático complejo; estudio cualitativo; análisis temático reflexivo; análisis narrativo; India

HIGHLIGHTS

- Adult survivors of childhood sexual abuse in India predominantly rely on themselves to manage their emotional and behavioural difficulties.
- These adult survivors, whether to inform or seek support, will contact their social networks in India. They also would prefer psychological treatments over any other form of formal support, such as medication, healing and meditation.
- Adult survivors have had mixed experiences with a range of professionals and Government and public initiatives.

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Conclusión: Los hallazgos sugieren que las sobrevivientes adultas de CSA en India recurrieron predominantemente a sus propias estrategias de afrontamiento personales ante la ausencia de apoyo holístico. Esto se debió debido a la escasez de servicios de salud mental y apoyo social para aquellos que han experimentado CSA en India. Salvo algunas excepciones que accedieron a atención profesional, la mayoría reportó apoyarse en redes sociales, actividades recreativas y la compañía de animales para facilitar su recuperación. Se recomienda que futuras investigaciones profundicen en el análisis del significado y el lenguaje en torno al CSA, con el objetivo de diseñar intervenciones culturalmente sensibles.

1. Introduction

Childhood sexual abuse (CSA) is often recurrent and prolonged, taking the form of complex trauma (Ford & Courtois, 2021). Children and young people with such complex trauma histories may experience biological and psychological impacts in their childhood and adult lives (Danese & McCrory, 2015; Manukrishnan et al., 2024; Musliner & Singer, 2014). CSA has been shown to be associated with mental health difficulties and is a risk factor for Post-Traumatic Stress Disorder (PTSD) and even more so for Complex Post-Traumatic Stress Disorder (CPTSD) (Bak-Klimek et al., 2014; Cloitre et al., 2013).

CPTSD, in addition to the symptoms of PTSD, includes disturbances in self-organisation- affective dysregulation, negative self-concept and disturbance in relationships (World Health Organisation-WHO, 2018). Treatment recommendations for CPTSD are still in development, with some additions to standard PTSD treatment suggested. The NICE Guideline (2018) for treating CPTSD in the UK recommends the same treatments as for PTSD with the addition of an increased number or duration of therapy sessions, managing any barriers to engaging in therapy, considering the safety and stability of the person and discussing any ongoing needs they may have regarding ending treatment.

Studies in India have reported that CSA has been experienced by between four and 41% of the population (Choudhry et al., 2018). Specific to India, the Protection of Children from Sexual Offenses (POCSO) Act of 2012 aims to 'protect children from offences of sexual assault, sexual harassment and pornography and provide for the establishment of Special Courts for trial of such offences and matters connected therewith or incidental thereto' (Ministry of Women and Child Development, 2023a). Utilising econometric models with CSA data stored with the National Crime Record Bureau (NCRB), a recent study reported that since the POCSO Act came into being, reported cases of CSA in India have reduced (Maity & Chakraborty, 2023). However, underreporting of CSA is likely, due to shame (Sharma & Gupta, 2004), a lack of knowledge about how to respond, and parents' perceived failure in protecting their children from CSA (Shirley & Kumar, 2020). Even in adulthood, male survivors of CSA in India experience difficulties in disclosing their abuse; this is further deterred by the silence in society on topics such as sexuality (Sharma, 2022).

Sociocultural contexts, specifically norms, structures and environmental stressors, have been postulated to have an impact on the mental health of survivors of sexual violence (Dworkin & Weaver, 2021). Latiff et al. (2024) conducted a systematic review of socio-ecological factors impacting disclosure of CSA and found that culture (especially Asian culture) was a barrier. A literature review on CSA survivors from ethnic minority communities in Australia reported that a multicultural framework was needed as CSA survivors from these minority communities, including South Asians, often have treatment needs which Western practitioners may not be able to support (Sawrikar & Katz, 2017).

A systematic review on adult CSA survivors' experiences and views of the psychotherapy/ counselling services in the UK included nine articles, of which all except one were qualitative studies (Chouliara et al., 2012). The authors synthesised the data into positive experiences (therapeutic relationship, knowledge about issues) and negative experiences (showing sexual interest in the survivor, ineffective in dealing with issues, prescribing heavy medication, unresponsive). Chouliara et al. (2014) explored the recovery process of CSA survivors in the UK and proposed a theoretical model that entails guilt, over-reliance on self and stigma and moving on to the recovering self. A research report with Survivors in Transition highlighted the survivors' experiences of formal support as mixed (Bond et al., 2018).

Despite a growing body of research with adult CSA survivors in the UK and the USA, a systematic review reported that there is scant literature in South Asia on the experiences of adult CSA survivors (Talwar et al., 2024a). Further, to date, there are no evidence-based treatments that have been culturally adapted to survivors in this context (Talwar et al., 2024a). Mental health professionals and key stakeholders in a qualitative interview study also reported the need to develop treatments according to survivors' culture and requirements (Talwar et al., 2024b). In this study, we aimed to explore the experiences and views of adult

survivors of CSA in India on the psychosocial interventions available to them. We also aimed to consider survivors' perspectives on reconfiguration of current evidence-based treatments that have been developed in a Western context.

2. Methods

2.1. Ethical approval

The study was approved by University College London's Research Ethics Committee. The study is reported according to the Reflexive Thematic Analysis Reporting Guidelines (Braun & Clarke, 2024).

2.2. Population

We included individuals who were at least 18 years of age, with experience of being sexually abused before turning 18, and who were of Indian origin residing in India. Their experiences with CSA could include contact or non-contact CSA (including physical touch or not), penetrative or non-penetrative CSA and single or multiple incidents.

2.3. Sampling and recruitment

Using purposive and snowball sampling, we aimed to interview 8–15 participants from diverse geographical and cultural backgrounds of varying ages and occupations to allow for varied views and representation. Adult survivors of CSA were recruited through the first author's (ST) professional network of clinical psychologists in India. These professionals informed any eligible current or past adult clients about the study and asked them to contact the study team if they were interested in finding out further information. We also advertised the study details through a recruitment flier on LinkedIn informing mental health professionals in India and asking them to pass on this information to their clients. Potential participants were given a participant information sheet and had the opportunity to ask questions before completing the consent form.

2.4. Data collection

Data were collected between October 2023 and January 2024. After noting participants' demographic details, ST conducted semi-structured interviews via Zoom/Teams or face-to-face using a topic guide developed by ST, RA and JB. The topic guide (supplementary material 1) included questions on formal and informal sources of support, and experiences of receiving that support. There were specific questions on participants' views of potential treatments and specific needs of survivors in their community/gender/region/age group and within India. All the interviews were transcribed using MS Stream, checked and edited for accuracy, and then stored securely and separately from the audio files and demographic information. Most of the interviews were conducted in English. For those interviews which were mostly in Hindi or had a few Hindi words, ST transcribed them using the English alphabet, thus retaining the original text and its meaning. However, the quotations used from the data in the results section were translated into English for the ease of the reader.

2.5. Data analysis

We used a multi-method qualitative analysis approach including reflexive thematic analysis and narrative analysis.

(A) We analysed the transcripts using reflexive thematic analysis (Braun & Clarke, 2022). This enabled us to identify patterns across the data from all the participants. After familiarising ourselves with the data, ST coded all the transcripts on NVivo version 12. She maintained a reflexive journal during data collection and coding to record reflections and feed them into the analysis. She presented the initial findings, followed by the categories and preliminary themes to RA and JB. Feedback was incorporated to develop the themes, including comments from HKe, an expert clinician working with adult CSA survivors in the UK. The final themes, subthemes and their labels were refined following feedback from all the team members. We sent a summary of findings to all the participants in the form of an infographic inviting further feedback.

(B) We also drew on Kohler Riessman (2000) narrative analysis approach and Thornhill et al.'s (2004) adaptation of it. There is no fixed way of conducting narrative analysis and the approach depends on the investigator and research aim (Riessman, 2008). With the motive of presenting a brief and systematic analysis of survivors' narratives, and to further illustrate themes from the reflexive thematic analysis, we purposively selected two transcripts, one who sought professional help and the other who did not (Nicholls et al., 2023; Thornhill et al., 2010). First, we read and re-read the whole transcripts to understand the story and its structure. Then, we drew upon Thornhill et al.'s (2004) approach in their study on recovery from psychosis. This approach included identifying narrative genre, narrative tone and core narrative. Narrative genre or holistic form analysis was determined to answer 'what kind of story is this?'. We also identified two dominant narrative tones to highlight the change

in the tones of our participants while narrating their stories; here, we aimed to answer 'how is the storyteller feeling while narrating it?' (McAdams, 1993) based on our subjective response to the story and the narrator's way of conveying it. The third component, core narrative, was used to identify the key message of the narrative. It was used to answer 'what meaning does this story convey?' and we summarised the whole narrative using a few words to identify one core narrative (Mishler, 1986). These elements of the narratives were established on the basis of the viewpoints of ST, reviewed closely by RA and JB. We sent the analysis to the respective participants for their feedback and the final analysis was reviewed by all authors.

2.6. Researcher characteristics and reflexivity

All team members had academic backgrounds in mental health. ST is an Indian female and licensed clinical psychologist in India. HKe is a white British female consultant clinical psychologist in the UK. SJ is a male consultant psychiatrist and medical anthropologist of Indian origin. HKi is a white female British consultant psychiatrist in the UK. RS is an Indian male Consultant Psychiatrist. RA is a white British female academic researcher in the UK. JB is a white British female consultant clinical psychologist in the UK.

As a team, we reflected on the study design and materials as well as findings, being mental health professionals and researchers. With an upbringing and clinical training in India, ST was able to engage with the participants and, along with RS and SJ, was able to reflect on the data in a more culturally, structurally and legally informed manner. JB and HKe engaged with the data as clinical psychologists experienced in working with adult survivors of CSA. HKi further informed the design and analysis as an experienced Psychiatrist working with complex presentations. RA and JB supervised ST with their extensive qualitative research background.

Table 1. Characteristics of participants.

Characteristics ($n = 10$)	n (%)
Gender	
Female	10 (100%)
Age (years)	
21–30	3 (30%)
31–40	6 (60%)
41–50	1 (10%)
Highest degree completed	
Undergraduate	3 (30%)
Postgraduate (Masters)	5 (50%)
Postgraduate (MPhil)	2 (20%)
Sexual orientation	
Heterosexual	9 (90%)
Pansexual	1 (10%)
Place of residence (region in India)	
South	2 (20%)
South West	2 (20%)
North	5 (50%)
North East	1 (10%)
Occupation	
Healthcare	3 (30%)
Teaching	1 (10%)
Technical/Managerial	4 (40%)
Social work	1 (10%)
Student	1 (10%)
Relationship status	
Single	7 (70%)
Partnered	3 (30%)

3. Results

We interviewed 10 adult survivors of CSA in India. All of them were female, and all except one were heterosexual. All had completed at least undergraduate degrees and were working professionals or students. Their ages ranged between 22 and 47 years. Please see Table 1 for further details of participant demographics. The interviews lasted between 52 and 87 min (average 69.5 min). All except one interview were conducted online.

3.1. (A) Reflexive thematic analysis

We have conceptualised the findings in chronological order, with a non-linear flow to illustrate the healing process of adult CSA survivors in the aftermath of their CSA experiences. Participants' transition from victimhood to survivorhood was likely to begin from within, followed by seeking support from or disclosing within their social networks, to sometimes seeking professional help. Finally, they interacted with broader national and international institutions and initiatives. Figure 1 illustrates the non-linear journeys of CSA survivors. Within these chronologies, we have presented the themes and subthemes developed, listed in Table 2.

3.2. Experiences within themselves

Beginning their recovery process from victims of abuse to survivors, the participants in our study reported their initial struggles within themselves before disclosing their abuse to another person.

3.2.1. Familiar does not mean safe

Survivors in our study were mostly exploited by familiar people, including family members or someone staying nearby. These perpetrators included parents or other relatives, priest, family friends, staff at home and tenants. Some participants reported multiple experiences of abuse, either by the same or different perpetrators. These multiple incident exposures ranged from a few months to most of their childhood and adolescence. As the abuse occurred in known locations, it had an impact on their sense of safety

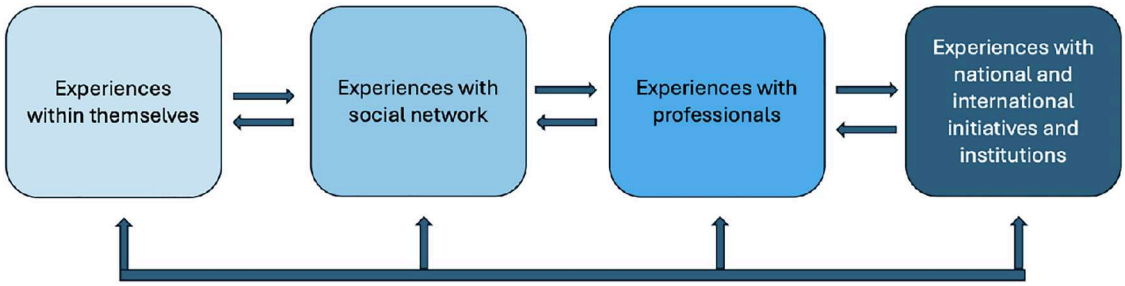

Figure 1. Chronological, non-linear journey of adult CSA survivors.

Table 2. Themes and sub themes.

Chronology	Themes	Sub-themes
1. Experiences within themselves	1.1 Familiar does not mean safe	Impact on sense of safety
		Violation of a potential haven
	1.2 Bottomless pit	Whirlwind of thoughts and emotions
		Struggle to feel loved
	1.3 Higher power and inner self	
	1.4 Solace in expression	
	1.5 Saviour for others	
	1.6 How will 'they' take it?	Hesitant to disclose
		Fearing vulnerability to close and intimate relationships
2. Experiences with social network	2.1 Leaning on friends, family and partners	
	2.2 Unacknowledged need for professional support	
3. Experiences with professionals	3.1 Seeking help on my own	Self-initiated process
		Consulting mental health professional could have eased healing process
	3.2 Aware of problems, less aware of available support	Voice their difficulties
		Uncertain of the treatment
		Preferred receiving psychological help
		No information on non-statutory help
	3.3 Roadblocks in accessing professional help	
	3.4 Hopes and expectations from professionals	Empathy, trust and feeling heard
		Expect treatment to be discussed
4. Experiences with national and international initiatives	4.1 Government initiatives for broader change	Hope Government would prioritise CSA prevention
		Mental health awareness
	4.2 Involving public figures, media and places of faith to implement change	Public figures impact wider audiences
		Utilising social media to advertise about special initiatives and mental health
		Reliance on opinion of faith leaders

even within familiar spaces when perpetrated by familiar people.

> … it has happened from someone who was considered a friend and all of them (family) just choose to still keep him in the friend circle because he was considered the good guy. South Indian in her 20s

One survivor experienced abuse by her father and resented her mother for not protecting her. Some other survivors echoed this sentiment, whilst others felt that their parents would have saved them if they knew. These experiences were described as a violation of a potential haven for them. Some of the survivors continued to stay or visit those locations, as these were their places of residence or those of their relatives.

> I was having such a difficult time at home, and we had so many unsaid and spoken clashes at home. I was abused even in my own house, so I never felt safe at home. South West Indian in her 30s

Some others stopped visiting those places or moved to another city for education or work.

3.2.2. Bottomless pit

Our participants, on acknowledging that those childhood experiences were abusive, felt a whirlwind of thoughts and emotions. They predominantly described anger, shame and disgust, with low self-esteem and self-blame. The survivors reported that, while some of these recurring thoughts and feelings have resolved over time, they continued to experience some of these, either frequently or in waves. Therefore, the 'bottomless pit' explains the presumably never-ending fate of survivors experiencing distress. Below, a participant's quote highlights that even though they mostly feel settled, the news of someone being a victim of CSA brings back their own memories of abuse.

> … but off and on whenever anything like this would happen with anybody around me, so those thoughts would resurface again. I always felt angry for not knowing what to do, for not knowing for not been given a chance to stop it. So it comes up again. North Indian in her 30s

Some survivors highlighted that they struggled to feel loved, physically and emotionally, after their bodies were treated exploitatively.

> So I met this guy … interested in me. I probably didn't spend enough time in analysing whether I like them enough … North Indian in her 30s

3.2.3. Higher power and inner self

Some survivors credited embarking on their healing process to religious and spiritual practices. Faith came across as a crucial protective factor for some survivors in preventing them from harming themselves as a response to the abuse.

> … it came from a strong space of faith … we don't believe in taking lives, even your own. So my faith in God is what completely stopped me from ever changing thoughts to actions and letting go of the thoughts. South West Indian in her 30s

Engaging in church-based activities and visiting temples became central to these participants' recovery. One of the survivors believed that God sacrificed Himself for their lives, implying that she needed to continue her life to serve others. She also speaks below about being 'flawed' due to the abuse and still being accepted by her God.

> I felt guilty, I felt ashamed that my body has been used that way, I felt disgusted also. So I think those emotions actually put me closer to Christ in a way that you know all the others are for sharing, but the actual help is through the Lord … even if how imperfect I feel, how flawed I feel, He accepts me and He has given me life through His death in the cross and His resurrection. And I think that faith brought me this far rather than anything else or anyone else. North East Indian in her 30s

Some participants practiced Buddhism, specifically Nichiren Buddhism, including attending regular groups and chanting. These participants found support for dealing with their CSA experiences, either with or without disclosing, by engaging in discussions about the self.

3.2.4. Solace in expression

For some survivors, forms of art and literature like painting, writing poetry and stories, and reading enabled them to comprehend and express the impact of CSA. Some of the participants engaged in soulful singing, choir music and listening to specific songs.

> … when one can express his or her emotions, that's the way of healing. And for me, poetry helps … prose and poetry … when I jot down my feelings, I feel relieved. When I read some poetry, I feel relieved because sometimes you can connect with others' emotions. The situations may be entirely different, but they help … art in its form, music. Umm, so healing. I still remember crying with Lady Gaga when she sang 'till it happens to you, you don't know how it feels' … that there are other people like me who have faced such a situation. North East Indian in her 30s

In the quote above, the survivor spoke about the relatability of words used by popular artists, serving as a channel for our participants to express herself. One survivor relied on her pets for comfort when she could not rely on another person.

> I started raising cats. Then, I raised her children. So, animals definitely were the best coping mechanism. North Indian in her 30s

3.2.5. Saviour for others

All our participants felt the need to protect others from exploitation, be it young family members or members of the community. Some of the survivors asserted against their perpetrators who were blood relatives.

> Like my niece. She's the world to me … So, I did my part as an adult in making sure that the kids that come after me, their adults know. North Indian in her 30s

Some of our participants opted for careers as clinicians or in charities working with trauma-affected people. They reported experiencing flashbacks when working with other survivors. Nevertheless, they intended to protect others when they could not protect themselves.

3.2.6. How will 'they' take it?

Our participants were hesitant to disclose their abuse. They were uncertain of their families', especially parents', reactions. Participants feared being dismissed or blamed.

> Victim shaming is a huge thing in the family and that's one of the reasons I haven't spoken about that in the family. South Indian in her 20s

Some of the survivors wondered if they would burden or risk hurting their loved ones by informing them.

Most participants reported fearing vulnerability to close and intimate relationships in their adult lives. Irrespective of current or past experiences in connections, they struggled to engage in romantic and/or sexual relationships, with some citing extreme difficulties with physical intimacy and trusting others.

> I am extremely afraid to let my guard down. If I'm always afraid that someone will take advantage of me … I will always want to have the upper hand like … being the one who gives the most, being the one that the friend is most indebted to … all because I don't want to be in a space where I am the weaker one. South West Indian in her 30s

> … it's like I tolerated that horrible behaviour … I, unknowingly in romantic relationships … tend to tolerate people who hurt my feelings. North East Indian in her 30s

3.3. Experiences with social networks

The survivors we spoke to, after initially deliberating within themselves, then tended to choose to disclose to people in their social network. The responses received to disclosure were then likely to determine the survivors' next steps.

3.3.1. Leaning on friends, family and partners

Our participants had disclosed their abuse experiences to friends, family and partners (or potential partners), all known figures in their lives. As they had expected, there were some dismissals and blame, but there was also acceptance by siblings and parents, especially female family members. Some participants had not felt comfortable disclosing to their male family members. With friends, survivors either deliberately expressed or inadvertently brought up sex related experiences, sometimes without realising that these experiences were exploitative. Most friends normalised these disclosures, having experienced such instances themselves. Others asked the survivors to disregard those memories. With partners, the responses experienced by the participants in this study were mostly supportive.

> I was myself saved by (a) good and loving relationship. Had that part of my life also would have gone the other way, maybe this trauma would have kind of stayed for a very long time or would have resurfaced in a much bolder way … when one part of your life is very good or happy, the other part which was bad, it is easier to forget. So definitely I haven't forgotten, but I do not feel that sorry for myself anymore. North Indian in her 20s

3.3.2. Unacknowledged need for professional support

None of the survivors in our study were encouraged by friends or family members to seek support from mental health professionals or the charity sector. Participants mentioned that they wished someone had noticed their struggles, suggested or accompanied them to see a professional or had better knowledge of the mental health impacts of CSA.

> I mean, when I look back at that girl, I'm like anybody who would have spent thoda bohot (a little) amount of time, would have seen that there are so many blasting signs in that kid … screaming that that kid needs help … very outspoken … I don't give two flying fucks to say what and I just say what I have to say … North Indian in her 30s

Most often, the survivors did not receive any advice to seek professional help.

> … in school, we used to have a counsellor … but nobody has told us that you could go there, and you know you could just talk about your mind or anything for that matter. North Indian in her 30s

4. Experiences with professionals

Some participants, irrespective of others' response to their disclosure of abuse, independently decided to seek advice to manage their physical and psychosocial difficulties. During this support-seeking phase, they continued to additionally manage themselves internally and engage with people in their social networks.

4.1. Seeking help on my own

Some participants in our sample who sought professional help self-initiated the process. Below, a participant speaks about finding a professional on their own by trial-and-error.

> … I realised that … the low phases are actually not low phases … it was just Googling and figuring out like a psychiatrist with a decent number of reviews, and I booked an appointment, and I went and I met him. South Indian in her 20s

These survivors consulted psychiatrists, clinical or counselling psychologists, shamanic healers, neurolinguistic programming practitioners or a combination of these. They reported being diagnosed with anxiety, depression, personality disorders and neurodevelopmental disorders. Flashbacks, suicidal ideas and nightmares, in the past or present, were also commonly reported difficulties.

Reflecting on the questions during the interview, some of the other survivors who had not visited a professional wondered if consulting a mental health professional could have eased their healing process. Some participants reported not being aware of CSA or available support in their childhood or early adulthood.

> So people today are really fortunate, but during our childhood, I wasn't aware of any of these … North East Indian in her 30s

> … if that awareness that had just come in right now, I would have definitely gone. North Indian in her 30s

Our participants considered professional help without any support or suggestions from others. In the next subtheme, although linked with this one, we highlight that these survivors knew that they needed help, but were unsure of the available facilities and modalities.

4.2. Aware of problems, less aware of available support

Our participants were able to voice their difficulties, i.e. explain their problems. Those who approached clinicians sought help for interpersonal issues, mood disturbances, sleep disturbances and anxiety. Some survivors expressed bodily complaints related to stomach problems, sexual difficulties and stiffness. One participant reported being displeased with her misdiagnosis of borderline personality disorder,

which dominated her traumatic experiences, thus obfuscating the symptoms of ADHD.

> I feel like BPD was the harder one to take because it almost felt like a self-diagnosis at that point because I was at the psychiatrist clinic, he passes me this pamphlet. He's like 'do you relate to these', and I was like 'yes, I do', and that's it … I did feel misdiagnosed with BPD. I did suspect neurodivergence … back then, I did not know it was a thing … it did take me a couple of years to actually go to a psychiatrist or at least bring that conversation … So this time I did talk to a clinical psychologist, had a proper assessment done for two things, Personality disorders as well as ADHD. South Indian in her 20s

Those participants who consulted a psychiatrist experienced either unpleasant circumstances (i.e. sexual harassment, exploitation) or unhelpful symptom-specific, medicalised conversations. Nevertheless, one survivor appreciated her psychiatrist's efforts to manage her risk to self and her sleep difficulties. With psychologists, most of the survivors were uncertain of the treatment they received. They spoke about grounding, mindfulness, Neurolinguistic Programming, Rational Emotive Behaviour Therapy and Emotion Focused Therapy. However, these terms were mostly used by those who had psychology or social work backgrounds. Other survivors were less aware of the treatments, one even mentioning that they were consulting a psychologist but were not receiving any treatment.

One survivor contacted a medical professional for physical health problems who prescribed antidepressants, but it was a while before the survivor consulted a mental health professional. Another participant found resolution in shamanic healing along with psychological support. Reflecting on their ongoing or past treatments, some survivors mentioned that the discussions during this research interview helped them understand the support received so far and other available treatments. Overall, those participants who sought help and most of those who may consider contacting a professional preferred receiving psychological help over medication.

> If I had to choose out of all these professionals, a good psychologist would be my first choice. North Indian in her 30s

Except for those who were working in the charity sector, most survivors had no information on non-statutory practitioners working with survivors. When asked about such support programmes, they did not know of ongoing ones in India. Nevertheless, they were keen to access them if made available.

4.3. Roadblocks in accessing professional help

Most survivors who sought professional help or attempted to explore found that a good psychologist's fee was high or unaffordable. Some spoke about being privileged to access resources, considering their socio-economic status and education. A participant in the quote below highlighted that if there has been a dearth of credible mental health services in the main cities of India, small towns would not have much support.

> … good services in India, we don't have, forget about 2 tier cities or 3 tier cities. We don't even have them in metros … if you need good therapy, you need to be ready to shell out (a) good amount of money. And not every survivor would have that kind of liberty to spend. North Indian in her 30s

Participants also reported that it may take time to find the right psychologist for their needs.

Most of the survivors mentioned that the stigma associated with seeking support for difficulties related to CSA and mental health is discouraging. They highlighted stigma being more pronounced in some regions and communities, impacting the hesitation and openness to suggesting or seeking it. For example, a survivor highlighted that her community would disapprove of consulting a mental health professional, despite her background in psychology. The participants in our study had similar opinions of their families and communities stigmatising sex, disclosure of CSA and associated shame. Some further described concerns about their confidentiality if there were other survivors from their communities in a pair or group therapy setting. However, for other survivors, if they were paired or put in a group with survivors from another community, it would not deter them from participating. Of note, whilst some of the survivors' responses are based on their lived experience of attending professional consultations, the suggestions are based on hypothetical scenarios.

4.4. Hopes and expectations from professionals

The survivors highlighted that empathy, trust and feeling heard were some of the most important qualities they would need in a service provider.

> Being able to listen and being mindful … these would be very delicate conversations. South West Indian in her 20s

Most survivors suggested that they would expect their treatment to be discussed with them by their clinicians. During the interview, we explained the recommended phase-based approach to trauma-focused interventions (Cloitre et al., 2012; Herman, 1992) and explored our participants' views on each phase. They suggested that all three phases would be important to retain, explaining the relevance of stabilising a survivor as crucial to entering the processing of traumatic CSA memories. However, stabilisation may be combined with trauma memory processing to accelerate the processing while supporting them to regulate their emotions. An additional benefit, according to

the participants, would be to reduce the length of therapy. Further, they said that reintegration needs to reflect the present needs of the survivor. For example, a survivor highlighted that the tasks in reintegration should add value to their current requirements and interests, not simply reflect tasks which they were unable to do in their developmental years.

When discussing different approaches to treatment, some survivors highlighted the age of the client and therapist as crucial. One of the survivors explained that a novice therapist of similar age as the survivor (client) may be able to offer relatable illustrations but may not be as skilled as required by the client. In the interviews, we discussed potential methods of delivery of therapy in groups or pairs based on hypothetical scenarios. Participants stated that the ages of members, religion, socioeconomic status, region/community and gender would impact the therapy or support. Most of the survivors were willing to try group therapy as well as group support, and some participants showed interest in being treated in pairs.

> a survivor always feels alone … one of the biggest factors (is) that there are people apart from me who have gone through similar experiences and healed so I can too. It gives them motivation. It makes them feel like they belong. It doesn't make them feel like an outcast … It makes them focus on the bigger picture a little better. South West Indian in her 20s

Participants suggested that a combination of individual and group therapy would be ideal. However, they also highlighted that a high level of distress would suggest that a survivor may not be a good fit for a group.

> A mix of group and individual, right? Because whatever the person is not able to talk about it in the group can be spoken about in the individual sessions after or prior. South West Indian in her 20s

5. Experiences with national and international initiatives and institutions

The experiences of interactions with self, others and professionals intertwined with a broader level of impact of the Government, social institutions, media and public figures on the survivors in our study.

5.1. Government initiatives for broader change

The survivors in our sample hoped that the Government would prioritise CSA prevention and create awareness about its impact. A major recommendation from most survivors was to include sex education as an important element of the school curriculum. One survivor hypothesised that even for those without access to school education, messages on public transport and through Indian media about CSA could help improve awareness. These initiatives, according to our participants, need to be developed and implemented by the government.

> I wish we were given this knowledge at a very young age so we could realise it … kids … will get information eventually from somewhere … every child is entitled to get information about puberty, information about sex education, very important. North Indian in her 30s

Some participants suggested initiatives for mental health awareness and mentioned services such as Tele MANAS (a free 24 × 7 tele mental health service in India), which need to be advertised.

5.2. Involving public figures, media and places of faith to implement change

Some survivors highlighted the relevance of public figures impacting wider audiences. Music and film celebrities speaking about their traumatic histories impacting their mental health empowered these survivors to understand themselves. One of the participants spoke about resonating with a musician of a Korean band's healing journey.

A few survivors reported witnessing special initiatives such as #MeToo, which helped them view themselves as belonging to a larger group with similar exploitative experiences.

> MeToo hashtag. That helped … North East Indian in her 30s

Some participants suggested utilising social media platforms to advertise mental health initiatives for broader impact. One survivor specifically spoke about the needs of her community and their reliance on the opinions of faith leaders; she highlighted that if their faith leaders were involved in promoting CSA prevention programmes and support for CSA survivors, community engagement would be assured.

5.3. (B) Narrative analysis

We have presented below narrative summaries of two participants. One of those participants sought help from a mental health professional, and the other relied mainly on her social network. On reviewing their narrative, both participants expressed that they were content with the stories. We have used pseudonyms for confidentiality purposes.

5.3.1. Narrative 1

Manya narrated her experiences of first informing her friend at the cusp of adolescence and adulthood, only to realise that her friend had difficult experiences in childhood too. Later, she disclosed to her partner, again as a part of discussing their early years. She

spoke about finding solace in sharing rather than asking for help.

> … we were all seeking … solace from each other when we open up to the others, it's not always seeking for any help but solace that we are in it together …

Manya's story is one of 'surviving and saving'. This narrative genre captures how she navigated her emotions with the support of family and her partner but mainly on her own. She then went on to shelter others and continued to take measures to make help available for others. During the interview, Manya had a narrative tone of anger and disappointment when speaking about her abuse-related memories. It kept shifting between that tone to love and empowerment when she spoke about sheltering others and preventing CSA.

> I can be the provider. Maybe that has saved me over the years.

Manya's story had the core narrative of mental health literacy. She wished that she was aware of the consequences of CSA and the disappointment with the lack of information. Manya empathised with other survivors who may not have the resources to overcome the traumatic experiences. She took on the psychoeducation role to empower others who needed support and information. She has been endeavouring to make information on CSA, mental health consequences and professional services available.

5.3.2. Narrative 2

Alisha's narrative involved her process of finding the person she could confide in and self-exploration. She spoke about her disclosure not being well received, further increasing thoughts of self-blame. Eventually, her 'surprised inner child' was sheltered by her colleague (and later partner) and her mother. She has been consulting a clinical psychologist and spoke about the 'damage' that had been done and which needed to be dealt with in therapy.

This story is encapsulated in the narrative genre of 'self discovery'. Alisha emphasised that the perpetrator being punished should be the inevitable outcome; the survivor's survival needs to be the focus. The care from her partner and mother, and later, the sense of safety she felt that her family members were aware of, was crucial for her to move forward. Further, working on the 'damage' with her therapist has been paramount in understanding herself.

> … good to know somebody paid for what they did, but it doesn't help you. It doesn't take away every damage that has happened to you … .has to be about the person surviving it and people forget that …

During the interview, Alisha had a narrative tone of disappointment and discouragement when speaking about her experiences of disclosure.

> … (physical intimacy) is either supposed to be a conquest or supposed to be disappointing, but it's never been talked about as an emotion, as a feeling …

Her narrative tone changed to warmth and empowerment when Alisha was narrating her journey and the support available.

The core narrative in Alisha's story revolved around trust and safety. She trusts and listens to her body for any signs of discomfort. This trust also plays a key role in her relationships, and she believes that the ease of disclosing abuse could save anyone else from experiencing it. As Alisha stated, moving away from the 'collective narrative' of the victim being 'difficult' and moving towards enabling disclosure could help the survivor seek support.

6. Discussion

We explored the views and experiences of adult survivors of CSA in India on their treatment and support needs and reconfiguration needed in current treatments and support available to them. Overall, we found that they viewed their recovery process as comprising a myriad of experiences within themselves, known persons, professionals and the wider world.

6.1. Psychosocial difficulties

Our findings suggested that adult survivors of CSA face intrapersonal and interpersonal challenges often linked to psychosocial difficulties arising from traumatic childhood experiences. In line with previous studies, we found that intrafamilial perpetration and abuse by acquaintances are commonly reported (Ferragut et al., 2021). Whilst the link between familiarity with the perpetrator and the severity of psychopathology is still debatable (Yancey & Hansen, 2010), adult survivors of CSA often struggle with trusting others (Cavanaugh et al., 2015). They also have a hampered sense of safety in physical spaces and interpersonal relationships (Manukrishnan & Bhagabati, 2024).

Similar to our findings, anger, shame, self-blame, guilt, depression, anxiety and suicidal ideation are reported globally by adult CSA survivors (Cavanaugh et al., 2015; Talwar et al., 2024a). These thoughts and feelings could be explained by symptoms of CPTSD (WHO, 2018). Specific to the South Asian ethnic group worldwide, shame within the family determines appraisal of one's CSA experiences and potential disclosure (Gilligan & Akhtar, 2006; Lim et al., 2022; Sharma, 2022).

Relationship difficulties such as problems in setting boundaries and feeling vulnerable in interpersonal relationships with families, peers and partners have been reported globally, including India (Cavanaugh et al., 2015; Sharma, 2022). This also encompasses

physical intimacy as well as in distinguishing between consensual experiences and exploitation (Cavanaugh et al., 2015; Manukrishnan & Bhagabati, 2024). A related struggle is low self-esteem, exhibited as inadequacy in receiving affection (Manukrishnan & Bhagabati, 2024).

6.2. Sources of support

Our study propounds that our survivor participants in India rely on family, friends and partners to seek support by disclosing their abuse experiences. Research in the USA has found that friends and family emotionally supporting an adult survivor of CSA lowered the odds of depression (Musliner & Singer, 2014). Extra-familial support from peers and romantic partners has specifically been shown to be associated with fewer depressive symptoms and better resilience (Powers et al., 2009). This could be due to the parents being implicated in the perpetration of abuse (Musliner & Singer, 2014). In India, the fear of bringing shame to the family could also impact disclosure (Sawrikar & Katz, 2017).

Our findings are in concordance with studies in other countries where the survivors feared their children or other young ones being abused and the adult survivors' dedication to protect them (Cavanaugh et al., 2015; Wright et al., 2012).

Aligning with our analysis, religion has been a source of support for adult CSA survivors in a review with predominantly White population and some representation from Latinos, Africans and Asians (Tailor et al., 2014).

One of our participants talked about how she sought support from her pets. Hamilton (2022) has posited that the human-pet relationship for adult CSA survivors offers safety, a resource for coping and social interaction and support for human interaction. Public figures of relevance speaking about their struggles and mental health difficulties (Gronholm & Thornicroft, 2022) and the #MeToo movement have reportedly shown improvements in recognition of past unwanted sexual experiences as sexual assaults, increasing conversations on sexual violence (Jaffe et al., 2021; Sigurdardottir & Halldorsdottir, 2021).

6.3. Status of professional treatments in India

Barriers to consulting a mental health professional included stigma and finances, resonating with findings in the West (Ahmedani, 2011). Our study participants further voiced difficulties in even identifying a suitable professional. With a global average of nine mental health practitioners per 100,000 people (Gupta & Sagar, 2022), India has 0.047 psychologists, 0.301 psychiatrists and 0.329 mental health outpatient services per 100,000 people (Centre for Mental Health, 2010). This dearth of qualified professionals in India means limited availability of all mental health services in the country, let alone specialist services for adult CSA survivors. A movement towards improving the availability and accessibility of the services and professionals for survivors could help in increasing support for survivors.

Often diagnosed with CPTSD, such survivors are recommended to be treated with psychological treatments such as trauma-focused CBT and EMDR (NICE, 2018). The phase-based approach to the treatment of CPTSD has been under review, with some critics arguing against the necessity of a stabilisation phase (de Jongh et al., 2016). Reintegration interventions evaluated to date have included varied activities such as physical exercise and using service dogs, among other recommendations (Purnell et al., 2021). Our participants propounded retaining all three phases. This sets the premise for evaluating the feasibility and acceptability of trauma-focused treatments with adult CSA survivors in India.

A systematic review of the treatments for adult survivors of CSA concluded that there are currently no studies on culturally sensitive treatments with survivors in South Asia (Talwar et al., 2024a). In this review, it was found that CBT was the most common treatment researched with adult CSA survivors. However, there is still a need to understand what constitutes trauma and CSA in an Indian and South Asian context. Then, developing interventions for adult CSA survivors in South Asia would follow. A qualitative study with mental health professionals and key stakeholders in South Asia also suggested the need for culturally validating interventions for trauma survivors, specifically adult CSA survivors in South Asia (Talwar et al., 2024b).

6.4. Wider initiatives available

In our study, social reactions to disclosure varied but had in common the unidentified mental health impact of CSA and the unrecognised need for professional help. This highlights that the link between CSA and mental health is not explicit in India. In concordance with our participants' suggestions, there is a rising need to implement CSA prevention and awareness programmes focused on carers and stakeholders, policy-level change and perpetrators. Sexual health literacy and comprehensive sex education, as voiced by our participants, could be foundational (Abrams et al., 2023). However, such teachings would need to be sensitively conceptualised and delivered in line with the Indian culture and accessible to those who may not be enrolled in a structured education system.

With limited mental health professionals to meet the needs of diverse communities in India, healthcare

services are currently delivered by limited specialist professionals through the task-sharing/shifting approach. One of the popular ways of this approach in India is the Accredited Social Health Activists (ASHAs) programme workers who complete 10 years of school and receive training to work at the district level with different health conditions (Sivakumar et al., 2023). If ASHAs could be trained to assess the impact of trauma and respond to the disclosure of sexual violence, they would be able to share the burden on currently limited professionals. This approach, however, needs to be carefully considered depending on the level of supervision and support for the ASHAs. Instead of framing India and other LMICs as bereft of mental health awareness, culturally relevant conceptions of mental health and management need to be understood.

The District Mental Health Programme and the National Mental Health Programme under the National Health Mission in India have expanded the scope of mental health services (Mahapatra & Seshadri, 2023). Similarly, Tele MANAS, launched in 2022 under the National Mental Health Programme to offer free, 24/7 mental health telephone service to Indians (Ministry of Health & Welfare, 2024a). Other health initiatives, such as Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (for national public health insurance) and Ayushman Bharat Digital Mission (for improving digital health infrastructure), have been implemented to enhance the reach and accessibility of health services in India (Ministry of Health & Welfare, 2024b,c). Despite these initiatives, there is a need to improve the reach of sensitive, specialised centres for adult CSA and other trauma survivors, such as One Stop Crisis Centres (Ministry of Women & Child Development, 2023b). There is a lack of awareness of the existence of such centres and potential hesitation to visit them. In our study, the survivors have expressed concerns about the awareness and reach of existing mental health programmes.

6.5. Strengths and limitations

Our present study has several strengths. To the best of our knowledge, it is the first qualitative study to explore adult CSA survivors' experiences of treatment and support, rather than abuse, in India and the South Asian region. We have reported participants' sexual orientation, often unreported in such studies with survivors in India. This data is important to understand paticipants' understanding of intimacy after experiencing sexual exploitation at an early age. Our findings, although taken with caution, also contribute to the developing work on sexual orientation and CSA. We focused on capturing survivors' voices for modifying their treatments and available support, especially a phase-based approach. There were additional strengths in the participants we interviewed. The participants were residing in diverse geographical regions across India and had varied professional backgrounds, with some diversity in socioeconomic statuses.

There are, nevertheless, limitations to the study. No participants identified as being male, transgender or non-binary. We could not reach people in rural areas, and only formally educated participants could be approached through our network and social media. Because we had a combination of participants who sought professional help and those who did not, their recovery process would have been different in terms of means and strategies to rely on. They were also varied in the amount of informal support, the ability to afford professional help and how recovered they felt at the time of the interview. As an example, one participant volunteered for this study after a discussion with her psychologist about being equipped enough to speak about her experiences. Another participant, who did not seek professional help, wanted to support the study to improve the evidence for her survivor friends and protect her child. Exploring those participants' views, who did not consult a professional, on potential therapeutic approaches and modalities was intended to understand their willingness to access and engage in those approaches. This would imply that some of the suggestions need to be taken with caution.

Whilst we were able to recruit 10 participants, which is a strength in a context where the stigma about CSA is so high, a larger number of participants might have reported different experiences and provided further insights than explored here. A further limitation was that all, except one, participants were interviewed virtually, potentially deprived of the understanding of 'social body', which, therefore, may have limited our ability to observe participants' body language to help us give context to the interview (Scheper-Hughes & Lock, 1987). Finally, not knowing the demographics and challenges of any survivors who chose not to participate made it difficult to understand how recruitment could have been tailored for them.

6.6. Implications for practice, research and policy

For mental health professionals and non-statutory practitioners, interactions with adult CSA survivors must be empathetic and non-dismissive. These practitioners could consider offering treatments and support in groups as long as the survivor client is willing (Kennerley, 2015). Group participation needs to be thoughtful with respect to clients' demographics and could be coupled with individual sessions. Finally, mental health professionals and other practitioners would need to bear in mind that adult CSA survivors

require sustained support beyond centres and clinics, perhaps in support groups or with the help of their existing social networks where this is appropriate and where support for the individual's wider social network can be provided. Many of our participants reported that they had sought help informally through their social networks and whilst many found this helpful, some did not. However, this does suggest that there may be potential to develop through future research, a greater understanding of the role and support required for these informal social networks to provide or augment treatment and support for adult survivors of CSA.

For researchers, conceptualising trauma in the Indian context is paramount. Then, developing and evaluating a culturally sensitive treatment for adult CSA survivors in India, either individually delivered or in groups, would be a crucial next step. This implication is also in line with the research priorities highlighted in a recent review of psychotraumatology literature to consider subjective interpretation of traumatic experiences based on culture, context and norms (Olff et al., 2025). A brief treatment catering to the needs of a wider population could be explored. However, evaluating these developed treatments and services would need participants and once developed, delivering them would require survivors to access services. Exploring creative ways to recruit adult CSA survivors and facilitators and barriers to accessing mental health services and non-statutory sector organisations would require further research. Understanding how to increase recruitment in India into studies on topics such as sexual violence and engaging participants with less formal education and of different genders would be paramount.

For policy makers, wider initiatives for CSA prevention and mental health awareness are important implications of our findings. Increasing the number and reach of one stop centres and making them gender inclusive could improve access to support. Providing specialist training to health professionals to screen for a history of CSA as part of general health assessments could also help CSA survivors to disclose these experiences and potentially access support earlier. Finally, improving the retention of professionals in District Mental Health Programme with job stability and benefits could improve the familiarity of survivors with professionals at these district-level services.

6.7. Conclusion and contribution to knowledge

The present study provides an analysis of the experiences of adult CSA survivors' access to treatment and support in India, their views on the formal and informal sources of support available and their suggestions for improving the currently available services and support. Overall, we found that most survivors do seek help, often from their informal support network, though some also seek professional help. Whilst most of those accessing professional help preferred psychological treatments, there appears to be uncertainty about the nature of the interventions offered. Of note, individuals also reported that they found strength to deal with their experiences through non healthcare related sources, such as their faith, the arts, and pets. This study emphasises the need to investigate Indian mental health professionals' sensitivity to understanding CSA and other cognate abuse and to provide training for health professionals in screening for CSA. Conceptualising trauma and CSA and then improving availability of evidence based psychological interventions for survivors, including culturally tailored trauma-focused interventions will help progress support for survivors.

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Data availability statement

The data that support the findings of this study are available from the corresponding author, ST, upon reasonable request.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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