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**Children's and carers' perspectives of a therapeutic intervention for children affected by sexual abuse.**

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## Abstract

This paper presents the findings of a qualitative study with children affected by sexual abuse who had recently completed a therapeutic intervention (N=12), and their carers (N=17). Four themes emerged from the thematic analysis that influenced participants' satisfaction with the service: the attribution of the child's recovery to the therapeutic support received; the therapeutic relationship between the child and practitioner; children's recollection of important aspects of the intervention; and the relationship between the carer and the child's practitioner. The findings indicate that the process elements of therapeutic support, including the development of strong relationships and allowing children choice and control, are as important as the content.

Keywords: Child Abuse, Research with Children, Social Work, Therapy, Young People, Sexual Abuse

## Introduction

Child sexual abuse (CSA) is associated with a wide range of possible psychological and behavioural consequences in both childhood and adulthood (Berliner & Elliott, 2002; Putnam, 2003). These include, but are not limited to post traumatic stress (PTSD), depression, suicide, sexual promiscuity, sexual abuse perpetration and poor academic achievement (Paolucci *et al.*, 2001). The traumagenic dynamics model (Finkelhor & Browne, 1985) proposes that the possible effects of CSA may be mediated by four trauma-causing factors: *traumatic sexualisation, betrayal, stigmatisation* and *powerlessness*. A recent qualitative analysis of the case notes from nearly 3000 calls to a telephone helpline in Scotland provides some insight into how children self-report the impact of CSA. Children most frequently described experiencing fear and worry. Pain, confusing sexual arousal, depression and low self-esteem, guilt, loss and were grief also common (Jackson *et al.*, 2015)

While not all children affected by CSA may seek or require professional support (Finkelhor, 1990), the development of interventions that seek to ameliorate the effects of CSA is important. Empirical research into interventions for children who have been sexually abused is relatively under-developed, however a number of studies have been undertaken (Finkelhor & Berliner, 1995; Ramchandani & Jones, 2003). A Cochrane systematic review of cognitive behavioural therapy (CBT) for children affected by CSA reported a modest reduction in depression, post-traumatic stress and anxiety symptoms (Macdonald *et al.*, 2012). Research into the impact of other therapeutic approaches is less well developed (Parker & Turner, 2014).

Studies that seek to understand how children *experience* CSA interventions are yet more limited. An online survey in the UK of 299 young adult survivors of CSA identified 52 respondents who had received some form of therapeutic support before the age of 18 (Allnock *et al.*, 2015). The most common forms of support received were individual counselling (56%), play therapy (25%), other counselling (12%) and CBT (10%) (individuals may have experienced more than one type of support in childhood). Less than half of this group reported that their childhood therapeutic support had been 'helpful'. Respondents reported positive experiences of therapy when they attributed some form of personal recovery to it. Therapists' demeanour was important to respondents' experience, including their skills in listening, being warm and friendly, funny, and accepting. Negative experiences of therapeutic support were influenced by long waiting lists, fear of having to talk directly about the abuse experienced, lack of control over what happened within therapeutic sessions, poor understanding of the purpose of the intervention, and not feeling believed.

We can find few studies that directly ask children and young people about their experiences of CSA interventions during childhood. Ethical and safeguarding concerns may account for this, including

fears about disrupting the therapeutic alliance between the child and their practitioner, maintaining anonymity and confidentiality, protecting children's rights to participate whilst avoiding re-traumatisation and the avoidance of harm to a vulnerable set of participants (Hutchfield & Coren, 2011; Mudaly & Goddard, 2009). Even when carefully planned for and managed, participation rates can be low (Coren *et al.*, 2013, Hill, 2009a). Despite these challenges it is important to gain children's views directly; there is evidence that child sexual abuse service users may have different perceptions of their needs to those of the practitioners working with them (Draucker & Petrovic, 1997) and those responsible for referring them (Potter *et al.*, 2002). Service user involvement in child mental health research is frequently limited to carers, who will also have their own needs, including for emotional support, information, and access to counselling (Prior *et al.*, 1999, Hill, 2012, Hill, 2001). However, carers may not always represent their children's views accurately (Davies & Wright, 2008, Prior *et al.*, 1999).

In the UK, CBT is recognised in statutory guidance as the preferred approach to interventions for children experiencing symptoms associated with CSA including PTSD and depression (NICE 2005a; 2005b). Two recent studies have explored young people's experience of CBT and trauma-focused CBT (TF-CBT). In the first, three young women were interviewed following completion of a CBT intervention in the UK (Donnellan *et al.*, 2012). The participants were referred for symptoms including anxiety, low mood, eating disorder and/or self-harming behaviour, not because they had experienced CSA. CBT had impacted on their symptoms in a way experienced as positive and allowing them to 'get back on track'. The intervention structure, including pacing and focus, influenced participants' perceptions of it while therapeutic relationships emerged as an important mediator of progress. The authors conclude that the process of therapy is as important as its content; that young people may benefit from careful tailoring of the delivery to their individual needs, in particular consideration of young people's life goals, and promoting the young person's sense of control during therapy.

Young people's perception of TF-CBT was explored in post-therapy qualitative interviews with 30 adolescents (aged 11-17 years) in Norway (Dittmann & Jensen, 2014). Two-thirds of the group met the diagnostic criteria for PTSD, nearly three quarters for depression, and two-thirds for anxiety. Twenty-nine percent identified sexual abuse as the main reason for these difficulties. Young people's prior expectations of therapy were often negative; concerns included meeting their therapist and having to describe their traumatic experiences. However over half also felt that they could talk to their therapist more easily than to other adults, which they attributed to their expertise, neutrality, ability to understand and empathise, and the confidential nature of the relationship. Many reported positive changes post-therapy, most commonly feeling happier, but also better sleep patterns, reduced anxiety and irritability, and thinking less about the traumatic incident. The authors conclude that young people need to understand the reasons for therapeutic approaches, such as talking about trauma, and providing an explanation and encouraging their collaboration and agency would benefit the therapeutic alliance. Therapeutic alliance has been shown to be an important predictor of outcomes of therapy with children and young people (Shirk *et al.*, 2011).

A Norwegian study of 15 children aged 5-16 years who received psychotherapy following CSA, concentrating on the therapeutic alliance between children and their therapist, also suggests that young people may have negative expectations and not always understand why they are attending therapy at onset (Jensen *et al.*, 2010). These negative expectations did not impact on the development of a good therapeutic alliance between the child and therapist, as children were more influenced by the therapists' demeanour, including being nice, kind, and making the child feel safe and believed.

Carers' views of such services are also important as they are likely to influence children's access and attendance. A qualitative study on the impact of carer involvement in a therapeutic service for

children affected by CSA reviewed 13 cases from one team of therapists in the UK (Hill, 2009a, Hill, 2009b). Eighteen interviews were undertaken with parents, four of which included fathers. Mothers experienced the sexual abuse as a betrayal of trust, and felt a sense of guilt and failure that had to be managed in order to build trust with the practitioner. Some parents welcomed the involvement of practitioners because they recognised that they were often too emotionally involved or did not feel equipped to help, or that the child would want to protect them from difficult feelings. However in some cases parents could feel excluded by the relationship between the practitioner and child. As a result practitioners had to negotiate parental involvement carefully. Carers were also interviewed as part of Jensen *et al.*'s study, who describe them as '*accomplices and collaborators*' in therapy, often responsible for the child's referral, allowing the intervention to take place, and motivating the child to attend. Carers may also be crucial to enabling a good therapeutic alliance between the child and therapist. As such, carers' understanding of the purpose and goals of the intervention is key (Jensen *et al.*, 2010, Shirk *et al.*, 2011).

### **The current study**

The small range of studies involving children's and carers' views begin to fill gaps in understandings of how children and family members experience and perceive CSA interventions. The overall aim of the current study was to provide further insights into the experiences of those affected by CSA from the point of view of both children and their carers. In particular, our primary research questions were:

- What do children, young people and carers value about the therapeutic work undertaken with them following an experience of CSA?
- What factors inhibit children's and carers' satisfaction with therapy?

### **Method**

This was a qualitative study using in-depth interviews to collect data from children, young people (hereafter referred to as children), and carers affected by sexual abuse who had recently completed a therapeutic intervention. Fieldwork took place between July 2014 and January 2015.

### **The intervention**

'Letting the Future In' is a guide for a therapeutic intervention for sexually abused children developed by the National Society for the Prevention of Cruelty to Children (NSPCC). Based on the largely psychodynamic 'recovery and regenerative model' (Bannister, 2003) the guide is deliberately multi-theoretical and recovery is conceptualised through the use of the therapeutic relationships, creative therapies and symbolic play (Axeline, 1964). CBT (Deblinger & Heflin, 1996) and motivational interviewing (Miller & Rollnick, 2002) may be used with older children. The guide is not intended as a manual but rather a practice resource to be used flexibly, with an approach that is tailored to the child's developmental stage, specific needs and preferences. The areas suggested for the child and practitioner to cover include socio-educative work, sexually inappropriate behaviour (if relevant), power relationships, awareness and management of feelings, self-esteem, identify, and the integration of traumatic experiences.

At the time of the current study, the intervention was being delivered to children aged between four and 17 years across 20 NSPCC service centres in England, Wales and Northern Ireland. Children were offered up to four therapeutic assessment sessions followed by up to 20 intervention sessions (extended up to 30 if assessed as necessary) with a children's services practitioner (CSP). The

majority (88%) of CSPs were qualified social workers with additional training in therapeutic work with children. At the same time, the child's safe carer (typically a non-offending parent) was offered up to eight sessions to support the child in their recovery.

### *Participants*

Fifteen families were recruited to the study. Interviews were undertaken with 17 carers and 12 children. The children in those families ranged in age from 5-18 years; the youngest child interviewed was seven years old. All had completed the intervention and attended between six and 30 individual sessions. Three of the interviewed children were male, nine were female and all were White-British. Table 1 provides details of the sample *Procedure*

Participants were recruited from NSPCC service centres in several phases. The research team initially selected a random sample of cases where children had completed the intervention. Cases were excluded if one or more of the following conditions were met: the abused child was living with the alleged perpetrator; the case was subject to an ongoing or re-opened joint investigation; there were new or newly surfaced allegations of abuse; or the child was in an unstable placement. Remaining families were sent a letter inviting them to opt in to the study. After writing to over 100 carers across 18 teams, only one case opted in at this stage. The recruitment strategy was revised in partnership with NSPCC staff, who reviewed all closed cases and contacted carers directly to discuss the study and ask consent to pass their contact details to the research team. This resulted in a further fourteen cases.

Respondents were provided with information leaflets about the research. Carers were asked to sign a consent form immediately prior to interview. They were also asked to sign consent for children under 10 years of age; older children signed their own form although verbal consent was sought from all children regardless of age. Carers could also consent to take part without their children, and three chose this option.

Most interviews with carers were conducted face-to-face in the family home, but where participants preferred some were carried out by telephone. All interviews with children were in the family home, and where the child requested it, with their carer present. Detailed topic guides were developed, using a chronological approach beginning with the symptoms and effects of CSA the child was experiencing prior to the referral, expectations of the service, experiences of the intervention, and its perceived impact. Participants were not asked to discuss the CSA the child had experienced. The team developed participative tools for children, including facial emotion cards, 'storyboards' and adjective cards, but the children who participated expressed a preference to talk directly with the interviewer rather than use these.

### *Analysis*

All interviews were digitally recorded to ensure accuracy and transcribed in full to allow review by all authors, and examined using thematic analysis (Miles & Huberman, 1994). A set of draft analytic frameworks were developed that included the key themes and sub-themes that emerged from the data, as well as those relating to the research questions. Separate frameworks were used for data from carers and children. Draft frameworks were tested with a small number of interview transcripts, adding and refining themes. Once finalised by all authors, they were used to code the data, providing a detailed and accessible overview of the data populating each theme and sub-theme from every respondent. This approach afforded the possibility of exploring the data by both theme, and respondent-type.

The study design and procedures were approved by the independent Research Ethics Committee of the NSPCC and the Research Ethics Committees of the Universities of Bristol and Durham.

## **Findings**

Four overarching themes emerged:

- the attribution of the child's recovery to the therapeutic support received;
- the therapeutic relationship between the child and practitioner;
- children's recollection of important aspects of the intervention;
- and the relationship between the carer and the child's practitioner.

### *The attribution of the child's recovery to the therapeutic support received*

Children frequently reported low mood and withdrawal as a consequence of their experiences of sexual abuse. Some described themselves as 'scared' to interact with others because of feelings of low self-esteem and low-confidence, as well as concerns that talking about the sexual abuse or its impact would further upset their carers. Carers reported a wider range of impact issues in their children although the most salient of these was low mood or depression, resulting in withdrawal from normal family life. Other reported common impacts included anger, anxiety, aggression towards carers and siblings, sleep disruption, self-harming behaviours, suicidal thoughts, poor body image, low self-esteem and confidence, guilt about the abuse and the effects of the disclosure, becoming disruptive at school, distrust of other people, and developmental delay. Some carers witnessed their child behaving so differently that they had worried the effects of sexual abuse would be irreversible:

*The only way to describe it really is that when she first came to live with me, because of the couple of years that she had had, she carried a dark cloud around with her. You could see it, I was desperate to help her. Carer(Case 7, child aged 12)*

All children said that the intervention had helped them, describing themselves as more confident and outgoing. They frequently used 'happier' to describe their mood. This had practical impacts for older children in particular, who clearly attributed changes in their behaviours to the therapeutic support received:

*It's like a big weight off your shoulders. I always, always stayed in my room. I would never come out, ... Now it's fine to interact with other people, come downstairs and interact, that's the main thing. Child aged 18 (Case 3)*

Children described the benefits of becoming more relaxed around others including enjoying spending more time with family, taking part in after-school activities and seeing more of friends than they had done previously. Other changes in behaviour associated with improved mood included a reduction in physical symptoms (tension headaches, self-harming behaviours) and better sleep patterns, including the cessation of nightmares. Many also spoke specifically about the relief they felt after their practitioner had addressed their feelings of guilt and blame about the sexual abuse. They described feeling responsible either for the abuse or the consequences of disclosing it for their family and, in some cases, also for the perpetrator. Coming to realise that it was 'not their fault' had a powerful effect for many respondents:

*I don't think it is my fault anymore. I don't think that people are judging me about it like I thought they were. ... I used to think I could not exactly read minds but by how people were looking at me I used to think they were thinking terrible things. Child aged 10 (Case 13)*

Carers also talked about their relief when children began to understand they were not to blame for the abuse. One mother described this as '*the most important lesson*'. Carers also experienced their own guilt and, coupled with often negative experiences of investigations by both police and children's services following their child's disclosure of sexual abuse, this could lead to anxiety about being referred to the service. Often this was because of their perception that attending would stigmatise the family:

*I was just worried about how we'd be judged by the people there. You think the NSPCC is something that – it's really bad, something really bad has happened to the family, the parents are really, really bad at looking after that child, we were always worried about how people would judge [us] for being involved. Carer (Case 9, child aged 10)*

In all cases these anxieties were quickly assuaged, which carers attributed to the sensitivity of CSPs from first contact, and the welcoming, child-friendly environment of the service centres.

Carers were also unanimous in reporting that the service had had a positive impact on their children. All made mention of their child's improved mood. For most, this was evident though their child looking happier and expressing positive thoughts about the future. Some children were described as much less anxious and stressed after the intervention. Two carers witnessed even starker changes, including the cessation of self-harming behaviour and suicidal thoughts. Many linked these changes to their child's improved self-confidence, evidenced in one or more of several ways: becoming more talkative and joking more often; more able to spend time away from their parent(s); taking a more active part in school lessons and activities; and making more friends and spending time with them:

*She was confident, smiley, she would joke. We have got friends who come round, she was more interested in doing things. She is more talkative, doesn't stop now. Just more willing and more comfortable in her own space with who she is as a human being, and I think that is what I wanted most out of it, that she found her own confidence in who she was. Carer (Case 12, child aged 15)*

Other changes in mood reported by carers included children who were less angry, and in some families this also meant the child had stopped behaving aggressively towards family members. Carers of very young children were more likely to mention an improved understanding of appropriate sexual behaviour as an outcome for their child. This had two aspects; learning how to protect themselves from further sexual abuse, and not displaying any harmful sexual behaviour towards others.

These improvements in mood and behaviour were not always sustained and in two families the child's symptoms of anxiety had begun to return since the end of the intervention. Even when this had not happened many carers worried about the return of symptoms or other problems as their children got older:

*There is a little fear in me that at some point I'll have to go back with him when he gets to an age, when he enters teenage years of whatever. Carer (Case 1, child aged 5)*

For most carers however was a strong sense of relief as a result of seeing positive changes in their children, and gratitude towards their children's practitioners. During interviews many talked about '*getting their child back*':

*She is back, I feel like I have the little girl back. Two years ago I would never have thought that possible. Carer (Case 11, child aged 13)*

*Therapeutic relationship between the child and practitioner*



All carers mentioned the strength of the therapeutic relationship, often using terms like *'best friend'* to describe their child's feelings towards their CSP. Children also talked positively about their CSP, echoing their carers' terms such as *'best mates'* to describe the relationship they had with them. When asked about the CSP, children most often said that they were *'nice'*, but could also be more detailed about what they liked about the practitioners and their approach. These included being polite, friendly, kind, helpful, easy to talk to, welcoming, cheerful, and attentive to the young person. Their carers used similar language and also frequently mentioned the importance of the CSP making the child feel safe, building trust, and encouraging the child to talk openly. Children often talked unprompted about how this made them feel when they were with the practitioner:

*Every time I saw her she used to always cheer me up like if I was sad, she used to always cheer me up.* Child aged 15 (Case 12)

Children talked about feeling happy, welcome and relaxed in the CSPs' company. Several mentioned how important it was that they felt the CSP understood them. Both children and carers noted that CSPs were skilled at demonstrating these attributes and making children feel comfortable quickly; many respondents said that they liked the practitioner on first meeting them and after a very few sessions began to trust them completely. Carers of younger children were likely to report that they stayed with their child during initial sessions to help them 'settle in' and build trust with the practitioner, but that this was only required for a very few number of sessions. Trust was important in supporting children to talk openly in sessions and address issues that they could not talk about elsewhere. All children agreed that they could talk about anything within the session, even though this could be difficult at times. This feeling of trust and safety was helped by both the confidential nature of the relationship, and the lack of coercion. Several children raised previous experiences with police officers and social workers where their confidence had been broken. Carers also valued the continuity of the relationship, particularly where children had experienced numerous brief contacts with staff from different agencies.

Knowing that what was said within therapeutic sessions was private and confidential was hugely important to children. Often this was linked to wanting to keep the extent of the harm caused by the sexual abuse secret from family, in particular parents, to avoid further distress. Trust could also be influenced by their carers – *"people who mum trusts, I trust"*. Carers understood that the relationship needed to be confidential, but there could be conflicting feelings about this. Some felt threatened or excluded by the strength of the relationship between the child and CSP:

*You feel a wee bit left out, you know, but at the same time as long as you know that it's benefitting her, but you do feel a wee bit left out.* Carer (Case 3, child aged 18)

However all carers acknowledged that their child felt unable to be open with them about the sexual abuse and its impact, and were relieved that their children had someone to talk to:

*He knew that he could say anything to [CSP], even things he wouldn't say to me in case I worried because he didn't want to worry me more. It was very nice to know he had that. [CSP] would only tell me the necessary stuff that I needed to know, like the self-harming.* Carer (Case 15, child aged 14)

Children also valued a sense of control over what they did and did not talk about, knowing the practitioner would stop, take a break or support them whenever they felt distressed:

*If it was difficult, she made me feel comfortable, and said 'if you don't want to carry on with this, we'll do it later'.* Child aged 11 (Case 10)

The strength of the relationship meant that some children felt that the hardest aspect of the intervention was stopping seeing the practitioner regularly.

### *Children's recollection of important aspects of the intervention*

Children identified specific aspects of the intervention that were important to them. Their initial responses tended to focus on *process*, the way in which the intervention was delivered. Often this meant having fun, and looking forward to going each week because they knew they would enjoy the time. Usually this was because of the types of creative activities they would do, including playing games, role-play, art activities such as drawing and modelling, or reading books together with the practitioner. Some children talked about enjoying doing things they would not at home or at school, often because they felt they had outgrown them. One reported that they made him feel '*like a younger person*'. Children also recognised that creative activities helped them engage in the therapeutic process:

*I liked the art stuff a lot of the time but whilst I was doing the art I would talk. When I am doing something I would talk, anything that I was thinking about would just come out. Child aged 10(Case 13)*

Children also liked having control over what they did during sessions. In some cases there would be an informal agreement with the practitioner about how much of the session would be devoted to 'play' and children generally had complete freedom to decide on the activity during this time. Children also valued choice during 'work' time. Often they would work with the practitioner to create a list of problems or issues that would be addressed during the intervention. As well as feeling in control of this list, children recalled that their practitioner would let them lead on when each issue would be discussed, often withdrawing from a topic if the child did not feel ready. Children valued this choice and control, and some made mention that they were particularly relieved that they did not have to talk directly about the abuse that had happened to them if they did not want to:

*She wouldn't hit me with difficult questions. She'd suggest something else if talking became difficult. Child aged 15 (Case 14)*

Children also talked about the content of important sessions, and the most frequently mentioned of these were those that dealt with becoming more aware of and managing their feelings. Younger children often recalled being helped with 'worries', usually by identifying and talking directly about them with the practitioner. Older children were more likely to recall being taught 'grounding' and relaxation techniques to help with anxiety, or anger management exercises:

*She'd say, "Put your feet on the floor, tap something and knock on your knee. You're not there, you're in a safe place, I know it's you" and that really, really helps with it. Child aged 16 (Case 6)*

Sessions that dealt with children's sense of disempowerment, particularly in relation to the perpetrators of sexual abuse, were particularly important. Many children described sessions in which they had written letters to their abuser, created models or drawings of them, or in one instance creating a model jail cell in which a model of the perpetrator was placed. In most cases, the letter or model was purposefully destroyed, with young people describing '*ripping*', '*smashing*', '*flushing*' and/or '*burning*' them. Participants talked about the sense of satisfaction this gave them, one commenting that it showed that '*he [perpetrator] no longer matters*'.

Children valued activities that directly addressed their feelings of guilt and blame. For some these were specific sessions when the practitioner had focussed the discussion directly onto the circumstances surrounding the sexual abuse, providing socio-educative information about how they may have been manipulated by their abuser. Others did not describe a specific session, but rather the practitioner challenging them every time they expressed feelings of guilt, either about the abuse itself or the impact the child's disclosure had had on their family. Children also appreciated being

supported to build their self-esteem through exercises designed to self-identify personal strengths and positive qualities.

#### *Relationship between carers and children's practitioner*

There were several opportunities for carers to communicate with their child's practitioner. Children would have regular review sessions throughout the intervention at which carers were often present, and these were perceived as a useful way to learn about their child's progress. Carers would talk with the practitioner when dropping off or collecting the child. Many reported phoning the CSP between sessions to talk about concerns over their child's mood or behaviour, and valued the advice and support received. In some cases, the CSP had liaised with the child's school to negotiate additional support or explain the child's challenging behaviours. Most carers placed huge value on this kind of support:

*She even went in there and talked to the school. That was really, really impressive...[] You didn't feel you were being fobbed off. You felt that you were being dealt with; you felt you were being helped. Carer (Case 2, child aged 12)*

While all carers welcomed the support for the effects of CSA, two felt that the service was *too* focussed on the effects of sexual abuse at the expense of other difficulties faced by the child, or by the carer. In one instance the carer would have liked the NSPCC to address his child's problems forming normal friendships at school, while another wanted the service to intervene in Family Court proceedings over contact with the alleged perpetrator.

#### **Discussion**

Children and young people who have experienced child sexual abuse are a group that has been disempowered and silenced as a result of their sexual abuse experiences. Giving voice to children, as we have sought to do in this study, is important both in informing the development of interventions after sexual abuse, but also challenges the silencing of victims of abuse.

At the same time, the study is limited in several respects. As we were unable to sample participants at random, it is possible that those who perceived the intervention favourably were more willing to participate and the findings may not be representative of the full range of service users. We believe that participants' contact with a trusted professional to discuss the study was vital to gaining their consent and recommend that future studies facilitate this contact with a larger pool of potential participants to help avoid this potential source of bias. This was a small sample (though larger than some of the previous attempts to seek children's and carers' views following child sexual abuse), raising questions about the generalisability of findings to the wider range of children who have experienced CSA across the UK. Nevertheless, the findings of this study facilitate a better understanding of children's perceptions of a therapeutic intervention and in particular, the elements of that intervention that they value. The views of their carers, whose support is vital if the child is to attend, have also been explored.

Carers were more likely to report some dissatisfaction with elements of the service than their children, echoing previous research into the professional response to CSA (*Prior et al*, 1999). The only negative aspect of the intervention reported by children was their sadness at its ending. Some carers felt excluded, even threatened, by the strength of their child's bond with the CSP, echoing the experience of parents in previous studies (Hill, 2009b, Jensen *et al.*, 2010). The fears and concerns of carers in this study appear to have assuaged by seeing their children begin to engage in and benefit

from the intervention, good communication with the CSP over the children's progress, and the provision of advice and support directly to carers. However, an awareness of this process may help practitioners to prepare carers for the emotional burden and potential stress of their child engaging in positive therapeutic relationships.

Overall both groups of participants were positive about the intervention and expressed gratitude for the support. The main influencing factor was their attribution of the child's recovery from the effects of CSA to the therapeutic support received, a finding that reflects previous studies (e.g. Allnock *et al*, 2015; Donnellan *et al* 2012). Carers frequently talked about getting the child 'back' however some worried about the sustainability of this recovery. As in Dittman and Jensen's (2014) study of TF-CBT the most important self-reported change for children in this study was simply feeling 'happier'.

Since its publication, the traumagenic dynamics model (Finkelhor & Browne, 1985) has had considerable impact on the study of CSA and its sequelae, with CSA assessment tools, therapeutic interventions, and research methodologies designed around it (Canton-Cortes *et al.*, 2012). The findings of this study, in particular children's accounts of the content and process elements of the intervention, lend credence to the model. The first dynamic, *stigmatization*, may occur through the receipt of negative messages including shamefulness and badness during and after the abuse, either directly from the abuser or from others. In turn, this may lead to low self-esteem, feelings of guilt, and self-destructive behaviours. Many children in this study experienced self-blame following CSA. CSPs' focus on challenging guilt and self-blame was hugely valued by children and brought relief to many. Sessions that helped them become more aware of and manage their feelings and in particular to cope with anxiety and anger were important. Studies have shown that interventions that seek to address self-attributions of blame can impact positively on post-traumatic symptomatology and functioning (Daigneault *et al.*, 2006; Feiring *et al.*, 2002). Children also experienced *powerlessness*, and sessions where their feelings towards the perpetrators of sexual abuse were directly addressed and activities in which the abuser was 'punished' frequently emerged as important. Children also valued having choice over the activities within sessions and knowing that the CSP would give them control over what they would (or would not) talk about. The importance of empowering children in this way during therapy has been also evidenced in previous studies and may have helped to strengthen the therapeutic bond between the child and CSP (Jensen *et al* 2010, Carroll 2002).

*Betrayal* is the third trauma-causing factor in the traumagenic dynamics model. Overcoming this and supporting the child to build trust in their CSP is considered key to the success of the intervention. All of the children in this study reported trusting their CSP. It was reinforced by the confidential nature of the relationship, CSPs' respect for children's choices, and their carers' reassurance and support. The strength of the relationship was reported by both children and their carers as critical element of the intervention, supporting previous research indicating the relationship between therapeutic alliance and treatment outcomes (Shirk *et al*, 2011). Children were sensitive to their CSP's demeanour and often used '*kind*' and '*nice*' to describe their CSP, echoing descriptions of therapists in many other studies of CSA interventions (e.g. Allnock *et al* 2015; Dittman & Jensen, 2014; Carroll 2002).

The fourth and final traumagenic dynamic in Finkelhor and Browne's model, *traumatic sexualisation*, describes the process by which the experience of sexual abuse may shape a child's sexual feelings and behaviour in a dysfunctional or developmentally inappropriate way. Carers of very young children were particularly concerned about this, and valued the socio-educative content of the intervention to help children understand 'right from wrong' in sexual behaviour.

## Conclusion

Overall, this study demonstrates the value of undertaking research on children's and carers' views. The *process* elements of therapeutic support, in particular the development of strong relationships, allowing children choice and control, and fun, are as important as the content. It underlines the critical importance of social workers' abilities in establishing positive relationships with children and their carers. Practitioners should use these relationships to free children from guilt and blame associated with their abuse experience and to challenge isolation and withdrawal brought about by CSA.

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**Table 1: Participants**

Case No.	Child's age	Child's gender	Child interviewed (*with carer present)	Carer interviewed
1	5	M	–	Mother
2	12	F	Yes*	Grandmother Grandfather
3	18	F	Yes	Mother
4	11	M	Yes	Mother
5	6	M	–	Mother
6	16	F	Yes	Mother
7	12	F	Yes*	Father
8	7	F	Yes*	Mother
9	10	F	Yes*	Mother
10	11	F	–	Mother
11	13	F	Yes*	Mother
12	15	M	Yes*	Mother
13	10	F	Yes*	Mother Father
14	15	F	Yes	Mother
15	14	M	Yes	Mother