Adults with a history of child sexual abuse: evaluation of a pilot therapy service

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Abstract

Objective—To evaluate a pilot service offering therapy specifically to adults with a history of child sexual abuse.

Design—Questionnaire survey.

Setting—Specialised therapy unit, Breakfree, which offers care, therapy, and support.

Subjects—116 clients presenting to the service who were offered therapy.

Main outcome measures—Scores from three psychological questionnaires—the social activities and distress scale, the general health questionnaire, and the delusions, symptoms, and states inventory—and from questionnaires about the clients' abuse, previous use of health services, and opinion of the Breakfree service.

Results—Clients had received previous help from health services and other agencies without apparent effect; they were highly distressed according to their psychological scores; and they were very frequent users of the health services. The clients showed significant improvement in their psychological scores (Wilcoxon's matched pairs signed ranks test): social activities and distress scale, $z = -3.3$, $P = 0.001$; general health questionnaire, $z = -5.8$, $P < 0.00001$; delusions, symptoms, and states inventory, $z = -4.8$, $P < 0.00001$. This was most pronounced for those who had completed therapy by the end of the study. Whereas 82/88 clients had a score for the general health questionnaire that indicated clinical distress at the start, only 28/58 did so at the end of the study (only 17/35 among those who had finished therapy).

Conclusions—This group of adults with a history of child sexual abuse were highly disturbed and previous high users of the health service. The specialist service Breakfree was effective in the short term and, if the benefits are sustained, would yield a net cost saving to the health service.

Introduction

Until recently child sexual abuse was a taboo subject, barely acknowledged and seldom discussed. As public and professional awareness have heightened, articles have begun to contribute to our understanding.¹⁻¹³

A review of the surveys of larger, non-clinical populations in 21 different countries clearly confirms that child sexual abuse is an international problem and that the prevalence is estimated at between 7% and 36% for women and 3% and 29% for men.⁵ In Britain, Kelly *et al* found in a survey of 1244 students that one in five women and one in 14 men had experienced contact sexual abuse, one in 20 women and one in 50 men experiencing severe abuse (masturbation or rape).⁸ Two per cent of the sample reported incestuous abuse and a further 4% reported abuse by other family

members or "safe" family contacts. In Kelly *et al*'s study only 5% of cases of abuse were reported to any agency.

The long term effects of child sexual abuse are well documented and comprise a wide range of psychological, emotional, physical, and social effects.^{4,7,14-17} These include anxiety, depression, obsession, compulsion, grief, post-traumatic reactions, poor self perception, sexual dysfunction, social dysfunction, dysfunction of relationships, poor education and employment records, and a range of physical symptoms. The symptoms in an individual may be specific or general, episodic or chronic. The percentage of adults who experienced sexual abuse as children and had long term effects is not known, although in one British study 13% of a sample of such adults reported that they had been permanently damaged.²

A specialist approach to adults who experienced sexual abuse as children has been reported to be of benefit.^{18,19} Such specialist provision is patchy, however, and is generally attached to mental health facilities in secondary care. To identify the need for and the efficacy of a special community based service for adults who have experienced sexual abuse as children Lincolnshire Family Health Services Authority (and then Lincolnshire Health) funded a pilot service for such adults and an evaluation of it. The service, Breakfree, was established in Lincoln on the basis of a preliminary investigation of these adults' needs, which showed a demand for acceptance, belief, and understanding; confidentiality; a safe environment; honesty, respect, and trust; and a service that was stable and available. The service began in September 1993 as a primary care based centre that offered a comprehensive, user defined package of care within a multiagency setting (box).

Breakfree, which continues to offer a service, although the pilot period is over, is housed in a separate building in a primary care complex. The team consists

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Package of care offered at Breakfree

- Individual therapy focusing on the abuse with a nominated support worker. The length of each session is negotiated with the support worker (usually 30 to 120 minutes once or twice a week)
- Daytime "drop in" facility and telephone contact
- An out of hours paging service
- A limited befriending service in which a support worker offers support, comfort, and care to a client who has no support network
- A limited "time out" facility where a client can stay in a safe environment for a night or two
- Support for family and close friends at a client's request

of Breakfree's originator (LP); a medical director (DS, who is also a local general practitioner); and several support workers, all of whom received training in humanistic counselling, specialist training focusing on the abuse itself, and training in allied subjects such as child protection and offenders' behaviour. The support workers had already expressed an interest in working with adults who had experienced sexual abuse as children, and most came from agencies where they had encountered such adults. Initially, the support workers were regularly supervised and were debriefed with colleagues after each therapy session.

All the key local agencies—social services, the area child protection committee, the probation service, the police, the victim support scheme, and the National Society for the Prevention of Cruelty to Children—participated in setting up the service and have continued to influence it through an advisory committee. The local providers and health authority are also represented on the management committee.

We evaluated Breakfree's pilot service, which operated for one year.

Methods

The pilot service for adults who had experienced sexual abuse as children operated from 1 September 1993 to 31 August 1994; clients were accepted for therapy during the first nine months. Publicity was minimal as demand for the service stretched its therapeutic resources; most referrals were generated by word of mouth.

All the clients who were accepted for therapy were asked for their informed consent to be enrolled in the evaluation study, and it was emphasised that having therapy did not depend on agreeing. Those that agreed to be in the study completed three standardised psychological questionnaires—the social activity and distress scale,²⁰ the general health questionnaire (28 item version),²¹ and the shortened version of the delusions, symptoms, and states inventory^{22 23}—once at the start of therapy and again at the end of therapy (or end of the pilot study). At the start of therapy, the clients were asked to complete a questionnaire about their previous use of health services and their opinion on previous care they had received and a questionnaire about their abuse. At the end of therapy (or the end of the pilot) clients completed a questionnaire on their satisfaction (on a five point scale) with the service they had received from Breakfree.

In addition, we identified a subgroup of clients who were registered with three general practices. With these clients' consent, we compared their medical records with those of two age and sex matched controls for each case to determine any differences in use of health services.

TABLE I—Reported characteristics of child sexual abuse in sample of 67 adults starting therapy

	No of clients
Sex of client:	
Male	11
Female	56
Location of abuse:	
Outside the family	21
Within the family	33
Combination of both	13
Type of abuse:	
Non-contact	4
Contact (non-genital)	6
Contact (genital)	54
Penetration	37
Abuse with violence	24
Other	4
No of abusers:	
One	38
More than one	29
Sex of abuser(s):	
Male	58
Female	1
Male and female	8
Age at start of abuse (years):	
0-4	15
5-9	32
10-14	13
≥ 15	2
Did not answer	5

TABLE II—Case-control comparison of the general practice medical records for 18 adults with history of sexual abuse as children and 36 randomly selected age and sex matched controls*

	Cases (n=18)	Controls (n=36)
Over past five years (average No):		
Contacts with general practitioner or nurse per year	15.6	4.2
Prescriptions for short term treatment per year	5.2	1.7
Psychiatric teams ever involved	2.9	0.2
Non-psychiatric secondary care teams ever involved	8.3	3.9
Hospital admissions ever	8.4	3.5
Psychiatric admissions ever	3.4	0
Suicide attempts ever	1.6	0.1
Average No of surgical operations (% with negative findings)	2.9 (33)	1.9 (10)
No (%) of clients:		
With weight problems	10 (56)	11 (31)
Who misuse alcohol or drugs, or both	5 (28)	21 (6)
With diagnosis of asthma	7 (39)	6 (17)
With diagnosis of irritable bowel syndrome	6 (33)	5 (14)
Average thickness of general practice medical records	3.04 cm	1.54 cm

*Two controls per client.

Results

RESPONSE RATES

Of the 128 clients who presented at Breakfree during the first nine months of the service, 116 were offered treatment; of these, two declined therapy and a further eight did not attend for therapy. Of the 106 clients therefore eligible to enter the study, 92 (87%) consented to take part.

Of the 92 clients who took part, 89 completed all or part of the three psychological questionnaires at the start of therapy, and 59 completed all or part of them at the end of therapy or end of the study. The clients who did not complete these questionnaires at the end of therapy did not do so partly because they had stopped their therapy (seven); were still in therapy at the end of the study (six); had taken a planned break in their therapy, intending to restart therapy when ready (11); or had not received enough therapy to complete the questionnaires (six).

SOURCE OF REFERRAL

Seventy three of the 89 clients who completed the three psychological questionnaires at the start of therapy had been referred from primary care (29), mental health services (16), or social services (seven) or had referred themselves (21). The remaining 16 clients had been referred by voluntary agencies, the police, religious organisations, or by friends or carers.

HISTORY OF SEXUAL ABUSE

Sixty seven clients completed a questionnaire about their sexual abuse at the start of therapy (table I). The rest of the clients thought that the questionnaire was too sensitive and declined to complete it. The duration of the sexual abuse ranged from one episode (seven clients) to 28 years (one client).

PREVIOUS USE OF SERVICES

Seventy nine clients completed the questionnaire about their previous experience of health services and therapy for their sexual abuse. Ten clients had received no previous help. The remaining 69 had received help from a total of 281 sources, of which 138 were the mental health services (including psychiatrists, community psychiatric nurses, psychologists, and counsellors); 85 were general practices, general hospitals, and accident and emergency services; and 58 were outside the health service and included social services, the police and probation services, the church, and groups for victims of rape. Clients were asked to give their reasons for no longer receiving help from these sources, and 12 quotes out of 265 answers are shown in the box.

We identified 18 clients as being registered with the three general practices. Table 2 shows the comparison between these clients and 36 age and sex matched controls.

THE THREE PSYCHOLOGICAL MEASURES

Of the 89 clients who completed the three psychological questionnaires at the start of therapy, all completed the social activities and distress scale, 88 completed the general health questionnaire, and 87 completed the delusions, symptoms, and states inventory. Table III shows how disturbed the clients were at the start of therapy.

Of the 59 clients who completed the three psychological questionnaires at the end of therapy or end of the study, all 59 completed the social activity and distress scale, and 58 completed the general health questionnaire and the delusions, symptoms, and states inventory. Table III shows the results of the tests for those clients who completed the psychological questionnaires both at the start and at the end of therapy. The differences between scores at the start

and end of therapy were tested with Wilcoxon's matched pairs signed ranks test (two tailed), and they were all significant (social activities and distress scale, $z = -3.3$, $P = 0.001$; general health questionnaire, $z = -5.8$, $P < 0.00001$; delusions, symptoms, and states inventory, $z = -4.8$, $P < 0.00001$).

Of the 89 clients who completed the three psychological questionnaires at the start of therapy, eight clients had a normal score (< 9) on the social activity and distress scale, nine had a score showing no clinical distress (< 5) in the general health questionnaire, and eight had a score showing no clinical distress (zero) in the delusions, symptoms, and states inventory. Of the 59 clients who completed the three psychological questionnaires at the end of the study, 15 had a normal score on the social activity and distress scale, and 30 and 24 had scores showing no clinical distress in the general health questionnaire and the delusions, symptoms, and states inventory respectively.

By the end of the study, 35 clients were still receiving therapy but sufficiently advanced to be evaluated and 24 had completed their therapy. When the scores for the psychological questionnaires for these 24 clients alone were considered, the number of clients with a normal score on the social activity and distress scale increased from 3 to 11 and a score showing no distress increased from 3 to 18 on the general health questionnaire and from 2 to 18 on the delusions, symptoms, and states inventory.

CLIENTS' SATISFACTION

Fifty seven clients completed the questionnaire about the service they had received from Breakfree. All 57 clients found the service "very approachable" or "approachable" and found Breakfree's staff "very helpful" or "helpful"; 55 felt "very safe" or "safe" at the centre. When asked to rate the effect of their therapy on a five point scale, 51 clients reported that it had helped them "enormously" or "a lot," and 48 (out

TABLE III—Clients' scores in defined ranges for the three psychological questionnaires at start of therapy and at the end of therapy. Values are numbers (percentages) of clients

Score	All clients at start of therapy (n=89)	Clients who completed questionnaires both at start and end of therapy*† (n=59)	
		Start	End
Social activity and distress scale:			
0-4	5 (6)	2 (4)	10 (17)
5-8	3 (4)	2 (4)	5 (8)
9-12	9 (10)	8 (14)	6 (10)
13-16	11 (12)	6 (10)	10 (17)
17-20	22 (25)	15 (25)	9 (15)
21-24	19 (21)	14 (24)	10 (17)
25-28	20 (22)	12 (20)	9 (15)
Questionnaire not completed	0	0	0
General health questionnaire:			
0-4	9 (10)	6 (10)	30 (51)
5-8	7 (8)	1 (2)	8 (14)
9-12	9 (10)	7 (12)	6 (10)
13-16	13 (15)	13 (22)	2 (4)
17-20	10 (11)	4 (7)	5 (8)
21-24	25 (28)	15 (22)	3 (5)
25-28	15 (17)	12 (20)	4 (7)
Questionnaire not completed	1 (1)	1 (2)	1 (2)
Delusions, symptoms, and states inventory:			
0	8 (9)	5 (8)	24 (41)
1	7 (8)	6 (10)	5 (8)
2	7 (8)	5 (8)	11 (19)
3	17 (19)	12 (20)	4 (7)
4	20 (22)	11 (19)	5 (8)
5	14 (16)	11 (19)	3 (5)
6	10 (11)	6 (10)	4 (7)
7	4 (4)	2 (4)	2 (4)
Questionnaire not completed	2 (2)	1 (2)	1 (2)

Normal score in social activity and distress questionnaire < 9 ; score showing no clinical distress: in general health questionnaire ≤ 5 , and in delusions, symptoms, and states inventory ≤ 0 .

*Or end of study (n=35).

†Differences between scores (Wilcoxon's matched pairs signed ranks test): social activity and distress scale, $P = 0.0001$; general health questionnaire and delusions, symptoms, and states inventory, $P < 0.00001$.

Quotes from clients explaining why previous source of help was not satisfactory

"Diagnosed as adolescence, and will grow out of it"

"They frightened me"

"No assistance—prescribed medication"

"Could not help—referred back"

"Did not believe me"

"Absolutely no understanding of my mental state—a total unwillingness to accept that sexual abuse created long term problems"

"The psychiatrist asked me to stop because I made him feel sick—he left me in a very distressed state"

"I left because the psychotherapist had limited experience and training in the field"

"Did not understand the problem"

"No benefit. The community psychiatric nurse cried over the abuse"

"Left as felt doing more harm than good"

"He thought things were all right, although I had just overdosed"

of 49 who had experienced other sources of help) rated their therapy at Breakfree as "very much better" or "much better" than help received from previous sources.

COSTS OF THE SERVICE

The therapy comprised 1345 sessions totalling 2365 hours for the 77 clients for whom complete records were kept—a mean of 17.5 sessions and 30.7 hours per client. The pilot service cost a total of £70 000.

Discussion

The client group in this study may not be representative of all adults who have experienced sexual abuse as children. Our clients self selected themselves or were selected by others aware of the new service, and no attempt was made to compare them with the population of potential clients. However, only 12 potential clients were not offered treatment (six were considered unsuitable for therapy (and were referred to other agencies) and six wanted information only. Moreover, of the 116 who were offered treatment, only 10 either refused therapy or did not attend for therapy. The client group entering this study was not therefore highly selected from those referred. We considered it impractical and probably unethical to randomly allocate clients to groups receiving or not receiving therapy. This study cannot therefore definitively establish the benefit of therapy. The clients may well have presented when in crisis, and their psychological scores might have been expected to return towards normal with time. The size of this effect cannot be assessed.

NEW FINDINGS

Despite the shortcomings of the study some new and interesting conclusions can be drawn. Some adults who have experienced sexual abuse as children are severely damaged people. They use the health services much more than other adults, and more of them have weight problems, misuse alcohol and drugs, and have the irritable bowel syndrome—conditions that many general practitioners find difficult to manage.

The psychological profiles of our clients at the start of therapy showed a high level of disturbance. This could be because they were starting a therapy that they found threatening, but the clients reported that they felt safe at the centre, and the drop out rate was low. The clients reported to the staff that their distress was

Key messages

- A history of child sexual abuse is common: 1 in 5 women students and 1 in 14 men students have reported it
- Breakfree was set up as a pilot service to offer help to adults with such a history
- The clients presenting to this service reported that conventional services had failed them
- Adults who have been sexually abused as children are high users of the health service and are highly distressed psychologically
- A specialist service offers a highly effective therapy, which, if the benefits are sustained, will be cost effective

long term and that it was often their distress that had led them to seek help.

The clients were eight times more likely to have attempted suicide than the case controls. In view of the pronounced morbidity shown by the psychological profiles this finding is not surprising, but it has implications for success in the *Health of the Nation's* targets for reducing suicides.

The dramatic falls in the scores for psychological distress at the end of therapy could of course be a temporary effect of the therapy, and abnormal psychological scores might return.

Clients' opinions of the service were positive, as were the opinions of the referrers, which we had also sought. The costs per client compared favourably with local service costs—for example, for regular visits from a community psychiatric nurse. If the clients' high rates of health services' use (especially the high numbers of investigations with negative findings and psychiatric team referrals) were reduced to normal levels then the service provided by Breakfree would be a net cost saver to the NHS.

CONCLUSION

We have assessed a service to clients. We could not conduct the study under laboratory conditions, but the study comprises the largest series of adults who have experienced sexual abuse as children reported in the United Kingdom and is the first evaluation of such adults' previous use of resources and the only assess-

ment of a community based therapy and support service designed to offer help to such adults as a specific group.

The traditional health services have clearly failed adults who have experienced sexual abuse as children; these adults continue to show their distress through their increased use of health services. All doctors and nurses should become sensitive to the possibility of previous child sexual abuse being an underlying problem for patients, and specialist services such as Breakfree should exist to treat these patients.

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"Explain in simple words—ensure the words are understood"

The old man in the bed next to mine in the mixed gender customer care facility (ward) woke me with his sobbing, quiet but continuous and infinitely distressing. I hobbled to his bedside and asked what troubled him. "Damn youse men, keep quiet," said the old lady next along the ward. At first the man ignored me, weeping on, his face and the pillow wet with his tears. I held his hand and dried his face, and he turned his eyes to me. "It's you, doctor?" he asked. It had become known to my fellow patients that I was medical. "There's nothing you can do for me—or for my woman, but thank you," and he turned away from me.

"What's with your wife, then?" I asked, for she had seemed a bonny character, full of vitality and good sense, when she had sat with her husband on the first days after his operation. "She had this kirkel [lump] in her bubbly [breast] and our doctor said it should be taken out to see just what it was, in case it was something bad. So the surgeon cut it out past Tuesday and yesterday the doctor called at the house to tell her what it was she had." And he began to wail, but quietly. "And what did the doctor say?" I asked. He hid his face in the pillows as his body shook again with the sobs.

When he looked at me next there was fright and distress in his eyes. "Benign," he said, his whisper so faint that I scarcely heard the word, and so I doubted at first what it was he had said. "The doctor says it's benign. That's what the two of us both feared it would be," he added, his voice flat and dull, his eyes now staring far into the night beyond the ward. "What is the use of all this operation on my heart if she is gone and I live on?"

So it was. Benign. The primary care provider (family doctor) had called on the old woman at her home to tell her this good news. She did not look at him as he spoke, and she missed the satisfaction and relief that must have been in his expression. To her, "benign" was a word outwith her own vernacular, perhaps not even heard before. So it was to her man also. A doctor's word, strange, frightening, mistaken to be cancerous in meaning, and so bringing the old couple the opposite of the good news that the doctor had thought he was offering when he added, "So there's nothing more to be done about it—it's all finished."

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*W W D Thomson, professor of medicine, Belfast, 1923-50.