THERAPEUTIC SERVICES FOR SEXUALLY ABUSED CHILDREN AND YOUNG PEOPLE

Scoping the Evidence Base

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Summary report

NSPCC
Cruelty to children must stop. FULL STOP.

NSPCC charity registration number 216401 and SC037717,

CONTENTS

EXECUTIVE SUMMARY

Introduction and background (Chapter 1)

Research suggests that a large minority of children and young people under the age of 18 may experience sexual abuse, and many could benefit from therapeutic support. The NSPCC has already undertaken a mapping study, to ascertain what therapeutic services are available in the UK to help children and young people who have been sexually abused. This current report reviews existing research to find out what types of therapy are effective. Both pieces of work have fed into the development of a guide for therapeutic practitioners.

The impacts of sexual abuse (Chapter 2)

Sexual abuse can have many varied impacts on children and young people. The stress suffered by an abused child can disturb the development of the child's brain architecture, impairing cognitive, behavioural and physical development. Abuse can cause direct physical harm during childhood and continuing symptoms of ill-health later in life and in some cases is a factor in substance misuse, self-harm or suicide. Childhood sexual abuse has been linked to childhood and adult mental health issues including anxiety, depression and post-traumatic stress disorder (PTSD). It can impact on behaviour and relationships, including risky or harmful sexual behaviour, delinquency, crime and poor parenting. In time, the consequences can limit the survivor's future opportunities and lead to further adversities later in life. Dealing with the consequences of childhood sexual abuse also has a significant economic cost to the UK.

Resilience factors (Chapter 3)

Not every child who experiences sexual abuse is affected to the same degree and between 20 and 40 per cent come to show no ill-effect later in life. Among the factors that can build resilience to the impacts of sexual abuse are personal characteristics such as high self-esteem or self-reliance, the development of positive coping strategies, and informal support from adults known to the child, or through school, religious groups or social clubs.

Therapeutic interventions (Chapter 4)

The types of therapy commonly provided to support children and young people who have been sexually abused fall into two broad categories: talking therapies (including cognitive behavioural therapy – CBT – psychodynamic psychotherapy and counselling) and creative therapies (including play therapy, art therapy or drama therapy). Creative therapies and counselling are the most common among NSPCC services, while CBT has become more prominent among therapies offered by other service providers.

There is limited hard evidence on the effectiveness of different therapeutic approaches. Therapy in general has been found to relieve aspects of distress among sexually abused children and young people. Abuse-specific interventions, rather than non-directive therapies, appear to give the best results in relieving depressive symptoms.

There is considerable evidence for the effectiveness of CBT with certain groups of children and young people, particularly in alleviating PTSD and some behavioural problems. It has therefore been recommended by the National Institute for Health and Clinical Excellence as a first-line treatment for symptoms associated with sexual abuse. Other specific types of therapy have not received so much attention from researchers, probably because they are harder to study in manualised and standardised trials. It would be wrong to conclude that other types of therapy do not work, but the evidence is lacking to prove that they do. New research is needed, both to test a wider range of therapeutic approaches and to answer more detailed questions about which specific elements of therapy, used in what ways, deliver the best results. Establishing this will be one of the aims of the NSPCC's sexual abuse programme.

Qualitative research from surveys and case studies has generated some useful findings. The therapeutic alliance between the therapist and the client is held to be key to successful therapy. The effectiveness of therapy with an abused child can often be improved if a non-abusing parent is involved in some way. It is important that practitioners are adequately trained and have good supervision, and that all relevant agencies concerned with the child work together. The more recent use of manuals by practitioners has supported evidence-based practice, and does not appear to have inhibited the therapeutic alliance or the ability of therapists to use the personal attributes and skills which are central to therapy.

What children and young people say about therapy (Chapter 5)

Surveys provide some evidence of what children and young people think about the therapy they have received, and what they like and do not like. They want the practitioners who work with them to be accessible, non-judgemental and non-directive. They want space for humour. They value straight talking, trust and confidentiality. They like being listened to, but may not want to talk about the details of the abuse itself. Group therapy can be successful in allowing a child to see that he/she is not alone with the experience of sexual abuse.

Adult survivors of childhood sexual abuse identify the skills and characteristics of the therapist as very important. As children in therapy, they wanted to be taken seriously, believed and supported, to feel safe and cared for, comfortable and at ease. They wanted to go at their own pace, with a therapist who could be flexible. They wanted to be kept informed about the course of therapy. They wanted continuity in their therapist so they could build trust, and they valued confidentiality.

Conclusions (Chapter 6)

Some broad themes from this review will underpin the development of the therapeutic practice guide. High quality assessment of each child is a crucial first step, to develop and understanding of the individual experience of the child, the impact of the abuse and the wider context. Therapy should take a child-centric approach, focused on the child's needs and preferences. Elements of different therapeutic approaches should be drawn on, in an integrated model which enables practitioners to respond to those individual needs and preferences. Establishing a strong therapeutic alliance with the child is vital. The involvement of a non-abusing parent in the therapeutic process should be considered as a potentially beneficial approach.

Therapeutic approaches need to be culturally-aware and tailored where necessary to meet the cultural context and world view of children from different communities. There is almost no supporting evidence on this in a UK context, and research is urgently needed to ensure that the needs of the growing population of Black and Minority Ethnic children can be adequately and appropriately met in therapeutic practice.

A therapeutic guide based on these key themes has been drafted and is currently undergoing testing. Its declared aims are to support practitioners in relieving the symptoms of sexual abuse, destigmatising abused children, increasing their self-esteem, and preventing further abuse.

The current shortage of hard evidence about the effectiveness of different therapeutic approaches underlines the importance of designing a robust evaluation methodology for the guide. This will include assessing outcomes, using matched control groups, at the completion of therapy and again at intervals thereafter, and testing outcomes of services delivered at different locations by different teams to check whether results can be replicated. The analysis will take pains to disentangle where possible the effects of abuse and of therapy from other factors which may affect the child's wellbeing. A cost benefit analysis of the guided therapeutic approach will be included in the evaluation.

As the guide advocates an integrated approach to therapeutic practice, drawing on different types of therapy, the evaluation should provide valuable new evidence about the effectiveness of a broad range of therapies in a UK context, supplementing the somewhat limited evidence in current literature. Qualitative research will supplement the quantitative evaluation by getting at important factors which are difficult to measure, such as the therapeutic alliance.

1. INTRODUCTION AND BACKGROUND

1.1 The context of the literature review

1.1.1 The NSPCC's strategic focus on sexual abuse

In 2009, the NSPCC launched a new strategy, prioritising specific types of abuse and children who are most at risk, to ensure that its various interventions have the greatest impact. Sexual abuse is now an area of specific strategic focus. The literature review described in this report sits within the wider programme of research, evaluation and service development which makes up the NSPCC's work around sexual abuse.

1.1.2 The mapping study

The literature review contributes to a body of activity to improve knowledge about effective treatment for children and young people who have experienced sexual abuse. This began in 2007 with a mapping study, exploring the availability of such therapeutic services across the UK. This study revealed a significant gap in provision[1], meaning that some children cannot get the support that they need. There was also little evidence about the range and effectiveness of the different interventions on offer. It was to fill this evidence gap that the NSPCC commissioned the programme of work of which this literature review forms part.

1.1.3 The good practice guide

Another element of the work commissioned in the light of the mapping study was the development of an evidence-informed good practice guide for the treatment of children and young people. As well as supporting decisions practitioners have to make about appropriate interventions, it also aims to improve knowledge about the longer term outcomes of therapy, provide evidence about the role of the therapeutic relationship, and build a body of knowledge to inform policy and practice development.

The guide is being informed by NSPCC and external practitioners and draws on research evidence on what works, practitioner wisdom (both theoretical and practical) and the views of adult survivors of sexual abuse as gathered in an online survey about their experiences of therapy when they were children or young people. A draft is currently being tested, and the guide will be rolled out to selected NSPCC teams for implementation from November 2011 It will be subject to longitudinal evaluation. Further information about the development of the guide can be found in Chapter 6.

1 Allnock et al. (2009)

1.2 The purpose of the literature review

As part of the wider programme of work, this literature review aimed:

1) to assess the quantity and quality of existing research on therapeutic services for children and young people affected by sexual abuse, and summarise what is already known about the treatment and the efficacy of therapeutic services;
2) to assess a range of other important aspects of interventions, such as the therapeutic alliance, involvement of a non-abusing or 'safe' parent or caregiver in treatment, resilience factors which may impact on treatment effects, and factors related to the practitioner which may be important for outcomes (such as supervision, experience or qualifications);
3) to inform the development of the good practice guide about the possible range of treatment options or continuum of interventions to meet the wide ranging needs of children and young people who have experienced sexual abuse.

1.3 Sexual abuse of children and young people

1.3.1 Defining child sexual abuse

The World Health Organisation defines child sexual abuse as:

> *"The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violate the laws or social taboos of society. Children can be sexually abused by adults or other children who are – by virtue of their age or stage of development – in a position of responsibility, trust, or power over the victim."*[2]

The UK Government has provided this definition:

> *"Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children."*[3]

In recent years there has been increasing awareness of specific contemporary contexts where abuse takes place, and specific definitions have been developed for them. These include sexual exploitation, where the National Working Group for Sexually Exploited Children and Young People has developed a

2 World Heath Organisation (2006)
3 HM Government (2010), p.38

definition[4]; child trafficking, where the relevant UN Protocol[5] recognises that sexual exploitation is one form of exploitation children may face; and online and internet abuse[6].

1.3.2 How prevalent is child sexual abuse?

The evidence suggests that a large minority of children and young people in the UK have been sexually abused. A recent literature review found that between 5 and 10 per cent of girls and 5 per cent of boys are exposed to penetrative sexual abuse and up to three times as many exposed to any form of sexual abuse[7], while an NSPCC survey found that 16 per cent of young adults reported experiences of child sexual abuse[8]. A nationally-representative survey in 2010 found that 7.3 per cent of under-18s had experienced contact and/or non-contact sexual abuse in their lifetime and 4.1 per cent in the last year.

Official child protection statistics do not come close to capturing this level of abuse. In 2009, only around 2,200 children were the subject of a child protection plan because of concerns about sexual abuse[9]. If official statistics such as these are relied upon, there is bound to be a serious shortfall in provision of specialist services.

Disabled children were found to be more than three times more likely to be sexually abused than non-disabled children in one study[10] and 2.2 times more likely in another[11]. There is limited information about the prevalence of child sexual abuse in Black and Minority Ethnic (BME) communities. Government statistics for 'children in need' from 2003 suggest that the proportion with 'ethnicity other than white' was between 1.2 and 1.7 times the national average. This covers a significant variation between communities, however, with children of a black or mixed ethnic identity over-represented and children of an Asian ethnic identity under-represented[12].

4 www.nationalworkinggroup.org/what_is_child_sexual_exploitation
5 United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (2000)
6 For an informative description, see Palmer and Stacey (2004)
7 Gilbert et al. (2008)
8 Allnock et al. (2009)
9 DCSF (2009)
10 Sullivan and Knutsford (2000)
11 Sullivan et al. (1997)
12 Barn et al. (1997); Qureshi et al. (2000); National Statistics/Department for Education and Skills (2004), p.6

2. THE IMPACTS OF SEXUAL ABUSE

2.1 Introduction

Many writers have attempted to assess the impact of child sexual abuse (CSA), and the literature is robust and informative.

CSA does not inevitably have long term consequences for those who experience it, nor are precise impacts possible to predict. Studies paint a general picture of elevated risk of problematic outcomes, but they also report an array of factors that can militate against lasting harm, as explored in Chapter 3. Nevertheless, the literature allows us to understand some of the potentially damaging impacts and highlights the need for effective interventions.

The literature covers five broad areas which are outlined in sections 2.2 to 2.6 below: impacts on brain development, on physical health, on mental health, on behaviour and relationships, and on future opportunities and adversities. These are convenient categories, but the dynamics are complex. Some impacts are more common in the short term, while others may appear in adulthood. Impacts may overlap or lead in turn to other consequences.

2.2 Impacts on brain development

Exposure to stress in early childhood can impact on an individual's cognitive, behavioural and physical development, by disturbing the development of brain architecture[13]. Whether stress is damaging depends on its duration and intensity, individual variations in the child's responses to stress, and the degree to which the child receives backing from a supportive adult. Examples of 'toxic' stress include repeated abuse and neglect, persistent substance abuse by parents or the exposure to violence in the family or the community. The family environment is greatly significant. Poor relationships, insecurity and fragmentation are all found to contribute to maladjustment[14]. Children who have 'secure' relationships with their mothers show higher levels of self-esteem than those with 'insecure' relationships[15]. A significant body of literature and research provides evidence for the consequences of stress[16].

Early life events can influence enduring patterns of emotionality and stress responsiveness and alter the rate of brain and body aging[17]. Continuous stimulation of the stress response system may also affect the immune system and other metabolic regulatory mechanisms, resulting in elevated risk of stress-related physical illnesses such as hypertension and cardio-vascular disease, or mental ill-health. Children who have experienced toxic stress are also more likely to develop health damaging behaviours and lifestyles[18].

13 National Scientific Council on the Developing Child (2007)
14 Higgins and McCabe (2003)
15 Kim and Cicchetti (2004)
16 Heim and Nemeroff (2001); Teicher et al. (2003); Grassi-Oliveira et al. (2008)
17 McEwan (2007)
18 NSCDC (2007)

2.3 Impacts on physical health

Sexual abuse can both have immediate physical consequences and impact on a child's long-term health into adulthood.

During **childhood** itself, the physical manifestation of sexual abuse is often hidden, but there are studies[19] which describe direct pain and physical trauma in children who have experienced sexual abuse. Among the more commonly reported symptoms are tearing of the hymen or blood loss among girls, and painful genital area and painful urination among both girls and boys. Other symptoms include difficulty walking, painful defecation, vulval sores, itchiness or warts, infections and abnormal anal conditions. Sexually transmitted diseases (STDs) pose longer-term physical risks, though fortunately most sexually abused children do not acquire an STD[20]. In the USA, the prevalence of all STDs in sexually abused girls has been found to range from 2–7 per cent and from 0–5 per cent in sexually abused boys[21]. However, HIV has been found to be higher in countries with high overall rates of HIV, and in general infection may not become evident for many years[22].

In **adulthood**, general health and self-perceptions of health may be affected by experiences of child sexual abuse. Studies have shown that participants with a history of CSA report more persistent complaints about physical symptoms without an identifiable physical origin and more negative perceptions of overall physical health than participants without such history[23]. A history of CSA has been linked to a higher risk of a range of definable health issues[24] including gastroenterology disorders[25], irritable bowel syndrome[26], headaches[27], musculoskeletal pain symptoms such as back aches, muscle aches, fibromyalgia or joint pain[28] and general pain symptoms[29]. These findings have been found by some to be significant for females but not males[30]. Individuals with a history of CSA have been found to be at increased risk for obesity[31] and eating disorders, particularly bulimia[32]. A link has also been made to chronic pelvic pain[33]. Some studies have suggested links with gynaecologic symptoms[34] while others have found no significant differences in the gynaecologic health of women with and without a history of CSA[35].

Substance misuse can be a way people cope with emotional impact of CSA experiences. In the longer term, this can lead to significant physical health consequences. CSA has been associated with higher rates of smoking[36]. In one study[37], girls who had experienced both sexual and physical abuse were 5.9 times more likely to be regular smokers, 3.8 times more likely to consume alcohol regularly and 3.4 times

19 Kellog and Adams (2003); Birdthistle et al. (2009)
20 Woods (2005)
21 Ingram et al. (1982); Atabaki and Paradise (1999)
22 Woods (2005)
23 Irish et al. (2010); Najman, Nguyen and Boyle (2007); Springs, Friedrich et al. (1992); Zlotnick et al. (1996); Golding, Cooper and George (1997)
24 Draper et al. (2008)
25 Irish et al. (2010)
26 Talley, Fett and Zinsmeister (1995)
27 Domino and Haber (1987); Felitti (1997)
28 Irish et al. (2010); Golding (1994); Gelfand et al. (1999); Newman et al. (2000); Walker et al. (1997)
29 Golding (1994); Jamieson and Steege (1997)
30 Bendixen, Muus and Schei (1994); Najman et al. (2007)
31 Aaron and Hughes (2007; Chartier et al. (2009); Felitti (2007). For an exception, see Johnson et al. (2002).
32 Connors and Morse (1993)
33 Harrop-Griffiths et al. (1988); Walker et al. (1988); Walling et al. (1994)
34 Ernst, Angst amd Foldenyi (1993); Jamieson and Steege (1997); Springs and Friedrich (1992)
35 Lechner et al. (1993); Runtz (2002); Sickel et al. (2002)
36 Draper et al. (2008)
37 Diaz et al. (2002)

more likely to have used illicit drugs in the past 30 days than were other girls. Other studies provide support for such links[38].

Some authors[39] have found associations between CSA and deliberate **self-harm**. However, a recent meta-analysis[40] found relatively little relationship, concluding that rather than CSA being a direct unique predictor of self-harm, CSA and self-harm may instead each correlate with a similar range of other psychiatric risk factors.

Ideas of **suicide** and suicide attempts have all been found to be associated with histories of CSA[41]. A study of national data[42] found that the frequency of suicide attempts was greater for men and women who had experienced child sexual abuse. Another study[43], looking at females only, investigated the relationship between suicide and different variables such as mental health issues and substance misuse. The researchers found that women with a history of childhood and adulthood victimization were associated with a lifetime of suicide attempts. PTSD, depression and alcohol-dependence were associated with suicide ideation, and traumatic life events and depression were associated with suicide attempts.

2.4 Impacts on mental health

A growing number of papers[44] conclude that exposure to CSA is associated with mental disorder and adjustment problems of varying types and severity[45].

Links have been identified to psychological distress in the form of **anxiety**[46]**. Depressive symptoms and disorders** are the most commonly reported[47] and best documented[48] outcomes in survivors of CSA, but authors are not unanimous on the association. A recent review[49], covering 60,000 participants from 160 studies, concluded that while CSA is a risk factor for depression, it is also significantly related to other forms of psychopathology, with which it may interact, and so cannot be identified as a specific risk factor.

Some traumatic experiences can "alter people's psychological, biological and social equilibrium to such a degree that the memory of one particular event comes to taint all other experiences"[50]. **Post-traumatic stress disorder (PTSD)** has long been associated with war, but exposure to traumatic events during and after puberty is also associated with increased risk of the disorder[51], with 30–50 per cent of sexually abused children meeting full criteria for a PTSD diagnosis[52] and many more exhibiting at least some

38 Polusny and Follett (1995); Southwick Bensley, Spieker, Van Eenywk and Schoder (1999); Brems et al. (2004); MacMillan et al. (2001); Widom and Hiller-Sturmhöfel (2001); Wilsnack et al. (1997)
39 Fliege et al. (2009); Briere and Gil (1998)
40 Klonsky and Moyer (2008)
41 Fromuth (1986); Neumann et al. (1996); Paolucci et al. (2001); Fergusson et al. (2008); Hawton et al. (2002)
42 Molnar, Berkman and Buka (2001)
43 Ulman and Brecklin (2002)
44 Fergusson and Mullen (1999); Finkelhor (1990); Finkelhor and Hashima (2001); Holmes and Slap (1998); Kendall-Tackett, Williams and Finkelhor (1993); Putnam (2003)
45 Briere and Runtz (1993); Elliot and Briere (1992); Johnson and Kenkel (1991)
46 Fergusson et al. (2008); Putnam (2003); Paolucci et al. (2001); Neumann et al. (1996); Polusny and Follette (1995); Beitchman et al. (1992); Browne and Finkelhor (1986)
47 Browne and Finkelhor (1986); Neilson (1983)
48 Putnam (2003)
49 Magnilio (2010)
50 van der Kolk and MacFarlane (1996), p.4
51 Koenen (2006); Breslau, Chilcoat, Kessler and Davis (1999); Breslau, Davis, Peterson and Schultz (2000); Bromet, Sonnega and Kessler (1998); Davidson, Hughes, Blazer and George (1991); Duncan, Saunders, Kilpatrick, Hanson and Resnick (1996)
52 McLeer et al. (1988); Widom (1999); Deblinger et al. (1989); Darves- Bornoz et al. (1998); Giaconia et al. (1995)

relevant symptoms[53]. Some authors have identified particular complex patterns of symptoms in children who have experienced chronic abuse, which go beyond 'simple' PTSD[54]. These include dissociative and affective symptoms, personality changes, vulnerability to repeated harm, hypervigilance, a sense of a foreshortened future and sleep difficulties. Such symptomology has become known as 'Complex PTSD' (CP), and requires particular modes of therapeutic work. Children may also manifest symptoms in different ways to adults, for example through nightmares rather than the dissociative flashbacks that adults experience[55].

Sexual abuse is also understood to impact significantly on **attachment**. Infants who feel in danger or in need become physiologically and emotionally aroused and display of a range of distress signals including crying and clinging to an adult. These signals are intended to attract the adult's attention and re-establish care, protection and safety. Attachment is fundamental to a child's emotional development and this can interrupted or distorted if the infant receives a persistent set of negative responses to his/her signals[56].

Guilt and shame are part of a constellation of emotions that may be experienced in relation to a traumatic event, which also include **fear, anger and sadness**[57]. Guilt and shame in particular have been found to be components of the post-traumatic state among CSA survivors[58]. Fear has been found to be heightened during trauma, with emotional responses such as guilt, shame, anger and sadness being heightened afterwards and increasing over time, particularly for those who have experienced sexual assault[59]. Such emotions can interact dynamically with other symptoms. One study found that where shame had been addressed effectively during treatment, PTSD symptoms reduced[60]. Guilt and shame can however be more resistant to treatment than other symptoms such as depression, anxiety and anger[61].

2.5 Impacts on behaviour and relationships

The literature identifies a range of maladaptive behaviour patterns as being associated with a history of CSA, which can in turn impact on health or life opportunities.

A history of CSA has been linked to **risky sexual behaviour** such as a high number of sexual partners or unprotected intercourse among both males and females[62], early consensual sexual initiation[63], exchanging sex for drugs or money[64] and using alcohol prior to or during sex[65]. A recent study[66]found that the impact of CSA on risky behaviour for females decreases with age, while for men risky behaviour continues longer into adulthood. Elevated rates of STDs have been observed in both male and female

53 McLeer et al. (1992); McLeer et al. (1988); Cuffe et al. (1998)
54 Connor and Higgins (2008); Herman (1992); Ginzburg et al. (2008)
55 Koverola and Foy (1993)
56 Bowlby (1969)
57 Amstadter and Vernon (2008)
58 MacMillin and Zuravin (1997); Rahm et al. (2006)
59 Amstadter and Vernon (2008)
60 Ginzburg et al. (2008)
61 Moller and Steel (2002)
62 Purcell, Malow, Dolezal and Carballo-Dieguez (2004); Stock et al. (1997); Putnam (2003); van Roode et al. (2009); Brown, Lourie, Zlotnick and Cohn (2000); Saewyc, Magee and Pettingell (2004); Bartholow et al. (1994); DiIorio et al. (2002); Holmes and Slap (1998)
63 Wilsnack, Vogeltanz, Klassen and Harris (1997)
64 Van Dorn et al. (2005)
65 Senn, Carey, Vanable, Coury-Doniger and Urban (2006)
66 van Roode et al. (2009)

survivors[67]. High risk sexual activity increases the likelihood of unplanned pregnancies among teenagers and adults[68].

Harmful sexual behaviour is a complex and sensitive topic. Many children engage in activities which are a normal part of their sexual development and are not abusive to others. If a child's healthy sexual development is disrupted through abuse or by living in a sexualised environment it may cause them to develop behaviours which are potentially harmful both to themselves and to others. However, there is a shortage of specific literature in these areas. The proportion of children and young people who go on to abuse as adults is not known, but there is little evidence to suggest that the majority of young people with harmful sexual behaviour go on to become adult sex offenders[69].

Numerous studies[70] have revealed a link between child maltreatment and **delinquent behaviour** in adolescence, with a recent longitudinal study[71] concluding that child sexual abuse does predict criminal offending and delinquent behaviour. One study[72] made the link between sexual abuse and feelings of anger among adolescents, which is in turn associated with the outward display of emotion through delinquent acts. The classic assumption that females are more likely to internalise emotional difficulties is challenged by findings that females who have experienced CSA are especially likely to carry weapons in adolescence[73], and are three times more likely to engage in serious delinquency than other girls[74].

An association between CSA and **illicit drug use**, in both adolescence and adulthood, is well documented[75]. A number of studies have linked child abuse and neglect to **prostitution**[76], which itself is associated with drug use[77]. Researchers disagree about the direction of this association – that is, whether drug use precedes prostitution or prostitution leads to initiation or exacerbation of drug use. Several large studies explore the relationship between childhood maltreatment and **criminal behaviour** in adolescence or adulthood[78], and this seems to be another pathway to drug problems[79].

Sexual abuse in childhood impacts on a survivor's sense of trust and safety in other people[80] giving rise to intimacy problems, emotional discomfort, alienation, anger and distrust which can make it difficult to build lasting, healthy **relationships**[81].

Several characteristics linked with CSA would usually be expected reduce the likelihood of women **breastfeeding** their babies, including abuse in adulthood[82], unintended pregnancy[83], low educational attainment and status[84], and mental health problems. Interestingly, however, some research shows that

67 Futterman, Hein, Reuben, Dell and Shaffer (1993); Holmes and Slap (1998); Paul et al. (2001); van Roode et al. (2009)
68 Raj et al. (2000); (Prentice et al. (2002)
69 Glasser et al. (2001)
70 Garnefski and Arends (1998); Widom (1989); Smith and Thornberry (1995); Brezina (1998); Paperny and Deisher (1983); Alfaro (1981); Famularo et al. (1990)
71 Swantson et al. (2003)
72 Sifusdottir et al. (2008)
73 Lewis et al. (2007)
74 Bergen et al. (2004)
75 Simpson and Miller (2002)
76 McClanahan et al. (1999); Nixon et al. (2002); Potter et al. (1999); Van Brunschot and Brannigan (2002)
77 Chen et al. (2004); Potterat et al. (2008); Cusick (2002)
78 Maxfield and Widom (1996); Smith and Thornberry (1995); Stouthamer-Loeber et al. (2001); Zingraff et al. (1993)
79 Joshi et al. (2001); van den Bree and Pickworth (2005)
80 Briere (1992)
81 Kendall-Tackett, Williams and Finkelhor (2001); Urquiza and Capra (1990)
82 Fleming et al. (1999); Benedict et al. (1999); Acheson (1995)
83 Heise (1994); Fiscella et al. (1994); Dietz et al. (1999); Abma (1997)
84 Mullen et al. (1996); Grimstad and Schei (1999); Ryan (1997)

women with histories of CSA show higher rates of breastfeeding[85]. For some women, birthing and breastfeeding appear to facilitate healing from the effects of the abuse, but they can also act as a trigger for remembering or re-experiencing abuse[86].

Survivors of CSA can struggle with **parenting**, particularly maintaining an appropriate balance between discipline and affection[87] and showing maternal warmth and involvement[88]. They are more likely to resort to physical strategies to control their children[89] or may be more permissive in their parenting practices[90], and women may engage in role reversal behaviour with their children[91], becoming emotionally dependent upon them.

There is much controversy over the topic of the **intergenerational transmission of abuse**. Early theory took a 'violence breeds violence' approach[92], suggesting that people learn abusive behaviour patterns from their parents. Later work suggested that about one-third of maltreated children will in time maltreat their own children[93]. Other authors[94] question this research and the underlying evidence, finding[95] that while adults who were abused as children are likely to develop inappropriate parenting styles (characterised as aggressive for mothers, rejecting for fathers), the dynamics at work can be complex. Other linked factors such as impaired interpersonal skills, problems with aggression, affect regulation or empathy, adversity or substance abuse can all be effects which in turn increase the likelihood of people maltreating their children. Given the conflicting research findings, it is not yet possible with confidence to support or reject the notion of intergenerational transmission.

2.6 Future opportunities and adversities

All the types of effects of exposure to CSA described above have the potential to impact on long-term opportunities and quality of life, as do further linked factors explored below.

Children with histories of CSA have been found to have poorer **educational outcomes**[96] and adaptation, showing poorer cognitive and intellectual performance and lower achievement[97], often engaging in disruptive behaviour or failing to integrate[98], and being more likely to engage in truancy or drop out of school[99] than other children.

Some research has found that adults maltreated as children are more likely than others to have **low socioeconomic status** and experience **unemployment**. Maltreatment (of any kind) has been found to negatively affect income, and adults who had experienced multiple types of maltreatment were found

85 Benedict et al. (1999); Prentice et al. (2002)
86 Wood and Esterik (2010)
87 Gelinas (1983)
88 Lyons-Ruth and Block (1996)
89 Dubowitz et al. (2001); Newcomb and Locke (2001)
90 Ruscio (2001)
91 Alexander et al. (2000)
92 Curtis (1963)
93 Belsky (1993); Kaufman and Zigler (1987)
94 Widom (1989); Newcomb and Lock (2001)
95 Newcomb and Lock (2001)
96 Daignault and Herbert (2009)
97 Mannarino, Cohen and Gregor (1989); Paradise, Roset, Sleeper and Nathanson (1994); Wells, McCann, Adams, Voris and Dahl (1997)
98 Calam, Horne, Glasgow and Cox (1998); Dubowitz, Black, Harrington and Verschoore (1993); Mannarino et al. (1989)
99 Garnefski and Arends (1998); McBroom (1994)

to be almost twice as likely to have a low family income and three times as likely to be in poverty than other adults[100].

Reviews of the available research conclude that a history of CSA increases the likelihood of **revictimisation** later in life[101], and several hypotheses have been put forward for why this might be. Risky lifestyles may make CSA survivors more vulnerable to continuing abuse[102], or post-traumatic symptoms affect the exercise of judgement[103]. The findings of a national longitudinal study[104] suggest that children who experience sexual abuse and have psychological distress are more likely than non-abused children to experience any kind of victimisation, including further sexual abuse or assault. A revictimisation pattern may be an ongoing experience throughout childhood, with adult revictimisation continuing the pattern.

2.7 Four Traumagenic Dynamics Model

The lack of a single pattern of symptoms to characterise the consequences of CSA has led some researchers to develop models to understand the psychological process and effects of CSA. One such is the Four Traumagenic Dynamics Model[105], which suggests that four trauma responses or dynamics are encompassed in CSA: ***traumatic sexualisation*** (where sexuality, sexual feelings and attitudes develop inappropriately or dysfunctionally), a sense of ***betrayal*** (because of harm caused by someone the child vitally depended upon), ***powerlessness*** (because the child's will is constantly contravened), and ***stigmatisation*** (where feelings such as shame or guilt are constantly reinforced and become part of the child's self-image). A later author[106] has added ***secrecy*** (including the fear and isolation this creates) and ***confusion*** (because the child is involved in 'naughty' behaviour, invoked by trusting adults). While these six dynamics are not unique to CSA cases, it is argued that it is the combination of these dynamics which makes this type of trauma unique. The individual dynamics may vary in degree in different CSA survivors, and this both explains the variation in symptoms and suggests that treatments need to address each specific dynamic appropriately rather than take a general, rigid approach to every individual survivor.

2.8 Variables that may affect the impact of child sexual abuse

As explored above, the pattern and degree of symptoms vary between CSA survivors because of the complex dynamics that can be in play. Further variation in impact, and in the therapeutic approaches appropriate to employ in response, may also result from differences in situations of the children who experience CSA. Four such variables are considered below: gender, the context of the abuse, culture, and disability.

100 Zielinski (2009)
101 Arriola et al. (2005); Roodman and Clum (2001); Polusny and Follette (1995); Beitchman et al. (1992); Maniglio (2010)
102 Koss and Dinero (1989)
103 Chu (1992)
104 Cuevas et al. (2010)
105 Finkelhor and Brown (1986)
106 Glaser (1991)

2.8.1 Gender

Gender is a characteristic which may militate against certain adverse consequences for some children and increase difficulties for others. Girls and boys express their distress in different ways[107]and may therefore have different therapeutic needs.

Until the last decade, research (and practice) has tended to focus on sexual abuse of females, supported by the popular, but inaccurate, view that males are the perpetrators of child sexual abuse, not victims[108]. An extensive literature review[109] observed that child sexual abuse can have similar psychological impacts on males as on females, males are less likely to disclose that they have been abused, and clinicians are less likely to explore this. There is an urgent need for services to better identify and address the needs of male survivors.

Research has found that girls are more likely to internalise their distress through, for example, anxiety, depression and self-harm, whereas boys are more likely to externalise and display 'hypermasculine compensation'[110] such as aggression, anti-social behaviour, violence to others and homophobic behaviour[111]. Females have also been found to display higher levels of eating disorders, suicidal behaviour and alcohol consumption, and males more difficulties at school, substance misuse, delinquency and reckless sexual behaviour[112]. They also face additional impacts in pregnancy and childbirth: increased risk (over non-abused girls) of adolescent pregnancy[113], stress, depression and negative life events during pregnancy[114], childbirth complications[115], post-natal depression[116], abortions and STDs[117].

Females CSA survivors are more likely to come from families demonstrating greater conflict and less cohesion[118]. Women may find it more difficult to separate from abusive parents, because they feel a duty to care for them in old age or to maintain a kin network[119]. Family dysfunction is not common for males[120], but issues around socioeconomic status can be[121].

For males, constructions around masculinity and male sexuality may make coming to terms with the experience of abuse difficult in a particular way[122]. For many men abused in boyhood by other males, seeking help is inconceivable[123], inhibited as they can be by feelings of shame or confusion of sexuality and identity[124]. However, boys abused by women are even less likely to report their abuse[125], and this is an area that needs further research.

107 Lisak (1995)
108 Holmes and Slap (1998); Yancey and Hansen (2010)
109 Holmes et al. (1997)
110 Lisak (1995)
111 Finkelhor et al. (1990); Kendell-Tackett et al. (1993); Lisak (1994); Stern et al. (1995); Durham (2003); Yancey and Hansen (2010)
112 Chandy et al. (1996)
113 Rainey et al. (1995)
114 Stevens-Simon and McAnarney (1994); Benedict et al. (1999)
115 Farley and Keaney (1997)
116 Buist and Janson (2001)
117 van Roode et al. (2009)
118 Alexander and Lupfer (1987); Ray et al. (1991); Benedict and Zautra (1993); Meyerson et al. (2002)
119 Hooper and Koprowska (2004)
120 Meyerson et al. (2002)
121 Holmes and Slap (1998)
122 Lisak (1995)
123 Fisher et al. (2008)
124 Durham (2003); Maikovich-Fong and Jaffee (2010)
125 Maikovich-Fong and Jaffee (2010)

2.8.2 The importance of understanding the context of abuse

There may be issues specific to the circumstances of abuse which would be important for therapists to understand. For example, young men who are sexually exploited through prostitution remain a largely hidden population[126], inhibited from seeking therapeutic help[127]. Online and internet abuse also pose challenges to a clinical understanding of the impact of abuse which is based in the 'real world'. Trafficking constitutes another unique experience and may produce specific impacts, for example on self-perception, or additional challenges such as the lack of language skills to communicate with therapists[128].

2.8.3 Culture

Practitioners are increasingly likely to work with children and young people from ethnic groups other than 'White British', and need to have an understanding of cultural context. However, prevalence studies in the UK have been unable to adequately assess impact in BME communities. All the available studies which seek to understand ethnic differences originate in the USA, which may not be applicable in the UK because of different social and cultural contexts. Their conclusions are also inconsistent, leading a reviewer[129] to conclude that it was not possible to determine whether the treatment needs of children vary by ethnicity. A better understanding of cultural context is urgently needed.

Treatment in the area of sexual abuse touches on a range of sensitive issues that are highly influenced by ethnic and religious beliefs[130], such as beliefs about sexuality, virginity, nudity, discipline, family boundaries and parent-child relationships[131]. How children and young people experience feelings related to abuse, and how abuse is handled by others, vary accordingly[132]. For example, some Asian cultures may believe abuse to be a form of 'karma' (or punishment for wrongdoings) or be especially sensitive to its social stigma[133].

The Government's Framework for Assessment of Children in Need and their Families[134] provides a systematic way of analysing what is happening to children and young people within their families and the wider context of the community in which they live. It is based on a wide range of research across a number of disciplines and from the accumulated experience of policy and practice. The guidance emphasises that cultural differences must be approached with knowledge and sensitivity in a non-judgemental way, avoiding stereotyping or damaging assumptions leading to an inaccurate analysis of a child's needs.

126 Lillywhite and Skidmore (2006)
127 Trust for the Study of Adolescence (1999)
128 Pearce et al. (2009)
129 Cohen et al. (2001)
130 Cohen et al. (2001)
131 Fontes (1995)
132 Laungani (2004)
133 Fontes (2005)
134 DH (2002a)

2.8.4 Disability

There is virtually no UK data on the impact of abuse to children and young people with some form of disability, and there is lack knowledge amongst professionals on how to identify, address and respond to the needs of children with disabilities[135].

Disabled children may be at increased risk of abuse because of a number of factors, including how society can disempower them and increase their vulnerability, barriers to services, lack of awareness that disabled children can be abused, lack of available skills or joined-up services, and unwillingness to see a disabled child's mood or behaviour as being indicative of more than his/her disability. Disabled children can also be especially dependent on their carers, which can make disclosure difficult. There is an urgent need for further research to underpin better responses to the needs of this vulnerable population.

2.9 Economic impact

In addition to the impact of CSA on the individual, there is substantial economic cost to society (including to health, social care, education and housing services and the criminal justice system). A recent study[136] estimated the annual cost to the UK economy of child maltreatment as at least £19.8bn, of which an unquantifiable proportion would be attributable to CSA.

135 Stalker et al. (2010)
136 NIESR/NSPCC Unpublshed

3. RESILIENCE FACTORS

Not all children who experience CSA suffer consequences later in life. It has been estimated that between 20 and 40 per cent of CSA survivors do not go on to develop psychological problems as a result[137]. Children can develop resilience in a number of ways. Research in this area has been particularly influenced by the ecological model of child development[138], under which children are understood to both interact with and be affected by the settings in which they spend time. The conceptual framework for resilience has therefore come to encompass both internal and external factors.

3.1 Internal factors that promote resilience

3.1.1 Personal characteristics

Characteristics identified as playing a positive role in increasing a child's resilience to abusive experiences include having high self-esteem and a positive self-concept[139], the ability to self-reflect[140], self-reliance and the ability to think and act independently[141], problem-solving abilities[142], an internal locus of control[143], the ability to maintain a positive outlook[144], tolerance for a negative affect[145], high levels of activity[146], an enduring set of values[147], intelligence[148], and being ready to disclose and discuss abusive experiences[149].

3.1.2 Coping strategies

Coping strategies have been defined as responses that help manage a threat, manage its meaning (to limit its impact), and manage negative feelings associated with it[150]. They may be particularly important for those who experience sexual abuse[151]. Coping strategies can be adaptive or maladaptive[152]. Adaptive strategies, such as problem solving, seeking support or information and gaining a sense of control, are generally considered more helpful[153] than maladaptive strategies, such as denial, disengagement or substance abuse, which may lead to long-term problems[154]. However, in CSA cases maladaptive strategies at the time of the abusive experience may be considered positive[155].

137 Finkelhor (1990)
138 Bronfenbrenner (1979)
139 Garmezy (1993)
140 Cicchetti and Rogosch (1997); Garmezy (1993)
141 Herrenkohl et al. (1994); Masten et al. (1990)
142 Himelein and McElrath (1996); Banyard (1999)
143 Werner (1995); Liem et al. (1997); Herrenkohl et al. (1994)
144 Himelein and McElrath (1996)
145 Smith (1999)
146 Garmezy (1993)
147 Rutter (1985, 1987)
148 Masten et al. (1988); White et al. (1989)
149 Himelein and McElrath (1996); Banyard (1999)
150 Nurius (2000)
151 Taylor (1991)
152 Macy (2006)
153 Collins, Taylor and Skokan (1990)
154 Updegraff and Taylor (2000)
155 Oaksford and Frude (2009)

Following earlier studies of coping strategies in childhood and adulthood[156], a review of the process[157] concluded that the immediate, short-term strategies which are employed by abused children are: 'wishful thinking' (hoping that they can have a normal life), seeking support from others, actively avoiding, resisting or running away from the abuser, and cognitive appraisals (contemplating the experiences, which can lead for example to emotional suppression). In the longer term, adults may cope by the use of psychological escapes (for instance substance abuse or denial), seeking support, action-oriented strategies, cognitive appraisal (including acknowledgement of abuser's culpability, cognitive rumination or emotional suppression), and positive reframing (where survivors interpret abuse as beneficial in some way, such as developing a stronger personality, self protection, improved empathy for others, strengthened relationships and protection for their own children).

There are particular tools in use which measure coping, the most comprehensive to date being the Ways of Coping Checklist – Revised[158], a 42-item self-report measuring a range of cognitive and behavioural strategies. This measure is, however, intended for use by adults and would have to be adapted if used to measure coping in children.

3.2 External factors that promote resilience

3.2.1 Informal support from adults

When children decide to disclose abuse, they are more likely to talk to someone they know personally (such as an adult in the family, friend, neighbour or teacher) than to authorities like the police, social workers or their GP[159]. Attachment theory[160] suggests it is innate for children to seek closeness to a reliable adult figure when facing stressful situations.

Normally, children will look to their parents, particularly mother, or other older family members for this closeness and protection. Sources of support in the family, particularly from a parent who is not the perpetrator of abuse, have been found to be important to the development of resilience[161]. Parental support has also been found to promote positive outcomes following abuse. Survivors whose mothers provide emotional support tend to fare better psychologically[162].

Adults outside the family can also positively affect a child's development[163], including in cases of child maltreatment[164]. Abused children who are able to develop close relationships with other adults have displayed greater resilience[165].

156 DiPalma (1994); Binder et al. (1996); Himelein and McElrath (1996); Perrott et al. (1998)
157 Oaksford and Frude (2009)
158 Vitaliano et al. (1985)
159 Allnock (2010)
160 Bowlby (1969)
161 Werner and Smith (1992); Cassidy and Mohr (2001); Cowen and Work (1988); Heller et al. (1999); Sagy and Dotan (1990); Spaccarelli (1994); Cozzarelli et al. (2003); Weinfield et al. (2004); McLewin and Muller (2006); Cohen and Mannarino (1998); Spaccarelli and Kim (1995)
162 Egeland et al. (1993); Everson et al. (1989); Jellinek et al. (1992)
163 Eccles et al. (1993); Gottlieb (1991)
164 Berliner and Conte (1995); Everson et al. (1989); Spaccarelli and Kim (1995); Valentine and Feinaur (1993)
165 Cicchetti and Rogosch (1997)

3.2.2 Support through school

Research has found that good school experiences may be beneficial to maltreated children. Supportive peers, positive teacher influences and success (academic or not) have all been identified as important protective mechanisms for children[166]. They can also provide a foundation for forming pro-social and supportive partnerships, which are primary ways to reduce stress and promote mental health[167].

3.2.3 Religion

A number of studies have examined the significance of religion in people's lives and its potential beneficial effects as a protective factor against mental health problems, substance abuse and crime. In a review of the findings, membership in a congregation and faith in a higher power where identified as protective factors[168]. A spiritual relationship with a benevolent higher power has also been cited as a crucial factor in enduring significant trauma over time and reclaiming a sense of meaning and agency in spite of abuse[169]. Within certain BME communities, religion may be seen a very important source of resilience.

3.2.4 Spare time activities

Spare time activities such as dance or theatre, sport or volunteering have been found to contribute to developing social skills and strengthening a young person's social network[170]. They can enhance a young person's sense of self-efficacy, promote a sense of belonging, offer a passport to new areas of social contact and introduce young people to positive peer relationships, including adult mentors[171]. In all these ways they can help build resilience.

3.3 Culture and resilience

Little is to be found in UK literature about culture and resilience to CSA, which is unsurprising given that even basic information such as prevalence and impact in different cultural communities are not well understood.

One article from the USA does however provide rich information about resilience among South Asian immigrant women who had survived CSA[172]. The study found that women made meaning of their experiences of abuse within the context of South Asian culture. Resilience strategies were very tied up with their cultural and community contexts. They included holding a sense of hope for validation of their experiences, the use of silence as a way of healing internally, seeking social support from family and friends within their community, making positive contributions within their communities, and 'intentional self-care' – giving attention to mind, body and spirit to provide healing.

166 Rutter (1987); Werner (1995)
167 Quinton and Rutter (1988)
168 Masten, Best and Garmezy (1990)
169 Williams et al. (2001)
170 Quinn (1995)
171 Gilligan (2000)
172 Singh et al. (2009)

These themes appear to be markedly different to Western cultural notions of resilience, and this provides further evidence of the importance of assessing cultural contexts within therapeutic interventions, to ensure that they are person-centred and culturally relevant.

4. THERAPEUTIC INTERVENTIONS

This chapter provides an account of the sorts of interventions used with children and young people who have experienced sexual abuse. It draws on the mapping study undertaken in the first phase of the programme of research (see Chapter 1, section 1.1.2).

4.1 Overview of common types of therapy for child sexual abuse

Therapeutic support for children and young people who have experienced sexual abuse are provided via statutory, voluntary and private sector agencies, which range from very small specialist sexual abuse services to very large settings such as residential homes.

Only around 20 per cent of services considered in the mapping study were specialist post-sexual abuse services. Most CSA work is subsumed within generic mental health provision[173], though there is evidence that this may not be the best option for children and young people[174]. Various therapeutic interventions were found to be in use, sometimes integrated.

Among **NSPCC services** offered at the time of the mapping study, creative therapies (for instance, play, art and drama therapies) were most common, offered by 91 per cent of services. Counselling was delivered by 83 per cent, attachment theory approaches and cognitive behavioural therapy (CBT) each by 69 per cent and psychodynamic psychotherapy by 66 per cent. Less common were transactional analysis, available in around one-third of services, and sensory motor therapy (in 17 per cent). About a half of services offered a range of 'other' types of therapy, including person-centred, narrative, family and group therapy.

Non-NSPCC services also offered a range of therapies, but with more variation in provision. No one particular type of approach was found to be available from more than around a half of all providers, with the more common being creative therapies, counselling and CBT. Had statutory health services not been under-represented in the mapping study, it could have been expected that the percentage of services offering CBT would be higher, on the basis that the National Institute for Health and Clinical Excellence (NICE) guidelines recommend the use of CBT for depression, PTSD and obsessive compulsive disorder[175]. Psychodynamic psychotherapy was offered by about one-third of non-NSPCC services, and just over one-quarter offered group therapy and 'other' types of therapy.

4.2 Psychotherapeutic approaches

Psychotherapy can be delivered from a broad range of ***theoretical perspectives***, including, behavioural/ cognitive, existential/humanistic, gestalt, interpersonal, psychoanalytic/ psychodynamic, Rogerian/ person-centred and systemic. Therapists typically employ one of these guiding theories, though

173 Allnock et al. (2010)
174 Fonagy (2002)
175 NICE (2008)

integrative approaches, which aim to multiply the benefits of different approaches, are becoming more common[176]. Some of the more common integrative approaches within sexual abuse services for children in the UK are CBT, eye movement desensitisation and reprocessing, and transactional analysis[177].

It is important to distinguish the way in which the therapies are used with children as compared with adults. A child-centred approach is widely used across the NSPCC, where the child is considered an active subject with the ability to speak and act on his/her own[178] interests, in contrast to the more paternalistic notion of intervention or 'rescue'[179].

Some specialist sexual abuse services apply a ***trauma-focused approach***, which aims to eliminate or reduce symptoms specific to trauma, such as PTSD and anxiety. Other interventions are ***abuse-focused***, an approach which suggests that symptoms in individuals who have experienced inter-personal violence differ in nature from, for example, 'ordinary' anxiety or depression[180], or even symptoms found in other types of trauma victims[181]. Common elements of this approach usually include encouraging the child to express abuse-related feelings, clarifying erroneous beliefs about self or others, teaching abuse prevention skills, and diminishing the sense of stigma and isolation[182].

Psychotherapies can be ***talking therapies***, based on conversation with a trained therapist, or ***creative therapies***, which instead focus on the body, and on action. Brief descriptions of some of the most common types of therapy under each heading are given below.

4.2.1 Talking therapies

Psychodynamic psychotherapy is based on the notion that emotional problems can be attributed to a client's unconscious motives and internal conflicts, which may be maladaptive. It greatly depends upon the interpersonal relationship between client and therapist. The therapist first intervenes to treat the discomfort associated with the poorly formed function and then helps the client acknowledge the existence of the maladaption and develop strategies for change.[183]

Counselling as a term is often used interchangeably with 'psychotherapy', but in some settings there are subtle differences between them. In the context of mental health services, counselling is generally a relatively brief treatment (between 1 and 20 sessions) and can therefore be more accessible and affordable for clients. It aims to alleviate suffering, solve problems and help people live more satisfying lives[184]. It often targets a particular symptom or situation and explores ways of dealing with it. Distinct methods of counselling start from different theoretical bases – typically humanistic, psychodynamic, cognitive or behavioural[185].

Group therapy recognises the power of groups to bring about change in individuals through psychology[186]. Group therapy is often seen as a particularly powerful way of working with sexual abuse victims. As they

176 Prochaska and Norcross (1999)
177 Allnock et al. (2010)
178 Wattam and Parton (1999)
179 Lee (2001)
180 McGregor (2000)
181 Herman (1992)
182 Finkelhor and Berliner (1995): 1418–9
183 Gabbard (2009)
184 Dryden and Feltham (1992)
185 Prout et al. (2007)
186 Barlow et al. (2004)

are exposed to other victims, they do not feel so alone, which may go some way towards reducing their feelings of shame[187].

Family therapy emerged from systems theory, which sees families as living systems[188] whose dynamics are constantly altering as each family member deals with life, creating unpredictable outcomes. There are different models of family therapy, but often common elements include the use of genograms or family trees, videos or one-way screens and narrative therapy (see below). There is focus on context of problems, thus family therapy can be seen as an ecological approach. Feminist approaches can be incorporated.

Solution-focused therapy is a brief strengths-based approach based on social constructionist philosophy[189]. It rests on the notion that we can never know the real causes of people's problems, but we can construct alternative interpretations. It focuses on what clients want to achieve through therapy rather than on the problem(s) that made them seek help, and therefore emphasises the present and future rather than the past[190]. The therapist first aims to raise the client's awareness of exceptions to their problem patterns, then helps the client to choose a preferred future and find pathways towards it[191].

Narrative therapy[192] also takes a social constructionist viewpoint. Therapists encourage clients to explore their past by developing stories that they tell in the present, and then work with them to help discover richer (or 'thicker') narratives that emerge from disparate descriptions of experience, weakening the hold of negative ('thin') narratives.

Cognitive behavioural therapy (CBT) is a relatively short term psychotherapy based on the concept that the way we think about things affects us emotionally. In CBT, the therapist helps the client to develop new skills, including those involved in monitoring thought streams and in subjecting attitudes and biases to more realistic reasoning. It can be used in individual as well as group settings, and in different contexts from very simple interventions to in-depth psychotherapy. A trauma-focused CBT (TF-CBT) has been developed which focuses on specific problems of traumatised abused children[193]. In Government guidance[194], CBT is recommended as a first line treatment for symptoms associated with sexual abuse. It is not, however, suitable for use with very young children.

Eye movement desensitisation and reprocessing (EMDR) is an integrative approach including elements of other therapies including psychodynamic, cognitive behavioural, interpersonal, experiential, and body-centered[195]. EMDR addresses the factors that contribute to a wide range of problems, looking at past experiences that lie at their root, current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviours and mental health[196]. One element of the 'reprocessing' uses bilateral eye movements, tones or taps while the client focuses on past memories, present triggers or anticipated future experiences. Through this, clients generally experience the emergence of insight, changes in memories, or new associations[197].

187 Domingeuz et al. (2010)
188 Burnham (1986)
189 DeShazer (1985); Berg and Miller (1992)
190 Prochaska and Norcross (1999)
191 Miller, Hubble and Duncan (1996)
192 White and Epston (1990)
193 Saunders, Berliner and Hanson (2001)
194 NICE (2008)
195 Shapiro (2002)
196 Shapiro (2001)
197 EMDR Institute (2010)

Transactional analysis (TA) is another integrative approach, combining individual dynamics with interpersonal behaviours within a humanistic or existential framework. It focuses on people's interactions with each other[198]. As such, the therapeutic relationship is a central part of both the content and process of transactional analysis, and the 'games' that clients attempt to play with therapists are a critical part of the analysis.

Sensorimotor psychotherapy[199] is a body-centred therapy that makes it possible for clients to discover the habitual and automatic attitudes, both physical and psychological, by which they generate patterns of experience. It teaches clients to follow the processes of body and mind to promote healing. It is held to be particularly helpful in working with the effects of trauma and abuse. It has become widely used with disabled children.

4.2.2 Creative therapies

Creative therapies use arts and play in therapeutic ways. They tend to use movement in addition to speech, recognising the connection between our bodies and minds. They aim to create an attachment relationship and simulate the stages of development which have been distorted or neglected, encouraging the child to regulate his/her own emotions[200].

Play therapy in general is based on the belief that play links a child's internal thoughts to the outside world. It connects concrete experience and abstract thought while allowing the child to safely express experiences, thoughts, feelings and desires that might be more threatening if directly addressed[201].

Non-directive play therapy employs Carl Rogers' person-centred approach to therapy. The child is offered a safe and consistent environment together with a safe and consistent relationship with the therapist. All feelings are accepted and are explored symbolically and/or explicitly. The child chooses how to spend the time, and the play therapist offers Rogers' 'core conditions' of unconditional positive regard, empathy and congruence. During and between sessions, the therapist forms interpretive hypotheses about the meaning of the child's activities. This enables the therapist to work with the child toward resolution[202].

CBT-based play therapy (CBPT) involves both child and therapist in selecting play materials, and play is used to teach skills and alternate behaviour. The therapist offers interpretations, in order to bring conflict into verbal expression[203].

Gestalt principles can also be introduced into play therapy, using a range of creative arts media: drawing, painting, clay, sand tray, music, movement and puppets, where the therapist, not merely observes but communicates using the medium chosen by the child.

Structured group play therapy is designed primarily to improve the child's peer social interactions. The therapist chooses the play materials and activities and the format of the groups sessions are predetermined[204].

198 Transactional Analysis Association (2010)
199 www.sensorimotorpsychotherapy.org/referral/prUK.html
200 Bannister (2003)
201 Kot et al. (1998)
202 Cattenach (2000)
203 Cattenach (2000)
204 ibid.

Filial play therapy is a brief intervention combining play therapy and family therapy. The therapist trains and supervises parents to play in non-directive ways with their own children. Sessions can then be conducted at home without the therapist's direct supervision[205].

Drama therapy is a mechanism for bringing about change in individuals and groups through direct experience of theatre art. All aspects of theatre art – voice, movement, improvisation, role play, script-work, performance, costume, lighting and staging – are employed as elements of the therapy. This type of therapy is based on the notion that all art expresses things we are unable to express in any other way[206].

Psychodrama differs from drama therapy in that it works with a person's own life script – the actual events that have happened in the client's past, are happening in the present, or may happen again in the future. The therapeutic work involves the re-creation of an episode, with different members of the group playing the roles of significant others in the scene[207].

Art therapy invites clients to express their feelings, dreams, wishes and inner experiences through different art media. The art work is considered to be a representation of the object world, but those creating it project part of themselves onto the work. The art, therefore, is seen to contain both the object and a representation of the client's self. It can allow clients to distance themselves from what they are working with[208].

4.3 Treatment for different needs and groups

4.3.1 Responding to the range of needs

The mapping study discovered a range of types of work with children and their families which go beyond a focus on mental health issues to consider the practical issues they face[209]. As one researcher[210] has identified, a wide range of needs are presented to therapists, including physical or medical needs, needs experienced by siblings, the needs of schools (such as to ensure attendance) or the courts system, of ensuring safety, of providing sex or parenting education, or of referring the child or family to other service providers. Practitioners and researchers have identified the need for a continuum of interventions, employing a toolkit of responses, to meet these diverse needs[211]. This also points to the importance of a child-centred approach to therapy, which examines the full range of needs which a child brings to the therapeutic process.

4.3.2 Harmful sexual behaviour

It is important to treat children and young people who exhibit harmful sexual behaviour (HSB), since sexual abuse is a crime, is damaging to victims and can escalate if it is not addressed. There are high success rates in treating HSB, and real opportunities to divert young people away from such behaviour at a point at which they are still developing. Early therapy programmes used cognitive behavioural

205 ibid.
206 Jennings and Minde (1992)
207 ibid.
208 ibid.
209 Allnock et al. (2009)
210 Monck (1997)
211 Saywitz, Mannarino, Berliner and Cohen (2000); Itzen et al. (2010)

approaches, enabling the young person to fully acknowledge and take responsibility for the action in ways which avoid or lessen the risk of further offending. HSB tended to be treated in isolation. However, thinking and services have developed significantly since the early 1990s. Professionals now recognise that close interagency working is essential for developing effective services for children and that child protection work and the criminal justice system need to dovetail their work[212].

Relevant service provision is patchy across the UK, with some centres of good practice such as GMAP and the AIM Project, both based in Manchester. Understanding of what constitutes a good assessment of a child or young person with HSB has improved significantly with the development of the AIM2[213] and MEGA[214] models. Less is known about what comprises effective treatment, and more research is needed.

Further analysis is also needed into HSB among learning disabled children. Assessment and intervention approaches require adaptation and modification to take account of their specific needs. Such service provision is particularly sparse, while anecdotal evidence indicates that referrals of children and young people with learning disabilities are increasing[215].

4.3.3 BME communities

As explored in Chapter 3, it is important to ensure that services are culturally relevant and aware of differences between cultures. However, the development of culturally relevant therapeutic services in the UK is in its infancy.

Researchers and practitioners are currently working in Southampton to adapt an existing CBT manual for use by therapists working with patients with psychosis from specific ethnic minority communities. Preparatory research[216] examined how members of African-Caribbean, Black-African/Black British and South Asian Muslim communities typically view mental health problems. It found that CBT would be an acceptable treatment if adapted culturally, for instance to include cultural health beliefs. As an example, mental illness was associated among the groups studied with previous wrongdoing, supernatural beliefs and social factors, while the African-Caribbean sample also associated it with being arrested and with drugs. The research concluded that therapists need to understand such factors that may influence the way in which clients perceive or respond to therapy.

Further adaptations still may be needed in services focused on BME abused children rather than adults with psychosis. This may involve, for example, accepting that treatment takes place in parallel with traditional non-scientific approaches, respecting the roles of the family and extended community, or addressing questions of spirituality or religion.

At this early stage of development, evidence is limited, and more information will need to be gathered in future about how effective such adaptations can be for BME service users.

212 Hackett et al. (2003)
213 www.aimproject.org.uk
214 Micca-Fonseca (2006)
215 Brown et al. (2010)
216 Rathod et al. (2010)

4.3.4 Children with disabilities

Few of the services covered by the mapping study have the resources and expertise to provide therapeutic support for children with disabilities, particularly those with severe impairments. While few referrals were made for children with disabilities, one reason may be the lack of in-house skills and resources[217] which would raise questions about where children with severe or even moderate disabilities can receive support.

Creative therapies may be particularly relevant for children with disabilities, particularly for those who may find it difficult to express themselves linguistically. Play therapy might help children with disabilities express their feelings and help with coping, building resilience and self-esteem[218]. One study[219] found art therapy to be particularly effective at improving bonding for children with learning disabilities, while another[220] found that social skills taught through art therapy, as well as cognitive therapy and group therapy, improved assertion scores and behaviour for children on the autistic spectrum. However, in all these areas, evidence is patchy and further research is needed.

4.4 What evidence is there that therapeutic approaches are effective?

4.4.1 The value of existing quantitative evidence

This study has found 12 published literature reviews, including six meta-analyses, relating to therapeutic interventions for child sexual abuse, the most recent in 2008[221]. The majority of the studies covered have taken place in the USA. The literature reviews show that, for at least 30 years, researchers have attempted to learn through outcome studies whether therapeutic services help children recover from sexual abuse.

Most of the early reviews noted that the majority of studies up to that point studied treated cases without 'before and after' assessment, and were therefore of limited evidential use. A review in 1995 covered 29 studies that used quantitative outcome measures of treatment effectiveness, and all of these employed pre- and post-therapy assessments of varying psychiatric and behavioural outcomes. Most demonstrated positive changes among children who received therapy, especially for self-esteem, anxiety and depression, and also for sexual behaviour in some studies. However, 17 of the 29 studies did not use a comparison group and so could not reliably attribute positive changes to the treatment rather than to other changes in children's lives or spontaneous improvements. In general, reviewers in the 1990s considered the evidence base to be weak.

There has since been a growth in the number and rigour of studies. The most recent systematic reviews have focused on evidence from controlled trials. Well-designed randomised controlled trials (RCTs), where participants are randomly assigned to groups which receive treatment and groups which do not, appear to provide the firmest evidence, and several of the most recent RCTs have used standardised instruments, manualised treatments and adherence or fidelity procedures[222]. However, only three of the

217 Allnock et al. (2009)
218 Porter et al. (2009)
219 Freilich and Schectman (2010)
220 Epp (2008)
221 Wethington et al. (2008)
222 Saywitz (2000)

12 reviews included in this study are reviews of RCTs. This may be because of the ethical issues involved in randomly deciding that a child or young person is not going to receive treatment that he/she may want or need. Study designs can alternatively randomly assign children and young people to different types of interventions[223] which allows for emerging evidence of treatment types, but this does not provide evidence of 'treatment' versus 'no treatment'.

4.4.2 What existing quantitative evidence tells us about therapeutic effectiveness

Among well-designed studies, active treatments for sexually abused children demonstrate significant improvements in alleviating aspects of distress, compared to children receiving no treatment[224]. Abuse-specific interventions, particularly with children and non-offending parents, show greater improvements than more non-directive approaches, particularly for children's depressive symptoms and improvements in parenting skills.

The most commonly-evaluated therapy to date is CBT, and a growing body of evidence has documented its positive effects. The strongest evidence of effect has been identified[225] among children with symptoms of PTSD, and some improvements have also been found in behavioural problems, including sexualised behaviour. The most encouraging findings appear where a parent or guardian was involved in the treatment. It is unclear, however, what components of the treatment are particularly effective, or how effective it would be in different cultural contexts.

A systematic review and meta-analysis of randomised and quasi-randomised CBT studies[226] found reductions in symptoms including depression, PTSD and anxiety at one year follow-up, but no overall effect on sexualised behaviour or externalising symptoms. Another review of 11 studies[227] concluded there was "strong evidence that individual and group CBT can decrease psychological harm among symptomatic children and adolescents exposed to trauma (eg including decreases in anxiety, PTSD, depression, and externalizing and internalizing symptoms)".

Such findings have led to the recommendation of CBT as a first-line treatment for sexually abused children and their families[228]. However, some remain cautious about existing CBT research, for several reasons. The overall methodological quality of studies to date is considered to be low, some claimed results are in fact statistically non-significant, and important questions remain unasked, such as what is the optimal timing of CBT and how do outcomes vary by severity of symptoms or client history.

There have been an increasing number of evaluations on other types of therapies. However, many reviewers conclude that the evidence is insufficient. Studies have found mixed results, often due to methodological differences. Fewer studies have tested these therapies with the same rigour as CBT, and so less is known about their effectiveness. The conclusion[229] drawn on four studies of play therapy were that the modes of intervention varied too greatly and the evaluation was too limited to determine the effectiveness of this type of therapy. The same authors said they could not reach conclusions on the

223 For example, Trowell et al. (2002)
224 Stevenson (1999)
225 Ramchandani and Jones (2003)
226 MacDonald et al. (2007)
227 Wethington et al. (2008)
228 NICE (2008)
229 Wethington et al. (2008)

basis of a single study each on art therapy and psychodynamic therapy. Many studies of non-directive play therapy are based on a small number of individual cases and are often excluded from systematic literature reviews. It would be wrong to conclude that such therapies 'do not work', but clear evidence of their effectiveness is missing.

One helpful summary of evidence of therapeutic outcome studies in general[230] concluded that "studies demonstrate empirical evidence for extending and modifying treatment models from mainstream clinical child psychology to sexually abused children." While the authors noted that current evidence supports CBT, they suggested that this might be because CBT is easier than other types of therapy to study in manualised trials. This statement may be even more pertinent today than when it was made 10 years ago, given the growth in CBT studies compared to those looking at other therapies.

4.4.3 The need for new quantitative outcome research

Given the gaps and shortcomings in previous research and the doubts about the validity of the evidence, there is a strong case for further outcome research to be undertaken.

As well as taking a rigorous methodological approach, any new research should aim to address deficiencies of existing evidence. For instance, it should aim to assess a range of interventions, including creative therapies. It should compare the effectiveness of general, targeted and abuse-focused approaches, and try to ascertain what elements of therapy are most effective in an integrated approach. It should use a large enough sample size to generate statistically relevant results. It should aim to provide a long term view, following up cases over a number of years, recognising that some impacts do not become apparent for some time. It should try to capture the needs of a diverse range of children with different histories and from different backgrounds, for whom therapeutic requirements may vary considerably. It should look beyond the child and consider the impact of the parental and family involvement in therapy. Researchers should also aim towards more consistent approaches, which better allow comparisons to be made and conclusions to be drawn over time. It is particularly important to see new research carried out in the UK, given that the bulk of existing evidence relates to the USA.

4.4.4 Qualitative studies

Only four relevant qualitative studies were identified in this literature review. In one study[231] of outcomes, an activity book was used to collect children's views about their experiences of therapy and how they felt before and afterwards. Only three children (out of 12 studied) completed it, but this is an interesting approach which may be used again to generate useful information in future studies. Another study[232] investigated how the therapeutic alliance between therapist and client can be established where children are involved, taking a case-by-case look across 15 psychotherapies. The views of children, caregivers and therapists were recorded at the end of therapy and at a one year follow up. Key findings were that the alliance is related not only to the child's understanding of the therapeutic process, but also the caregiver's, underlining the value of caregivers supporting their children in therapy; and that while children may not come to therapy with the notion of a goal or understanding of process, they do nevertheless have a positive expectation of the encounter with a therapist.

230 Saywitz et al. (2000)
231 Coren et al. (2010)
232 Jensen et al. (2010)

It is clear that qualitative research in this area of inquiry is under-developed. While robust quantitative designs have the greatest possibility of capturing effectiveness, they do little to reveal what is responsible for improvements and struggle to produce information about context (for example, family or cultural context). Associated qualitative research is therefore of considerable value in filling such gaps in our understanding.

4.5 Some important factors in therapy

While the literature lacks firm evidence about the effectiveness of different types of therapy, taken together it does describe a range of factors which may be relevant to outcomes, regardless of type of therapy used. Some key factors are outlined below.

4.5.1 The therapeutic alliance

The therapeutic alliance between client and therapist is considered an important relational factor in child psychotherapy[233]. It has been defined as the therapist's ability to develop a warm relationship and engage the child in the therapeutic process[234], and should be seen as an evolving process which continues throughout the time the child is receiving therapy[235]. Unfortunately, there is not much empirical literature on the therapeutic alliance in child psychotherapy, and no such studies have been identified in relation to sexual abuse cases. Inconsistent measurement makes comparing results across studies difficult[236].

However, the therapeutic alliance has been found to help promote positive outcomes in CBT interventions for children and young people with anxiety[237], helping to ensure active participation of children in skill-building tasks and building trust to underpin emotionally demanding elements of therapy. The quality of the alliance early in treatment appears to affect outcomes during the therapeutic process itself, but post-treatment improvements seem to depend upon a high quality alliance being maintained throughout therapy[238].

Within play therapy, the therapeutic alliance is seen as crucially intertwined with the therapy itself. Play therapists see play as a natural way of communicating with a child and therefore central in the construction of the therapeutic alliance. Commentators have noted the importance of 'rational' interaction between child and therapist – the warm, friendly and engaging aspect, and the ability to agree goals for change – or, in the case of one author[239], the early object ties which help motivate a child to grow and prosper in the family. At present, however, no empirical evidence has been identified in this area.

4.5.2 The role of the 'safe carer'

Research has shown that the role of the non-offending parent or caregiver ('safe carer') in child sexual abuse cases can be important in producing better outcomes.

233 Shirk and Karver (2003)
234 McLeod and Weisz (2005)
235 Axline (1989)
236 Shirk and Karver (2003)
237 Chu et al. (2004)
238 Chiu et al. (2009)
239 Chethik (2002)

At the point of disclosure of abuse, having a supportive safe carer can help buffer the impact of the abuse[240], while lack of such support can make things worse. The anticipation of a negative response can strongly influence a child's decision not to tell someone[241].

The inclusion of safe carers in treatment has been reported to be advantageous to a child's recovery[242]. It can help ameliorate safe carers' own traumatic response to disclosure and so better equip them to focus on supporting their children, enable them to recognise and respond sensitively to the child's symptoms and behaviours, and help prevent them prematurely terminating the therapy[243].

One review of the literature[244] advocated involvement of safe carers in play therapy in CSA cases and encouraged further research in this area. Filial therapy does actively involve parents, teaching them non-directive therapeutic techniques, but it was suggested that it neglects the emotional needs of parents themselves, which could have a negative impact on its implementation and effectiveness. Involvement in CBT treatments can include individual and joint sessions focused on 'coping skills training, gradual exposure, cognitive and affective processing and education'[245] and can have very positive effects, though further research is needed to validate this conclusion. Various limitations were identified with family therapies, as the structure around adult language can inhibit the participation of young children and so make a child-centric approach difficult to achieve.

4.5.3 Practitioner training and supervision

Sexual abuse is a complex form of abuse, and practitioners providing a specialist service to children who have experienced it should have some understanding and experience of working with them so they can make sound judgements about the needs of each child and how best to respond and seek the support of others. The mapping study found that most services in the UK are staffed with practitioners who have specialist training and qualifications in the particular therapy they are delivering, in addition to degree level or other general qualifications. In some services, however, specialist training occurs on the job or through post-qualifying training[246].

Supervision of staff delivering sexual abuse interventions is viewed as crucial to good practice, helping both to develop practitioner skill and to monitor the welfare of the client[247]. Clinical supervision can also help practitioners deal with their own emotions in an area of work which can be very distressing. Very little is known about the effects of supervision on improving client outcomes, however. While it is assumed to be occurring, there is no clear evidence base[248].

4.5.4 The multi-agency context

Many different agencies are involved in the life of a child, in particular across health, day care and education services. A practitioner providing a specialist sexual abuse service is not therefore working in

240 Finkelhor (1979); Adams and Bukowski (2007)
241 Bentovim (1993)
242 Corcoran (1998)
243 James (1989)
244 Hill (2005)
245 ibid. p.350
246 Allnock et al. (2009)
247 Bernard and Goodyear (2004); Falender and Shafranske (2004)
248 Freitas (2002)

isolation with a child. The knowledge held by other agencies and practitioners are an essential component of any assessment. Inter-agency collaboration is essential to ensure understanding of what is happening and ensure an effective response[249]. This context further complicates the assessment of the effectiveness of therapeutic interventions in isolation from beneficial impacts which may be contributed by other agencies in an effective multi-agency collaboration, such as a supportive teacher or social services work in the child's home.

4.5.5 Treatment manuals

Treatment manuals set out theory and techniques for treatments and allow practitioners to draw on an array of different approaches, providing a form of standardisation of practice. The shift towards evidence-based practice has led to a proliferation of manualised treatments for a variety of mental health problems[250]. Through practice and research, manualised treatments should allow us document what, how and why treatments are most popular and effective, which will in turn inform and potentially improve future manuals and practice.

Manualised treatment is not without controversy, with some practitioners hesitant to use them because of concerns about performance measurement issues, logistical considerations or perceptions about the appropriateness of such an approach[251]. Some believe that using manuals can dehumanise the therapeutic process, obstruct the therapeutic alliance or the focus on the client[252], limit the practitioner's freedom to exercise the full range of skills, stifle innovation, and overlook the importance of unmeasurable skills such as showing warmth and empathy. It is also argued that manuals can become outdated as the research base expands[253].

The positive point of view sees manuals as a problem-solving tool, containing suggestions for techniques to use during therapy[254], and as a way of ensuring treatment integrity, allowing replication studies to be conducted and determining if changes in treatment advocated in the manual are effective[255]. There is little evidence in the literature to suggest that the therapeutic relationship is undermined by the use of manualised treatment programmes, with case studies finding that they do not preclude expressions of empathy and positive regard, and parents citing the relationship with the therapist as one of the most beneficial aspects of the manualised treatment[256].

Important considerations in the development of manuals include ensuring that examples are realistic, sounding notes of caution, including all necessary resources to ensure practitioner proficiency, including culturally-relevant material, and updating them every few years[257]. Further research is also needed to assess the effectiveness of manuals and collect the views of clinicians, to clarify the status and use of manuals, to assess the process and outcome of manual use, to develop guidelines for use, and to seek the views of social workers[258]. This last point is particularly relevant to CSA cases, where social services play a pivotal role.

249 DH (2000a)
250 Silverman (1996)
251 Abrahamson (1999)
252 Addis and Krasnow (2000)
253 Marshall (2009)
254 Najavits et al. (2000)
255 Mann (2009)
256 Herman-Smith et al. (2008)
257 Najavits et al. (2000)
258 Addis and Krasnow (2000)

5. WHAT CHILDREN AND YOUNG PEOPLE SAY ABOUT THERAPY

The NSPCC is a voice for children, and the current body of work is directly related to improving outcomes for children and young people. It is therefore important to hear what children and young people themselves have said about their experiences of therapy.

5.1 Evidence of children's views

The literature on children's perspectives of therapy for sexual abuse is small. This may be because relatively few children under the age of 18 receive such therapy[259]. Ethical and practical reasons can also prevent the inclusion of children and young people in research about sexual abuse[260], and child-friendly methods for gathering views are still in their infancy.

However, research for the NSPCC[261] has uncovered a number of themes in what children say they want and do not want from professionals working on their behalf. They want them to be accessible, non-judgemental and non-directive. They want space for humour. They value straight talking, trust and confidentiality. Other research echoes such themes[262].

The research highlights the caution with which most children and young people approach the adult – especially the professional – world, and puts forward child-centred principles in relation to practice and planning in the area of child protection. Practitioners must establish what children themselves see as the primary causes of pain, distress and fear, and address their perceptions and fears at all stages, and these should be incorporated into work plans. Practitioners should actively address the consequences and difficulties faced by the child, including actions taken specifically to protect the child. Children should be involved in setting objectives and timescales for treatment, and be able to express any preference as to the gender, race or culture of their practitioner. Services providers should seek to ensure the continuity of key practitioners or other people trusted by the child. Practitioners should be sure they know why children are sharing any information and what help they are seeking. Children's views about the reliability and effectiveness of their treatment should be recorded and addressed[263].

In research into children's reactions to child sexual abuse therapies[264], group therapy was most positively evaluated, with 10 out of 11 children saying they 'liked' it and it 'helped'. Children liked not being 'forced' to talk, being able to engage in other creative activities, the sense of not being alone with their experience, and the safety of the group as a place to talk. Twelve out of 15 liked individual therapy and 11 said it helped. Work with families was less popular, with only five out of 13 giving it a positive rating, four neutral and four negative. Some welcomed the opportunity for the whole family to talk and bond, but others said family members were angry about taking part, making the child feel uncomfortable or

259 Cohen et al. (2001)
260 Coren and Hutchfield (2010)
261 Butler and Williamson (1994)
262 McGee and Westcott (1996)
263 Butler and Williamson (1994)
264 NCH Action for Children 2010

scared. In general, the research discovered that children did not find it comfortable or helpful for therapy to be primarily concerned with encouraging them to talk about the abuse.

A study of what children and referrers each wanted from a multi-disciplinary post-abuse service in Wales[265] found that children wanted to be 'listened to' but did not want to talk about the details of the abuse itself and did not want to be blamed. In contrast, referrers were focused on the need for more practical help for the children.

A consultation[266] with 10 children and young people aged 10 to 21 who had received a sexual abuse service from the NSPCC found a positive overall response. The users liked using creativity to express how they felt without having to use words. Being able to set the agenda of the sessions meant they felt more in control and therefore more able to discuss issues. They identified the relationship with the therapist as vital, and any lack of continuity as detrimental. Trust was the main factor in an effective relationship, and it helped where therapists took time early in the process to understand individuals' own circumstances.

5.2 Evidence from the online survivor survey

As part of the current body of work, an online survey was carried out among survivors of sexual abuse aged 18 to 35, to elicit their views and perspectives on their experiences of therapy under the age of 18. Of the participants, 52 had received such therapy and were able to comment on it, covering a diverse range of approaches including play therapy, psychodynamic psychotherapy, individual counselling, group counselling, family counselling, cognitive behavioural therapy and art therapy.

Positive reactions included messages about the skills and characteristics of the therapist: good listening skills, interest in the child, exhibiting care and reassurance, and flexibility. Negative reactions were also concerned with the qualities and skills of the therapist, and some learning points which can be drawn from this feedback are that children want to be taken seriously, believed and supported; they want to feel safe and cared for, comfortable and at ease; they want to go at their own pace, with a therapist who can be flexible; they want to be kept informed about the course of therapy; they want continuity in their therapist so they can build trust; they want the therapist to have good interpersonal skills; and they value confidentiality. Regarding the types of therapy, learning points to be drawn are that not all types suit every child, so therapists should try to identify how best to engage the child in his/her preferred modes of expression; that in family therapy, the child wants to remain the focus; that children do not always want to talk about their abuse; and that children's wider needs – physical or practical – should be addressed, not just their emotional issues.

265 Potter et al. (2002)
266 NSPCC (2010)

5.3 Overarching messages for the development of a manual

This work suggests some overarching messages important in the development of a manual for working with children and young people who have experienced sexual abuse:

1) Children and young people experience a range of different impacts and have diverse coping strategies. A good assessment should account for this.

2) The role played by the therapist is crucial. Therapist skills, characteristics and their ability to meet children's needs are key ingredients in engaging children in therapy.

3) External factors may inhibit the child or young person from engaging in the therapeutic process, at any particular time or over the longer term. Therapists need to assess and understand the barriers a young client might face, and be ready to suggest the involvement of other agencies or professionals.

4) Informal support may be very important for some children and young people in supporting the therapeutic experience, but the mere existence of informal support is not enough. Therapists should uncover the specific nature of informal support that surrounds the child and understand how it may help or hinder the therapeutic process.

6. CONCLUSIONS

This chapter recommends components of a guide which may include manualised components for therapeutic intervention for sexually abused children and young people, rooted in the evidence explored in this report. It also draws on that evidence for lessons about research and evaluation of the guide.

6.1 Themes relevant to the development of a guide to intervention

A number of broad themes have emerged from this review, relevant to the development of a guide of intervention. These are explored below and recommendations made in each case.

6.1.1 Assessment

There is ample evidence that high quality assessment is crucial in child sexual abuse interventions. The range of impacts of CSA is considerable, and some impacts suggest particular models of therapy over others. Impacts are often closely interlinked with the context within which the abuse occurred and with the child's family or wider community norms. Practitioners must understand these individual and environmental contexts.

The Framework for the Assessment of Children in Need and Their Families[267] is of proven worth in providing assessments which emphasise context, and values the views, needs and preferences of service users. It can also create conditions for involving parents and for bringing about improvements in areas where it highlights issues for parents, and can assess strengths and weaknesses in the family context. In these ways, it can help practitioners to develop appropriate and targeted treatment plans for each child or young person.

6.1.2 A child-centred approach

Child sexual abuse treatment involves children of all ages, with a variety of histories and presentations, with many different kinds of symptoms. It is vital to start with the child's needs, preferences and context. Taking a child-centred approach sits well with the United Nations Convention on the Rights of Children, which establishes children's rights to access appropriate treatment and to be heard in matters which concern them. It also reflects the philosophy of the NSPCC and work that staff have been delivering for years.

6.1.3 An integrative approach

Particular types of therapeutic approaches will be more appropriate than others depending upon the child's developmental stage (whether, for instance, they are old enough to rely on language), their own

267 DH (2000)

preferences (for example, whether they feel comfortable discussing abuse) and the specific impacts they are experiencing.

Interventions (and individual therapy sessions) should therefore be specifically targeted and designed with each child's needs in mind. Talking therapies such as CBT are not always the most appropriate method for working with a child or young person, and a combination of therapies may be particularly helpful for some children. It should also be recognised that their needs may not be confined to emotional issues, but may also include, for example, physical, practical or education needs. Practitioners may not be able to appropriately address all of these needs within the intervention, but it is important to recognise these and, where they cannot be dealt with, involve other services through signposting.

6.1.4 The therapeutic alliance

The therapeutic alliance emerges from the evidence as of primary importance, and children and young people themselves identify it as key. An effective therapeutic alliance depends upon practitioners being able to consider the needs of children, provide a safe space, address children's preferences, treat them with respect, and explain the therapeutic process. Children say they like to feel that they have some control, so working with the child's preferences as far as possible will help to build trust. These aspects of the therapeutic alliance are closely intertwined with a child-centred approach and may indeed underpin positive outcomes.

6.1.5 Involving a safe carer

There is evidence that involving a non-abusing parent or other 'safe carer' in treatment can improve outcomes. By acquiring learning about the dynamics of abuse, its impact and the process of therapy, safe carers can more effectively support their children in therapy. Carers may themselves gain emotional support from the therapy, helping them in time to stay focused on the needs of their child. Carers who understand the value of therapy are more likely to ensure the child attends regularly and completes the course.

6.1.6 Children and young people from BME communities

There is an astonishing lack of evidence on the impact and treatment of sexual abuse among children and young people from different BME communities. The BME population in the UK is increasing, and white, western and medicalised models of therapy emphasising the individual may not be relevant or useful for children and young people from backgrounds where their world view may be more consistent with a socio-centric formulation.

Very early work is emerging on culturally relevant approaches to adult mental health provision, exploring how psychotherapies – in particular CBT – can be adapted to be culturally relevant with technical, practical, theoretical and philosophical modifications. These seem likely also to be relevant to the other types of therapy typically provided in the UK. The development of the guide should encompass consideration of ways in which it can be made more culturally relevant for BME groups. This recommendation sits comfortably with earlier recommendations on assessment and a child-centred approach.

6.2 Scope and design of the guide

In line with the themes above, the guide currently in draft and undergoing stress-testing is child-centred, centralises the therapeutic relationship, and involves, where possible, a safe carer. It encompasses a range of interventions, dependent upon the assessment of the child and the child's needs, including directive or non-directive creative therapies or talking therapies. Clinical judgement is emphasised as are appropriate levels of supervision. Advice and recommendations at key junctures in the intervention are provided.

The primary **aims** of the guide are:

- relieving symptoms, which may be accompanied by encouraging the child to think differently about the event, facilitating the expression of negative feelings, affirming the child's experience and providing emotional support;
- destigmatising, which may be achieved by the therapist's supportive stance;
- increasing self-esteem through cognitive and interpersonal exercises, roleplays and games;
- preventing future abuse by changing either the victim's environment or his or her behaviours and awareness in that environment.

It is acknowledged that the guide will not be able to provide appropriate treatment for all children and young people. The primary **inclusion criteria** include:

- Age and gender – The guide has been developed for males and females aged 4 to 18.
- BME clients – It provides advice on making interventions culturally appropriate for children and young people from BME communities.
- Disability – It is intended to be appropriate for children and young people with disabilities, where a third party is not required to facilitate communication.
- Disclosure – It will be used with children where there has been a joint investigation (or, exceptionally, where a formal statement to police cannot be made but children's social care believe the allegation and protective action has been taken because of it).
- Stability – It will be suitable for children who have a degree of stability in their lives. Children in care need to be in a stable placement.
- Harmful sexual behaviours – It can be used with children exhibiting sexualised behaviour up to the age of 11, if the child has been sexually abused and his/her behaviours are assessed as impacts of the abuse. Beyond that age, criminal responsibility comes into play and the intention is that only interventions started before the age of 11 should continue afterwards.
- Court – The full model of intervention in the guide will be suitable for children and young people only after any court or legal processes have been resolved but most of it will be applicable in the interim.

6.3 Implications of the evidence for the evaluation of the guide

6.3.1 Overall evaluation design

The methodological issues are complex for a study of this type because, over the longer term, there are many variables which may impact on a young person's life and influence their recovery from child sexual abuse. Longitudinal studies have sometimes been of limited value because they lack detail on the type, intensity and duration of interventions.

It is intended the evaluation should meet the following externally verified criteria:

1) strong research design (randomised trials or matched control studies executed with fidelity, decent sample sizes and well-administered high quality measures);
2) sustained effect at least one year beyond treatment, with no subsequent evidence that this effect is lost;
3) multiple site replication (demonstrated success in diverse settings, with at least one replication with demonstrated effects);
4) analysis of mediating factors linking the programme effect to the change;
5) a cost-benefit analysis.

A quasi-experimental design using pre- and post-test measures and involving a matched control group (to be determined but e.g. children in a local authority area where the NSPCC does not provide services,) will be used.

Data will be collected at the start of the intervention and at the end, and at additional points after intervention. This longitudinal approach will allow for the examination of sustained change in symptoms over a long period, and can capture 'sleeper effects', impacts which do not manifest immediately but appear later.

Different teams will deliver the guide, for the purposes of multiple site replication. A further service may be added to capture outcomes for at least one BME group.

The evaluation has access to resources which can produce a sophisticated analysis of mediating factors and so disentangle effects which pre-date the abuse and which can capture impacts which may appear later in life.

A cost-benefit analysis will weigh the total expected costs against the total expected benefits of the intervention, providing evidence to national and local government of the importance of funding CSA interventions. This will include a process study which has the power to identify those processes which make the intervention work, to share with other services.

6.3.2 Evaluating types of treatment

CBT has the greatest evidence base to date. Other types of treatment have insufficient evidence as to their effectiveness, yet they are used frequently within specialist abuse services in the UK. Research which examines alternative interventions would therefore provide much needed information and build on the

evidence base. The manual delivers an integrative approach, which has been noted as posing challenges in previous evaluation[268], since the greater the number of variables involved, the more difficult it becomes to assess the value of individual types of therapy. Given the weight given in the evidence for the key role of the therapeutic alliance, the evaluation team should consider centralising this dynamic as the agent of change. The process evaluation could then underpin this through detailed description of provision.

6.3.3 Duration of treatment

The emerging view following clinical advice is that there should be a minimum of 30 therapy sessions. The evaluation may, however, benefit from variation in treatment duration to examine whether or not shorter or longer lengths of therapy produce better outcomes.

6.3.4 Inclusion and exclusion criteria

Criteria for which children and young people are to be included in the evaluation are a crucial early decision. The guide itself provides specific inclusion and exclusion criteria (see section 6.2 above), which provide the broad parameters of inclusion for the evaluation:

- Ideally, the full age range (4 to 18) would be included, though small sample sizes might make it necessary to narrow the range evaluated.
- The same challenges may apply to participants of different ethnicity, given the low numbers of referrals from some ethnic communities, which makes a strong case for testing the guide in at least one area of high BME population.
- It is not intended that children should be included or excluded based on any grading or 'level' of symptomology.
- In all cases, consent for inclusion in evaluation must be given by the child and their parent, carer or legal guardian.
- Some case-by-case exclusions may be needed, depending on other factors.

6.3.5 Outcome measures and other data

Outcome measures are vital to robust evaluation, and these must be aligned to the intervention's aims. Decisions have yet to made on the precise combination of measures, but the Trauma Symptom Checklist for Children (TSCC) will certainly be used, having been recommended[269] as an appropriate abuse-specific outcome measure. It has also historically been used in NSPCC provision.

The evaluation team will have to consider how best to collect information on other traumatic events or mental health issues which may have pre-dated the abuse, whether within the assessment by a practitioner or as a separate questionnaire implemented by researchers. The analysis will also aim to components and aspects of maltreatment which are related to longer term adverse effects, to produce some new learning on this issue. A range of contextual information will need to be gathered to control

268 Oates et al. (1994)
269 Finkelhor and Berliner (1995)

for the complex reality of children's lives. High quality assessment is the key first step. Information about ethnic background and any disability will also need to be captured.

Resilience data will be crucial to capture as some children show greater improvements in outcomes where they have greater social support or positive coping strategies. Some will emerge at the assessment stage, but it will be a key task for the evaluation to suggest the range of data to be collected and ensure it is collected consistently. Additional questionnaires may need to be developed for the purposes of the evaluation research.

6.3.6 Process evaluation

Nearly all the studies included in the literature review evaluated a single intervention. None of the studies evaluated either an explicitly child-centred intervention or one which was integrative in approach. The guide has both of these characteristics, making it a unique intervention. Key to the theory of change is the therapeutic alliance, which is a complex concept to measure. It is important that the evaluation appropriately assesses the process in order to describe the intervention being provided. Qualitative approaches will be used, including some form of ethnographic observation, though this poses ethical challenges. Diaries kept by practitioners may be another option, as well as in-depth interviews with staff.

6.3.7 Attrition

Drop-outs from treatment are a potential challenge, but it is not intended to follow recommendations of earlier authors[270] for some kind of early screening (offering ongoing treatment only to those subjects assessed to have the commitment to proceed), since commitment to proceed could diminish at any time over the period of the treatment. A question yet to be answered is why some children do drop out[271]. It will therefore be useful to examine the reasons why the intervention fails to meet the needs of certain groups of children and their families, and to examine any particular social, ethnic or psychological factors. Relevant psychological and contextual information about each child will need to be gathered (possibly at assessment stage) to enable this to happen.

6.3.8 Ethical oversight

Each stage of the evaluation will be presented to the NSPCC Ethics Committee for ongoing ethical guidance and approval. The set-up phase, which included the online survivor survey, had already received ethical approval. The next phase of ethical review will be focused on the design of the evaluation design and ethical protocols for the support of participants.

270 Finkelhor and Berliner (1995)
271 Murray (1995)

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