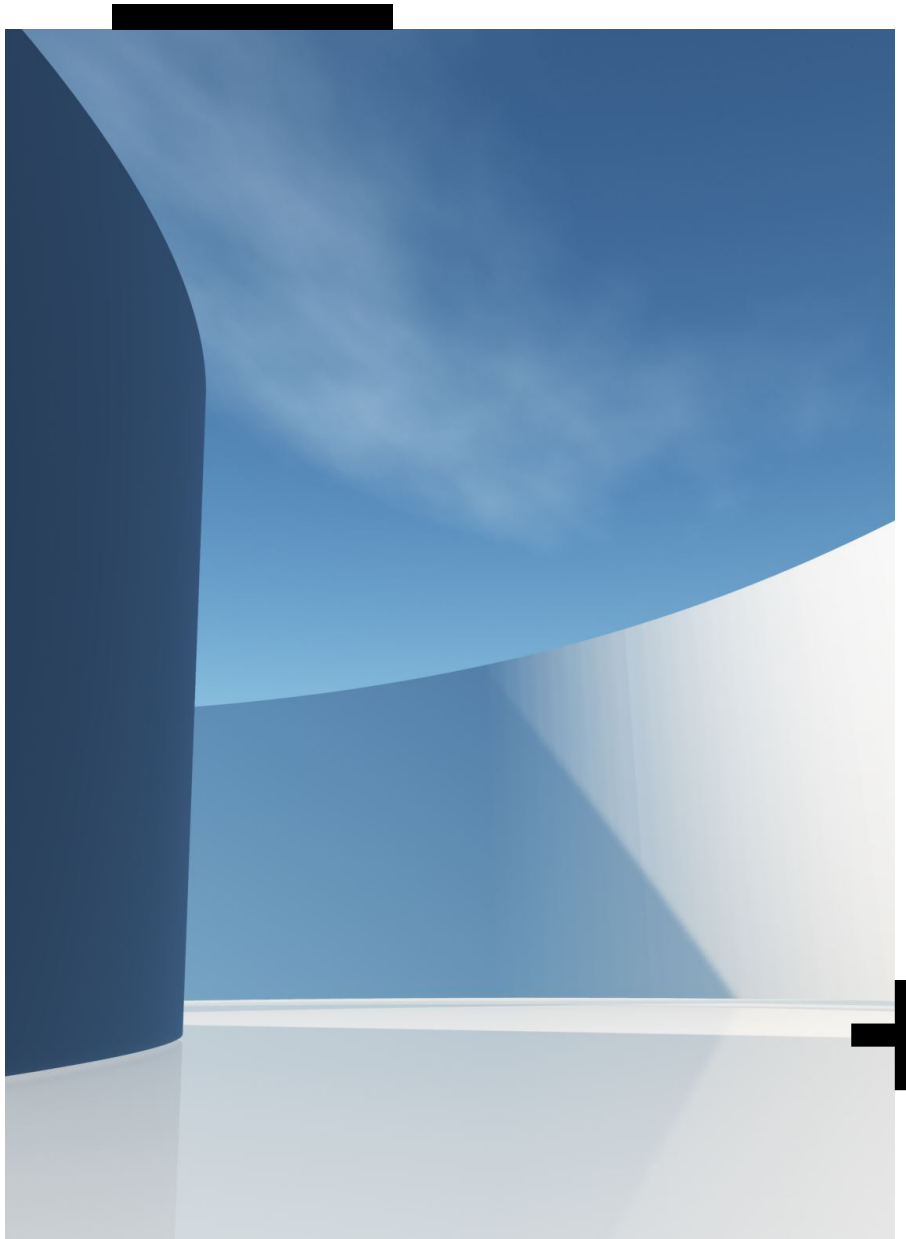

Grooming and Sexual Abuse

An introductory workshop

Overview

– Purpose and stages of grooming and sexual abuse.

– Lived experience examples.

– Why child and adolescent inpatient units?

– Culture and complicity.

- Communicating distress (of grooming and sexual abuse).

- What now?

– Questions, comments and debrief.

Grooming and SA: purpose and stages.

Sexual abuse happens with and without grooming:

- **Opportunistic SA:** abuse when an opportunity presents (like singular instances)but may still invest some time to groom.

– **Predatory offenders:** actively orchestrates and seeks out opportunities to abuse. Grooming occurs to prepare and maintain SA.

- **Opportunity ‘taker’ vs ’maker’**

- Inpatient units? **Both!**

https://www.csacentre.org.uk/documents/new-typology-of-child-sexual-abuse-offending/

Opportunistic SA, ‘takers’

- Little to no personal connection with the victim.
- Typically (though not always) involves the use of force to carry out.

Inpatient units?

- Agency staff, visiting professionals/individuals.
- Regular staff (if no prior attempt to groom the victim).
- Other patients (if no prior attempt to groom the victim). **Often older, physically larger, and the intent is about power and control, not a consensual relationship.**
- Takes place within the hospital itself.

https://www.csacentre.org.uk/documents/new-typology-of-child-sexual-abuse-offending/

Lived experience: examples

- A patient assaulted me within the first week of his admission by locking us both in the bathroom and standing in front of the door to prevent me from leaving. I was 13, he was 17, he was laughing and didn't seem aggressive or angry even though he physically pushed/held me against the wall and kissed me. I didn't think too much about it, he seemed okay and, because I went along with it, I thought it was just a bit of fun. I later discovered he had been transferred from a different unit where sexual safety concerns had been raised by other patients there.
- I was being restrained by an agency staff member and a regular staff member after an incident of self-harm. I hadn't met the agency staff member before and he hadn't spoken to me other than repeatedly telling me to "just calm down". The agency staff member started patting and stroking my upper thigh. I couldn't stop him doing this because the other staff member was holding both of my arms behind my back.

Predatory offenders, ‘makers’

- Personal connection between perpetrator and victim.
- Actively makes, finds and maintains access and opportunity to abuse (i.e. job role gives access to children and/or highly vulnerable individuals).
- Prefers the process of grooming over the use of force.
- Both singular and multiple instances of SA.
- Involves perpetrator’s perceived hierarchy and/or position of power over the victim.

Inpatient units?

- Typically permanent staff members and professionals.
- Other patients (use of grooming). **Often older, physically larger, and the intent is about power and control, not a consensual relationship.**
- Takes place both inside and outside of the hospital.

Grooming

Why groom?

*Grooming involves a **'transfer of responsibility'** from the abuser to the victim so that the abuser overcomes their internal inhibitions around abusing, and the victim is shamed into remaining silent. (Carolyn Spring, www.carolynspring.com)*

- to develop an emotional connection with the victim in order to carry out and maintain abuse.
- they also groom the family, institutions and the surrounding society, convincing everyone that they are good and that their motives are pure.
- to isolate the victim and ensure dependency on the perpetrator, decreasing the likelihood of the victim identifying it as abuse and telling someone.

Carolyn Spring's 10 steps of grooming.

1. Target Area

The perpetrator 'identifies a social group or setting in which access to children is viable':

- Places where children typically are (schools, playgrounds, online)
- Businesses, charities and organisations that cater for children (**hospitals**, churches, nurseries, Scouts/Guides, etc).
- Children from specific families where vulnerability is likely (patients, single-parent families, **presence of disability, neurodivergence, mental-ill health** in parents and/or children).

2. Select Victim

Offenders particularly target children with obvious vulnerabilities: children who are unloved, unpopular, with family problems, who spend a lot of time alone or unsupervised, who lack confidence and self-esteem, have physical or intellectual disabilities, and are isolated from peers etc. (Carolyn Spring, www.carolynspring.com)

Inpatient Units

Patients who:

- have little contact with family and/or families who are distant, little involvement with care/treatment.
- present with psychotic symptoms.
- are autistic and/or have communication/learning difficulties.
- have a documented history of SA and/or trauma.
- are consistently sedated and/or on heavy psychotropic medication.
- are physically disabled, frail or underweight.
- are detained under the mental health act.
- are at greater risk of institutionalisation (e.g. have been admitted and/or stayed in the system for longer).

3. Recruit Victim

A relationship is built with the victim based on emotional seduction. The offender offers 'goodies', such as toys, food, treats, outings; pays special attention; shows understanding and offers a listening ear; and finds and fills a void in the child's life. (Carolyn Spring, www.carolynspring.com)

Inpatient units

- The perpetrator shows particular 'fondness' for a patient with no therapeutic value to their relationship (different intent; support versus isolate a patient).
- Spends more time with a particular patient, e.g. offers to place themselves on a patient's one-to-one, be on their escorted leave.
- For the patient, the staff member/peer may gradually seem to be the only one that understands them, or is able to support them, or truly cares about them.
- The perpetrator 'gifts' the victim with compliments and/or things they might not normally have access to in the hospital, for example, special food, jewellery, books or DVDs.

Lived experience: examples

“The staff member called me ‘beautiful’ the first time I met him.”

“When I was on escorted leave with the staff member and we visited the local shop, he would always pay for anything I bought.”

“The staff member would offer to take over from other staff who were supporting me when I was on one-to-one. He would go out of his way to spend more time with me than other patients.”

“The staff member bought me gifts, and would let me borrow personal items belonging to him. For instance, he let me borrow his hoodie and a book. He would give me money, food and jewellery in secret.”

4. Introduce secrecy, including 'forbidden' activities

'A trap is laid for the victim, manoeuvring so that the abuser has power over them due to compromising information which the victim's parent may disapprove of [...]' (Carolyn Spring, www.carolynspring.com)

The stage **before** actively involving the victim in secret activities (abuse); intent is to normalise and reduce victim's ability to know/identify 'forbidden' activities.

Inpatient units

- Boundaries become blurred; the staff and victim have a 'friendship' rather than a therapeutic relationship with clear boundaries.
- Similarly, a peer develops a friendship with the victim where there is an imbalance of power between the peer and victim, e.g. the victim feels that they might get in trouble for having the 'friendship' with their peer, or that they are solely responsible for the peer's safety.
- Perpetrator offers/provides activities that are considered 'forbidden' by hospital (sharing notes, gifts, being inside a patient's bedroom with door closed, etc).
- Allowing a patient to self-harm/knowing a patient has self-harmed and using this to build trust, isolate the patient and introduce secrecy.
- Other patients: may conceal alcohol, drugs, 'contraband' and share with patient.

Lived experience: examples

- “A staff member knew I had self-harmed and was hiding numerous sharps in my bedroom. On one occasion, they took my bloody towels and washed them for me prior to the staff team finding out. On another occasion, they told me that the staff were about to do a room search, helped me pack away all the sharps I had, hid them in their locker during the room search and returned them to me afterwards.”
- ”A regular agency staff member would lie across my bed, the door closed, and chat with me for hours. If other staff came in, he would move quickly onto the floor by my bed and then return casually, slowly to the bed once the other staff had left.”
- “An older patient used to share his antipsychotics with me. He’d hide the tablets under his tongue and we’d split them between us. It got to the point where it was a daily routine; we’d go into his room, share the meds and sit there for hours chatting.”
- “The staff member told me lots about his personal life. He told me about where he used to go to school, the address where he lived and he used to complain to me about his wife or parents.”
- ‘A regular agency staff member would tell me about all the things he’d seen and the ways patients had hurt themselves in forensic psychiatric prisons.’

5. Test the victim's ability to keep secrets.

'With the relatively innocuous secrets and forbidden activities introduced at the prior stage, the abuser tests the victim to see if they 'tell' or if their manipulation has been successful.' (Carolyn Spring, www.carolynspring.com)

Inpatient units

- A staff member perpetrator might increase the number of 'forbidden' activities during this stage or 'test' new activities; e.g. sharing personal details about their life, their phone number, details about their family members.

- Can include verbal secrets and explicit actions that, without the prior stages of grooming, would seem more obviously 'wrong' to the patient.

- The perpetrator may begin testing the extent to which the victim can 'see' what the perpetrator is doing, how dependent the victim is on them or how far they will go along with what they say. For instance, they may gaslight the victim, make the victim feel ashamed about other friendships or begin to criticize/act cruelly toward the victim.

Lived experience: examples

- “There were CCTV cameras in the hospital. The staff member knew where these were, and would avoid them if we were spending time together.”
- “The staff member would say things like “don’t tell anyone I told you this, but….”, “you can’t tell anyone I said that, okay?”, “I’ll end up getting fired if anyone knows about…”.
- “The staff member would communicate with me through writing, rather than speaking, so that nobody else would know what we’d said.”
- “The staff member exchanged phone numbers with me.”
- “The staff member used to say things like “if it was allowed, I would kiss you”, or “if I didn’t have a girlfriend, you’d be my girlfriend.”
- “The staff member would speak negatively of his wife, calling her a ‘bitch’.”

6. Isolate and alienate

'[...] to create a sense that the abuser is their only 'real' friend, the only person that really loves them and cares for them. This increases the victim's dependence on the offender and reduces the chance of them disclosing, by distancing them from appropriate sources of support and protection.' (Carolyn Spring, www.carolynspring.com)

Inpatient units

– Undermine the authority, caring ability and professionalism of other staff members.

- Disclose things that are supposedly wrong/dangerous/scary about other staff members/patients.
- Hint, indicate or (where trust is strong) outright undermine and diminish a patient's attachment with their family/loved ones/friends.
- Make other victims seem 'mad' or untrustworthy.

Lived experience: examples

- “The staff member used to make jokes about other staff to me, like calling them names or making fun of them.”
- “The staff member would constantly tell me that other staff were useless, or not trustworthy.”
- “The staff member used derogatory and misogynistic language to talk about female staff, sometimes under the guise of a joke. For instance, he’d call female staff “birds” or say things like “look at the pair of legs on that one”.
- “When he was with me, the staff member would make fun of other patients, especially other ones he had groomed. He called one patient a ‘psychopath’ and a ‘stalker’. He used to tell me I was ‘more ill’ than the other patients’.”
- “Another patient used to tell me how sorry they were that my mum is autistic, and ‘no wonder I was so lonely and in hospital’.”
- The staff member used to make other patients he’d groomed on the ward seem as if they were simply mad (he would say they were ‘clingy’ or ‘too attached to me’).
- “I was friends with another girl on the ward; the staff member made me feel guilty about this friendship and acted as if I was cheating on him. I’d bought him a crystal as a gift and he responded by saying ‘are you sure you didn’t mean to give this to…’.”

7. Introduce ‘harmless’ physical contact.

‘An accidental brush of the shoulder, a hug offered as comfort, etc., introduces a low level of physical contact to break down the victim’s defences and increases the [victim’s] acceptance of touch by desensitising them to it and breaking down their inhibitions.’ (Carolyn Spring, www.carolynspring.com)

Inpatient units

- ‘Comforting touch’ when patient is distressed (e.g. before, during or after incidents). Touch might include: a brief hug, hand on shoulder/arm, touching hair/forehead.
- ‘Accidental touch’, e.g. nudging/brushing/patting a patient when walking past.
- During restraint: can look like touch that seems unnecessary (isn’t part of a restraint hold) or inappropriate in any other context (e.g. stroking a patient’s arm, holding patient’s hands, etc).
- Other patients: sitting too closely, brushing knees/elbows against another patient, play-fighting, or any unwanted or unexpected touch that makes the victim feel uncomfortable.

Lived experience: examples

- ”I used to watch another patient gaming on PlayStation. Over time, he started to sit fairly close to me, resting his thigh next to mine.”

– “The staff member gave me a brief hug after a restraint when he knew there were no other staff looking.”

– “The staff member used to play with her hair when there were no other staff present in a room.”

– “An older male patient would be tactile with younger female patients. For instance, during summer we’d all sit outside on the grass and the patient would lie closely to other patients so that he was touching them.”

8. Introducing overt sexual touching and abuse.

'The victim may be manipulated into engaging in sexual acts which are beyond their understanding, or the offender may feel secure enough to progress to overt abuse quickly.' (Carolyn Spring, www.carolynspring.com)

Inpatient units

Sexual touch and abuse from a staff member includes:

- Putting a hand on the victim's waist, thighs, stomach, neck, chest, pelvic area.
- Any form of kissing.
- Extended hugging and/or handholding with or without clothing.
- **Any touch of a patient by a staff member that happens when the patient is not wearing clothing is immediately assault** (or limited clothing, e.g. pyjamas, underwear).

NB: The line between staff member and patient is more clear; any sexual touch by staff is abuse. A patient cannot consent to sexual relations with a staff member, but can with other patients. Sexual touch and abuse by another patient can look the same as above (without consent).

Lived experience: examples

- “An older patient and I used to meet up outside of the unit when we were both on leave. On one occasion he came to my house and we watched TV in my room. He made repeated attempts to touch me over the course of a few hours, and eventually kissed me and touched my intimate parts. He left shortly afterwards and the next day I saw him back at the unit and it was like nothing had happened.”
- “The staff member took me for a walk on escorted leave. He put his hand on my waist and then kissed me.”
- “The staff member was supervising me in the garden. We walked to the bottom of the garden where we couldn’t be seen from the building. She pulled me towards her and gave me a long, tight hug. Her hands were around my waist. She was obvious about the fact that this was something we weren’t allowed to do.”

9. Control

'Using manipulation, threats and emotional blackmail, the offender ensures that the child remains available for abuse and reduces the risk of detection. The victim is effectively silenced and remains available for further abuse due to their dependence on the offender. Alternating abuse with affection, the attachment bond between victim and offender is strengthened and the victim is trapped.' (Carolyn Spring, www.carolynspring.com)

Methods of maintaining control & secrecy (inpatient units)

Consequences: 'You will get in trouble. I'll get in trouble. We'll both end up in prison. They'll section you forever. You'll end up in care. Your mum will go mad, she'd never recover from this.'

Flattery: 'You're not like the other patients. You're so special. I love you so much.'

Shame: 'You made me do this. You came back. You were smiling – you like doing this.'

Emotional blackmail: 'I will be so angry with you. I won't love you anymore. Please don't do this to me. No one will love you anymore. How could you do that to me after all I've done for you and given to you?'

Entrapment: 'You might not even get told off, they'll probably just think you're even more psychotic than you already are. Everyone will know what you've done.'

'Not me': 'Only paedophiles would do that. You should stay away from him, he's already been suspended twice. How can you think I'd do something like that?'

Lived experience: examples

- “The staff member used to say ‘I’ll go to prison and I’ll be sexually assaulted there’.”
- “The staff member said ‘you’re my soulmate. I’m in love with you. You’re my girlfriend.’”
- “The staff member said ‘I’d kill myself if I couldn’t be with you’.”
- “An older patient used his mental ill-health as a reason as to why it wasn’t his fault.”
- ”The other patient used to say to me that it was always ‘girls that had been abused by their dads that had an issue with [him]’.”
- “The staff member put his hand around my waist and I flinched. I said ‘I’m really sorry’ and he replied ‘well where am I supposed to touch you?’”

10. Repeated assaults

*'The victim continues to be abused, often **with increasing levels of offending**. The abuse remains secret as the abuser reinforces silence and compliance through further coercion, threats or manipulation.'* (Carolyn Spring, www.carolynspring.com)

Inpatient units

- More 'severe' acts of SA are introduced (penetrative assault, extended sexual contact).
- Assaults often increase in frequency and duration. The perpetrator can appear more 'cocky'.
- Control tactics (coercion, threats, gaslighting) may increase at this point to match the severity and frequency of abuse.
- Conversely, less methods of control may be used, as the victim may thoroughly believe that they are in a relationship at this point, and prior methods of silencing have been successful (pertinent in long term admissions).
- Subtle and/or noticeable change in the dynamic between the victim and perpetrator (there is a sense of urgency to the relationship; the perpetrator may seem more 'desperate' and desensitised to the 'hit' of previous assaults and needs more of increasing severity and frequency).
- Previous methods of silencing used by the perpetrator are intensified; the perp usually reinforces silencing and control after every assault (common in short-term admissions).

Lived experience: examples

- “The staff member repeatedly assaulted me in the woods behind the unit during escorted leave.”
- ”The staff member held my hand and assaulted me in public, in the middle of a big city during the day.”
- “The staff member began treating me as though I were his girlfriend. We talked as if we were dating. For instance, he bought a bottle of aftershave and asked me whether I liked it or not.”
- “When I was on home leave and near discharge, the staff member would ask me to stay awake in case he needed me during the night. He would often call as late as 4am and would be sobbing down the phone, saying he was a horrible person and he’d go to prison.”
- “Outside of the assaults, the staff member became much more needy and mean. During the assaults it was like he was a totally different person; he seemed really calm.”

Why inpatient units?

- Clinical environments that don’t reflect ‘real-life’; easier to compartmentalize abuse within an already unfamiliar and fabricated environment.
- No touch policies and safeguarding procedures have counterproductive effect (need for basic human connection not allowed).
- Patients are inherently isolated; one less step for predators to take (easy targets).

Culture and complicity

- Hospital themselves may be complicit in SA happening by allowing a perpetrator access to a patient where abuse is known or suspected (e.g. allowing the perpetrator visits to the victim in the hospital, or granting the victim home leave into an unsafe/abusive environment).
- A culture of blame and disbelief in the hospital. Patients are seen as attention-seeking, manipulative, difficult or outright liars. Diagnoses given to patients at the hospital may reflect and enable this culture of blame.
- Blurred boundaries between staff and patients are normalized. Staff may relate to patients as their children or friends.
- Sexual language, conversation and jokes may be normalized within the hospital (e.g. misogyny, homophobia).
- Multiple instances where numerous staff have been suspended and/or investigated (creates a culture where misconduct and inappropriate behaviour is accepted).
- Low percentage of staff have been sufficiently trained (in all aspects, not just safeguarding). High use of agency staff.
- No clear understanding and communication of safeguarding procedures. Safeguarding (and how to report) is not openly discussed with staff and patients.

All of these factors (and more) make a hospital complicit in sexual abuse.

Lived experience: examples

- ”I was systematically sexually abused by a family member for over 10 years before going into hospital. The staff and MDT all told me off for refusing to see him when he turned up for visits. Despite numerous concerns raised by my key-nurse and one particular staff member, the psychiatrist did not escalate the safeguarding concerns, nor involve social services. I was discharged back into the family home, where the abuse continued.”
- “I reported the sexual abuse to a member of staff. She told me that ‘lots of people have big age gaps in relationships’ and did not flag or escalate what I’d told her as a safeguarding concern.”
- “Multiple patients on the ward described being ‘in relationships’ or having ‘special’ relationships with staff members. We didn’t realise this wasn’t okay.”
- “Misogynistic and derogatory language were frequently used by male staff to describe female staff and patients. A male staff member said, ‘look at the pair of legs on that one’ about a more senior female staff member.”
- “Patients were frequently accused of ‘faking’ their illnesses by staff. One female patient had been gang raped as a child prior to admission; male staff made comments like ‘she must be lying, no one would want to rape her.’”

Communicating distress

Sexual abuse and grooming are not always (and rarely) explicitly disclosed by victims. The point of grooming and manipulation is to strip a victim of the vocabulary and understanding that enable them to say ‘they did this to me’.

Distress and experience of SA is communicated in a number of different ways, including:

- an increase, or the emergence of, instances self-injury.
- an overall deterioration in the patient’s mental-health.
- the patient themselves identifying and raising safeguarding concerns about another patient.
- a change in the victim’s presentation of mental ill health. For instance, patient begins to display psychotic symptoms or has outbursts of anger where they were previously little outbursts.
- no obvious signs, but they seem ‘different’ to friends and family.
- the patient shuts off from friends and family.

What now?

Survivors of SA often don’t ‘tell’ until years later, and often only when the physical and physiological sense of threat has passed. How can we help these people to talk, process and recover from SA?

- Know that everyone is different; some people won’t ever talk about it, but can and do process SA.
- Put the responsibility back where it belongs: SA (and all it comes with) is **never about the person, and always about the abuser.**
- If you are a parent or loved-one of a survivor, meet your own needs first.
- **Hold hope.**

A lot of talk about self-care seems to suggest that it's all about scented candles and bath bombs. That just doesn't cut it for me. Self-care for me is much more potent and world-changing than that. It's much more edgy and rebellious and 'up yours'. Self-care is the way that we draw a line in the sand and say, 'No more. No more unkindness. Abuse is wrong, and I refuse to participate in it.'

CAROLYN SPRING

PODCAST #13: KINDNESS IS REVOLUTIONARY

www.carolynspring.com/podcasts/kindness-is-revolutionary