Cover sheet

Title

Cognitive-behavioural interventions for sexually abused children

Reviewers

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Dates

Date edited:	26/05/2004
Date of last substantive update:	31/08/1999
Date of last minor update:	27/10/1999
Date next stage expected:	30/08/2004
Protocol first published:	Issue 1, 2000
Review first published:	

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Internal sources of support

None

External sources of support

None

Contribution of reviewers

Geraldine Macdonald, Paul Ramchandani and Julian Higgins each contributed to all drafts of the protocol.

Acknowledgements

Potential conflict of interest

None known.

Background

Definition

Methodological problems, including problems of definition, mean that estimates of the incidence and prevalence of child sexual abuse vary considerably. Unlike the majority of health problems, child sexual abuse typically refers to an event or series of events, and like other forms child abuse definitions vary accordingly amongst professionals and the public and between the public and professionals. One commonly used definition is that by Schechter and Roberge (Schechter 1976) "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, and to which they are unable to give informed consent, and that violate the social taboos of family roles". Despite differences in perceptions of what constitutes child sexual abuse there is a general consensus amongst clinicians and researchers that this is a substantial social problem which affects large numbers of children, of both sexes, of all ages, and across culture and social class (Prentky 1996, Finkelhor 1994).

Sequelae of sexual abuse

The consequences of sexual abuse on the social and emotional wellbeing of children and on their development are increasingly well documented, although there is a need for methodologically more appropriate and more robust studies in this field. To date, cross-sectional studies have pointed to a number of factors which appear to influence the extent and severity of the effects of sexual abuse, such as age of child, frequency and duration of abuse, severity of abuse (including penetration), relationship of child to perpetrator (see Friedrich 1986) . A growing number of longitudinal studies shed some light on the likely developmental trajectory of problems over time and on those factors which limit adverse consequences and/or aid recovery (Oates 1994, Tebutt et al 1997). The effects of child sexual abuse manifest themselves in a wide range of symptoms which typically cluster around different developmental age bands. For example, pre-school children are more likely to experience anxiety, nightmares, general post-traumatic stress disorder, internalising, externalising and inappropriate sexual behaviours (see Kendall-Tackett 1993; Trickett 1997). Fear, aggression, nightmares, school problems, hyperactivity and regressive behaviour are more typical of school age children. Adolescents are more likely to suffer from depression, withdrawal, suicidal or self-injurious behaviour, substance misuse or offending.

Impact on adult functioning and use of services

Not all victims of sexual abuse have consequent psychological problems throughout their life. However there is an association between having suffered such a trauma in childhood and experiencing higher rates of a wide range of problems in psychological and social functioning in adult life. Many of these difficulties are similar to those reported by children who have been more recently abused, including: depression, anxiety, phobias (Briere & Runtz 1988), low self-esteem, sexual dysfunction and relationship and parenting difficulties (Green 1993). Although often based on retrospective studies and so subject to biases, these findings appear consistent enough across studies to warrant acceptance of long-reaching adverse effects of childhood sexual abuse.

There are two other sequelae which are particularly associated with sexual abuse, as opposed to other forms of abuse in childhood. First is the sexualising effect of sexual abuse. Young women have been reported to engage in high risk sexual behaviour (Farmer and Pollock [Farmer 1998]), and experience higher rates of sexual revictimisation (Miller 1978). Second is the small but important minority of abuse victims who go on to sexually abuse others. Factors associated with becoming a subsequent abuser are still far from clear, but early studies suggest that being brought up witnessing or experiencing intra-familial violence may combine with the experience of sexual

abuse to increase the risk of a young man subsequently abusing others (Skuse 1998). Longer-term prospective studies testing and examining these consequences are awaited.

Successful intervention may not only reduce the psychological and social impact of sexual abuse for a victim and their family, but also modify the impact on future generations, through improved functioning as a parent, or by reducing the number of potential abusers for future generations.

Cognitive-behavioural approaches
Cognitive-behavioural approaches derive philosophically, theoretically and empirically from four theories of learning: respondent conditioning (associative learning e.g. of sexual arousal and trauma), operant conditioning (the effect of the environment on patterns of behaviour, particularly reinforcement and punishment), observational learning (learning by imitation) and cognitive learning (the impact of thought patterns on feelings and behaviour). They combine to provide an integrated approach to assessment and intervention which pays careful attention to the developmental and social contexts in which learning occurs. In the treatment of children who have been sexually abused, cognitive-behavioural approaches focus particularly on the meaning of events for children and non-offending parents, endeavouring to identify and address maladaptive cognitions (e.g. being permanently 'soiled'), misattributions (e.g. feelings of blame and responsibility), and low self-esteem. In addition, interventions drawn from respondent, operant and observational learning paradigms are used to address more overtly behavioural problems such as externalising behaviours (aggression or 'acting out'), internalising behaviours (anxiety, self-blame or deprecation) or sexualised behaviour, usually through mediation by the non-offending parent.

Cognitive-behavioural approaches also have a promising record of experimental evidence of effectiveness in dealing with a wide range of emotional and behavioural problems, many of which feature in the symptomatology of children who have been sexually abused, e.g. anxiety (Kendall 1994), internalising and externalising behaviour (Harrington 1998; Kazdin 1989) and post-traumatic stress symptoms (Deblinger et al 1996). Conceptually they provide a broad, evidence-based framework for assessing the effects of sexual abuse on personal, inter-personal and familial relations, and planning interventions tailored to individual circumstances. As a focussed, time-limited form of intervention it may also be a cost-effective way of helping a larger number of children than currently receive help.

Previous reviews within the field (Finkelhor 1995; Stevenson 1999) also suggest that cognitive behavioural interventions, as part of a broader psychosocial intervention, may be an effective form of treatment for sexually abused children. However, these reviews have included studies of a wide range of methodological type, and have not selected studies on the basis of methodological rigour, and have included a range of therapeutic interventions.

Objectives

The aim of this review is to assess the effectiveness of cognitive-behavioural approaches in treating the immediate and longer-term sequelae of child sexual abuse.

Criteria for considering studies for this review

Types of studies

Studies are eligible for the review if the allocation of study participants to experimental or control

groups was by random allocation or quasi-random allocation i.e. by day of week, case number or alphabetical order.

Studies comparing one type of intervention with another with or without placebo control, and studies comparing one intervention versus control will be included.

There are no language restrictions.

Types of participants

Children and adolescents up to age 18 years with recent experience of sexual abuse (viz. within the 12 months prior to participation in the study) defined as "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, and to which they are unable to give informed consent, and that violate the social taboos of family roles" (Schechter 1976).

Types of interventions

Interventions which are described by the authors as behavioural or cognitive-behavioural or which describe the use of cognitive-behavioural interventions.

Treatments may or may not include parents. If possible, sensitivity analyses will be used to explore the differential impact of parental involvement in treatment.

Types of outcome measures

A. Psychological functioning of child:
i) Depression
ii) Post-traumatic stress disorder
iii) Anxiety

B. Child Behaviour problems
i) Sexualised behaviour
ii) Externalising behaviour (e.g. aggression, 'acting out')

C. Future offending behaviour
i) Of child when adolescent and/or adult.

D. Parental skills and knowledge
i) Of child sexual abuse and its (possible) consequences
ii) Belief in their child's story
iii) Accurate attributions for their child's behaviour or psychological problems
iv) Behaviour management skills

Rating scales. A wide range of instruments are available to measure behavioural and psychosocial problems associated with the consequences of child sexual abuse. These instruments vary in quality and validity. For this analysis the minimum standards for the inclusion of data from outcome instruments will be i) that the psychometric properties of the instrument have been described in a peer-reviewed journal; ii) that the instrument was either (a) a self-report, or (b) completed by an

independent rater or relative.

Search strategy for identification of studies

The Cochrane Controlled Trials Register, published on the Cochrane Library will be searched. This is a compilation of about 250,000 published trials identified so far by handsearching by various individuals within the Cochrane Collaboration.
Search terms will include all terms likely to capture studies by type of participants i.e. children who have been sexually abused, and intervention i.e. cognitive-behavioural approaches. Full details of the sources and search strategies are published in The Cochrane Library.

A search using the same terms will be conducted within the specialist register of the Developmental, Psychosocial and Learning Problems Review Group.

The following databases will also be searched from March 1998 in order to identify studies that may not yet have been catalogued in CCTR: PsycLIT, EMBASE, CINAHL, Sigle, (Clinpsych) (Lilacs) and PsyIndex.

Search terms will be combined with the Cochrane highly sensitive search strategy for identifying randomised controlled trials. Details of this can be found in appendix 5 of the Cochrane Handbook.

Latest searches performed:
Cochrane Library: December 1999
MEDLINE: December 1999
EMBASE: December 1999
CINAHL: December 1999

Previous reviews will be used, and references will be checked on all studies and reviews. Authors and known experts will be contacted to identify any additional or unpublished data. Efforts will be made to establish contacts in countries in which English is not the dominant language.

Methods of the review

Selection of trials
Two reviewers (GM and PR) will independently select studies for inclusion in the review. Where possible, disagreement will be resolved by discussion. Where this is not possible the third reviewer (DJ) will be asked to assess the study in question. Where disagreement may be resolved with additional information this will be sought from the authors.

Assessment of methodological quality
Two reviewers will independently assign each selected study to quality categories described in the Cochrane Collaboration Handbook (Mulrow 1996). This is as follows;
A indicates adequate concealment of the allocation (for example, by telephone randomisation, or use of consecutively numbered, sealed, opaque envelopes).
B indicates uncertainty about whether the allocation was adequately concealed (for example, where the method of concealment is not known).
C indicates that the allocation was definitely not adequately concealed (for example, open random number lists or quasi-randomisation such as alternate days, odd/even date of birth, or hospital

number).

Data management
Data collection. Data will be independently extracted by two of the three authors. Again, any disagreement will be resolved by discussion where possible, and when not possible, the third author will adjudicate. All decisions will be documented and where necessary, the authors of studies will be contacted to assist in resolving problems or disputes.

Data synthesis
1. Incomplete data.
Where there is evidence of a significant differential drop-out rate between the experimental and control groups, data will not be included any meta-analysis.

2. Binary data: For binary outcomes, for example, 'attempted suicide' or 'not attempted suicide', a standard estimation of the Odds Ratio with the 95% confidence interval will be calculated. NNT will not be calculated from these data given the uncertainty about base rates of symptomatology in children who have been sexually abused.

3. Continuous data. Continuous data will be analysed if (i) means and standard deviations are available and (ii) there is no clear evidence of skew in the distribution. Where scales are measuring the same clinical outcomes in different ways mean differences will be standardised in order to combine results across scales.

4. Meta-analysis. If there are sufficient data and it is appropriate to do so, a random effects meta-analysis will be performed.

5. Investigation of heterogeneity. If significant statistical heterogeneity is identified within a meta-analysis, we propose the following potential sources which will be investigated by subdividing the studies: I) studies which include non-offending parents in the treatment programme and those which do not, and/or studies which focus on abuse-specific behaviour and those which do not.

6. Sensitivity analyses. Primary analyses will be based on available data from all included studies relevant to the comparison and outcome of interest. In order to assess the robustness of conclusions to quality of data and approaches to analysis, sensitivity analyses will be performed. These will include:

a) Intention to treat. For dichotomous outcomes, such as 'offended' or 'attempted suicide', the authors will assume that those who were lost to follow up (i) had proportionately the same outcomes as those who completed in the control group (ii) experienced the successful outcome (iii) all experienced the unsuccessful outcome.

b) Differential drop-out. Studies with severe imbalance in terms of numbers of attrition will be excluded from the analysis to assess their influence on the overall result.

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