Child Abuse Review Vol. 6: 163–177 (1997)

Evaluating Therapeutic Intervention with Sexually Abused Children

Elizabeth Monck*

Behavioural Sciences Unit
Institute of Child Health
London

The progress of sexually abused children attending community-based treatment programmes run by selected voluntary agencies was evaluated on several different dimensions. By the end of the treatment programmes, improvement was apparent in the children's scores on the Children's Depression Inventory and self-esteem scores and in behaviour (CBCL) reports from parents. Young people over the age of 11 years reported for themselves improvements in the CBCL total problem and internalizing scores, but no improvement in the externalizing scores. The reasons why many therapists had difficulty providing all the necessary information were explored in interviews with senior managers and suggestions are made for improving the ways in which abused children's progress through treatment can be evaluated.
© 1997 by John Wiley & Sons, Ltd.

Child Abuse Review 6: 163–177, 1997.

No. of Figures: 2. No. of Tables: 3. No. of References: 26.

KEY WORDS: child sexual abuse; evaluation; outcome

Compared with estimates of cases of child sexual abuse in the UK (Creighton, 1992), it appears that the number of children being offered therapeutic help is still small (Sharland, Jones, Aldgate, Seal and Croucher, 1996). Most of the therapy is offered by specialist teams working in the NHS, Social Services departments or voluntary agency, community-based centres. The effects of these therapeutic services are seldom systematically evaluated. A few studies have established that, at least in the short term, the mood and behaviour of some (but not all) sexually abused children improves following treatment (Gomes-Schwartz, Cardarelli, Horowitz and Sauzier, 1990; Friedrich, Luecke, Beilke and

‘The effects of therapeutic services are seldom systematically evaluated’

*Correspondence to: Dr E. Monck, Behavioural Sciences Unit, Institute of Child Health, 30 Guilford Street, London WC1N 1EH, UK.

CCC 0952–9136/97/030163–15. $17.50. Accepted 23 December 1996
© 1997 by John Wiley & Sons, Ltd.

Place, 1992; Monck, Sharland, Bentovim, Goodall, Hyde and Lwin, 1995).

From 1991, the Department of Health allocated funds for the development or expansion of services for sexually abused children and teenagers to selected voluntary agencies working in the field of child protection. The Department also commissioned researchers based in the Institute of Child Health to monitor the progress made by those children who had been referred to specialist programmes run by these agencies. This paper discusses some of the results from this evaluation study.

Procedure and Measures

'Children and teenagers who entered the treatment programmes'

The sample consisted of the children and teenagers who entered the treatment programmes provided by the six voluntary agencies (see Appendix). The children were between ages 4 and 16 years at the time of referral and had been identified as sexually abused by the referring agency. Cases in which there was serious doubt about whether abuse had occurred were not included.

The geographical spread across the UK dictated the way in which the data on the children and their families could be collected. It was arranged that therapists (most of whom were social workers) would be responsible for getting consent from eligible families, and for recording demographic and abuse information and administering the self-report questionnaires to older children and primary carers. Teachers would be approached with parental permission. Information was to be obtained at the time of referral to the centre (time 1), at completion of treatment (time 2) and 12 months after therapy began (time 3). The research team (at the Institute of Child Health) collated and analysed this information.

Therapists provided information about the child's household, family and schooling, and a history of the abuse, the disclosure and subsequent interventions or therapies. Therapists were also asked to complete a section identifying the current needs of the children (see Figure 1). An open format was chosen after discussion with selected centre workers in preference to a behaviour checklist to allow for a style of recording assessment which was more familiar to most social workers. Therapists were asked to record all needs whether or not they were directly able to tackle the problem: thus 'being bullied' might be recorded although the solution lay in the hands of the school, not the social workers. The reports were

'Therapists were asked to record all needs'

© 1997 by John Wiley & Sons, Ltd.

Figure 1. The identification of needs by therapists.

Cluster	Components
Psychological needs	Depression, anger, fear, anxiety Develop hope, optimism Feel emotionally secure in own family Resolve ambivalent feelings about family members
Conduct problems	Learn to accept rules Reduce challenging behaviour Learn boundaries round behaviour Listen and take instruction
Needs in relation to peers	To be treated as normal by peers To develop normal relationships To develop trusting relationships
Physical/medical needs	Needs in relation to chronic illness/condition Bladder control problems Bowel control problems Paediatric referral needed
Needs in relation to abuse experience	To be able to talk about experience without fear of distress or anger in others Understand that is believed Stop denying aspects of abuse Clarify feelings about abuser
Post-traumatic symptoms	Nightmares, flashbacks, hyperarousal, etc. Others need to be sensitive to PTSD Reduce avoidance of talking about abuse
Needs of siblings	Need to feel more secure Need to be investigated for abuse Need to know effects of abuse on abused sib(s)
School/college needs	School performance problems Attendance problems Protection from bullying Reduction in own bullying behaviour Specific help of teachers
Feelings self-worth	Build self-confidence and self-esteem Build assertiveness and social skills Learn not to blame self for abuse and consequences of abuse Know that it was right to tell
Safety needs	To feel safe in own family and elsewhere Injunction needed against perpetrator Placement needs Parents need to protect victim from further abuse
Sexuality and sex education	Understand how abuse might affect future choices and attitudes Clarity about appropriate touching Learn/revive appropriate modesty Learn about sexual relationships between peers Sex education Learn age-appropriate sexual behaviour
Strengths of young person	Has supportive parents/family Has temperamental strengths Has support from community (school, teacher, religious body, etc.)
Parents' own needs	To cope with anger towards perpetrator Get help with own feelings: failure, guilt, hopelessness To deal with own experiences of abuse as child/adult Marital/sexual counselling Own mental health needs
Parenting needs	Avoid overcompensation to victim Cope with child's behaviour Trust other adults with child Parenting skills and competencies Provide positive role-model for victims/sibs Believe and support victim
Referral needs	Refer to child psychotherapy Refer to child psychologists or psychiatrists
Needs in relation to court procedure	Support and information about court procedure Visit to court

© 1997 by John Wiley & Sons, Ltd.

rated independently by the two researchers, who reached 95% agreement that needs were present or absent and 93% agreement on allocation to the 16 clusters (some of which referred to parents or young abusers).

Standardized self-report questionnaires were used to elicit the psychological status of the children and their primary carer at time 1, time 2 and time 3. These are summarized in Figure 2.

Figure 2. Questionnaires used in the study

Informants	Self-report (SR)	Questionnaire title
Abused children	SR	Children's Depression Inventory
Abused children	SR	Self-Esteem Inventory
Abused children	SR	Youth Self-Report (from age 12) (CBCL)
Abused children	SR	Fears Schedule
Parents	SR	General Health Questionnaire
Parents	SR	Beck Depression Inventory
Parents	SR	Self-Esteem Inventory
Parents or carers	On the child	Child Behavior Checklist (CBCL)
Teachers	On the child	Teachers' Report Form (CBCL)

'The children were asked to complete the Children's Depression Inventory, a self-esteem questionnaire and a short form of the Fears Schedule'

The Abused Children

The children were asked to complete the Children's Depression Inventory (CDI) (Kovacs and Beck, 1977), a self-esteem questionnaire adapted from Harter's (1982, 1985) Self-Perception Profiles for children and adolescents and a short form of the Fears Schedule for Children—Revised (Ollendick, 1993; Stevenson, Batten and Cherner, 1992). Children of 12 years or over also completed the Youth Self-Report version of the Child Behavior Checklist (CBCL) (Achenbach, 1991).

Parents and Other Primary Carers

Parents receiving therapy were asked to complete the Beck Depression Inventory (Beck, and Steer, 1987) and the 28-item General Health Questionnaire (Goldberg and Hillier, 1979) on their own current mood, and an adult self-esteem questionnaire based on work by Messer and Harter (1986). All primary carers were also asked to complete the Child Behavior Checklist (Achenbach and Edelbrock, 1983). This is the third-person version of the Youth Self-Report described above.

Teachers

Teachers completed the Teachers' Report Form (TRF) (Achenbach, 1991).

© 1997 by John Wiley & Sons, Ltd.

It should be noted that the length of time from discovery of the abuse to entering therapies varied (reportedly from 2 to 14 months). Uncovering the reasons for this was not part of the research plan nor, given the small numbers entering treatment, was it possible to control for this variation.

Results

At time 1, some information was available for 239 children and their carers, but complete for only 144 (60%). Among children aged over 8 years, only 12 failed to complete the self-report questionnaires, but 67 data schedules were missing from the centres. Checklists on the children's behaviour came from 163 mothers, but only 144 completed their own self-report questionnaires. At time 2, some data were to be had on 79 children, but again not the full range: data came from only 52 mothers and 66 therapists. Time 3 material was available for so few children that it is not presented here.

'Checklists on the children's behaviour came from 163 mothers'

The ratio of boys to girls among the 239 children was 1 : 3; family size was significantly larger than the national average (current sample mean 3.45; national mean family size 1.8 (OPCS, 1989)). Boys were significantly younger on average than the girls, largely because there were no teenage boys. A substantial number of children had lived in reconstituted families (69—41%) or with their own parents (61—36%) at the time of the abuse, but by referral nearly half (78—45%) were living with lone mothers; only 36 (21%) were in reconstituted families and only 31 (18%) were still with their own parents.

Aspects of the Abuse Experience

The very large majority of perpetrators were male (204 : 13, male : female) and more than one-third were fathers or father-surrogates; one-quarter were other relatives. Most of the 66 (40%) non-family perpetrators were neighbours or family friends well known to the children; only five were genuinely strangers. The ages of current perpetrators were recorded for 119 victims and ranged from 7 to 74 years; only 14 of these were within 5 years of the victim's own age: the mean difference in age was 23 years. It appears that, although many of the perpetrators were teenagers, the majority were targeting children considerably younger than themselves.

'The very large majority of perpetrators were male'

The perpetrators involved with the present cases came from a broad age range and all parts of the family or

© 1997 by John Wiley & Sons, Ltd.

neighbourhood and very few (27/172—16%) from among those with previous convictions for crimes of personal violence or child abuse. Apart from the predominance of males, no 'typical' abuser can be picked out from demographic information. This, together with the fact that only five perpetrators were strangers, underlines the point made by Smith (1994) that abusers are 'hidden' within the child's familiar environment.

'Only five perpetrators were strangers'

The treatment agencies gave information about the child's age at the onset of the abuse (and therefore the duration) in only 140 cases; for these the age ranged from 3 to 16 years with a mean of 8 years. For 138 children for whom the beginning and end of abuse was dated, duration ranged from less than 1 month to 14 years 9 months, but for about half these children duration was less than 12 months.

The sexual abuse experienced by the children appeared to include more severe abuse than has been reported in other community-treated samples (Research Team, 1990). Abuse was recorded under 16 headings and where information was available (163 children), therapists recorded 412 abuse events in total. The 16 'types' of abuse were condensed into three groups: penetrative, non-penetrative but contact, and non-contact. Among the 163 children, 11 (7%) had experienced only non-contact abuse, 54 (33%) contact but non-penetrative abuse and 98 (60%) penetrative abuse. The proportion of children reporting penetrative abuse increased with more 'types' of abuse, suggesting that demands had escalated over time. Two-thirds of the children (108) had experienced two 'types' of abuse, 70 (43%) three 'types', 40 (25%) four 'types', 31 (19%) five 'types' and 21 (13%) six 'types'. The closer the relationship with the abuser, the greater appeared to be the risk of penetrative abuse. For 161 children, evidence of the abuse experienced and the relationship with the perpetrator was available. Penetrative abuse had occurred with 64% of fathers (including surrogate fathers), 25% of other family members and 11% of non-family ($\chi^2 = 10.31$, 2 df, $p < 0.01$).

'The closer the relationship with the abuser, the greater appeared to be the risk of penetrative abuse'

Violence and threats of violence to achieve the child's compliance were experienced by 10% of non-contact abuse cases, 23% of contact non-penetrative cases and 51% of penetrative cases.

Disclosure and Discovery of the Abuse

Among the children for whom disclosure information was available, nearly half disclosed to parents (72/166), predominantly mothers (68/72). Most of the mothers were

'Nearly half disclosed to parents'

© 1997 by John Wiley & Sons, Ltd.

reported as having believed the child's story (138/161—86%), but 11 (7%) believed only in part and 12 mothers (8%) rejected it completely. Although the mothers' belief in their child's story was not associated either with higher self-esteem or lower depression scores reported by the abused children, this may have been an artifact arising from the very high proportion of believing mothers.

Behaviour and Symptoms of the Abused Children

The information on the children's behaviour and symptoms was collected at the time of the referral to therapy and therefore may bear little relationship to their behaviour and symptoms while the abuse was continuing. Many of the informants rated the children in the 'clinical' or 'borderline' range of CBCL scores (Table 1) (further details of the scores from the teachers, parents and the children can be found in Table 7, Monck and New, 1996). Mothers/carers were, in particular, most likely to rate the children in these two categories of more severe psychopathology. The possibility that mothers/carers were (accurately) recording worse symptoms in the younger children who did not complete the CBCL for themselves was found not to be the case. Neither teachers nor mothers/carers were more likely to report higher CBCL scores for the children under 11 years.

'Many of the informants rated the children in the 'clinical' or 'borderline' range'

Primary carers and teenagers tended to report more externalizing than internalizing behaviour, both in the scores overall and the more severe range of scores (Table l); the trend was the same but not so marked in teachers' observations.

However, when the relationship between the CBCL scores and the CDI (depressed mood) scores were compared, it was found that high CDI scores were significantly related to higher CBCL scores. Primary carers were significantly more

Table 1. Child Behavior Checklist scores within the clinical and borderline ranges: information from primary carers, teachers and abused children over 11 years

Informants	Clinical range	(%)	Borderline range	(%)
Primary carers				
Total problems	67/163	(41)	10/163	(6)
Internalizing	41/163	(25)	12/163	(7)
Externalizing	50/163	(31)	19/163	(12)
Teachers				
Total problems	17/91	(19)	11/91	(12)
Internalizing	13/91	(14)	10/91	(11)
Externalizing	14/91	(15)	3/91	(3)
Youth Self-Report				
Total problems	30/110	(27)	11/110	(10)
Internalizing	22/110	(13)	16/110	(15)
Externalizing	19/110	(17)	12/110	(11)

© 1997 by John Wiley & Sons, Ltd.

likely to report high internalizing, externalizing and total problem scores ($t = 4.68$, 2-tail $p < 0.001$; $t = 3.83$, 2-tail $p < 0.001$; and $t = 4.46$, 2-tail $p < 0.001$, respectively) when the children had given high CDI scores. The same was true of the teenagers who completed the Youth Self-Report version of the CBCL (internalizing problems: $t = 5.74$, 2-tail $p < 0.001$; externalizing problems: $t = 3.84$, 2-tail $p = 0.001$; and total problem score: $t = 5.77$, 2-tail $p < 0.001$). So it appeared that depressed mood was related not only to the internalizing symptoms but also to externalizing behaviour.

'The factors which are frequently used to describe severity of abuse were not significantly associated with higher CBCL scores'

The factors which are frequently used to describe severity of abuse (duration, age at onset, type of abuse, relationship with abuser) were not significantly associated with higher CBCL scores from any source. It is, of course, possible that differences in CBCL scores between those with differing abuse experiences might have shown up if the CBCL had been completed when the abuse had only just ceased.

Sexualized Behaviour

Sexualized behaviour has been identified as probably the only symptom which might be expected to differentiate the sexually abused from non-sexually abused children. However, almost no studies have noted even a majority of sexually abused children exhibiting this type of behaviour (Monck *et al.*, 1996; Kendall-Tackett, Williams and Finkelhor, 1993). This was also the case in the present study, but again it is important to remember that many of the present sample of children were several months away from their abuse experiences. In the present study, out of 172 replies, 15 children (9%) were reported as involved in 'sexually abusing other children', but 79 (46%) were reported as showing no such behaviour; among the remaining 43 children, at least one 'type' of sexualized behaviour was reported.

The Therapists' Identification of the Children's Needs at Entry into Therapy

'Total needs scores were not related to the type of abuse experienced'

This information was potentially available only for the 172 children for whom therapists had completed the full data schedule. Table 2 gives the proportions of abused children who were reported as showing needs in each cluster. Total needs scores were derived from summing the individual scores (present: 1 & absent: 0). At referral these scores ranged from 0 (seven children) to 11 (mean 5.3). Total needs scores were not related to the type of abuse experienced (penetrative

© 1997 by John Wiley & Sons, Ltd.

Table 2. Percentage of abused children reported by centre workers as showing problems at referral

Problem area	Percentage of children with some identified needs
Sex education needs	66%
Self-image problems	65%
Psychological problems	59%
Problems of personal safety	48%
School problems	37%
Problems arising from abuse experience	35%
Conduct problems	32%
Post-traumatic stress symptoms	33%
Problems with peers	22%
Physical ill-health/disabilities	17%
Need for referral to other professionals	4%

or not penetrative), nor to the child's relationship with the abuser (parent or not).

Outcomes of the Children's Treatment

As we have already noted, the number of children for whom information was available at the end of treatment was smaller than the number for whom information was available at referral. Among the 52 children for whom the information was available, the number of planned therapeutic sessions varied from six to 35 (mean 12.6) and 90% were reported as having attended an average of 11.3 sessions. Only one of these children is known to have suffered further (touching) abuse and this on only one occasion.

Self-report questionnaires

Comparison of the self-report Fears Schedule scores at referral and the end of treatment for 42 children (aged 8+) showed no significant differences. By comparison, scores on the Children's Depression Inventory (CDI) and the Self-Esteem Inventory showed that significant improvement had taken place since referral. CDI scores were improved for 30 children and worse for nine (the rest remained the same) ($Z = -3.69$, 2-tailed $p < 0.0002$). Self-esteem scores improved for 27 children and worsened for 13 (the rest remained the same) ($Z = 2.34$; 2-tailed $p < 0.02$). Numbers are small and significance tests should be treated with caution.

'Scores on CDI and the Self-Esteem Inventory showed that significant improvement had taken place since referral'

Therapists' identification of needs

The relatively small numbers of children with several identified needs at referral meant that the opportunity for improvement on these measures was limited. If there had been no

© 1997 by John Wiley & Sons, Ltd.

'needs' at time 1, clearly the child could not 'improve'. The majority of the 66 children for whom there were therapists' comments on needs at time 1 and time 2 appeared to have identical levels of overall needs, but this was almost certainly an artifact arising from the fact that no comment had been made at either time. The two areas of need which showed some change for the better (the need for sex education and self-image problems) were the two measures on which more than half the children had been reported as showing needs at time 1.

'The "strengths" recorded by therapists had significantly increased'

Interestingly, the 'strengths' recorded by therapists had significantly increased: 23 children showed more 'strengths', four showed fewer 'strengths' and the rest were the same as at referral. It might be unwise to interpret this finding as indicating an improvement in personal attributes or family and community support, as the improved scores could have arisen from the increased knowledge the therapists derived from working with the family. However, therapists clearly identified improvement: for example, 'T has gained considerably from assertiveness training within the group, and is now able to get more and higher quality attention and care from her mother'. Another girl was described as having built up a positive relationship with her class teacher after bullying issues had been addressed during the treatment period.

Child Behavior Checklist

'Parents and young people reported improvement after treatment, teachers did not'

CBCL questionnaires were completed by 55 mothers, 36 young people and 16 teachers at both time 1 and time 2; comparisons are therefore only possible for this limited population. Table 3 shows that parents and young people reported improvement after treatment (except on externalizing scores); teachers did not, but this may be due to the very small number of teacher responses. It is important to state that many teachers were apparently not approached after treatment ended; the low number of responses in part reflects this point, but apparently many teachers did fail to complete the CBCL.

Young people reporting higher CDI scores at time 1 reported higher total problem, internalizing and externalizing scores at time 2 (t-test, $t = 2.73$, 2-tail p 0.01; $t = 2.80$, 2-tail p 0.009; $t = 2.19$, 2-tail p 0.036, respectively).

Predicting Longer-Term Outcomes

Therapists were asked to make long-term predictions of outcome. Researchers rated the comments into three categories:

© 1997 by John Wiley & Sons, Ltd.

Table 3. Parents', teachers' and Youth Self-Report on the Child Behavior Checklist: change over treatment period

	(*N*)	*Z*	2-tailed *p* (significance)
Primary carers			
Total problems	(55)	4.24	<0.001
Internalizing	(55)	2.47	<0.02
Externalizing	(55)	3.17	<0.002
Teachers			
Total problems	(16)	0.44	NS
Internalizing	(16)	1.09	NS
Externalizing	(16)	1.38	NS
Youth Self-Report			
Total problems	(36)	2.83	<0.005
Internalizing	(36)	3.25	<0.002
Externalizing	(36)	0.71	NS

'good', 'fair' and 'poor' (agreement between researchers was acceptably high at 86%). The majority of the comments (available for 59 children only) were pessimistic (37—63%), but for (12) 20% the outlook was 'fair' and for 16 (27%) the outlook was 'good'. Reasons for an optimistic outlook included strong relationships between non-abusing mothers and children, and marked personal strengths of the abused children themselves.

'The majority of the comments were pessimistic'

There was no relationship between the predicted outcome and either self-reported depressive mood (CDI) or self-esteem at referral, age or gender, or abuse variables measuring severity. There was also no relationship (with one exception) with any of the time 2 behaviour or mood scores. The exception was the time 2 measure of identified needs: worse predictions were associated with higher total needs score. However, this association is highly tautologous: when therapists rated more problems for the child and her family, they were also pessimistic about the long-term outcome.

'When therapists rated more problems for the child and her family, they were also pessimistic about the long-term outcome'

Discussion

The aim of this study was to monitor the progress made by sexually victimized children from the time they entered to the time they left specialist therapeutic programmes. The effect of running a naturalistic, rather than research-driven study was the length of time between discovery of abuse and the start of therapies, and the varying length and content of the programmes. But it may reasonably be proposed that each programme optimally met the needs of the children who followed it. In such circumstances, the variation in therapies may be less important than the suitability for each child.

© 1997 by John Wiley & Sons, Ltd.

'There were some hopeful signs of improvement'

There were some hopeful signs of improvement in the children's CDI and self-esteem scores and in behaviour (CBCL) reports from parents. Young people over the age of 11 years reported for themselves improved scores in the CBCL total problem and internalizing scores, but no improvement in the externalizing scores.

These results are in line with the few published treatment outcome studies. For many treated sexually abused children, their 'mood' (depression and self-esteem measures are commonly used) improves; for some children, however, it is regularly observed that neither self-reported measures nor behaviour measures completed by others show improvement (Monck *et al.*, 1996; Kendall-Tackett *et al.*, 1993). In the present study, improvement on the chosen measures was not clearly associated with particular personal characteristics of the children nor with particular abuse experiences. However, it is likely that the failure to follow up all the children will have biased the results in ways that are not identifiable.

'The study produced smaller numbers than had been expected of children followed through to the end of treatment'

Finkelhor and Berliner (1995) have reviewed available outcome studies and concluded that most still suffered from the disadvantages of small numbers and varying measures of the children's psychopathology. The current study produced smaller numbers than had been expected of children followed through to the end of treatment, and because of the implications for other outcome studies, the reasons for this were explored in interviews with senior managers. It is important to emphasize again (Monck and New, 1996) that the following points should not be read as criticism of individual workers but as issues to be addressed.

Part of the reason for the lack of success in obtaining information at the end of treatment probably lies in the study design. The geographically scattered treatment centres meant that therapists rather than the researchers collected the data and this task presented difficulties for many therapists, partly due to unfamiliarity in using the research instruments and partly to pressures of time. However, these were not the only reasons for the quite widespread failure to get time 2 data, and it appeared that there might be barriers to be overcome before staff in community-based treatment centres accepted that data should systematically be collected on the progress of all sexually abused children. Four main reasons emerged from discussion with managers.

First, some therapists thought that evaluating children's progress would lead to evaluation of staff (noted by Wiffen, 1994). Second, some therapists described the processes of evaluation (like administering self-report questionnaires) as further abusing the abused child. Third, some therapists

© 1997 by John Wiley & Sons, Ltd.

believed that it was no part of their *therapeutic* responsibility to fill in data-gathering forms. Finally, the evaluation exercise was often seen as imposed from outside. All these issues need attention from management and in training.

Others have noted similar difficulties: for example, Wiffen (1994) found that social workers tended to be 'defensive and uncertain about what evaluation is for'. Evaluation which seeks to ensure that the best treatment is available has been described as the client's right (Wiffen, 1994; Newman, 1994). There was plenty of evidence of success in the present study. But it is increasingly important to be able to show that the children who attend therapies are in need of help, and are the most in need of help (two different points). One of the messages to emerge from this piece of work is the necessity for therapists in these community-based services to receive positive support in the development of evaluation as an integral part of their own work. In the present study, it may well be that support from the research team was not well targeted, or was too intermittent (arising from the geographical scatter). There was, however, some sense in which the researchers and the social workers appeared to be speaking different languages when evaluation was discussed. But as it becomes increasingly hard to fund large-scale social research, and increasingly urgent to establish the efficacy of existing therapies, research is more likely to be based on the sort of close collaboration which was sought in the present study.

'The evaluation exercise was often seen as imposed from outside'

'The researchers and the social workers appeared to be speaking different languages when evaluation was discussed'

Acknowledgements

The study was funded by the Department of Health and undertaken in collaboration with Dr Michelle New.

References

Achenbach, T.M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 Profile*. University of Vermont, Burlington, VT.

Beck, A.T. and Steer, R.A. (1987). *Beck Depression Inventory Manual*. Psychological Corporation, Harcourt Brace Jovanovich, New York.

Creighton, S. (1992). *Child Abuse Trends in England and Wales 1988–1990*. National Society for the Prevention of Cruelty to Children, London.

Friedrich, W.N., Luecke, W.J., Beilke, R.L. and Place, V. (1992). Psychotherapy outcome of sexually abused boys. *Journal of Interpersonal Violence*, **7**(3), 396–409.

Goldberg, D. and Hillier, F. (1979). A scaled version of the General Health Questionnaire. *Psychological Medicine*, **9**, 139–145.

© 1997 by John Wiley & Sons, Ltd.

Gomes-Schwartz, B, Cardarelli, M. and Horowitz, A.P. with Sauzier, M. (1990). The aftermath of child sexual abuse: 18 months later. In B. Gomes-Schwartz, M. Horowitz and A.P. Cardarelli (Eds), *Child Sexual Abuse: The Initial Effects* Newbury Park, CA: Sage.

Harter, S. (1985). *The Self-Perception Profile for Children*. University of Denver, Denver, CO.

Harter, S. (1987). *The Self-Perception Profile for Adolescents*. University of Denver, Denver, CO.

Harter, S. and Pike, R. (1982). The pictorial scale of perceived competence and social acceptance for young children. *Child Development*, **55**, 1969–1982.

Huxley, P. (1994). Outcome measurement in work with children: comparing plans in the UK with experience in the US. *Child Abuse Review*, **3**, 120–133.

Kendall-Tackett, K.A., Williams, L.M. and Finkelhor, D. (1993). Impact of sexual abuse on children: a review and synthesis of recent empirical studies. *Psychological Bulletin*, **113**, 164–180.

Kovacs, M. and Beck, A.T. (1977). An empirical approach towards a definition of childhood depression. In J.G. Schulterbrandt and A. Raskin (Eds), *Depression in Children: Diagnosis, Treatment and Conceptual Models*. New York: Raven.

Messer, B. and Harter, S. (1986). *The Adult Self-Perception Profile*. University of Denver, Denver, CO.

Monck, E. and New, M. (1996). *Report of a Study of Sexually Abused Children and Adolescents and of Young Perpetrators of Sexual Abuse Who Were Treated in Voluntary Agency Community Facilities: Monitoring the Progress of Abused and Abusive Children*. HMSO, London.

Monck, E., Sharland, E., Bentovim, A., Goodall, G., Hyde, C. and Lwin, R. (1996). *Sexually Abused Children: A Descriptive and Treatment Outcome Study*. HMSO, London.

Newman, T. (1994). Quoted in *Community Care*, **1008**, 14.

Ollendick, T.H. (1993). Reliability and validity of the Fears Schedule for Children—Revised (FSSC-R). *Behaviour Research and Therapy*, **21**, 685–692.

OPCS (1989). *General Household Survey*. HMSO, London, p. 10.

Research Team (1990). *Child Sexual Abuse in Northern Ireland*. Greystone, Antrim.

Rutter, M. (1967). A children's behaviour checklist for completion by teachers: preliminary findings. *Journal of Child Psychology and Psychiatry*, **81**, 1–11.

Sharland, E., Jones, D., Aldgate, J., Seal, H. and Croucher, M. (1996). *Professional Intervention in Child Sexual Abuse*. HMSO, London.

Smith, G. (1994). Parent, partner, protector: conflicting role demands for mothers of sexually abused children. In T. Morrison, M. Erooga and R.C. Beckett (Eds), *Sexual Offending Against Children* London: Routledge.

Smith, M. and Bentovim, A. (1994). Sexual abuse. In M. Rutter, E. Taylor and L. Hersov (Eds), *Child & Adolescent Psychiatry: Modern Approaches*. London: Routledge.

Smith, M. and Jenkins, J. (1991). The effects of marital disharmony on prepubertal children. *Journal of Abnormal Child Psychology*, **19**, 625–639.

© 1997 by John Wiley & Sons, Ltd.

Stevenson, J., Batten, N. and Cherner, M. (1992). Fears and fearfulness in children and adolescents: a genetic study of twins data. *Journal of Child Psychology & Psychiatry*, **33**(6), 977–985.
Wiffen, J. (1994). Quoted in *Community Care*, **1008**, 14.

Appendix

Voluntary agencies providing the treatment programmes

National Society for the Prevention of Cruelty to Children (NSPCC)
Action for Children: National Children Homes
Family Service Units
Northorpe Hall Trust
St Christopher's Fellowship

© 1997 by John Wiley & Sons, Ltd.