Good Enough Care? Looking After Sexually Abused Young People in Residential Settings

Autumn Roesch-Marsh
PhD student, Department of Social Work, University of Edinburgh

Introduction

Sexual abuse in childhood is a traumatic and damaging experience that can have a range of effects for young people as they grow and develop. These can include increased risk of mental health difficulties such as depression and anxiety, psychological symptoms such as low self-esteem and guilt, and problem behaviours such as substance misuse (Avery, Massat & Lundy, 2000; Cotgrove & Kolvin, 1994; Haggerty, Sherwood, Garmezy & Rutter, 1996; Mental Health Foundation, 1999; Richardson & Joughin, 2000). A range of research has assessed the impact of sexual abuse and interventions which have been used to help protect against or alleviate resulting symptoms (Finkelhor & Berliner, 1995; Monck *et al.*, 1996; Stevenson, 1999). Central to many of these studies has been the finding that involving the non-abusing parents of sexually abused children in any treatment approach greatly improves outcomes (Deblinger & Heflin 1996; Finkelhor & Berliner, 1995; Karp, Butler & Bergstrom, 1998). While many sexually abused young people remain in the care of their families, a significant number will be placed in substitute care settings. In such settings, opportunities for treatment may be influenced by a greater range of factors and will likely involve a wider range of professionals with less input from family members (Farmer & Pollock, 1998).

Research has suggested that not only are the opportunities for treatment and support of sexually abused young people restricted in residential child care settings, but that residential settings themselves can often be a context for sexually abused young people becoming re-victimised and further traumatised (Brogi & Bagley, 1998; Farmer & Pollock, 1998; Green & Masson, 2002; Lindsay, 1999). In comparing sexually abused and sexually abusing young people to others in substitute care, Farmer and Pollock state that 'sexually abused and abusing children are more disadvantaged than others in state care' (Farmer & Pollock, 1998, p. 129).

This claim may seem bold indeed, given the diverse mix of young people in most residential settings (Berridge & Brodie, 1998; Kendrick, Milligan & Furnivall, 2004). A close examination of policy reports relating to residential childcare shows, however, that there has been an awareness of the plight of sexually abused young people in substitute care for some time. The Skinner Report (1992), the Utting Report (1997) and the Edinburgh Enquiry (Marshall,

Jamieson & Finlayson, 1999) all recommend that the safety and needs of sexually abused young people in residential care should be recognised and prioritised by residential services, and that sexually abused young people should not be placed alongside sexually abusing young people.

More recently the *Scottish Needs Assessment Programme* (SNAP), a Child and Adolescent Mental Health needs assessment, identified a real gap in provision for sexually abused young people who are looked after in residential settings. The report identifies that residential and health services must take a closer look at joint provision for this group (Public Health Institute of Scotland, 2003). Health services have begun to respond to these recommendations by introducing dedicated health projects for looked after children (Kendrick *et al.*, 2004; Residential Care Health Project, 2004; van Beinum, Martin & Bonnett, 2002).

As a residential social worker, I found that the available research seemed to confirm many of the challenges and difficulties my colleagues and I encountered in working with sexually abused young people. These include: risks of re-victimisation; difficulty accessing specialist services; and difficulty managing some of the distressed behaviours exhibited by this vulnerable group of young people (Brogi & Bagley, 1998; Fanshawe, 1999; Farmer & Pollock 1998; Lindsay, 1999; Mistral & Evans, 2002). The following research, undertaken as part of a Social Work Masters dissertation project, had the aims of determining practitioners' perspectives on caring for sexually abused young people in residential settings and highlighting practice recommendations.

Methodology

This study sought the views of practitioners providing services or involved with service development for young people in residential care with an experience of sexual abuse. Semi-structured interviews were conducted with fifteen practitioners from one Scottish local authority: seven were working in residential child care; five were working for specialist projects providing therapeutic input for young people with an experience of sexual abuse; and three were involved with service development and advocacy. Respondents were chosen primarily because of their interest in the study, and their varied experience and involvement with sexually abused young people in residential care.

Interview questions sought to:

- establish the range of difficulties faced by sexually abused young people and clarify what workers from different services felt these young people needed from residential settings;

- identify the possible risks and benefits of accommodating sexually abused young people in a group care environment; and
- recommend what might be done on a policy and practice level to improve care for sexually abused young people in residential care.

The approach used in interviewing workers was flexible, allowed workers to explore the issue along their particular line of interest, and allowed comparison between the perspectives of different workers to emerge. The interviews took place in a range of work settings to make it as easy as possible for respondents to participate. They were carried out between March 2003 and May 2003. All respondents were assured confidentiality in their responses.

Data was collected in the form of extensive interview notes and typed up following the interview. Data analysis involved a process of coding responses under the three general headings.

The needs of sexually abused young people

Relationship difficulties

Residential practitioners stated that sexually abused young people in residential settings exhibited a number of behaviours which had a negative effect on their relationships with staff and other young people. This fits closely with the findings from research into the effects of sexual abuse on functioning and behaviour.

Practitioners described how sexually abused young people often experience difficulty maintaining appropriate personal boundaries, and that this manifests itself in a variety of ways. They described some young people as being 'too compliant' with the wishes or commands of others. Other young people could be very intrusive in their interactions with others; often described by staff and other young people as 'creepy' or 'over the top'. Equally, they felt sexually abused young people could be very guarded and closed, making it difficult for them to form new attachments and develop positive relationships. Practitioners found that sometimes an individual young person could exhibit all these behaviours, making it a challenge to develop a relationship with them or to predict their responses.

Sexualised behaviour and sexually promiscuous behaviour was a problem area practitioners linked to issues of personal boundaries and risk taking. Practitioners identified this as a particularly challenging issue that can create a very difficult group dynamic in a residential unit. One said that:

Young people can have difficulty relating to their peer group when they see themselves as a sex object because of their experiences. This can lead to an explosive and sexually charged atmosphere in the unit which is unsafe for everyone.

Another said:

Many of the sexually abused young people I have worked with have behaved in a very sexually promiscuous way. It is easy for many of these kids to slip into inappropriate sexual behaviour.

One of the specialist practitioners suggested that this was because:

The inner worlds of these young people have been very corrupted… they have had very different 'norms'.

Linked to this, specialist practitioners identified that most sexually abused young people lack accurate information about sex and sexual health. One said:

… we cannot assume that sexually abused young people have accurate information about sex; in fact the opposite is often the case. Workers should feel able to answer questions from young people about sex and sexuality, and units should ensure that structured sex education is provided by practitioners outside the unit.

The specialist practitioners highlighted the issue of young people and their attachments to abusive figures. One had found in her work that this was a particularly difficult issue for carers to come to terms with:

… many sexually abused young people have had few positive attachment experiences and sometimes their most positive attachment was to an abusive figure… Its hard for young people to give up these attachments and carers find it hard to understand why young people might go back to the abuser… there can be a lure back to that sort of life, they may love their abuser.

Another specialist practitioner suggested that transference and counter-transference was a much overlooked area relating to residential practice with sexually abused young people:

We need to be aware of how these young people affect us and interact with the existing team dynamic. Many of these young people, because of their difficulties with boundaries, have an acute sensitivity to staff feelings… these kids get inside you… Counter transference is going to happen; its about noticing it and trying to draw the young person's attention towards what is going on in their behaviour or response.

Anger and destructive 'acting out' behaviours were also raised by all the respondents as a major response to abuse experiences; this often manifests in a rejection of adult authority figures. One respondent said:

> *Many of these children don't know what it means to be a child because they have been sexualised and included in an adult world from such a young age. For this reason they often reject the caring and nurturing that is offered to them.*

Low self-esteem

All the practitioners identified low self-esteem as one of the major effects of sexual abuse. Many were keen to point out, however, that most sexually abused young people in residential care have also had a range of other negative experiences that impact on their sense of self, including: loss; physical abuse and neglect; and material deprivation. Practitioners felt the issue of self-esteem was linked to the feelings of guilt and shame commonly felt by young people who have been sexually abused (Herman, 1992; Karp *et al.,* 1998). One stated that, 'guilt and shame is with these young people much of the time'. She suggested that workers need to be aware of how they respond to behaviour so as not to reinforce feelings that the young person may have about being 'bad', 'dirty', or 'to blame'.

Disruption to daily routines

Practitioners described how many sexually abused young people struggled with daily routines and had difficulties with sleeping, eating, personal hygiene, and bedwetting and/or soiling. Practitioners noted that many of these difficulties related to young people's levels of anxiety. This was also reflected in their difficulty with concentrating on tasks.

Practitioners described how levels of chronic anxiety meant that many young people found it difficult to settle and appeared 'on edge' much of the time. One practitioner mentioned several girls she had worked with who 'would pace the unit, unable to settle and found it very difficult to be alone… Sometimes they would just stare into space, like they weren't there.' Although practitioners did not identify these as signs and symptoms of post-traumatic stress, they were clearly alert to this behaviour and aware that young people would need support in managing their anxiety; how to best to do this was not always clear (Parker & Randall, 1996).

Mental health difficulties and substance misuse

Practitioners identified cutting and self-injury as a common behaviour among sexually abused young people. They also reported high rates of alcohol and

drug misuse and many felt this was linked to a 'self destructive' or self-harming impulse. Specialist practitioners identified low mood, depression, and anxiety as the most common mental health problems among sexually abused young. Practitioners stressed the need for workers to be aware about how commonly depression among sexually abused young people can be accompanied by suicidal ideation, and emphasised that depressed young people need to be carefully assessed and monitored for suicide risk.

Risks and benefits of residential care

There was a general consensus among residential practitioners and specialist sexual abuse practitioners that residential care was not the ideal setting for sexually abused young people. Respondents often described residential care as 'the end of the line' for very troubled young people, where all other resources had been exhausted and social workers did not know where else to put these young people. Despite this, all practitioners could identify benefits, as well as risks, to placing sexually abused young people in residential settings.

Risks

Practitioners identified a number of risks in accommodating sexually abused young people in residential settings. The most significant and oft repeated of these was the risk of re-victimisation and further abuse. Workers highlighted examples of this happening. In most cases, abuse was perpetrated by other young people in units, but in some cases, it involved adults in the community who where known to the young person before admission. This concurs with findings from other research (Brogi & Bagley, 1998; Farmer & Pollock, 1998; Green & Masson, 2002; Lindsay, 1999).

Practitioners supported Farmer and Pollock's (1998) finding that negative behaviours and emotional difficulties often escalate when sexually abused young people enter residential care. Respondents felt that the dynamics of residential living were stressful for sexually abused young people; particularly, living with other young people with significant difficulties, and with large, and often changing, staff groups. One specialist worker asserted that for these reasons, 'coming into care can exacerbate their levels of distress and secondary symptoms can develop.' She also identified:

> *… a real danger that trauma will not be dealt with in residential care and it goes under the carpet, and things become more locked off which can cause greater damage when things resurface or are triggered later in life.*

Benefits

The primary benefits of a residential setting, according to most practitioners, were that for some young people a family placement would be 'too scary' given their experiences of abuse in the family. Alternatively, they might have so much loyalty to their own family that they would find it too difficult to accept another family. While practitioners felt the peer group could pose serious risks for sexually abused young people, in some cases, the peer group could also be a supportive force and might help young people to realise they were 'not alone' in their experiences.

Practitioners felt that in settled, well-staffed units, relationships with staff could be very positive. This would give young people an experience of nurturing and containing which could help 'remodel behaviour' and strengthen the young person's sense of self. One residential worker said:

> *Staff can be important role models and they can provide young people with a positive experience of adults who can be trusted.*

Another said:

> *… residential units can provide young people with stability and safety they have never had.*

While one specialist worker considered that:

> *In a well functioning unit young people grow stronger, they benefit from the routine and structure and get the opportunities to begin to unpack their experiences.*

Practice recommendations

Despite an awareness of the needs and difficulties of sexually abused young people, most of the practitioners felt that the levels of care for this group were not as good as they could be. In particular, they highlighted a number of barriers to good practice in the care of sexually abused young people in residential care:

- a lack of information about young people's histories at the point of referral and placement;
- a lack of staff trained to understand the causes and effects of sexual abuse and how to manage these in a residential context;
- difficulties accessing specialist therapeutic provision for victims of sexual abuse;

- a problematic mix of sexually abused and sexually abusing young people in units.

There was a clear tension in the general view that while residential care was not the ideal setting for sexually abused young people and posed certain clear risks, it was often the only available option and could, under the right circumstances, offer benefits to the young people placed there. The following 'practice highlights' are central to providing good quality residential child care for young people who have been sexually abused

Good basic care

When asked to identify what sexually abused young people need from their residential care setting, most practitioners prioritised good basic care and stressed that this was a priority for all young people, not just those with an experience of sexual abuse. The components of good basic care included: safety and privacy; clear boundaries and expectations; consistency of responses; meeting basic needs of health, education and leisure; regular contact with family and friends if appropriate; and good relationships with well trained, confident staff who prioritise their needs.

Safety and containment was emphasised as the cornerstone of good basic care. This should be a proactive process which involves engaging young people in meaningful discussion and ongoing work around boundaries, decision making and risk taking behaviour. Unless safety is created for the sexually abused young person, they will remain in a defensive and reactive place, unable to settle, and will continue to suffer post-traumatic symptoms relating to their abuse, including sleep disturbances and intrusive thoughts and memories (BAAF, 1989; Bray, 1997; Burke Draucker, 1992; Croll, 1994; Fulcher & Ainsworth, 1985). Creating safety is a huge challenge in residential social work given the complex mix of damaged young people and the low staff numbers in most residential units.

A culture of honesty and openness

Residential and specialist practitioners felt that anxiety levels around speaking to young people about their experiences of abuse were often disproportionate to the risks that might arise from young people sharing these experiences with staff. They felt workers should be honest with young people about what is understood about their case history, and it should be made clear that opportunities exist to talk about feelings or memories (Boston & Szur, 1983; Butler & Williamson, 1994; Croll, 1994; Fahlberg, 1994; Farmer & Pollock, 1998; Fulcher & Ainsworth, 1985).

Shame and guilt are so much a feature of sexual abuse trauma that it is important to have an open and communicative ethos in residential units to counterbalance the years of secrecy which young people have often endured (Bray, 1997; Croll, 1994; Herman, 1992). Farmer and Pollock found that among sexually abused young people in substitute care, 'the best outcomes in terms of behaviour gains were for those young people who were helped to explore their difficult experiences and feelings both in a therapeutic relationship and in their everyday lives in care' (Farmer & Pollock, 1998, p. 236).

Holistic assessment and care planning

It is difficult to be open, communicative and sensitive with sexually abused young people when units are too often provided with incomplete information. This is a major barrier to the assessment process which should be initiated prior to admission to establish 'if a child would be a good match with the existing group dynamic of young people' and if the skill base of staff and the ethos of the unit would best meet the needs of a particular child (Farmer & Pollock 1998, p. 234).

Practitioners acknowledged that current mechanisms for assessment are variable, despite the implementation of the *Looking After Children* materials. Assessment is often a rather reactive and ad hoc affair. Comments from one worker summarise the position of many units, 'we don't use an official assessment framework most of the time… we wait for things to hit and we look out for signs and symptoms of difficulty.' Minnis and Del Priore suggest that 'even optimal use of the LAC materials as a screening tool will fail to identify some children with significant problems' (Minnis & Del Priore, 2001, p. 35). They argue for a system of 'individualised psychological assessment of all children entering an episode of care' which includes an assessment of the impact of traumatic events including sexual abuse and highlights post traumatic symptoms for prompt treatment (Minnis & Del Priore, 2001, p. 35).

Practitioners need to have a range of models and a depth of understanding of sexual abuse to inform their assessment. Without assessment there is a tendency to respond to 'immediate behaviours' rather than out of 'consideration of their needs based on a full consideration of the child's history' (Farmer & Pollock, 1998, p. 242).

Along with holistic assessment, the care plan must attend to the trauma experience, whether that is by involving specialist provision in therapeutic work with the young person, or by ensuring regular time with a key worker to look at related issues and build self-esteem through positive activities.
A reactive approach to care planning is simply not good enough and residential

units must work in a way that is clear and purposeful and attends to the assessed areas of need.

Access to specialist provision

Specialist workers spoke of their frustrations in working with residential units and the difficulty in getting referrals to 'go anywhere' because of placement instability and logistical problems such as staff changes and transport. Specialist workers also sometimes felt that it would be irresponsible to begin therapeutic work with vulnerable young people while their living situations were chaotic and unsettled, and yet they acknowledged that for some young people this was the status quo in their particular residential setting. Residential workers, on the other hand, expressed universal frustration in accessing specialist mental health and sexual abuse services for young people. They highlighted waiting lists, attitudinal differences between health workers and residential workers, and over-cumbersome referral procedures as major barriers. For those that had used specialist projects, however, the overwhelming feeling was that they had been helpful for young people and supportive to staff in their work with young people.

With the introduction of more health and mental health provision specifically for looked after children, there is evidence that access to specialist mental health services for looked after and accommodated children is improving (Kendrick *et al.*, 2004; Residential Care Health Project, 2004). While the debates outlined above may continue, improving access and increasing provision should be applauded. Many sexually abused young people, however, will be unwilling or unable, for a variety of reasons, to undertake specialist therapeutic treatment. For these young people, the residential setting may be the only place where feelings and behaviours relating to their abuse will be acknowledged. Residential workers have opportunities, in the course of daily living, to provide the kind of supportive relationships and new experiences that can support young people to come to terms with their experience of sexual abuse and move on from it (BAAF, 1989; Croll, 1994; Farmer & Pollock, 1998).

Participative practice

The views of young people themselves must be sought and used to inform practice, service development and policy changes. Cashmore (2002) found that, despite the legislative duty on local authorities to encourage the participation of looked after children in decision making processes, 'participative practice still appears to be far from the norm' (Cashmore, 2002, p. 840).

Sexual abuse is a dis-empowering and violating experience and a range of

practitioners and researchers have highlighted that supporting survivors to speak about what they need and want, and empowering them to make choices is crucial to the process of recovery (Bannister, 1992; Bear, 1998; Butler & Williamson, 1994; Deblinger & Heflin, 1996; Herman, 1992). Listening to all young people and providing them with the means to impact on the treatment and decision making processes is crucial, but it is especially important to the well-being of sexually abused young people in residential care (Munro, 2001).

Conclusion

This study provides a brief snapshot of practice concerns relating to sexually abused young people looked after in residential settings in one Scottish local authority. It mirrors the findings of more comprehensive research in England (Farmer & Pollock, 1998). It identifies concerns that sexually abused young people are being re-victimised in residential settings, they are suffering from symptoms relating to their abuse without consistent access to specialist support, and that residential staff feel overwhelmed and dissatisfied by the levels of support they are able to provide around these issues.

In terms of both policy and practice, the issue of safety in residential settings for sexually abused young people must be addressed to ensure that we are not perpetuating an abusive cycle for victims. At the very least, we must be providing safe and nurturing residential settings. We must also address the training and support of residential workers to ensure that they can address the needs of sexually abused young people in residential care. We must further develop models of good practice in the specialist health provision for looked after children and provide these on a national basis.

Sexually abused young people must have a high priority in the agenda to improve the experiences and outcomes of those in residential care and to fulfil our statutory duty to safeguard and promote the welfare of looked after children.

References

Avery, L, Massat, C.R. & Lundy, M. (2000). Posttraumatic stress and mental health functioning of sexually abused children. *Child and Adolescent Social Work Journal 17*(1), 19-34.

BAAF. (1989). *After abuse: Papers on caring and planning for a child who has been sexually abused.* London: BAAF.

Bannister, A. (Ed.) (1992). *From hearing to healing: Working with the aftermath of child sexual abuse.* Harlow: Longman.

Bear, Z. (Ed.) (1998). *Good practice in counselling people who have been abused.* London: Jessica Kingsley.

Berridge, D. & Brodie, I. (1998). *Children's homes revisited*. London: Jessica Kingsley.

Boston, M. & Szur, R. (Eds.) (1983). *Psychotherapy with severely deprived children.* London: Routledge & Kegan Paul.

Bray, M. (1997). *Sexual abuse: The child's voice.* London: Jessica Kingsley.

Brogi, L. & Bagley, C. (1998). Abusing victims: Detention of child abuse victims in secure Accomodation. *Child Abuse Review*, *7*(5), 315-329.

Burke Draucker, C. (1992). *Counselling survivors of childhood sexual abuse.* London: Sage.

Butler, I. & Williamson, H. (1994). *Children speak: Children, trauma and social work*. Harlow: Longman.

Cashmore, J. (2002). Promoting the participation of children and young people in care. *Child Abuse and Neglect*, *26*(8), 837-847.

Cotgrove, A. & Kolvin, I. (1994). The long-term impact of child sexual abuse. In J. Tsiantis (Ed.), *Basic child psychiatry* (pp. 85-102). Kastaniotis: Athens.

Croll, L. (1994). *Caring for children and young people who have been sexually abused : A reader for child care workers and foster carers*. Basildon: Breakthrough for Youth.

Deblinger, E. & Heflin, A.H. (1996). *Treating sexually abused children and their non-offending parents: A cognitive behavioural approach.* London: Sage.

Fahlberg, V. (1994). *A child's journey through placement.* London: BAAF.

Fanshawe, R. (1999). Working in substitute care settings with sexually abused children: Issues for carers. In A. Harwick & J. Woodhead (Eds.), *Loving, hating and survival: A handbook for all who work with troubled children and young People*, (pp. 205-326). Aldershot: Ashgate.

Farmer, E. & Pollock, S., (1998). *Sexually abused and abusing children in substitute care.* Chichester: John Wiley & Sons.

Finkelhor, D. & Berliner, L. (1995). Research on the treatment of sexually abused children: A review and recommendations. *Journal of American Academy of Child and Adolescent Psychiatry*, *34*(11), 1408-1423.

Fulcher, L. & Ainsworth, F. (Eds.) (1985) *Group care practice with children.* London: Tavistock.

Green, L. & Masson, H. (2002). Adolescents who sexually abuse and residential accommodation: Issues of risk and vulnerability. *British Journal of Social Work, 32*(2), 149-168.

Haggerty, R.J., Sherwood, L., Garmezy, N. & Rutter, M. (1996). *Stress, risk and resilience in children and adolescents.* Cambridge: Cambridge University Press.

Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

Karp, C., Butler, T. & Bergstrom, S.C. (1998). *Treatment strategies for abused adolescents: From victim to survivor*. London: Sage.

Kendrick, A., Milligan, I. & Furnival, J. (2004). Care in mind: Improving the mental health of children and young people in state care in Scotland. *International Journal of Child & Family Welfare*, *7*(4), 184-196.

Lindsay, M. (1999). The neglected priority: Sexual abuse in the context of residential child care. *Child Abuse Review, 8*(6), 405-418.

Marshall, K., Jamieson, C. & Finlayson, A. (1999). *Edinburgh's children: The report of the Edinburgh Enquiry into the abuse and protection of children in care*. Edinburgh: City of Edinburgh Council.

Mental Health Foundation. (1999). *Bright futures: Promoting children and young people's mental health.* London: Mental Health Foundation.

Minnis, H. & Del Priore, C. (2001). Mental health services for looked after children: Implications from two studies.*Adoption and Fostering*, *25*(4), 44-54.

Mistral, W. & Evans, S. (2002). An innovative project for young people in care who have been sexually abused. *British Journal of Social Work*, *32*(3), 321-333.

Monck, E., Bentovim, A., Goodall, G., Hyde, C., Lewin, R., Sharland, E. & Elton, A. (1996). *Child sexual abuse: A descriptive and treatment study.* London: HMSO.

Munro, E. (2001). Empowering looked-after children. *Child and Family Social Work*, *6*(2), 129-138.

Parker, J. & Randall, P. (1996). Post-traumatic stress disorder in children:The social work challenge. *Journal of Social Work Practice*, *10*(1), 71-81.

Public Health Institute of Scotland. (2003). *Needs assessment report on child and adolescent mental health: final report – 2003*. Glasgow: Public Health Institute of Scotland.

Residential Care Health Project (2004). *Forgotten children: Addressing the health needs of looked after children and young people.* Edinburgh: Astron.

Richardson, J. & Joughin, C. (2000). *The mental health needs of looked after children*. London: Gaskell.

Skinner, A. (1992). *Another kind of home: A review of residential child care.* Edinburgh: HMSO.

Stevenson, J. (1999). The treatment of the long-term sequelae of child abuse. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 40*(1), 89-111.

Utting, W. (1997). *People like us: The report of the review of safeguards for children living away from home.* London: The Stationery Office.

van Beinum, M., Martin, A. & Bonnett, C. (2002). Catching children as they fall: Mental health promotion in residential child care in East Dunbartonshire. *Scottish Journal of Residential Child Care*, *1*(1), 14-22.