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A meta-analysis of the effects of psychotherapy with sexually abused children and adolescents

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ABSTRACT

This paper presents a meta-analysis of the psychotherapy treatment outcome studies for sexually abused children and adolescents. There were 39 studies included, most of which aimed to treat the psychological effects of childhood sexual abuse. Separate meta-analyses were conducted according to study design and outcome domain, in keeping with meta-analytic conventions. However, given heterogeneity across studies and the need for sufficient *n* in each category for meaningful moderator analyses, the study designs were pooled into a repeated measures meta-analysis. There were large effect sizes for global outcomes ($g = 1.37$) and PTSD/trauma outcomes ($g = 1.12$). More moderate effect sizes were evident for internalizing symptoms ($g = 0.74$), self-appraisal ($g = 0.63$), externalizing symptoms ($g = 0.52$), and sexualized behavior ($g = 0.49$), while small effects were found for measures of coping/functioning ($g = 0.44$), caregiver outcomes ($g = 0.43$), and social skills/competence ($g = 0.38$). Effects were maintained at follow-up more than six months after treatment for some outcome domains but not others. Studies represented diverse treatment approaches, and most treatments were effective in symptom reduction. Presence of probable moderators of treatment outcome varied across symptom domains, reflecting importance of targeting therapy to individual needs.

Contents

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1. Introduction

A substantial body of literature has documented the negative psychological impact of sexual abuse on children and young people. Post-traumatic stress disorder (PTSD), sexualized behavior, and internalizing and externalizing behaviors have been identified as relatively common psychological problems following sexual abuse (Kendall-Tackett, Williams, & Finkelhor, 1993; Putnam, 2003), and evidence suggests that negative outcomes can extend into adulthood (Neumann, Houskamp, Pollock & Briere, 1996). Furthermore, approximately 55% of children referred for treatment following sexual abuse experience comorbid psychological difficulties (Target & Fonagy, 1996).

In their seminal review of research on the treatment of sexually abused children, Finkelhor and Berliner (1995) found therapy to facilitate recovery, independent of the effects of time or factors external to therapy. They also called for large-scale randomized studies to clearly establish treatment efficacy and answer the perennial question of what works for whom, under what conditions. Since then, several studies have demonstrated the efficacy of trauma-specific cognitive–behavioral therapy in treating a variety of symptoms in sexually abused children as well as addressing the impact on non-offending caregivers (e.g., Celano, Hazzard, Webb & McCall, 1996; Cohen & Mannarino, 1996, 1998a; Cohen, Mannarino & Knudsen, 2005; Deblinger, Lippmann & Steer, 1996; Deblinger, Steer & Lippmann, 1999; for an overview, see Cohen & Mannarino, 2008).

Cognitive–behavioral treatment (CBT) with sexually abused children has also recently been subject to rigorous Cochrane Collaboration review (Macdonald, Higgins, & Ramchandani, 2006). Researchers have argued that this review provides evidence that the type of treatment matters (Berliner, 2005), although others have cautioned that not all sexually abused children respond equally to CBT, and that research is needed to identify the factors that mediate treatment outcome (King, Tonge, Mullen, Myerson, Heyne, & Ollendick, 1999) and provide the best symptom constellation-therapy match (Avinger & Jones, 2007; Lev-Wiesel, 2008). For example, some studies have found CBT to provide no advantage over a control group in reducing PTSD symptoms (Celano et al., 1996), or to not be the best approach for children with significant disruptive behavior problems (Berliner, 2005). Others have reported sexualized behaviors to be more responsive to behavioral therapy approaches than other models, such as play therapy (Cohen & Mannarino, 1996). Over the last decade or so, studies have shown that involving non-offending caregivers in therapy is associated with positive outcomes (Cohen & Mannarino, 1997, 1998a; Deblinger et al., 1996). Longer periods of treatment may be required for some sexually abused children given the nature of their abuse (Cohen et al., 2005; Lanktree & Briere, 1995), and other factors such as the gender, age, and developmental stage of the child may also have implications for treatment design. Therefore, there is increasing evidence that a number of factors might mediate or moderate treatment outcome, and that therapy approaches may be more effective when tailored to the individual needs of the child or young person.

In addition to narrative reviews of the treatment outcome literature, meta-analytic approaches have also been used in an attempt to be more systematic in summarizing the studies on treatment outcome for sexually abused children. To date, six such meta-analyses have been published, although all have limitations in assessing the outcome of these interventions. Two meta-analyses have examined treatment for child abuse or maltreatment generally, rather than sexual abuse specifically, and one of these only includes two studies of sexual abuse (Edgeworth & Carr, 2000). Skowron and Reinemann (2005) meta-analysed 21 independent samples studies of child maltreatment interventions. The overall effect size for the seven sexual abuse studies was $d = 0.69$ ($SE = 0.09$, range 0.15–1.54), significantly larger than that for the general maltreatment studies, $d = 0.40$ ($SE = 0.12$, range −0.18–0.97). Group effects were heterogeneous for the sexual abuse treatments. Unfortunately, the investigation of possible reasons for this variability was conducted across all 21 studies instead of separately for sexual abuse. Furthermore, the meta-analysis was limited in that it excluded studies using repeated measures designs and did not examine effect sizes at follow-up.

Three other meta-analyses have examined specific types of treatment with sexually abused children, including group treatment (Reeker, Ensing, & Elliott, 1997), cognitive–behavioral intervention (MacDonald et al., 2006), and therapies involving non-offending caregivers (Corcoran & Pillai, 2008). A large effect has been reported for group treatments ($d = 0.79$), which has ranged from 0.56 for externalizing symptoms to 0.99 for outcomes relating to sexual abuse prevention and knowledge (Reeker et al., 1997). Similar effect sizes have been reported by Corcoran and Pillai (2008) for treatments that include non-offending caregivers, although their meta-analysis is limited in its usefulness because it presented effect sizes separately for each study. A Cochrane Collaboration review of cognitive–behavioral interventions is similarly limited in reporting effects as changes in average score or standard deviation on the same outcome measure (Macdonald et al., 2006).

While these three meta-analyses have used more rigorous methodology (i.e., correcting for sample size and separating results according to outcome measures and study design), their utility is limited by a number of factors. Firstly, the studies are restricted to outcomes for specific types of treatment. Secondly, there is minimal consideration of the long-term effects of interventions. Only Corcoran and Pillai (2008) investigated post-treatment effects, and found that the small beneficial effect of parent-involved approaches diminished at follow-up. Finally, and perhaps most importantly, there has been minimal consideration of the factors that might account for the variability in treatment outcome for sexual abuse. No differences in the