

How are children and young people affected by sexual harm?

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Facts & Figures

- It is estimated that 1 in 20 children in the UK are sexually abused (NSPCC & OCC 2016)
- 1 in 3 children abused by an adult do not disclose
- Disabled children are 3 times more likely to be abused than non disabled children
- 13% of contacts to the NSPCC’s helpline last year were concerns about sexual abuse



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Facts & Figures

- Over 2/3 of sexually abused children reported to the police were abused by someone they knew (Children’s Commissioner for England, 2015). Prevalence surveys are higher (70%)
- Over 43,000 sexual offences against children were recorded in the UK last year (ONS)
- Childhood sexual trauma can result in predisposition to further abuse and PTSD in adulthood
- Earlier it starts the longer it continues average duration 7 years (FOS 2015)



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Facts & Figures II

- 2% to 9% will have an STI
- Pregnancy is reported in up to 2% of children seen for a medical examination following CSA
- Risk assessments for self harm and suicide frequently elicit mental health needs (36% of 16 year olds)
- Up to 47% of children have unmet general health needs unrelated to sexual abuse
- Children value the feedback provided and reassurance given after a medical examination



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Trends in agency data – not prevalence but how many recorded

Police forces publish data on offences

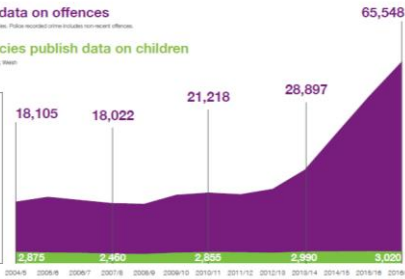
Source: Police recorded crime and clearance rates tables. Police recorded crime excludes non-recent offences

Child protection agencies publish data on children

Source: Department for Education, Child Protection Statistics, 2016
Children Reporting Care and Support Orders

What do we not know?

- Why are the numbers of children on child protection plans for CSA stable but police recorded crime is significantly increasing?
- Non-recent cases accounted for 27% of all sexual offences recorded by the police in 2016/17 – but how much of the CSA recorded was non-recent?
- How many CSA victims report to the police?
- How much actual CSE is being dealt with by agencies?



https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/391414/Police-recorded-crime-and-clearance-rates-tables-2016-17.pdf

Medical examinations

- No expiration date
- The Bridge (recent cases within 7 days)
- The STAR clinic
- <https://youtu.be/gOWX1xxnTWg>



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What is Trauma

A traumatic event involves a single experience, or enduring repeated or multiple experiences that completely overwhelm the individual's ability to cope or integrate the ideas and emotions involved in that experience.



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Type 1 Trauma

- Relatively short duration, that often involves fear of An unexpected, isolated traumatic event of dying during the event itself.
- Feelings are largely Fear Based



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Type 2 Trauma

- Is more longstanding in nature and often involves a series of expected, repeated traumas, such as ongoing sexual or physical abuse or torture, that result in a negatively altered schematic view of oneself, others and the world
- Complex feelings, may include shame and guilt



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Trauma is subjective

Everyone reacts to trauma differently. What is traumatic for one person may not be for another.

In children and young people their reaction is likely to depend on:

- The nature of the abuse
- Whether the abuse is chronic
- The relationship between child and perpetrator
- The nature of the child's previous relationships
- **The support within the family and the wider support networks**
- Subsequent changes in living situation
- The child's inherent resilience



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Adverse Childhood Experiences

- Domestic violence
- Parental abandonment through separation or divorce
- A parent with a mental health condition
- Being the victim of abuse (physical, sexual and/or emotional)
- Being the victim of neglect (physical and emotional)
- A member of the household being in prison
- Growing up in a household in which there are adults experiencing alcohol and drug use problems



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Trauma Responses

Fear	Anxiety	Guilt	Confusion	Feeling overwhelmed
Anger	Intrusive images	Sadness	Insecurity	Sleep problems
Uncertainty	Disgust	Frustration	Disbelief	Irritability



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PTSD

Sexual Trauma is more likely to lead to PTSD in the adult population than any other type of trauma (23-25%)

It is also the most common effect of sexual abuse in children and young people and the symptoms can extend far into adulthood.



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Manifestation of PTSD symptoms in Children & Young People

Distress at exposure to reminders of abuse	Re-enactment of the trauma through play	Feeling that the trauma is happening again	Recurrent memories	Nightmares
Specific fears	Persistent recounting of the traumatic event	Diminished interest in activities	Avoidance of reminders of the trauma	Problems with concentration
Relationship difficulties	Numbness	Poor self esteem	Flashbacks	Low mood



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Working with children and families who have experienced sexual abuse

The impacts of an experience of CSA in the family environment are complex and far reaching. There is no easy solution. Responding to these impacts requires a proactive welfare response that can span many different agencies (including health, social care and the third sector) and that prioritises consistency of support and the potential for long-term engagement and considers the needs of wider family and carers alongside those of the child.



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Working with children and families who have experienced sexual abuse

Professional responses to children and young people's experiences of CSA within the family environment can be experienced as both helpful and supportive (reducing the difficulties a child has to manage) and as subjecting children to further challenges, disruption and distress. Both these dynamics may occur simultaneously and this will increase the challenges of working with this group.

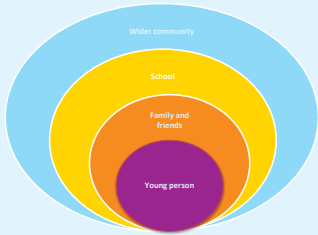


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Ripple effect



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What can we do as professionals and parents?

- Make sure the abuse or other trauma has stopped
- Continue to build a relationship, by being honest, reliable and doing what you say you will do
- Have a reasonable understanding of trauma
- Help them feel safe through nurture, structure and support
- Use boundaries and logical consequences
- Stay calm and well-regulated – even as you set limits on aggression – to avoid power battles



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Helpful Strategies

- Try to encourage a broad range of friendships in & out of school/nursery
- Keep an eye out for bullying or unhelpful relationships
- Talk openly about what makes a healthy or unhealthy relationship in an age appropriate way
- Encourage activities that were previously enjoyed – or new ones



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Helpful Strategies

- Be really clear and consistent on boundaries and communicate the reason why
- Model taking time to relax through activities and friendships, and seeking help if you need it
- Be available. It's ok to talk about it, but don't force a discussion
- Speak to family and friends so they can take a similar approach



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Common reactions to disclosure

shock	denial	anger
guilt	fear	distress



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Secondary trauma

Following the sexual assault of a child, family and friends often experience considerable emotional distress and physical and psychological symptoms that can disrupt their lifestyles and family structures. Parents may feel violated and different, have a sense of isolation and estrangement from others, and struggle with difficult feelings such as guilt or shame.



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“I should have known...”

- Sexual assault can happen to **anyone’s child** – however caring, protective, or well-informed parents are
- There are often no warning signs for parents – in fact, quite the opposite
- Perpetrators are extremely skilled manipulators ... of children, parents, professionals, organisations
- Yet parents are often consumed with guilt that they ‘should have noticed’
- How might this impact on trusting friends, family and professionals to support the child?



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Impact of Working with Trauma

Listening to reports of trauma, horror, human cruelty and loss can be **overwhelming** (Herman, 1992).

Helpers may feel **positive effects** associated with their ability to help and support but they may also feel **negative, secondary effects**.

Those who hear traumatic stories may experience **feelings of pain, suffering and fear similar to those of the people involved** in the event.

These effects are known as **compassion fatigue, secondary trauma or vicarious trauma**.



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Phases of Burn Out

Phases	Behaviours
Compulsion to prove oneself	Excessive ambition, determination and compulsion
Working harder	Take on too much, obsessed with doing everything yourself, see yourself as being irreplaceable
Neglecting needs	No time or energy for anything other than work, no time to eat, sleep, friends, family...
Displacement of conflicts	Somatization of stress
Revision of values	Isolate yourself, avoid conflict, denial of basic physical needs, changed perceptions of self, others and the world. Work consumes all energy you have left. Emotional blunting, only energy is your job
Denial of emerging problems	Intolerant, more aggressive, sarcastic, blame time pressures, refuses social contact
Withdrawal	Reduced social and professional contact, obsessive working by the book, use of alcohol, drugs to release, hopeless and lack of direction
Obvious behavioural changes	
Depersonalisation	No longer see yourself as valuable, lose track of personal needs, life view, mechanical functioning
Inner emptiness	To compensate eat, drink, drugs, sex...
Depression	Exhausted, hopeless, indifferent, no future, no meaning to life
Burnout syndrome	Physical and emotional collapse



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Minimising Secondary Traumatic Stress

- Seek professional and personal support
- Participate in debriefing sessions and share concerns
- Seek supervision, consultation, mentoring or counselling
- Recognise and acknowledge limitations
- Set limits and boundaries
- Take regular breaks
- Ensure connection to others
- Balance work with other activities
- Rest, diet, exercise
- Engage in regular physical activity
- Relaxation



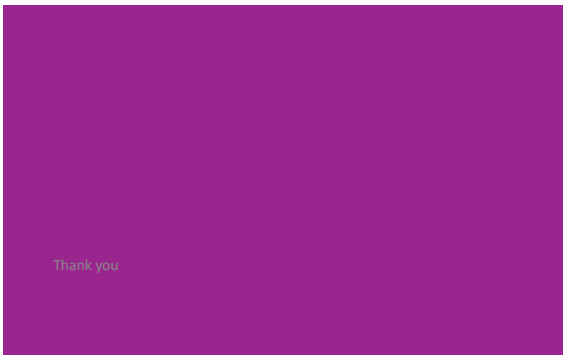
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Thank you



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