British Journal of Psychiatry (1991), **159**, 769–782

Review Article

Treatment Issues in Child Sexual Abuse

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Child sexual abuse is a commonly encountered and often emotionally damaging experience, maintained by secrecy and followed by denial after disclosure. Treatment in this field involves both the child and the family in a variety of treatment settings and modalities, often proceeding in parallel. Child developmental considerations dictate that treatment often proceeds in phases. It aims to protect the child from further abuse and the consequences of disclosure, and address the trauma and context of the abuse. Careful planning and co-operation is required by the many professionals working in this stressful area in order to avoid confusion, conflicts, and splits which may mirror relationships in the family. The heterogeneity of the problem is reflected in the fact that treatment cannot be offered in a uniform programme. Legal issues may influence the treatment process. Evaluation of treatment modalities, the identification of protective factors and achieving long-term adjustment in the least detrimental manner offer challenges in this newly developing field.

It may be regarded as a truism to say that treatment in child psychiatry always includes an attempt at healing as well as at prevention, and always includes consideration of the child as well as that child's context, dealing as it does with developing and dependent persons. A multidisciplinary approach is the prevailing mode. Treatment in child sexual abuse is no exception to these rules.

Child sexual abuse is not a newly recognised phenomenon. General Booth, founder of the Salvation Army, wrote in 1890: "I understand that the Society for the Protection of Children prosecuted last year a fabulous number of fathers for unnatural sins with their children" (Booth, 1890). Freud (1896) spoke of "sexual experiences in childhood" and "sexual abuse" in his delivery of "The aetiology of hysteria" to an audience in Vienna. Sporadic reports of child sexual abuse continued to appear, and since the early 1980s there has been a dramatic rise in reported cases, with a strong association becoming recognised between child sexual abuse and behavioural, emotional, and developmental disturbance in childhood (Graham, 1986; Alter-Reid *et al*, 1986) as well as with later adult psychiatric morbidity (Mullen *et al*, 1988). Furthermore, a significant correlation has been found between a mother's childhood sexual abuse and her maltreatment of her own children (Egeland *et al*, 1987).

Prevalence rates continue to arouse debate (Markowe, 1988) and are dependent on the source of the sample and the purpose of the definition employed – normative/sociological, legal, or pertaining to the mental health field (Haugaard & Reppucci, 1988*a*). In the context of the latter, a conservative estimate would indicate that 3–6% of women have suffered major long-term psychological disturbance in relation to their experiences of sexual abuse. The rate for men is likely to be about half that (Briere & Runtz, 1988).

Initially, only the adult survivors of this form of child abuse received recognition and attention. Intervention during childhood, leading to interruption of the abuse, did not occur. Many adult survivors have been reluctant to declare their previous victimisation and continue to live as untreated and troubled individuals, some presenting to adult psychiatric services as undeclared victims. Unmet though these adults' needs remain, this review is concerned with the treatment issues arising primarily following disclosure during childhood. This secondary, preventive approach is in part informed by the positive correlation found between duration of abuse and poor adjustment in adulthood (Browne & Finkelhor, 1986).

Definition

The most useful working definition remains that coined by Schechter & Roberge (1976), who stated:

> "Sexual abuse is defined as the involvement of developmentally immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles."

Abuse which is likely to lead to significant detrimental sequelae usually proceeds repeatedly, and in the context of a network of significant pre-existing relationships. The majority of abused children have known their abuser before commencement of the abuse (Haugaard & Reppucci, 1988*b*). The deleterious effects of child sexual abuse are primarily emotional,

https://doi.org/10.1192/bjp.159.6.769 Published online by Cambridge University Press

lasting physical sequelae such as infection, pregnancy, and injury being less common. However, a recent report suggests that adults who were abused in childhood may present with physical symptoms not referable to organic disease (Arnold *et al*, 1990).

Complexities of the issues

The psychological treatment of child sexual abuse presents a very complex challenge for several reasons. Firstly, the structural dependence of children on adults requires that any therapeutic approach will at the very least offer sufficient attention to the needs of the parent(s) to enable them physically and emotionally to support the treatment offered to the child. In practice, the non-abusing carer (most commonly the mother) as well as other members of the family and the abuser are all likely to require considerable support and psychological help, both in their own right and to help the abused child.

Secondly, treatment has to address issues relating both directly to the abuse and to those dysfunctional relationships associated with the abuse.

Thirdly, the secrecy which surrounds the abuse is almost universally replaced by varying degrees and manifestations of denial of the abuse, so that therapy may proceed alongside a denial of, or possible disbelief in, the existence of the problem.

Fourthly, both the civil and criminal law frequently become involved in cases of child sexual abuse. Therapy may thus have to proceed within the constraints of the particular legal system.

Finally, several statutory as well as supporting and therapeutic agencies are likely to be working with the family.

The temporal context of therapy

Professional intervention may be conceptually divided into several sequential phases:

(a) suspicion or partial disclosure of abuse
(b) investigation and validation (or, rarely, disconfirmation)
(c) decision-making in regard to protection, prosecution, and therapy
(d) implementation of decisions (Glaser & Frosh, 1988*a*).

In practice, there is considerable overlap between these respective phases and, indeed, a therapeutic approach, informed by the complex prevailing emotional issues, is required throughout. Treatment commences at the point at which sufficient consensus is reached about the likelihood of abuse having occurred.

Aims of treatment

Treatment is orientated both prospectively and retrospectively. Broadly, the aims are twofold: firstly, to sustain the interruption of the abusive relationship, in the least detrimental manner possible; secondly, to address the consequences of the abuse which have already ensued and to minimise their detrimental aspects. The term 'treatment' is used here in the broad sense of fulfilling the psychological and emotional needs of the child, rather than implying actual psychotherapy for disturbance.

Issues to be addressed

The issues considered relevant depend both on the conceptual framework or explanatory model employed and on who is regarded as the patient. Thus, for example, a family systems view of causation, such as put forward by Bentovim (1988), would seek to intervene with the aim of bringing about change in family interaction, beliefs, and functioning. By way of a contrast, the feminist perspective, which views child sexual abuse as one unacceptable expression of men's unjustified power over women and children, seeks to redress this imbalance (MacLeod & Saraga, 1988). A 'traumatogenic' model may concentrate primarily on the effects of the abuse on the child, and the child's responses and needs. Because, by definition, the child is the primary victim, treatment issues are addressed with the child's best interests as paramount.

Abusive factors

Anna Freud (1982) described the harm and confusion which child sexual abuse creates for the developing child, whose immature psychosexual development is disrupted by the intrusion of the adult's mature sexual contact. Finkelhor (1988) considered the relative merits of a model based on post-traumatic stress disorder (Eth & Pynoos, 1985) and concluded that this model is inadequate to encapsulate sufficient aspects of the abusive experience. He instead put forward a model of four traumatogenic dynamics affecting the abused child:

(a) traumatic (and inappropriate) sexualisation
(b) betrayal of trust
(c) stigmatisation or blame
(d) powerlessness.

This schema requires the addition of the effects of the almost universal secrecy imposed on the abused by the abuser, which leads to the often paralysing sense of fear and isolation which abused children feel

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until disclosure (Finkelhor & Baron, 1986). Furthermore, all sexually abused children experience some degree of confusion. They are confronted by sexual activities whose meaning and purpose they cannot fully, if at all, comprehend; unpleasant sensations are silently evoked by the actions of loving adults; 'naughty' and 'rude' behaviour, which may at times be pleasurable, is perpetrated by trusted persons.

The children's response

The variability of children's clinical presentation is the resultant of a complex interaction between diverse variables concerning the child, the abuse and the context.

There is wide variation in individual children's resilience in the face of adversity (Rutter, 1985). Budin & Johnson (1989) have described abusers' choice of vulnerable, isolated and unprotected children. Several writers have considered the variability in the child's adaptation to ongoing abuse (Friedrich, 1988). Summit (1983), in his classic paper, described the 'child sexual abuse accommodation syndrome', in which the child adapts to recurrent abuse by entrapment and accommodation; delayed and unconvincing disclosure follows, with subsequent retraction. Finkelhor (1988), too, refers to an 'overintegration' of the abusive experiences by the child. All are addressing the phenomenon of the child's adaptation to a cognitively and emotionally dissonant and incomprehensible experience. The child adopts certain beliefs and attitudes as a means of emotional survival in a situation where talking, 'making sense' or extricating oneself from the experience are not possible. As Mrazek & Mrazek (1987) point out, when disclosure finally occurs and the abuse ceases, the therapeutic task includes helping the child to relinquish the previously necessary but now redundant emotional coping strategies such as dissociation and self-blame.

The term 'sexual abuse' does not refer to a unitary experience. There is wide variation both in the relationship between the abuser and the child and the family, and in the nature (particularly whether vaginally, anally or orally penetrative), duration and frequency of the abuse, and the degree of accompanying threats and violence. Sex rings involve the abuse of several children together, by one or more perpetrators (Burgess, 1984; Wild, 1989).

Another factor which may explain the widely varying and seemingly non-specific response of sexually abused children is the lack of distinction between those responses attributed to the traumatic effect of the abuse itself, and those contextual factors and relationships associated with the abuse. Conte & Schuerman (1987) found a strong correlation between a poorly functioning family and the impact of abuse on children.

Lastly, any consideration of disturbances in the children needs to distinguish between those factors attributable to the abuse and the relationships surrounding it, and those responses relating to the consequences of the disclosure. The latter include particularly those steps taken to protect the child, and the response to the disclosure by those persons most important to the child, that is, the child's non-abusing carer(s) and often the abuser. Here denial, disbelief and blame often feature prominently.

Treatment for the child – addressing consequences of the abuse and its discovery

A uniform treatment programme is unlikely to meet an individual child's needs. On the basis of accumulated clinical experience it is, however, possible to broadly group the issues which need to be considered and to assess their relevance to individual children, in the light of their developmental stage and their experiences of abuse. For instance, confusion and anxiety may be particularly manifested by younger children, while guilt, anger, and depression develop with increasing maturity.

Inappropriate sexualisation is one of the unfortunate consequences of sexual abuse. It is perceived by carers as particularly worrying, involving, as it often does, other children, rendering the child vulnerable to further abuse, and placing carers in potentially compromising situations which will reflect negatively on the child. Some abused children sexualise relationships as a means of gaining recognition and affection, and this is one expression of low self-esteem.

By the nature of their biological state and structural position in society, children are to a considerable, and not necessarily inappropriate, extent, powerless and dependent. They are, therefore, vulnerable to harmful exploitation without protection. And yet, in other respects, sexually abused children can be regarded as placed prematurely in an adult sexual or parental position (Furniss, 1983*a*).

Minimum requirements

All sexually abused children need an opportunity to talk about the abuse and the attendant feelings, and gain relief from their inevitable confusion. Furthermore, there is always a need for therapeutic work addressing educational/informative and preventive aspects. However, the degree of psychological disturbance requiring therapy varies from child to child (Haugaard & Reppucci, 1988*c*).

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Settings for children's treatment

These may include both individual and group settings and children's preferences need to be taken into account in planning. A combination of supportive, psychodynamic, and cognitive as well as educative modalities is likely to be applicable at different stages of the therapeutic intervention. Play and uncritical acceptance through listening form cornerstones of much of this work.

Individual treatment

That aspect of treatment which is concerned with enabling children to describe the abuse and their feelings about these experiences can be offered to the child individually (Jones, 1986). Talking about the abuse is the first step towards reversing the secret and the sense of isolation which accompany sexual abuse. Recalling and describing the experiences also run counter to the defensive tendency to dissociate from them. This process commences at disclosure. Thereafter, the question of how much further opportunity and encouragement children should be offered to tell their story remains untested. Children are often reluctant to repeat accounts of the abusive experiences and it could be postulated that allowing them to determine to whom and what they will tell is a way of empowering a previously powerless child.

The child's feelings of guilt about (a) participating in the forbidden activity, (b) sometimes enjoying some aspects of it, (c) 'allowing' the abuse to continue, (d) not disclosing earlier, and (e) often continuing to harbour some positive as well as angry feelings towards the abuser, are all more easily expressed in an individual setting (Porter *et al*, 1982). However, despite the strong wish and need to help relieve the child of the burden of guilt, in practice this often proves one of the most intractable emotional sequelae of sexual abuse; it is related to the consequences of disclosure. The expression of other feelings, such as shame, anger and fears about having been damaged physically or emotionally are also more appropriately facilitated with children on their own.

Boys often fear that the abuse implies an irreversible homosexual orientation. This fear is based partly on the erroneous belief that the victim was specially chosen by the man (sadly mistaken since abusers of boys report targeting multiple victims (Abel *et al*, 1981)), and partly because anal penetrative experiences in particular are sometimes felt by the boy to 'brand' him as a homosexual (Nasjleti, 1980; Rogers & Terry, 1984).

More intensive psychotherapy may be offered to those children who have been particularly badly abused or who experience great difficulty in relinquishing their previously adaptive defences (e.g. Hunter, 1986).

Group therapy

This is being widely used (Berliner & Ernst, 1984). Membership of such a group effectively counteracts the isolation which many of these children experience and the belief that an abused child can be instantly recognised. As Furniss (1989) points out, belonging to a group whose members share the common attribute of having been abused allows individuals within the group to discover a new and personal identity. Sharing these experiences helps to raise low self-esteem (Hildebrand, 1988). The group setting also lends itself to considering normal sexuality and finding a language to communicate about this as well as about the abuse.

Secondary preventive aspects include identifying persons who could be trusted and confided in, and how the children might avoid conveying potentially sexualised 'messages', which would render them vulnerable to further abuse. Another important advantage of a group setting is that it offers an opportunity for the therapists to observe and assess individual children's further therapeutic needs.

Since the circumstances under which children are abused vary, it is thought helpful for children with particular abuse or abuser attributes not to be isolated within a group (Peake, 1989). Apart from very young children, groups are usually for children of the same gender. Groups for these younger ones tend to be brief but are nevertheless capable of offering a combination of psychodynamic and educational approach (Nelki & Watters, 1989; Corder *et al*, 1990). Groups for older children and adolescents usually last longer and, while careful containment and direction is required, the young persons' greater maturity allows for more exploration of feelings (Furniss *et al*, 1988).

Groups for boys may pose particular difficulties (Friedrich *et al*, 1988). Boys may show more disturbed behaviour which requires a great degree of control from group leaders in order to enable the therapeutic group process to proceed. Furthermore, boys may experience greater difficulty in talking openly (Peake, 1989).

Support for therapy by the child's carers

Children require escorting to therapeutic sessions or groups, and may wish to talk about issues raised in

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the group, particularly those of a factual nature such as sex education or self-protection. It is important that parents or carers be kept informed about these aspects. Otherwise group leaders may be criticised for introducing young children to sexual knowledge considered inappropriate by the child's parents, even though the children had been subjected to grossly inappropriate sexual acts. The offer of a parallel carers' group is usually accepted as helpful (Damon & Waterman, 1986).

Children receiving more intensive individual treatment are in need of understanding and support by their carers during this often painful process, not least when a negative phase is reached in therapy.

The child in context

Thus far, the children have been considered in isolation, in order to discuss their individual treatment needs. Clearly, however, this represents only one aspect of the child's reality, which may indeed not be readily accessible to change until contextual and family issues have been addressed. Furthermore, since therapeutic access to the child typically follows disclosure, most children's overwhelming preoccupation at that time is actually with the immediate issues. These consequences of disclosure include the response of significant persons, legal aspects including the prospect of possibly testifying in court, and not infrequently the question of the child's future family constellation or indeed home and carer.

The child may well not be ready for a meaningful exploration of the abuse experiences and associated feelings, leading to resolution and the re-editing of myths in the child's mind (Sgroi & Bunk, 1988) until the consequences of disclosure and the family's response are clearer.

Case 1

A ten-year-old boy and his six-year-old sister had been significantly sexually abused by their mother's cohabitee. They were now safely in the care of their natural father and his cohabitee, but were wholly preoccupied with their wish for more access to their non-believing mother, and with anxieties about their permanent home, pending a court decision.

All abuse other than that perpetrated by a stranger takes place within an established relational context. Since all children are dependent, it is the nature of their environment and the fact that abuse was possible within that environment which sometimes constitutes the major detriment to the child's development and social and emotional maturation, rather than the abuse itself (Hanks & Stratton, 1988). The declaration of some form of sexual abuse may draw attention to other dysfunctional aspects in the family and social environment, including early patterns of attachment (Cicchetti, 1987).

Working with these issues constitutes a significant part of the therapeutic endeavour, but this is not synonymous with family therapy. Treatment may be offered in one-to-one or group settings, and it often also involves work with the various dyads (Furniss, 1983*a*). At some point in the process, all family members living together with the abused child or planning to do so (including longer-term foster or adoptive families) may be seen together (Glaser & Frosh, 1988*b*). This requires considerable co-ordination, if confusion for the already troubled child is not to be compounded.

In approaching the child in context, two particular aspects may be highlighted. The first is the issue of denial; the second is the question of the nature of relationships between significant persons associated with the child and the abuser (Abel *et al*, 1988).

Denial

A degree of denial of some aspect, if not of the fact, of the abuse is almost universal (Herman, 1981; Abel *et al*, 1985). This denial, in its various manifestations, is facilitated by the secrecy surrounding the abuse, In considering denial, several questions may be asked, all of which have a bearing on the treatment to be offered.

(a) Who is denying?
(b) What is being denied?
(c) How is the denial manifested?
(d) What is the function of this denial?
(e) What are the consequences of the denial?

Denial by abusers

Following disclosure of abuse or investigation of suspicions which bring abuse to light, the majority of alleged abusers explicitly deny their involvement (Ballard *et al*, 1990). If any acknowledgement is made, it is likely to minimise the extent of the activity. To accept definition of this activity as abusive to the child requires a recognition of its seriousness and damage to the child, which is rarely present in the initial stages of intervention. The assumption of responsibility for the abuse, as opposed to externalising blame, is a stage only reached by some, and late on in treatment (Salter, 1988*a*).

These aspects of denial fulfil different functions for the abuser. They include warding off intolerable guilt, they remove fear of imprisonment and censure,

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fear of loss of vital relationships and consequent isolation compounding that which may have led to the abusive behaviour (Gilgun & Connor, 1990), they avoid the recognition of some abusers' own abuse, and they allow for the potential continuation of a psychologically addictive activity.

Unfortunately, quite apart from depriving the abuser of the possibility of treatment, outright denial has major implications for others' belief in the child's descriptions of the abuse, and therefore for the child's emotional welfare (Agosta & Loring, 1988) and safety.

Disbelief by carers

Disbelief of the child by the carers can be regarded as a form of denial and may take the forms described above. For the child's mother or other carers, belief is almost invariably accompanied by a deep sense of guilt for failing to protect the child, painful concern for the child's trauma and suffering, and worry about the implications for the child's future emotional development. It may well rekindle or heighten awareness of past abuse which the mother may have suffered. Belief usually entails some form of (possibly temporary) separation from the abuser, with difficult socio-emotional consequences. Alternatively, disbelief in the child's account or lack of responsibility for the abuse leaves the child unsupported and blamed.

Case 2

Despite considerable work with a mother, she continues to explain her gaoled husband's abuse of their daughters as an aspect of his love for them, leading to considerable confusion for the girls.

Retraction by children

Faced with denial and disbelief, abused children sometimes retract their previous accounts (Summit, 1983) in an attempt to deny the unbearable reality. This form of dissociation may become a lifelong pattern (Kluft, 1985; Coons, 1986).

The treatment of denial

In many ways, denial is emotionally more comfortable than full recognition of the facts and implications of the abuse. It is the task of treatment to deal with the various manifestations of denial and to offer credible and emotionally tolerable alternatives to this form of defence. Such therapeutic work is best carried out in a setting which considers the feelings and preoccupations of the individual rather than interpersonal relationships. Both individual and group work can fulfil this need. The advantages of an individual approach is that to admit to one's most strongly held fears and begin an exploration of avoided and uncomfortable feelings is often only possible within a safe therapeutic and trusted relationship. On the other hand, the group process and setting, in which membership is defined by the commonality of important aspects of experience or actions, facilitates the relinquishing of denial of realities by the unique combination of challenge and support. It is for that reason that currently much treatment of sexual abusers is carried out in a variety of group settings (e.g. Salter, 1988*b*).

The nature of significant relationships

These include the relationships between the carer and the abuser, the carer and the child, and the child and the abuser – a version of the familiar triangle. Emotionally damaging sexual abuse of children occurs within a variety of intra- and peri-familial settings, rather than being confined to the classic incestuous configuration of father–daughter incest (Sgroi & Bunk, 1988). The distinction between strictly intra- and extrafamilial abuse is not helpful.

Therapeutic approaches to past relationships

The significant past relationships are those with the child's mother/non-abusing carers and with the abuser. The marked contrast between the way the abuser behaved during the abuse and outside it are some of the most confusing and devastating aspects of the abuse, particularly concerning the child's sense of trust, betrayal, and self-esteem. The psychological absence of a non-abusing parent figure (Finkelhor, 1979), as well as rendering the child more vulnerable to abuse in the search for love and closeness, is also likely to be associated with prolongation of the abuse, owing to the absence of someone in whom the younger child could have confided.

After abuse, when treatment is likely to be offered, these issues may only be approachable when working with children on their own. Much therapeutic preparation of the child and of the adults involved is required before dyadic or family work and direct expression of feelings about these past relationships can begin. Children often fear such exploratory encounters, anticipating further blame and rejection. When successful, however, carefully prepared and supervised encounters between children and these adults afford considerable relief to the child (Mrazek & Mrazek, 1987).

Current relationships

The nature of relationships after disclosure crucially affect the child's future and may well be accessible to change through treatment.

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'Mother'–abuser relationship

Arguably the relationship which at the time of disclosure is the strongest predictor of the child's future emotional well-being is that between the non-abusing carer (usually the mother) and the abuser. The more entwined this relationship is (not necessarily in the mother's favour), the more compromised is the child's position (Everson *et al*, 1989; Sirles & Lofberg, 1990). This applies particularly to those frequently encountered situations when the abuser denies the abuse, thus forcing the mother, if she is in an active relationship with him, to make a choice in favour of her child or the abuser, who may be her father, cohabitee, son, brother or husband (O'Connell, 1986).

Work with mothers or non-abusing carers

It is important to note that many mothers believe and support their children from the moment of disclosure (Sirles & Franke, 1989). Their predicament is centred around feelings of guilt, their concerns about how best to help their child, and sometimes the need to adjust to a renegotiated relationship with the abuser. These mothers are more likely to require support and counselling than intensive therapy (De Jong, 1988). Much mutual support is offered in groups, sometimes of a self-help nature.

Evidence and proof of abuse continue to be sought by some mothers. This aspect of the work, which is of crucial importance for the child's future, may require painstaking re-examination with the mother of the factors leading to suspicion and disclosure, careful explanation of the status and meaning of positive and negative findings in the child's medical examination, and review of the child's often video-recorded description of the abuse.

Where necessary, there then follows a careful and thorough consideration of what are the obstacles and the losses she faces in accepting the view that her child has been sexually abused, is in need of support and is in no way to blame for any aspect of the abuse or its disclosure.

Exploring, and sometimes discovering for the first time, the mother's individual resources is very helpful (Sgroi & Dana, 1982). Those mothers who were themselves abused in childhood may request help to deal with the emotional after-effects, often re-awakened in the light of the discovery of their child's abuse (in a minority of cases by the same abuser). Thus, although the focus of treatment may at the outset have been the sexually abused child, not infrequently considerable work is required with adult victims, in order to help them to support their own abused children better. Group work with mothers is particularly helpful and may free a mother from identifying with her child to supporting her.

The relationship between the mother and the child

The closer this relationship has been, the better will be the prognosis for the child. Some mothers feel critical of their children for not disclosing and thereby terminating the abuse earlier, finding difficulty in realising the child's powerlessness during the abuse, even when aspects of the experience may not have been wholly unpleasant for the child. It is sometimes difficult to appreciate the power of the injunction for maintaining secrecy. The rivalry which a few mothers feel towards their child *vis-à-vis* the abuser is very painful to express but, unless voiced, may continue to stand in the way of the mother–child relationship.

Some children try to tell their carers or hint in a way which they assume will be understood. From the children's point of view, it is often difficult to comprehend why the mother did not intervene to protect them, even if she had actually been unaware of the abuse. Following disclosure, some children continue to be reluctant to tell their mothers the full details of the abuse, fearing her response.

For all these reasons, there is an important place for direct dyadic work to be carried out with mother and child (Herman, 1983) following preparatory work with the mother as described above. This work may also redress a previously emotionally distant or generationally inappropriate relationship in which the child may have been in a parental position.

The relationship between the child and the abuser

Before the abuse, the child may have had a close, neutral, negative, or distant relationship with the abuser. Although the abuse is bound to alter the child's feelings towards the abuser, leading to ambivalence and confusion, it is less likely to reverse them, particularly as in many cases the abusers attempt to maintain the emotional *status quo ante*, outside the actual abuse. This dissociative process helps to maintain both the abuse and its secret, and may feed the abuser's later denial.

Following discovery and cessation of the abuse, there is again an alteration in the relationship between the abuser and the child. Where the abuser was a close family member or associate, disclosure usually leads to a significant reduction of contact with the child. The fate of abusers, which has a considerable effect on the child, depends in part on their response, specifically the degree to which they are able to acknowledge and take responsibility for the abuse.

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As already discussed, one indirect effect of the abuser's response is mediated to the child via the mother. Few older children remain undisturbed by their awareness of an abuser's adamant denial, especially if this halts the prosecution process. Children's feelings about imprisonment of abusers are more ambivalent, and treatment offers the most promising prospect for safe resumption of contact, where this is desired.

The treatment of sexual abusers

Although this is an important area to consider from the social policy, crimino-legal and preventive points of view, three aspects of abusers' treatment are of particular importance here. They are: the relationship between treatment and reduction of denial; the treatment of adolescent abusers; and the treatment of female abusers.

The relationship between treatment and denial

There is sadly a degree of circularity here, in that outright denial prevents the abuser from being available to treatment (Ballard *et al*, 1990), while treatment is designed to enable the abuser progressively to relinquish the denial (Salter, 1988*a*). Assumption of full responsibility for the abuse and the opportunity to convey this to the child in a carefully planned way is one of the long-term goals of treatment, and is a prerequisite for rehabilitation of the whole family or re-establishing of safe contact between abuser and child.

There are different models and settings for the treatment of abusers (e.g. Wolf *et al*, 1988; Laws, 1989). Their primary and explicit aim is to limit or minimise relapse into abuse. The variety of conceptual models developed in the attempt to understand sexual abuse probably reflects the fact that several strands combine to culminate in this behaviour. They include the sexual misuse of power (Groth, 1982), the addiction model (Carnes, 1990), the role of isolation in the development of sexual abuse (Gilgun & Connor, 1990), and the repetition of the experience of having oneself been abused (Ballard *et al*, 1990).

Cognitive and behavioural treatment approaches, in groups as well as individually, are being used. Groups are considered particularly suitable for dealing with cognitive distortions manifested in the various stages of denial, in introducing victim awareness, and for addressing social relationship factors such as isolation.

The behavioural approaches require attention to the individuals' particular modes of abuse, and sexual ideation and fantasies. Groth (1983), who considers the developmental aspects of the abuser's behaviour, has described a comprehensive treatment programme which includes exploration of these evolutionary factors. Currently, however, the overall trend in treatment appears to include less retrospection.

The treatment of adolescent abusers

Adolescent abusers are increasingly being recognised and, insofar as they fall within the age group of child and adolescent psychiatry's patients, their treatment as abusers is of concern here. A significant number of these young people will themselves have been abused (Pierce & Pierce, 1987), and so are victims as well as abusers. Treatment approaches dealing with the abuse follow similar lines to those outlined for adult abusers, but may need a more individualised approach (Kavoussi *et al*, 1988). In addition, there is a need to address specific adolescent developmental issues, including sexuality and social skills, as well as the family settings of these still dependent youngsters (Pierce & Pierce, 1990).

It is to be hoped (although this is still under investigation) that if offered early therapy, complete denial following disclosure may thus be averted. Furthermore, there are indications that early abuse by adolescents may well lead to future continuation of this pattern and therefore merits early intervention (Becker *et al*, 1987).

The treatment of female abusers

Attention to women as abusers and their particular treatment needs are newly recognised (Wilkins, 1990). Current estimates of the prevalence of female abusers vary (Knopp & Lackey, 1989), but they are believed to represent not less than 10% of abusers. For this and other reasons, including society's views of women (Weldon, 1988), this aspect of sexual abuse has received little attention in terms of any specific treatment needs which ensue, for both the child victims and the abusers (Allen, 1990).

Family work

Family work does not imply a view that the family as a system is responsible for the abuse and, therefore, requires treatment. Rather, the family as the context of which the child is a member is invariably affected by the abuse and its disclosure. Meeting with the whole family, although often without the abuser, fulfils several important functions.

(a) It allows the inclusion of siblings, often 'forgotten', possibly themselves undeclared victims

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(Hanks *et al*, 1988). Siblings are often not fully informed (although usually more aware than is believed) of the reasons for the concerns about their abused sibling and for family changes. They may well harbour feelings of anger, blame, or sometimes rivalry towards the abused sibling (Haugaard & Reppucci, 1988*d*). They may have lost a father who was the stepfather of the abused child. Alternatively, they have sometimes been the silent, helpless, and guilt-ridden observers of the abuse.

(b) Even after individual, group and dyadic work has taken place, it may still be difficult for the whole family to talk about the abuse. Indeed, the therapist may be censured for encouraging mention of it.

(c) Meeting with the whole family is important for assessing a family's functioning and capacity for change (Elton, 1988*a*; Black *et al*, 1991*a*). This is necessary when doubt remains about the family's capacity to protect the child(ren) without emotionally abusing them through blaming, scapegoating, or denial. Such a therapeutic trial requires a time limit and must not be confused with family therapy, into which it might otherwise imperceptibly merge, leaving uncertainty about the children's permanent home. Some families are assessed as being untreatable (Jones, 1987). This conclusion is uncomfortable for clinicians and often unacceptable to families, leading to its test in court. It is, however, considered less detrimental to the child than the alternative – ultimately fruitless investment of emotions and resources.

(d) Although not causing the abuse, some dysfunctional aspects of family life and relationships may have facilitated the abuse, or may coexist with but independently of the abuse (Sgroi, 1982). These include inappropriate intergenerational boundaries, rigid or underorganised approaches to family tasks and life-cycle stages, and difficulties in affective expression (Bingley *et al*, 1984). Alternatively, the consequences of disclosure may well create new difficulties for the family. It is in these situations, in which the family's viability is not being assessed, that family therapy is indicated (Elton, 1988*b*; Haugaard & Reppucci, 1988*d*).

(e) Long-term foster and adoptive families into which sexually abused children sometimes move may well request help with management of these children, approaches to sexuality, and the place of the natural family in the children's lives.

The relationship between treatment and the law

In this area, law and treatment proceed in parallel, with, at times, cross-links and direct connections. This is because child sexual abuse is both a crime and often a matter calling for child protection. The criminal law requires a higher standard of proof, namely 'beyond reasonable doubt'; the need for child protection is judged on 'balance of probabilities'. This difference often leads to confusion and sometimes anger in children's and families' minds, when an alleged abuser is not prosecuted and yet a child is made subject of potentially far-reaching child protective legislation.

The current delays in legal proceedings, particularly in the higher courts, with uncertainties about verdicts and outcome for child and abuser, mean that treatment, which is designed to lessen anxiety and guilt, cannot proceed meaningfully. Indeed, in some situations the assumption that abuse has actually taken place is regarded as unsafe both by some professionals and by family members, until tested in law. Furthermore, there is an inconsistent pattern of decision-making about the likelihood of abuse having occurred, since by no means all cases reach the courts.

Meanwhile, children and families are often referred for treatment, which cannot proceed definitively. At best, clinical intervention must then be regarded as part of an assessment (Black *et al*, 1991*b*), since the content may well be required to be included as part of the evidence. To refuse this may not be in the child's interests, although awareness of this possibility has a bearing on the relationship with the child and family.

Finally, mandated psychotherapy for abusers under a probation order with a condition of treatment may run counter to traditional views about the relationship between motivation and therapeutic success, but is increasingly considered necessary.

Issues for professionals

The professional network

As has become apparent, the therapeutic task in this field is likely to involve many professionals, belonging to different agencies with different responsibilities. The police are not usually involved after the investigation unless a criminal prosecution proceeds (currently in less than 20% of investigated cases); the social worker remains involved at least until issues of child protection are resolved. Group work is being offered by a variety of agencies, including social services, various voluntary agencies, such as the National Society for the Prevention of Cruelty to Children, independent community-based projects, and child psychiatric/child guidance clinics. Probation officers become involved if the abuser is successfully prosecuted. School counsellors and

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sometimes teachers may be carrying out important supportive work with the child. The family's general practitioner may be consulted by the mother and may indeed initiate a referral to adult psychiatric services. Forensic psychiatrists and psychologists may work with the abuser. Most child psychiatric services are increasingly involved with sexually abused children and their families. Specialist child sexual treatment teams, often based in child psychiatric clinics, may be offering a comprehensive assessment, consultation, and treatment service.

While this list is not exhaustive, it illustrates the potential for confusion, duplication, and rivalry which may arise. Furniss (1983*b*) describes the interprofessional splits which may inadvertently mirror family patterns. The child and family are likely to sense the confusion most keenly.

The remedy, not easily achievable, lies with regular planning or review meetings which all those involved attend, to plan the therapeutic interventions, divide the treatment tasks, and become informed of new developments and progress of various processes, including legal proceedings.

The role of the child psychiatrist, if involved, is to monitor children's emotional welfare and needs, and to co-ordinate the treatment process, prepare reports for court, and participate in direct clinical work. Direct work may not be indicated at a particular stage, clinical experience over a number of years having shown that treatment proceeds in phases, according to the child's developmental stages. The child psychiatric clinic will sometimes offer the longest continuity in this complex process.

The place of self-help

Self-help groups and activities for parents form an important aspect of recovery from the trauma of discovering the abuse of one's children, and offer a valuable setting for self-development and mutual support, especially for those parents who had themselves been victims of abuse. As Ryan (1986), however, points out, self-help is not synonymous with therapy. There is an important interaction between professional intervention and self-help, the pioneering example of which is the 'Parents United' programme, developed by Giaretto (1982).

Confidentiality

This is an important issue for several reasons.

(a) Child protection is accepted as requiring the transgression of the usual boundaries of confidentiality (Department of Health, 1988).
(b) Child sexual abuse is a crime.
(c) Some professionals carry statutory responsibility for child protection.
(d) The medical profession carries its own professional code of practice in relation to confidentiality (Black *et al*, 1991*c*).
(e) Courts are in a position to require disclosure of what otherwise is confidential information.
(f) The issues under discussion concern personal details and intimate events in the patient's lives. The privacy of the patients has already been invaded by the abusive acts, and there is a particular need to avoid inadvertent repetition of this.
(g) Confidentiality may inadvertently merge into the maintenance of secrets, thus mirroring or perpetuating the secret surrounding the abuse.
(h) Interprofessional communication usually serves the best interests of the child.

In the face of these conflicting positions, it is necessary to gain clarity about whose interests are, and what is, being preserved, and to be able to argue the choice with integrity and conviction.

(a) Is it in the child's best interests?
(b) Is it the doctor–patient relationship, which is built on trust?
(c) Is it a promise not to tell?
(d) Is it the law?
(e) Is it one's professional position and viability?

Full confidentiality can rarely be maintained. However, no more than the minimum necessary should be discussed and an attempt should be made to distinguish between observation and report on the one hand, and inference on the other. As Bentovim (1988) argues, the interests of the child are regarded as paramount (see also Boszormenyi-Nagy, 1985). When consent for divulging information is sought, it may not be granted or may, by virtue of the child's age, not be informed. When receiving information, one's limited ability to maintain confidentiality must be conveyed. It is important to explain to patients, especially children who have already suffered a betrayal of trust (albeit of a different form), the reasons for having to talk to others, and who else knows what.

In the context of attempts to help abusers receive treatment, confidentiality issues also arise (Kelly, 1990). A balance is required between achieving a therapeutic alliance and protecting current and prospective victims. In the context of therapy following prosecution, it may be argued that further punishment for past abuse which comes to light in the course of treatment may be counterproductive.

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Therapist's gender

The question of the appropriate gender of the therapists is often raised, particularly in relation to men working with abused children (Frosh, 1988). The advantages include an opportunity for the child to 'work through' feelings in relation to the abuser, offering an alternative role model to the one previously experienced, and enabling the child to communicate trustingly with a man, in preparation for later life (Mann, 1989). Against these, there are children's potential fears of the repetition of abuse, especially in individual therapy and when details of the abuse are recalled (Peake, 1989). These considerations may be reversed in the rarer cases in which the abuser was female. Therapeutic work often precipitates sexualised behaviour, which in an individual setting could seriously compromise the therapist's position.

Conversely, there are advantages to women working with sexually abused children, including the fact that women are often perceived as safer and are often preferred by older girls. Furthermore, the role model of competent and trustworthy women is one which some sexually abused children have missed. While children's preferences need to be respected, it is profitable to explore with them the reasons and anxieties underlying their choice.

In group work, a male/female therapist couple offers the optimal therapeutic opportunity (Nelki & Watters, 1989). However, resources often dictate the therapists' gender and there is therefore a need to be aware of the implications for the particular children of the therapists' genders.

Emotional impact of working in child sexual abuse

In this stressful and emotive area of work, professionals' feelings and attitudes towards the various persons involved are unlikely to remain neutral or dispassionate (Carr, 1989). The range of feelings is wide, extending from condemnation, through anger, repulsion, distress, despair, to sympathy. Retaining a combination of sympathy for the children, recognition of the predicament of the mother, and an acceptance of the abuser (although not of the behaviour) requires considerable emotional and mental energy (Ryan, 1986). Feelings aroused may be uncomfortable both in intensity and quality, and may be difficult to acknowledge, especially those which are sexually repellent or arousing. A significant proportion of workers may themselves have been sexually abused in childhood, and this may well carry particular implications and stresses. The position of men as carriers of corporate guilt may be difficult (Frosh, 1987).

Opportunities for airing and exploring these feelings are a prerequisite for professional survival, and in order to preserve a therapeutic service (James & Nasjleti, 1983). There is a place both for personal and interprofessional settings to examine the impact of this work on individuals and the team. It is not advisable to work in this field in professional isolation, even though the possibility for conflicts among the professionals are legion.

Evaluation

Evaluation of psychotherapeutic efforts is both difficult (Vanden Bos, 1986) and in its early stages (Conte, 1984). Outcome for children and families is easier to assess than is the evaluation of respective elements of the intervention process.

Using longitudinal studies, some aspects of outcome following intervention, such as safety from further abuse, emotional/social adjustment, and changes in family constellation and relationships, can now begin to be assessed. An example of this is the Great Ormond Street Hospital study of 120 families (Bentovim *et al*, 1988). Follow-up, at approximately three years, of girls treated in a group (Furniss *et al*, 1988) showed good outcome in terms of the girls' self-esteem, symptoms, and safety.

A different outcome study reported by Bander *et al* (1982) showed that a carefully planned and integrated approach to incestuous families led to safety from further abuse for the majority of the girls, with the establishment of a firm and trusting relationship with an adult. However, the majority of the families did not remain together.

The question of when to intervene is an important one. While retrospective data now leave little doubt about the detrimental outcome for the adulthood and parenthood of many sexually abused children, this is not inevitable, and there is a need for developing predictive indicators at the post-disclosure stage. Since doubts have been expressed about the possibly detrimental aspects of intervention in this field (e.g. Inquiry into Child Abuse in Cleveland, 1988), we await results of further, long-term outcome studies in pursuit of the 'least detrimental alternative' for the future of these children.

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https://doi.org/10.1192/bjp.159.6.769 Published online by Cambridge University Press