Lessons From a Psychotherapy Outcome Study with Sexually Abused Girls

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ABSTRACT

In this article, we address diverse issues arising during the course of a psychotherapy outcome study for sexually abused girls. These issues relate to the organization and management of a comparison study, implications for professionals involved, the training needs and supervision requirements of staff, case management and implications for clinical services.

KEYWORDS

outcome, psychotherapy, research lessons

Introduction

THE HYPOTHESES WERE:

1. That focused individual psychotherapy, guided by both a manual consisting of agreed statements of the aims and objectives and by clinical supervision, will give rise to

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changes in the child's relationships and attachments and to their internal view of themselves and will improve their academic functioning and general social functioning. The contribution of individual psychodynamic psychotherapy with sexually abused children has not so far been addressed in Western European research.
2. That specific group therapy for sexually abused girls guided by a manual will be particularly helpful to their social skills and social relationships.
3. That patients receiving individual psychotherapy will benefit most in the long-term, while those receiving the group therapy will benefit more in the short-term; and that both will alleviate distress and promote emotional development.

Design and method

The sample

This is a multi-centre study which uses a comparison design with random allocation. Girls between 6 and 14 years who had been victims of contact sexual abuse were eligible to enter the study if they were symptomatic and had disclosed such abuse within two years of referral (although the abuse itself may have occurred prior to this).

The project was explained to the girl, her carers and the referrer, and consent obtained from each of them. Prior to proceeding further, a small number of girls or carers chose to withdraw, and a few were excluded as too troubled or where outpatient psychotherapy was considered inappropriate. Thereafter, 81 girls met the criteria for entering the study, but about 15% of families declined the offer of therapy, thus, 71 girls entered the programme. They received either up to 30 sessions of individual therapy or 12–18 sessions of group therapy depending on their age (the older girls receiving more group sessions). The number of sessions offered was the minimum considered by experienced therapists as likely to be effective.

The majority of the girls were living with a single mother and about one-quarter were living with foster carers. The carers were offered guidance and counselling in parallel to the therapy for the girls but their sessions were less frequent overall (one to two for the girls).

Methods

Prior to the start of the therapy (baseline), the girls were comprehensively assessed. Simultaneously, information was gathered from the main carers covering the child's development and abuse history, the carer's personal history and current circumstances. The professionals involved in the assessment exercise included child psychiatrists, psychologists and social workers.

The girls were reassessed one year after the commencement of therapy and a two-year follow-up is nearing completion.

The initial assessment of the girls revealed much serious psychiatric disturbance with considerable severity of the problems and a surprisingly high level of comorbidity. While few girls spontaneously volunteered that they were experiencing difficulties, during the systematic psychiatric assessment it was common for substantial problems to be uncovered (Trowell, Ugarte, Kolvin, Le Couteur, & Berelowitz, 1998). The referring agency was often unaware of the extent of the disturbance.

The girls and their families

Despite all the severe emotional and behavioural problems, many of these girls had received little or no help and the extent of their difficulties had not been recognized. Parents or foster parents were struggling to cope but often they were preoccupied with

their own issues. Referrers were concerned and wanting to help, but often more troubled by the overall situation in the family. The extent of the disturbance of girls raised many questions. To explore these issues further, a community sample of girls not known to have been abused and a sample of girls from local child and family mental health clinics were assessed to explore the extent of the comorbidity and severity of problems. The findings and the implications for our understanding of the sequelae of the child sexual abuse are discussed elsewhere (Trowell et al., 1998).

Two-thirds of the girls were white, the girls of minority ethnic groups were mainly mixed race and Afro-Caribbean. Very few Asian girls were referred to the psychotherapy outcome study, and of particular concern is the very small number of Bengali, Pakistani or Indian girls, despite being a considerable proportion of the London population. Some girls of Chinese origin entered the project. This suggests that girls from the Indian sub-continent still are either not disclosing abuse or are not willing or able to attend child and family mental health clinics.

A basic criterion for inclusion in the study involved the girls' safety and protection from further abuse. When concerns arose in this area during therapy, the relevant girl was told that social services needed to be informed. This happened infrequently but there were disclosures during sessions. The associated anxiety and uncertainty for the girls, the therapists and the families involved a great deal of professional time. Most of the abuse that emerged had occurred in the past but for a few girls it was not clear whether there was continuing abuse and so social services needed to be involved in investigations.

A number of the parents and carers themselves talked about abuse in their own childhood that had not previously been revealed. Their own experiences in care and domestic violence were also frequently preoccupying. As expected, their feelings about the abuser were intense and very painful, particularly the sense of betrayal, fear for the future and what might happen when the prison sentence was completed if the abuser wished to return to the district.

Therapy

It was necessary to ensure that the therapy within and across the different centres was comparable, that is as similar as possible. This applied to the group and individual therapy. This was achieved by the pre-project training but, more usefully, by having case discussions and by regular discussions between the supervisors who knew each other well.

Issues from the study

Multi-centre studies

The study involved the Child and Family Department of the Tavistock Clinic, the Children's Department of the Maudsley Hospital, Camberwell Child Guidance Clinic, the Royal Free Hospital and Guy's Hospital. An important issue is whether any one institution is likely to have enough referrals, enough professionals available for the assessments or enough therapists and supervisors to undertake the work. A careful review revealed that multi-centre studies are essential in order to recruit sufficient numbers of patients over a brief time span and also to ensure the availability of a sufficiency of psychotherapy.

However, using several sites carries not only benefits but certain problems and strains:

1. The demands of such a project may impose considerable strains on host institutions, for instance, there may be an influx of additional cases which are likely to create an

increased demand for room space and put pressure on the waiting room and reception staff. Also additional therapists and carer workers had to be accommodated.
2. Assessors, supervisors and therapists had to be trained and supported to meet the expectations of high quality of the research work.
3. The assessments may take far longer than anticipated especially when addressing complex families on seriously disturbed children.
4. The philosophy was of brief therapy that was focused and time-limited but some subjects were found to need much longer therapy.
5. Therapists were not accustomed to completing research forms.
6. The centres do not necessarily have the same abundance of senior professionals who could be recruited to the research.
7. Monitoring was needed to ensure both the comparability of therapy in that the research procedures were implemented in a similar manner across centres.

Travelling time proved considerable for those professionals who had to coordinate the clinical and research activities and had to discuss, explore and resolve uncertainties and problems. Understandably, all the staff on the project on the different sites wished to meet face-to-face in order to feel part of an overall staff team. The need for quite frequent meetings in the start-up phase and the travelling involved had not been anticipated. Thus a considerable amount of time and goodwill was required from the project leaders, assessors, therapists and supervisors. The above issues merit attention in future multi-site dynamic psychotherapy outcome studies.

Sexual abuse dynamics

Any multi-centre study inevitably leads to a number of conflicts and dilemmas. However, this project had, as its subjects, sexually abused girls many of whom had been or were living with carers who had themselves been abused physically or sexually. (This includes some foster carers as well as natural parents.) It was, therefore, probably inevitable that the dynamic processes that occur in abusing families be re-enacted in the project.

Whenever clinical work, training or research focuses on child abuse, and in particular sexual abuse, it is highly likely that issues of power and gender will lead to conflict. Not surprisingly therefore tensions arose at many levels of the project. We were informed that when male staff were the lead clinicians, some female potential referrers in the community were reluctant to refer. A few girls did not wish to be seen by a male clinician, either for assessment or treatment. Within the project staff team, some female staff felt that, at times, they were not listened to by the senior project staff. Issues of abuse, as the girls related their experiences, needed to be specifically addressed by the most senior and experienced psychotherapist. The above issues occur in all psychotherapy projects but were exaggerated by the dynamics of abuse.

The process of setting up the treatment programme became affected by feelings of persecution and powerlessness. Some families and referrers were angry at the delay between assessment and the provision of treatment. There was, inevitably, delay in setting up groups with the girls banded according to age; there were also delays for the individual treatment as the referrals tended to come in peaks and troughs and this did not always match therapists' availability. In addition, some potential therapists felt restricted by the research expectation of adherence to the brief focused work and to keeping research records and hence were reluctant to participate. Many therapists found the material coming from the girls distressing, and at times, felt the research team did not recognize the intensity and difficulty of the work and they too felt taken for granted or misused.

As follow-ups were implemented, some referrers and some girls and families declined further contact with the research team. The expectation of follow-up had been consented to at the outset, but some girls and their families wanted to forget once therapy was completed indicating that they did not want any reminders of the past. They did not want a review of their progress nor wish to contribute to knowledge and understanding of abuse. Inevitably, the research team were left understanding but also frustrated and powerless.

Recruitment

Considerable professional and public concern had been expressed at the lack of treatment resources for sexually abused children both in the media and by social services departments. As commonly described with outcome studies, however, once the study was ready to start, it proved difficult to recruit sufficient subjects. One contributory factor was that registration for sexual abuse on the Child Protection Register had decreased nationally and in the London area. Other issues that exacerbated the fall in referrals were as follows. For many years, child protection procedures had been refined and enormous resources had been invested in training to ensure the initial investigations and assessments were done carefully. However, there was very little post-protection work and it was thought that this was due to lack of available therapeutic resources. It appeared that this perception had become so accepted that there needed to be considerable raising of awareness to encourage potential referrers (mainly social workers) to appreciate that there were children on their case loads who could benefit from treatment.

Treatment had been available in patches – this varied by district, for example, some girls recruited to the project came very long distances because their own health districts had little or no local treatment resources. This could have unforeseen benefits as the girls often had a carer's individual attention during the journey which was for a longer time than they usually experienced. But some carers and girls found the long journey rather arduous and this may have detracted from the benefits.

A further problem arose from the fundamental design of the study – random allocation. In the initial design of the project, the ethical considerations dictated that no sexually abused girl could be referred to the project and not receive some help – it was unacceptable for there to be a 'no treatment control group'. There were no scientific or ethical objections to a comparison study with random allocation. However, some clinicians who worked in this field committed to a particular form of intervention were unhappy with random allocation. They indicated that, if in their clinical judgement the child needed a particular therapy, this must be what should be given and that it was unethical not to provide this (despite there being no current research evidence to support this view).

In the UK, there have been major changes in the structure and organization of the National Health Service and social services. Health and social care now resemble a market with some professionals holding a budget and buying services, and other professionals providing services for which they need to be paid. The free therapy service offered by the project proved attractive to those holding budgets. However, those health professionals who were wanting to provide a service did not welcome competition – with their potential patients 'siphoned off' by the project.

In some social services departments, reorganization meant that the local authority referrers often found it difficult to sustain and support the project work as required. Some social workers came under great pressure to close cases once they were accepted by the project, despite it having been made clear that families of abused girls were likely to need ongoing work not only during the referral but also during the treatment and probably when therapy ended.

Therapy issues

The individual therapy was mostly provided by qualified and senior trainee child psychotherapists who had been trained in the British Object Relations School of Psychoanalytic Psychotherapy. However, in some centres, some of the therapists had received less formal training and therefore, in our opinion, it was essential that good quality supervision be available. While the material which arose in the course of therapy was often distressing to the therapists, research demands were an additional complicating factor.

Therapists had constantly to bear in mind that the therapy was brief and focused. They also had to complete forms about evident (demonstrable) therapeutic processes. The therapists reported that these factors impacted on therapy and constituted constraints: partly it was the time required to complete research forms and anxiety about conveying the process accurately, but it was also different to work in a time-limited way. The supervision was essential to help the therapists hold to the task as stated in the research design and to enable them to process the pain, confusion, rage and shame described by the girls.

The group therapists were senior psychiatric trainees (senior registrars) and other (senior) members of the child mental health teams. All the therapists were very experienced in the field. Each group consisted of five girls, occasionally six, with two group leaders – usually one male and one female. The groups were more structured with an agenda set by the therapists, but there was also unstructured time. Again, the clinical work was extremely demanding and this was compounded by the expectation of data collection about the process of the group.

Carer issues

Parent/carer groups were organized alongside the group therapy for the girls. These did not work as well as had been hoped, mainly because the random allocation of the girls resulted in a mixture of carers such as single mothers who were very distressed, professional foster carers and functioning married couples where the abuser was in the extended family. They all found the groups supportive but their needs were different. Most of the carers, therefore, had individual work, mostly fortnightly. Some carers did not attend with the children who were brought by an escort or came by themselves if they were at secondary school. A few of the parents or carers needed to be seen weekly, where there were continued crises.

Some design and method issues

The comparison design

In the past, when there was not sound evidence about the efficacy of child psychotherapy, there were good arguments in favour of comparing a group of patients who were given therapy with a group who were not (the 'control' design: Kolvin, Macmillan, Nicol, & Wrate, 1988; Bell, Lyne, & Kolvin, 1989). However, this position is no longer considered tenable and there are strong arguments in support of comparing groups of patients who are given different forms of therapy (the 'comparison' design: Kazdin, 1986; Trowell, Berelowitz, & Kolvin, 1995).

For instance, on ethical grounds, the comparison design (represented in the current study by group or individual therapy) is preferable as it avoids a needy subject being 'located' in a no treatment control group which is both ethically unacceptable and clinically unwelcome to knowledgeable parents. Second, families do not like or want to be in a 'no treatment' group and often seek help elsewhere (Parloff, London, & Wolfe, 1986). Third, with the comparison design, the alternative therapy groups are equally credible. However, since it is more difficult to identify significant differences between

two forms of therapy than it is to compare a group receiving treatment with an untreated control group, the number of cases studied needs to be increased substantially.

The issue of duration of therapy

Improvement has been shown as being related to the duration of therapy; being proportionately greater in early sessions but increasing more slowly as the number of sessions grows (Garfield, & Bergin, 1986; Howard, Kopta, Kranse, & Orlinsky, 1986). This has led to the suggestion that when comparing two forms of therapy which are intrinsically different, the duration of therapy should be the same. However, such arguments are negated by the fact that different therapies are likely to have optimal effects at different points in time (Kolvin et al., 1988; Bell et al., 1989) and the specification of number of sessions could be counter-productive. It is also likely that each form of therapy has its own pace and rhythm. We consulted widely with very experienced therapists before finalizing the decision about the duration of the two therapies.

Clinical issues

Many of the therapists found the content of the sessions difficult and were often concerned about the practical arrangements for the girls. The pressure on the therapist to try and solve all the problems was great. The girls wanted all the problems in their families to be resolved. Having to accept the limitations of 30 sessions of individual work or between 12 and 18 sessions of group work was painful both for the girls and the therapists.

The work with the carers was rewarding but also demanding. Carers varied – there were those who were desperate to tell their story and needed considerable support; some very competent foster carers who were struggling to do a good job. Some attended rather reluctantly and intermittently and some were totally hostile to attending. Some non-attending carers tolerated the girls' attendance and were moderately supportive despite refusing to attend themselves, while others were overtly hostile and made it very difficult for the girls to attend. When this occurred, the girls all too easily dropped out of therapy. But some girls, especially the older ones in their early teens made great efforts to attend themselves without any parental support. Some even travelled great distances alone to attend.

Therapeutic issues

A pattern did seem to evolve during the treatment. Initially, the girls were suspicious and wary. Gradually, many girls became distressed but of these a number were able to recover by the termination of therapy, even if the ending itself was very difficult. It was helpful to the therapists later in the project to be aware of this pattern.

Thus, an important impression has emerged which indicates that the girls, in working through their abuse, become even more distressed prior to coming to terms with their experiences and showing a decrease in their previous psychiatric disturbance. Their evident distress could resemble increased disturbance rather than a reflection of the therapy process. Not surprisingly, given the extent of the comorbidity and severity of the problems, some girls have needed to be referred on for more help.

Of those girls who had denied that abuse had occurred, many are now much more aware of what happened and appreciated the damage done to their personality. These latter girls are now either depressed and troubled, or angry and disruptive, but in spite of this are more thoughtful and reflective than was evident in the early stages of the therapy.

Therapy vignettes

Many of the girls responded to their therapy, group or individual, and seemed to be able to work on the traumatic effect of the abuse. We illustrate this with some vignettes which have been heavily disguised and anonymized.

Concerns about parenting A number of girls were with current carers (mother or foster mother) where there were very considerable concerns about the child's past and present parenting.

Mary, aged 10 years, lived with a single mother who had been abused herself as a girl. Mother was depressed and preoccupied, frequently unavailable physically or emotionally, for her daughter and the younger siblings.

Mary was brought by social services transport. She was in a group and the leaders became anxious at her reports of her life at home. At times, she was very grown up and responsible, looking after the other girls in her group. But, at other times, she talked excitedly about relationships with older men outside her home which worried the psychotherapists. There were other sessions when she was depressed, despairing and unhappy.

The therapists were quite unsure about what was actually happening. At times, they thought they were the only adults really in touch with this girl and what she was doing and feeling. They found managing the therapy and thinking about whether confidentiality should be broken a difficult and painful exercise. By the end, Mary had made considerable progress and the situation at home was more settled.

The silent denying girl A number of girls could not recall the details of the abuse.

Imogen, aged 7 years, looked blank and vacant a lot of the time although she repeatedly insisted she was fine, and that there were no problems. She did not know why she was coming to the clinic; she had no problems. Any comments or questions about the abuse and events in her family were ignored. Week after week, her individual therapist tried to make contact with Imogen. She was able to talk about aspects of her life, for instance, school and outside activities, but she was unable to work on the 'here and now' issues in the room with the therapist – why she had been brought and seemed reluctant or unable to use any of the play material provided. Any conversation was rather short and it seemed difficult for her to be in the room.

However, Imogen, by the end of her individual sessions, had begun to think and talk about her feelings and her experiences and so she found the ending difficult. She needed to be referred on outside the project for further help.

The girl preoccupied with the abuse Some girls came into therapy with their minds full of the abuse or abuse-related experiences.

Harriet, aged nearly 13 years, was rather wary and suspicious. She talked repeatedly about the abuse, sometimes excited, at other times terrified and unable really to think of anything much else. She relived the abuse in her individual therapy sessions and at home. The therapist found the material very distressing, particularly when more abuse emerged. Thus, there was a need to clarify what had occurred in the past and what was occurring currently. The therapist struggled to help Harriet, wanting to see Harriet as a person and not just an abuse survivor. But this proved difficult as the abuse was so much in evidence it dominated everything – the thinking, any feelings and their relationship.

It seemed as though the therapy helped her recover. By the end, the flashbacks and the memories of the abuse were less overwhelming and Harriet seemed able to get on with her life.

The depressed girl Many of the girls were depressed, anxious, angry and irritable.

Rita, aged 9 years, talked in the group about her despair and hopelessness. At times, she was rude, contemptuous and defiant, at other times she expressed a wish to be dead. She was opting out of school and arguing and fighting with her parents and siblings. She and her brother fought physically. Her therapists felt considerable concern about her safety, and irritation and annoyance with her difficult and contemptuous behaviour. Slowly the group became able to contain the anger and the despair, and Rita began to improve. During the group intervention, Rita began to really think about her experiences and her impact on others.

At the one year follow-up, in some senses, Rita was just coping but, on the other hand, was aware that she was deteriorating again, at times wanting to be dead and was also angry. It was decided she needed referral to a local resource.

Training and supervision issues

Given the stress of the therapy itself and the expectations arising from the research, supervision was essential for all the therapists. This helped them reflect on the experiences within the therapy, cope with painful material and regain their objectivity. They also needed to plan future sessions. Without good regular supervision by experienced and competent supervisors, the project would have been much harder to manage. The brief focused nature of the work could all too easily have been felt by the girls to be tantalizingly short, but that it was felt to be a constructive helpful intervention for most girls is to the credit of the therapists and supervisors.

Case management issues

The enormity of the administrative and organizational task merits emphasis. A project coordinator and liaison person was needed in North and South London, to liaise with social workers, address attendance problems, organize therapists for children and carers, and arrange mutually convenient times for the therapy and find rooms in busy clinics for the treatment to take place.

In addition, there were ongoing issues of clinical case management. The intention was to provide a treatment package consisting of assessment and therapy, but with the responsibility for the case to be still held by the referrer. Despite carefully described ground rules, there were constant management issues. Case conference attendance was frequently requested to develop care plans or discuss current risk and this threatened to blur the role of the project. Furthermore, despite insistence that referrers should retain clinical responsibility, on occasion, this did not happen with the cases being closed by the outside agencies. Passing some of the cases back to the original referrer when the project ended was not always easy as they needed to reopen their file and reallocate.

A number of girls had not previously applied for criminal injuries compensation and completing relevant reports took time. In addition, there were demands for court reports or appearances.

Bringing together a large number of abused girls and their carers also had an impact on the institutions themselves, perhaps forcing uninvolved professionals to have to reflect on the issues. Many clinicians have mixed feelings about abused children, particularly sexually abused children. Sexual abuse is an experience that happens perhaps once, perhaps many times over years, but it is not a clinical diagnosis. Some professionals have suggested that individuals who have been sexually abused do not need treatment, but only protection from abuse. Others have suggested that working with children who have been abused is not appropriate for child and family mental health professionals with other mental health problems being given a higher priority.

However, when confronted with troubled, needy, distressed children, most clinicians, once aware of the problems, perhaps with reluctance and some difficulty, try to respond by offering help.

Conclusions

A psychotherapy outcome study is a major therapeutic and administrative exercise, and when it involves children and their carers, it can prove particularly complex. When the girls who are the subjects of the project have been sexually abused, then the complexity is increased disproportionately.

The work was painful and distressing. At times, some girls and their carers evoked despair, rage, shame and repulsion in the workers. The supervisors had to work hard to manage the therapists and the therapy. The senior staff had to manage the clinical work, the research requirements and the emotional impact provoked by the subjects. As well as the individual psychopathology and the dysfunction in the families, there was the underlying and fundamental issue of the abuse of the girls – children – by predominantly powerful adult (over 16 years) men. It is well known that dynamics and conflicts that surround abuse can all too easily be repeated in the professional network. In this study, this repetition also permeated the research team. The supervisors were able to help the therapists process and understand this repetition. It was more difficult to be aware of the dynamic repercussions for the senior staff and this resulted, at times, in considerable stress and conflict within the host institutions. It is vital in projects such as this, if there is to be a satisfactory clinical and research outcome, for there to be regular meetings, considerable trust and mutual respect, and staff sufficiently resilient to be able to express openly, and listen sympathetically to, concerns.

Notes

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