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Psychoanalytic/Psychodynamic Psychotherapy for Children and Adolescents Who Have Been Sexually Abused: A Systematic Review

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Campbell Systematic Reviews

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Abstract

BACKGROUND

The sexual abuse of children and adolescents is a significant worldwide problem. It is associated with a wide variety of negative psychological, social and physical consequences for the victims. These effects can often be seen immediately following sexual abuse, but they may manifest later on and sometimes only in adult life. There are a number of different interventions aimed at helping children and adolescents who have been sexually abused, and psychoanalytic/psychodynamic psychotherapy has a long-established tradition of being used for such victims. In this review, we set out to find the evidence for its effectiveness specifically in children and adolescents who have been sexually abused.

OBJECTIVES

To assess the effectiveness of psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused.

SEARCH METHODS

We searched the following databases in May 2013: CENTRAL, Ovid MEDLINE, Embase, PsycINFO, CINAHL, Sociological Abstracts, Social Science Citation Index, Conference Proceedings Citation Index - Social Science and Humanities, LILACS and WorldCat. We also searched three trials registers, checked the reference lists of relevant studies and contacted known experts.

SELECTION CRITERIA

Randomised and quasi-randomised trials comparing psychoanalytic/psychodynamic psychotherapy with treatment as usual or no treatment/waiting list control for children and adolescents up to age of 18 who had experienced sexual abuse at any time prior to the intervention.

DATA COLLECTION AND ANALYSIS

The review authors (BP and WT) independently screened search results to identify studies that met eligibility criteria.

RESULTS

No studies were identified that met the inclusion criteria for this review.

AUTHORS' CONCLUSIONS

There are no randomised and quasi-randomised trials that compare psychoanalytic/psychodynamic therapy with treatment as usual, no treatment or waiting list control for children and adolescents who have been sexually abused. As a result, we cannot draw any conclusions as to the effectiveness of psychoanalytic/psychodynamic psychotherapy for this population. This important gap emphasises the need for further research into the effectiveness of psychoanalytic/psychodynamic psychotherapy in this population. Such research should ideally be in the form of methodologically high-quality, large-scale randomised controlled trials. If these are not conducted, future systematic reviews on this subject may need to consider including other lower quality evidence in order to avoid overlooking important research.

Plain language summary

The sexual abuse of children and adolescents remains a significant problem worldwide. Children and adolescents who have been sexually abused often experience a wide range of psychological, social and physical problems and these problems often follow them into adulthood. This makes it very important to know how best to help those who have been subjected to sexual abuse. Treatments based on psychoanalytic or psychodynamic psychotherapy are often provided to victims of sexual abuse. These treatments work on the idea that difficulties in past relationships or experiences are often pushed into the unconscious, but later re-emerge in the form of problems in the present. Through a relationship with a psychoanalytic/psychodynamic psychotherapist, the person is helped to gain a greater conscious understanding of their unconscious conflicts and this is thought to help them recover. However, we did not find any studies of this kind of therapy that met the strict inclusion criteria for this review. As a result, we cannot draw any conclusions as to the effectiveness of psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused. The implications of this lack of evidence for research and clinical practice are discussed. High quality randomised controlled trials should be conducted, but future systematic reviews on this subject may need to consider including other lower quality evidence in order to avoid overlooking important research.

1 Background

1.1 DESCRIPTION OF THE CONDITION

The sexual abuse of children and adolescents is a significant worldwide problem (De Mause 1991), the scale of which was largely unrecognised until the late 1970s (Finkelhor 1994a). Sexual abuse is traditionally divided into contact and non-contact abuse (Peters 1986). Contact abuse can be further subdivided into penetrative and non-penetrative sexual abuse. Penetrative sexual abuse includes oral, vaginal and anal penetration (Glaser 2002). Non-penetrative sexual abuse includes touching, kissing and masturbation. Non-contact sexual abuse includes deliberate exposure of breasts or genitalia or witnessing a sexual act, either live or in films and photographs in print or electronic form.

Finkelhor's 1994 review of prevalence studies of child sexual abuse in 21 countries (mainly English-speaking and North European) reported rates ranging from 7% to 36% in women and 3% to 29% in men. Such variation was felt to reflect differences in the methodologies of studies, such as the definition of sexual abuse used, rather than substantive differences in the rate of childhood sexual abuse (Finkelhor 1994a). Adjusting for sample-related variation, response rates and differences in definitions, Gorey and Leslie estimated a rate of 16.8% for women and 7.9% for men from 16 cross-sectional North American community sample surveys (Gorey 1997). More recently, a meta-analysis of prevalence rates of child sexual abuse between 1980 and 2008, including 331 independent samples with a total of over nine million participants, estimated a worldwide rate of self-reported sexual abuse of 18% amongst female participants and 7.6% of male participants (Stoltenborgh 2011). Men make up the vast majority of abusers (85% to 90%) (Glaser 2002) and the majority of sexual abuse is perpetrated by either family members or acquaintances (Finkelhor 1994b).

Importantly, sexual abuse is an event or a series of events; it is not a disease or medical condition (Finkelhor 1995). It often comes to the attention of services due to psychological consequences, which can be remarkably heterogeneous in their nature. This heterogeneity is partly because sexual abuse rarely occurs in isolation: it can occur alongside other forms of abuse and neglect (Mullen 1994; Ney 1994) and a wide variety of other disadvantages (for example, parental mental illness or substance abuse, child disability or illness, economic deprivation etc).

The psychological effects of sexual abuse can range from significant symptoms and emotional distress to little discernible impact (one review of 45 studies looking at the impact of sexual abuse on children found four studies that estimated from 21% to 49% of victims to be free of symptoms (Kendall-Tackett 1993)). The most common childhood effects of childhood sexual abuse include symptoms of post-traumatic stress disorder (PTSD) and sexualised behaviour (Kendall-Tackett 1993); other common effects are aggressive or disturbed behaviour, depression, anxiety, low self-esteem, guilt, fear, eating disorders, self-harm, suicidal ideation and suicide, substance misuse and relationship problems (Browne 1986; Beitchman 1991; Cotgrove 1996; Tyler 2002). Effects are often dependent on the developmental stage of the victim. Overall, the severity of abuse, use of force and the victim's relationship to the perpetrator appear to have the greatest influence on the degree of impact of the sexual abuse on the victim (Tyler 2002). Another important factor is the reaction of primary carer(s) to a disclosure of abuse. Where adults around the child fail to acknowledge the abuse and fail to support the victim, the outcome for the child is likely to be worse.

Many children and adolescents who are sexually abused go on to experience a wide range of serious adverse effects in adulthood and some only begin to develop symptoms in later childhood and adolescence or beyond ('sleeper effects') (Putnam 2003). Intervention studies sometimes exclude asymptomatic victims as their inclusion is likely to cause an underestimation of the overall effect of the intervention for symptomatic victims. It is also unlikely for an asymptomatic victim to receive psychotherapy in everyday clinical practice; however, the possibility of an asymptomatic victim having 'sleeper effects' needs to be kept in mind**.** A higher than average rate of childhood sexual abuse is reported by adults suffering personality disorders and other psychiatric illnesses (Zanarini 1989; Brown 1991; Bulik 2001; MacMillan 2001), and besides intrapsychic difficulties, they experience a wide range of physical symptoms (Arnold 1990) and occupational, social and sexual difficulties (Mullen 1994).

1.2 DESCRIPTION OF THE INTERVENTION

Psychoanalytic and psychodynamic psychotherapy have their origins in the work of Freud (1856 to 1939) but the practice of psychoanalytic and psychodynamic psychotherapy for children and adolescents gained impetus through the theoretical interest and practice of Anna Freud and Melanie Klein (Daws 1987). Nowadays there are a variety of different approaches (for example, Kleinian, Freudian) under the umbrella of psychoanalytic and psychodynamic psychotherapy. These terms are often used synonymously (Gabbard 2005), but psychodynamic psychotherapy sometimes refers to a briefer form of therapy where the therapist is more active and focuses on a particular problem, rather than difficulties affecting the whole personality.

Despite there being different schools of psychoanalytic/psychodynamic psychotherapy used for a wide range of psychological problems, there are some common theoretical concepts: psychoanalytic/psychodynamic therapy involves a therapist listening to an individual and observing their behaviour. People are referred or seek help when they are in conflict over aspects of themselves or their relationships. Such conflicts are generally held to originate from difficulties in past relationships and experiences (for example, sexual abuse). These conflicts are thought to cause anxiety or psychic pain and are pushed out of consciousness and into the unconscious through the use of defence mechanisms (Bateman 2000). Some defence mechanisms may be helpful (for example, humour or altruism), but others may be developmentally immature and harmful (for example, denial, splitting, projection). Psychoanalytic/psychodynamic psychotherapy attempts to explore, through talking, play (with younger children) and the formation of a therapeutic relationship, how earlier experiences influence and perhaps seriously distort current thoughts, feelings, behaviours (actions) and relationships (McQueen 2008). Eventually therapy aims to help people have a better understanding of unconscious difficulties about which they may previously have been unaware and this is thought to allow resolution of their problems.

Psychoanalytic/psychodynamic therapy is usually one-to-one, but it can be done with families or with groups. One-to-one therapy tends to happen at a fixed time once or twice a week, but occasionally it can be more intensive: up to five times a week. If the therapy is with a child, parents or carers are often provided with parallel supportive work, which is vital to help them understand and manage their children's behaviour safely (McQueen 2008).

Psychodynamic psychotherapy can be brief, lasting only a few sessions, but it can also last for months or even years, particularly when the hope is for deep resolution of difficulties affecting the whole personality (such as in psychoanalytic psychotherapy). When funded by state healthcare systems, insurance companies or for research purposes, therapy may be offered for a fixed amount of time (usually up to one or two years in the UK) and may target a particular problem, but it can sometimes be more open-ended, especially when paid for privately. Therapists have usually completed a lengthy training, which includes undergoing their own psychoanalytic/psychodynamic psychotherapy. When providing treatment therapists tend to get outside supervision from a more experienced therapist.

Following recognition or disclosure of sexual abuse, the first priority is ensuring the child or adolescent's safety. If conservative measures are not sufficient in order to protect them, the potential benefit of removing them from the home in order to protect their safety has to be balanced against the risk of their secondary traumatisation through separation from their family, particularly if the suspicion of abuse is subsequently proven to be unfounded. When their safety is ensured, good practice then involves providing them with an adult with whom they can talk about

the abuse and their feelings (Glaser 1991). For children or adolescents who develop symptoms, treatment should be tailored to the developmental stage and needs of the individual (Finkelhor 1995; Ramchandani 2003). For many health professionals psychoanalytic/psychodynamic psychotherapy has been the psychotherapeutic treatment of choice. More recently Cognitive Behavioural Therapy (CBT), particularly Trauma-focused CBT, has become more prevalent and there are many studies evaluating this, but the evidence, although in favour of CBT, is "more equivocal than some reviewers would suggest, including those who have themselves conducted trials" (Macdonald 2012).

1.3 HOW THE INTERVENTION MIGHT WORK

There are a variety of theories about how the intervention actually works but, as with other forms of psychotherapy, the relationship between therapist and patient is felt to be important (Gabbard 2005; Midgley 2005). Insight (conscious understanding) of unconscious conflicts is thought to be particularly significant (Traux 1973). Insight is gained through interpretations offered by the therapist based on what the patient says and their behaviour. The patient is encouraged to talk about whatever comes to their mind ('free association'), but some therapists are more active and may ask questions. Therapists usually reveal very few details about themselves so that they are a 'blank screen'. The patient is thought to unconsciously behave towards the therapist in the same way that they experienced earlier relationships (for example, with a parent or an abuser), which also involves them re-experiencing some of the original anxieties and distress. The transfer of feelings from previous relationships onto the therapist ('transference') allows the therapist to hypothesise about the unconscious conflicts and defence mechanisms of the patient. The therapist can then begin to give interpretations of the unconscious conflicts and defence mechanisms, helping the patient to gain conscious understanding of these.

Play is seen as the primary way for younger children to communicate their unconscious conflicts. The child expresses himself or herself through imaginative and symbolic play, drawing and games, providing the therapist with a window to understanding the child's anxieties, conflicts and defences. Children also talk while they play, and play provides a safe background for talking about painful subjects. While interpretation is important, the primary agent of change is "enhancing the child's symbolic, imaginative and mentalising capacities by increasing the range, depth and emotional richness of his play" (Target 2005). Through play they become able to express their internal conflicts at a more developmentally mature level and this is thought to be curative (Passey 1994; Target 2005; Emanuel 2006).

Eventually, in psychoanalytic/psychodynamic psychotherapy, the relationship with the therapist and the new understanding of the self is thought to be internalised and neural networks based on earlier childhood relationships and experiences are modified (Schore 1994; Amini 1996; Schore 1997; Gabbard 2000; Westen 2002a;

Westen 2002b). In fact there is a rapidly growing evidence base (Midgley 2011) and research within the world of neurobiology and neuroimaging is increasingly providing experimental evidence for many of the psychoanalytic concepts (Beutel 2003).

1.4 WHY IT IS IMPORTANT TO DO THIS REVIEW

In commenting on a Cochrane systematic review of cognitive behavioural interventions for children and adolescents who have been sexually abused (Macdonald 2012), which confirmed "CBT's potential as a means of addressing the adverse consequences of child sexual abuse", Eamon McCrory observed there is a "need for evaluation of other therapeutic approaches, notably psychodynamic psychotherapy" (McCrory 2007).

To date, there has not been a systematic review of high quality evidence (randomised controlled trials) of psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused. This is in contrast to a greater availability of research relating to the effectiveness of other psychotherapies (especially CBT). However, it is important to mention that this is changing and there are ongoing trials for psychoanalytic/psychodynamic psychotherapy for children and adolescents with other mental health problems (for example, Goodyer 2011) and also for adults who have been sexually abused as children or adolescents.

If psychoanalytic/psychodynamic psychotherapy is to continue to receive funding from state healthcare systems and private health insurance companies for treating children and adolescents who have been sexually abused, there is a need to to evaluate the available literature. This review sets out to serve that purpose.

2 Objectives

To assess the effectiveness of psychoanalytic/psychodynamic psychotherapeutic approaches in treating the effects of sexual abuse (psychologically and in terms of behaviour and social functioning) in children and adolescents.

3 Methods

3.1 CRITERIA FOR CONSIDERING STUDIES FOR THIS REVIEW

3.1.1 Types of studies

Randomised trials, including quasi-randomised trials in which participants are allocated by means such as alternate allocation, person's birth date, the day of the week or month, case number or alphabetical order. Studies were deemed eligible for inclusion if they evaluated a psychoanalytic or psychodynamic psychotherapy versus treatment as usual (for example, treatment by a psychiatrist) or versus no treatment control/waiting list control. Studies that compared psychoanalytic or psychodynamic psychotherapy against an active comparison group (for example, Cognitive Behavioural Therapy) were excluded. The rationale for choosing to only include randomised controlled trials with no treatment/waiting list control or treatment as usual control conditions was informed by current methodological thinking that the implementation of this randomised controlled design has the potential to provide the least biased estimates of the efficacy of an intervention and as such these studies provide the highest level of evidence.

Eligibility for inclusion was not restricted by studies' publication type, location, language or publication date.

3.2 TYPES OF PARTICIPANTS

Children and adolescents up to age 18 years who have experienced sexual abuse at any time prior to the intervention. The participants had to be symptomatic at the time of entry into the study.

3.3 TYPES OF INTERVENTIONS

Interventions of any duration, delivered to individuals and/or groups, described by the authors as psychoanalytic/psychodynamic or that, in the judgement of the review authors, describe the use of predominantly psychoanalytic/psychodynamic interventions. The following forms of psychotherapy using

psychoanalytic/psychodynamic principles would have been considered for inclusion: child psychotherapy, child and adolescent psychotherapy, child analysis, child psychoanalysis, Freudian therapy, Jungian therapy, Kleinian therapy, Winnicottian therapy, brief psychodynamic psychotherapy and object relations based therapy. Studies where psychodynamic/psychotherapy is delivered as an adjunctive treatment, such as alongside medication, will be included (for example, psychoanalytic/psychodynamic interventions plus medication versus medication alone).

Studies may or may not include separate parallel supportive work with parents or carers of participants. Studies may or may not include family work (i.e. parents or carers seen together with participants).

3.4 TYPES OF OUTCOME MEASURES

3.4.1.1 Primary outcomes

- Post traumatic stress disorder (PTSD)
- Depression
- Sexualised behaviour
- Aggression/conduct problems
- Self harm

Adverse outcomes

- Suicide

3.4.1.2 Secondary outcomes

Measures of symptoms/psychiatric diagnosis

- For example, generalised anxiety, panic disorder, social phobia, somatisation symptoms, conversion symptoms, eating disorder symptoms, dissociation

Measures of underlying processes (relevant to psychoanalytic/psychodynamic psychotherapy)

- Defence mechanisms (for example, Comprehensive Assessment of Defence Style (CADS), Defence Mechanism Inventory (DMI) - Children's Version)
- Relationship with therapist (for example, Child Therapeutic Alliance Scale (CTAS))
- Transference (for example, Core Conflictual Relationship Theme (CCRT) - Child Version)
- Level/maturity of functioning

Measures of psychosocial functioning

- Quality of life
- Global functioning
- Social functioning (including peer relationships)
- Educational functioning
- Victim-perpetrator cycle (for example, conviction for sexual offences)
- Disturbed/externalising behaviour (for example, 'acting out')
- Drug and alcohol use

Measures of service use

- Number of hospital admissions/days spent in hospital (psychiatric)
- Emergency psychiatric contacts

Other measures

- Views of treatment
    - Satisfaction/acceptability with treatment of both participants and parents/carers
    - Withdrawal from treatment (dropout)
- Parental (carer) relationship with the child

Any scales would have been accepted for the purpose of the review. Outcomes were planned to be assessed immediately post intervention, for the short term (up to one year post intervention) and long term (over one year post intervention).

3.5 SEARCH METHODS FOR IDENTIFICATION OF STUDIES

3.5.1.1 Electronic searches

We ran the initial searches in November and December 2009 and updated them in May 2012 and May 2013. We were unable to run searches after 2009 in Dissertation Abstracts International and ASSIA because they were no longer available to the authors or editorial base.
We searched the following.

- Cochrane Central Register of Controlled Trials (CENTRAL), 2013 Issue 4, part of The Cochrane Library, last searched 9 May 2013
- Ovid MEDLINE, 1950 to May Week 1 2013, last searched 9 May 2013
- Embase (Ovid), 1980 to 2013 Week 18, last searched 9 May 2013
- CINAHL (EBSCOhost), 1982 to current, last searched 9 May 2013
- PsycINFO (Ovid), 1806 to April Week 5 2013, last searched 9 May 2013
- LILACS, all available years, last searched 9 May 2013
- ASSIA, 1987 to November 2009, last searched November 2009
- Sociological Abstracts (Proquest), 1952 to current, last searched 9 May 2013

- Sociological Abstracts (CSA), 1952 to December 2009, last searched 2 December 2009
- Social Sciences Citation Index, 1970 to 8 May 2013, last searched 9 May 2013
- Conference Proceedings Citation Index - Social Science and Humanities, 1990 to 8 May 2013, last searched 9 May 2013
- Dissertation Abstracts International, last searched 19 November 2009
- WorldCat (limited to theses/dissertations), www.worldcat.org/, last searched 9 May 2013
- metaRegister of Controlled Trials (mRCT), www.controlled-trials.com/mrct/, last searched 9 May 2013
- WHO ICTRP, http://apps.who.int/trialsearch/, last searched 10 May 2013
- ClinicalTrials.gov, http://clinicaltrials.gov/, last searched 9 May 2013

The search terms were modified, where necessary, to meet the requirements of the databases listed (Appendix 1). Appropriate randomised trials filters were used as appropriate. No language or date restrictions were applied to the searches.

This is the first published version of the review. The searches will be repeated within two years of publication and the review will be updated accordingly.

3.5.2 Searching other resources

References of previous reviews and studies were checked to identify any missing studies. Authors and known experts were contacted to identify any additional unpublished or ongoing relevant trials. Efforts were made to establish contacts in countries in which English is not the dominant language.

3.6 DATA COLLECTION AND ANALYSIS

3.6.1 Selection of studies

The two authors (BP and WT) independently screened titles and abstracts retrieved from the searches against the eligibility criteria stated above. For studies that appeared to be eligible RCTs or quasi-RCTs, the full reports were obtained and inspected to assess their relevance against the inclusion criteria. At all stages, reasons for inclusion and exclusion of articles were noted. The review authors were not blinded to the name(s) of the study author(s), their institution(s) or publication sources at any stage of the review. Disagreements in most cases were resolved through consensus. In the one case that consensus could not be reached (Trowell 2002), we sought further information from the study author. Copies of 20 articles were obtained and read independently by the same authors against the inclusion criteria as detailed in the review protocol. The study selection process is presented in Figure 1.

3.6.2 Data extraction and management

Data extraction was not possible as screening of database searches did not reveal any studies suitable for inclusion.

Future updates of the review will use the methods described below, though these may be subject to revision(s) to reflect the Cochrane Collaboration's up-to-date methodological approach to research synthesis.

3.6.3 Assessment of risk of bias in included studies

In future updates of the review, the two authors will independently assess the risk of bias for each included study, and report an agreed view in a 'Risk of Bias' table. The authors will describe and assign a judgement of low, unclear or high risk of bias for each of the six domains as recommended in the Cochrane Handbook for Systematic Reviews of Interventions (Higgins 2008a), namely sequence generation, allocation concealment, blinding of outcome assessors, incomplete outcome data, selective outcome reporting and 'other sources of bias'.

Sequence generation
We will assess whether the allocation concealment sequence was adequately generated (i.e. assignment to groups was truly random) and 'randomisation' will receive the following judgements: low risk of bias when participants were allocated to treatment conditions using randomisation based on computer-generated numbers, tables of random numbers or coin-tossing; high risk of bias when randomisation did not use any of the above methods; unclear risk of bias when randomisation method is not known or not clearly stated.

Allocation concealment
We will assess allocation concealment on the following basis: low when participants and researchers were unaware of participants' future allocation to treatment conditions until decisions about eligibility/suitability were made and informed consent was obtained; high when allocation was not used or allocation was not concealed either from participants before informed consent or from researchers before decisions about inclusion were made; unclear when information regarding allocation concealment is not known or not clearly stated.

Blinding
We do not expect that either the therapist or participant could be kept blind to the intervention. Given that many of the outcome measures are likely to be be self-reported, it is therefore probable that blinding of outcome assessments will be infrequent in the included studies. Risk of bias due to blinding will be determined primarily by whether those who assessed and coded outcome measures were blind to treatment conditions. Risk of bias due to blinding will receive the following judgements: low when assessors were blind to therapy conditions; high when

assessors were not blind to therapy conditions; unclear when blinding of assessors is not reported and this information is not available from the study authors.

Incomplete outcome data
We will assess incomplete outcome data in relation to all reported sources of attrition and exclusions, and whether or not these were adequately addressed by the study authors. We will extract data on attrition and exclusions as well as numbers involved (compared to total randomised) and reasons for attrition/exclusion where reported or obtained from the study authors. When attrition between groups differs within studies, we will use sensitivity analyses to determine the extent to which these studies may bias the results of the meta-analyses. We will judge the risk of bias due to the way the authors of studies dealt with missing data as follows: low when all participants were included in outcome measure analyses (including those who withdrew from the study) or intention-to-treat analysis can be performed using the available data; high when intention-to-treat analyses were not performed and cannot be performed using the available data; unclear when information about whether intention-to-treat analyses were performed is not available and cannot be acquired by contacting the authors of the study.

Selective outcome reporting
We will assess the risk of bias due to selective outcome reporting as follows: low when all collected data appear to be reported; high when the data from some measures used in the study are not reported; unclear when we are uncertain whether other data were collected and not reported.

Other sources of bias
We will assess whether the study is free from other problems that could put it at a high risk of bias, such as stopping the study early, changing methods during the study or other anomalies.

3.6.4 Measures of treatment effect

Dichotomous data
In cases of binary outcomes, we will calculate relative risk (RR) estimations with 95% confidence intervals (CI) (Higgins 2008).

Continuous data
When outcomes in the included studies are measured using the same scale, we will calculate mean difference (MD) will be calculated. To combine outcomes across studies that have used different scales, we will calculate standardised mean differences (SMD) using Hedges g. If means and standard deviations are not made available and cannot be calculated from the available information, we will contact study authors to provide the required information.

3.6.5 Unit of analysis issues

Multiple interventions per participant
In future updates of this review, if the participants in some trials receive psychoanalytic or psychodynamic psychotherapy plus treatment as usual (for example, treatment by a psychiatrist), we will meta-analyse those studies separately, with the psychoanalytic or psychodynamic psychotherapy plus treatment as usual arm compared to treatment as usual alone. We will report the treatment effects of these studies separately and consider the extent to which additional treatments may have influenced outcomes in the Discussion section.

Multiple time points
Studies of the effectiveness of psychotherapeutic interventions sometimes measure outcomes at multiple time points post-intervention. Ideally, time points for assessing the impacts of treatments would be taken from randomisation, but given the likely variability in the duration of interventions between studies, we have chosen to group measurements into those taken immediately post-intervention, those at short-term follow-up (up to one year post-intervention) and those at long-term follow-up (the final measure, greater than one year post-intervention).

3.6.6 Dealing with missing data

In future updates, we will manage missing dichotomous data through intention to treat (ITT) analysis, in which it will be assumed that participants who dropped out after randomisation had a negative outcome. We will calculate best and worse case scenarios (Gamble 2005) for the clinical response outcome, on the basis of the assumption that dropouts in the active treatment group had positive outcomes and those in the control group had negative outcomes (best case scenario) and that dropouts in the active treatment group had negative outcomes and those in the control group had positive outcomes (worst case scenario), thus providing boundaries for the observed treatment effect. As this approach is not without its problems in drawing inferences about the pooled effect estimate (Higgins 2008b), we will seek additional input from a statistician.

We will analyse missing continuous data either on an endpoint basis, including only participants with a final assessment, or using last observation carried forward to the final assessment (LOCF) if LOCF data were reported by the trial authors. Where SDs are missing, we will make attempts to obtain these data through contacting trial authors. Where SDs are not available from trial authors, we will calculate them from t-values, confidence intervals or standard errors, where reported in articles (Deeks 1997a; Deeks 1997b). If these additional figures are not available or obtainable, we will not include the study data in the comparison of interest.

3.6.7 Assessment of heterogeneity

In future updates, we will assess statistical heterogeneity among included studies will be assessed by using the Chi2 test, which provides evidence of variation in effect

estimates beyond that of chance. Since the Chi2 test has low power to assess heterogeneity when a small number of participants or trials are included, the P value will be conservatively set at 0.1. Additionally, we will use the I2 statistic (Higgins 2002; Higgins 2003) to determine the percentage of variability that is due to heterogeneity rather than to sampling error or chance (where a value greater than 50% suggests moderate to substantial heterogeneity). We will discuss the possible reasons for any heterogeneity and conduct sensitivity analyses accordingly, where data permit. We may use subgroup analyses and meta-regression to investigate this further.

3.6.8 Assessment of reporting biases

If we have sufficient studies in future updates, we will draw funnel plots to investigate relationship between effect size and standard error when possible (Egger 1997). When such a relationship is found, we will examine clinical diversity as a possible explanation. Asymmetry could be attributed to publication bias or related biases.

3.6.9 Data synthesis

The two review authors will enter data into Review Manager software (Review Manager 2012) (double data entry). A random-effects model meta-analysis will be used due to expected heterogeneity among included studies. We will synthesise results in a meta-analysis providing there is not significant clinical heterogeneity (in terms of participants, interventions, methodology, and outcome measurement). If we find significant heterogeneity (for example, when value of the I2 statistic exceeds 75% and/or when studies are dissimilar in terms of important participant factors (for example, age) or study factors (for example, definition of sexual abuse used) and there is inconsistency in the direction of effect, meta-analysis will not be not deemed appropriate (Higgins 2008) and we will present the results of the each individual study.

3.6.10 Subgroup analysis and investigation of heterogeneity

In future updates, we will conduct the following subgroup analyses for all outcomes that have a sufficient number of studies (normally greater than 10) to see if there are any differences in response between:

1. child (under 13 years) and adolescent (13 to 18 years) participants;
2. male and female participants;
3. studies of group treatment versus studies of individual treatment;
4. studies where psychodynamic/psychoanalytic psychotherapy is delivered as an adjunctive treatment versus studies of psychodynamic/psychoanalytic psychotherapy alone;
5. studies with the intervention lasting an average of 25 or fewer sessions versus studies with the intervention lasting an average of more than 25 sessions.

If a sufficient number of studies is identified, we will use meta-regression to examine study effect size variation as a function of potential sources of clinical heterogeneity.

3.6.11 Sensitivity analysis

If the methodologies or analyses of the studies may have affected the robustness of the results of the review, we will undertake sensitivity analyses to examine the effects of:

1. the removal of studies with quasi-randomisation;
2. the removal of studies with inconsistencies in the definition, measurement and/or reporting of results (for example, differential attrition, dropouts, lack of intention-to-treat analysis, outcome measures not taken at consistent time point for all participants);
3. the method used by review authors to impute values for missing data (for example, participants with a final assessment versus last value carried forward (LOCF));
4. analysing the data using a different statistical approach (for example, using a fixed-effect model instead of a random-effects model (Higgins 2008a)).

4 Results

4.1 DESCRIPTION OF STUDIES

See: Characteristics of excluded studies

4.1.1 Results of the search

Twenty potentially eligible studies (25 records) of treatment interventions for children or adolescents who have been sexually abused were identified: Baker 1987; Celano 1996; Downing 1988; De Luca 1995; Duffany 2009; Ghosh Ippen 2011; Gould 1995; Homstead 1986; Lampe 2008; May 1992; McGain 1995; McGregor 1993; Pfeifer 2003; Simoneau 2008; Sullivan 1992; Thun 2002; Tourigny 1998; Trowell 2002; Tourigny 2005; Witzmann 1995. However, careful screening of 19 of these showed none of them met our inclusion criteria. The Characteristics of excluded studies table gives more information.

We were not able to retrieve a copy of the study by Gould 1995 and so we have listed it under Studies awaiting classification. See Figure 1 for the study flow diagram. We were made aware of one article (Woller 2012) that referred to a planned trial to test the effects of psychodynamic psychotherapy for PTSD related to childhood abuse using an RCT design but this trial has not yet begun.

4.1.2 Included studies

We did not find any studies that met the inclusion criteria for this review.

4.1.3 Excluded studies

Reasons for exclusion refer mostly to study design issues (for example, non-random assignment of participants to conditions) or because the intervention examined was not based on a psychoanalytic/psychodynamic conceptual framework. The reasons for exclusion are as follows:

- the assessed intervention was not psychoanalytic/psychodynamic psychotherapy: Baker 1987; Sullivan 1992; Celano 1996; Tourigny 2005; Thun 2002; Witzmann 1995.

- non-random assignment: Downing 1988; De Luca 1995; Duffany 2009 Homstead 1986; Lampe 2008; May 1992; McGain 1995; McGregor 1993; Pfeifer 2003; Simoneau 2008; Tourigny 1998.
- the study did not involve examination of absolute effects, i.e. it did not compare psychoanalytic/psychodynamic intervention against treatment as usual or no treatment/waiting list control, as per protocol. The study by Trowell 2002 focused on the examination of relative effects, i.e. the comparison of a psychoanalytic/psychodynamic intervention against another psychotherapeutic intervention.
- participants witnessed domestic violence rather than being victims of sexual abuse: Ghosh Ippen 2011.

4.2 RISK OF BIAS IN INCLUDED STUDIES

Not applicable as we did not find any studies suitable for inclusion in the review.

4.2.1 Allocation (selection bias)

Not applicable as we did not find any studies suitable for inclusion in the review.

4.2.2 Blinding (performance bias and detection bias)

Not applicable as we did not find any studies suitable for inclusion in the review.

4.2.3 Incomplete outcome data (attrition bias)

Not applicable as we did not find any studies suitable for inclusion in the review.

4.2.4 Selective reporting (reporting bias)

Not applicable as we did not find any studies suitable for inclusion in the review.

4.2.5 Other potential sources of bias

Not applicable as we did not find any studies suitable for inclusion in the review.

4.3 EFFECTS OF INTERVENTIONS

Not applicable as we did not find any studies suitable for inclusion in the review.

5 Discussion

5.1 SUMMARY OF MAIN RESULTS

Our review did not find any randomised trials comparing psychoanalytic/psychodynamic psychotherapy with either treatment as usual or a no treatment/waiting list control for children or adolescents who have been sexually abused.

5.2 OVERALL COMPLETENESS AND APPLICABILITY OF EVIDENCE

The lack of randomised and quasi-randomised studies is perhaps surprising given that many children and adolescents have been treated in this way and for many health professionals it would still would be considered the psychotherapeutic treatment of choice.

There are likely to be many reasons for the lack of randomised controlled trials, but there is a strong case for arguing that psychodynamic/psychoanalytic psychotherapy has traditionally favoured the case study as a way of richly elaborating the complexity of each case (Kennedy 2005). There has been some reluctance in the field to engage with the demands of modern healthcare for a scientific evidence base (Midgley 2011). This reluctance may have been partly due to a perception that psychoanalytic/psychodynamic psychotherapy does not lend itself well to empirical evaluation and that it does not fit comfortably within a scientific framework. However, there are many who would challenge this point of view and consider it very important to add empirical studies to the established tradition of case studies to bring about an even greater understanding of the intervention.

5.3 QUALITY OF THE EVIDENCE

The lack of eligible studies emphasises the need for future methodologically rigorous studies that aim to examine, where possible, the absolute effects of psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused. Such studies should try to address the methodological issues (for example, comparison conditions, method of randomisation and

allocation concealment) that we identified in some of our excluded studies and their reporting should follow CONSORT guidelines.

5.4 POTENTIAL BIASES IN THE REVIEW PROCESS

In this review, we focused only on sexual abuse; however, sexual abuse rarely occurs in isolation (McQueen 2008). Children and adolescents who experience sexual abuse can be subjected to other forms of abuse and neglect as well as a wide variety of other adversities. By dividing victims into groups of different forms of abuse, we may be creating artificial groups; it may be more appropriate to put all victims of childhood maltreatment together. All forms of abuse tend to be intentional, repetitive and personally directed and can be particularly problematic when perpetrated by somebody in a caring role for the victim. Different forms of abuse may have more in common with each other than other traumatic incidents such as road accidents or natural disasters (Cohen 2006). However, most therapies including psychoanalytic/psychodynamic psychotherapy have developed specific theoretical models and treatment approaches for specific forms of abuse (Cohen 2006). Therefore it makes sense for research to evaluate interventions for these specific forms of abuse, such as in this review.

5.5 AGREEMENTS AND DISAGREEMENTS WITH OTHER STUDIES OR REVIEWS

We are not aware of any other reviews that specifically address this intervention in this population. There have been other reviews that look more broadly at all psychotherapeutic interventions for children and adolescents who have been sexually abused or focus on a single intervention type other than psychoanalytic/psychodynamic psychotherapy (Skowron 2005; Cohen 2006; Avinger 2007; Hetzel-Riggin 2007; Sánchez-Meca 2011; Macdonald 2012) and one meta-review (Coren 2009). Of the reviews looking at more than one intervention type, only one psychoanalytic/psychodynamic randomised controlled trial has been identified (Trowell 2002) and therefore the review authors could not come to any definitive conclusions about the intervention (Coren 2009).

The randomised controlled trial that compared individual psychodynamic psychotherapy with psychoeducational group therapy for 71 girls who had been sexually abused (Trowell 2002) was excluded from our review as it had an active comparison intervention and could not be described as a control group (i.e. treatment as usual, no treatment or waiting list). However, both interventions in the trial appeared to be effective. Individual psychodynamic psychotherapy had a greater impact on manifestations of PTSD following sexual abuse at a variety of different time points - effect sizes were mostly in excess of 0.50 (meeting Cohen's criterion of medium effect). Therefore, even though this study has not been included

in this review, it would support the continued use of psychodynamic psychotherapy in this population, but conclusions would still need to be tentative due to the small sample size.

6 Authors' conclusions

6.1 IMPLICATIONS FOR PRACTICE

Whilst we have not been able to identify any relevant studies in this review, it is important to remember that this does not mean that the intervention does not work in this population. However, it could make it more difficult to justify the continued use of psychodynamic/psychoanalytic psychotherapy for child and adolescent victims of sexual abuse.

6.2 IMPLICATIONS FOR RESEARCH

Well-implemented randomised controlled trials with no treatment/waiting list control conditions or treatment as usual control conditions should provide the least biased estimates of the efficacy of the intervention and therefore we chose to only include studies using these conditions. We also wanted to remain consistent with the Cochrane review of cognitive behavioural interventions for children and adolescents who have been sexually abused (Macdonald 2012). However, it is reasonable to expect that randomised controlled trials in this area are likely to look at the relative (not absolute) effects of psychodynamic/psychoanalytic psychotherapy. Randomisation (particularly to no treatment control conditions) may not be feasible or ethical given that the focus is on children and adolescents who have been sexually abused (Ammerman 1998; Skowron 2005). We point to Trowell et al's RCT (Trowell 2002), which was refused ethical approval for a no treatment control and so used an active comparison intervention instead. Therefore, future systematic reviews may need to pragmatically include randomised controlled trials that compare psychodynamic/psychoanalytic psychotherapy with active comparisons (such as CBT) and such findings will still be informative to clinicians and policymakers. In preparing future updates of this review, we will consider including quasi-experimental studies that meet some minimum quality threshold and trials that compare the effects of psychodynamic/psychoanalytic psychotherapy with alternate forms of therapy.

More generally, it is clear that randomised controlled trials of psychodynamic/psychoanalytic psychotherapy for children and adolescents who have been sexually abused are urgently needed. It is important to stress that these

would need to be high quality in their design and use clinically referred participants, rather than samples specifically recruited for research (Weisz 1987). As pointed out by Macdonald 2012, particular attention would need to be given not only to the general areas of study design such as quality of randomisation, but also to whether or not asymptomatic children and adolescents should be included. The risk of including such children and adolescents is that they would reduce the ability of a study to show any statistically significant difference, if there is one. There is also the ethical issue of whether it is appropriate to put an asymptomatic child or adolescent through a psychotherapeutic intervention.

Those designing future studies should think carefully about which outcome variables are appropriate. There should probably be more standardised outcome variables that enable results of different studies to be directly compared. In addition, outcome variables should be better suited to reflect some of the broader aims of psychoanalytic/psychodynamic psychotherapy (Hodges 1999), such as a change in the structure of personality or the development of a more coherent sense of self. By simply focusing on symptoms - which are then reflected in corresponding outcome variables - treatments can become too focused on a change in symptoms. Though these symptoms may end up being successfully treated, the person may still feel that more profound difficulties persist. Symptoms "may remain or increase whilst profound change is taking place" (Boston 1993). This is often well understood in the commonly held idea that ‘things get worse before they get better’. Psychoanalytic theory includes the idea of people having to painfully work through conflicts and grieve loss in their treatment. For example, before being able to recover, a child or adolescent victim of sexual abuse may have to gradually acknowledge the distressing idea that an admired or loved family member has abused the power of their position in the family. Furthermore, by simply focusing on symptoms and looking only at shorter term treatments, there is a risk that we miss underlying change and only measure symptoms at a time when as they are getting worse before they get better later in treatment.

Another important area of future studies should be to include outcomes that could identify potential harm to the child or adolescent as a result of the intervention. There are critics of psychoanalytic/psychodynamic psychotherapy who believe that it can be harmful to people. By including this outcome variable in future studies, professionals would be able to either highlight a link or dispel such fears.

Where possible, future studies should look at longer term interventions and they should ensure that the follow-up of participants continues for at least one to two years (if not more) after the end of the intervention, particularly in order to try to measure how long any improvements last for, or even whether improvements continue beyond the end of the intervention. There is evidence that the therapeutic gains following psychoanalytic/psychodynamic psychotherapy may be maintained and even increase following the termination of the intervention (Shedler 2010). It

would also be important to compare briefer forms against longer term treatment to see if there is any difference. Where possible, though, the interventions should initially compare more closely to clinical practice (i.e. therapy once or twice a week for at least one year) and should include parallel or family work with the parents or carers. In fact, one study has suggested that psychoanalytic/psychodynamic psychotherapy without parallel work with the parent or carers may be counter-productive (Szapocznik 1989).

Traditionally, much research in psychoanalytic/psychodynamic psychotherapy has occurred in groups, but most clinical practice uses individual treatment (Hodges 1999). Therefore, it would be helpful to look at whether individual and group therapy have different outcomes, but research should focus on individual treatment where possible.

It would be interesting to investigate the covariance of effect sizes with other treatment characteristics (for example, experience and training of the therapist, therapeutic relationship, number of sessions, attrition rates) or participant characteristics (for example, effect of developmental level, severity and chronicity of the abuse, co-occurence with other forms of abuse or neglect, ongoing prosecution or court procedures) (Coren 2009).

We agree with Macdonald's final recommendation in her Cochrane review of cognitive behavioural interventions for children and adolescents who have been sexually abused (Macdonald 2012) that observational studies would help us get a better idea of how symptoms develop and then perhaps diminish over time. This would help us to think carefully about who should be receiving an intervention and whether one is needed at all.

Further examination of the process of psychoanalytic/psychodynamic psychotherapy for this population and what aspects bring about change is also needed. This would greatly help therapists to increase the effectiveness of the intervention (Llewelyn 2001).

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7.1 CONTRIBUTIONS OF AUTHORS

The review was conceived by BP who also wrote the background, discussion and conclusion. The methods and results sections were written by WT. Both authors offered comments to all sections of the review. BP co-ordinated the work of producing the protocol and the review. The initial search strategy was designed and run by Jo Abbott in close collaboration with BP; the search strategy was later updated and run by Margaret Anderson (Trials Search Co-ordinator at CDPLPG).

7.2 DECLARATIONS OF INTEREST

Ben Parker - is the lead clinician and a consultant child and adolescent psychiatrist on an adolescent inpatient unit at the Priory Hospital Chelmsford. He has an interest in working with victims of abuse and trauma and has experience in psychoanalytic psychotherapy. BP received funding for travel and study leave to attend two Cochrane training days from South West London and St George's Mental Health NHS Trust.

William Turner - is a Counselling Psychologist with a particular interest in the evaluation of psychotherapeutic interventions.

8 Differences between protocol and review

Two databases (Conference Proceedings Citation Index and WorldCat) became available to us in 2012 and were added to the list of electronic sources.

In the protocol, we said 'Studies may or may not include separate parallel supportive work with parents/carers of participants, but must not include therapy with both the child and parent seen together'. After careful consideration, we removed this restriction on parents and children being in therapy together.

9 Published notes

This review is co-registered within the Campbell Collaboration.

10 Characteristics of studies

10.1 CHARACTERISTICS OF INCLUDED STUDIES

10.2 CHARACTERISTICS OF EXCLUDED STUDIES

Homstead 1986

Reason for exclusion	This dissertation describes, through a case study analysis involving pre and post measures, the multifaceted examination of one treatment group for adolescent females who were sexually abused; however, the study does not involve random assignment and the intervention is not psychoanalytically/psychodynamically informed.

Baker 1987

Reason for exclusion	The adolescent participants and the three therapists were randomly assigned to treatment conditions, but all therapists used Rogerian techniques in both individual and group therapy.

Downing 1988

Reason for exclusion	The study is limited by a number of methodological weaknesses (e.g. lack of standardised assessment tools and use of standardised treatment approaches), including nonrandom assignment of participants to conditions.

Sullivan 1992

Reason for exclusion	The assessed intervention was not psychoanalytically/psychodynamically informed.

May 1992

Reason for exclusion	The research design in this study involved a pretest-posttest non-randomised group design utilising an analysis of covariance.

10.2.1 McGregor 1993

Reason for exclusion	The study is limited by a number of methodological weaknesses (e.g. short length of time from pre-test to post-test, small sample size n = 5), including nonrandom assignment of participants to conditions.

De Luca 1995

Reason for exclusion	The study examined the effectiveness of group therapy for sexually abused children in a pre-treatment and follow-up assessment design without randomising participants to conditions.

10.2.2 McGain 1995

Reason for exclusion	The study aimed to examine the efficacy of an outpatient group treatment of sexually abused girls using a pre-post, matched control/treatment design.

10.2.3 Witzmann 1995

Reason for exclusion	The study is limited by a number of methodological weaknesses (e.g. small sample size n = 8), including convenience sampling and nonrandom assignment of participants to conditions. The intervention was also not psychoanalytically/psychodynamicaly informed.

10.2.4 Celano 1996

Reason for exclusion	The assessed intervention (RAP, Recovering from Abuse Program) was not psychoanalytically/psychodynamically informed.

10.2.5 Tourigny 1998

Reason for exclusion	The study involved a pre-, post-intervention evaluation of a treatment programme for sexually abused children without random assignment and the use of a control group.

10.2.6 Thun 2002

Reason for exclusion	The assessed intervention (a modified version of the multidimensional model proposed by Lindon 1994) was not psychoanalytically/psychodynamically informed.

10.2.7 Trowell 2002

Reason for exclusion	Multi-centre RCT that compared a psychoanalytical/psychodynamically-informed intervention with another active treatment modality; as such, it does not meet our inclusion criteria.

10.2.8 Pfeifer 2003

Reason for exclusion	The study involved nonrandom assignment of participants to groups and used a quasi-experimental design to evaluate the effects of a group art therapy programme for sexually abused girls.

10.2.9 Tourigny 2005

Reason for exclusion	The study used a quasi-experimental design to evaluate the effects of a group therapy programme for teenage girls who had reported sexual abuse. The group programme is described in the paper as 'psycho-educational' (p79) and does not meet our inclusion criteria.

10.2.10 Lampe 2008

Reason for exclusion	The study examined the efficacy of a three-stage psychodynamically-oriented inpatient treatment program (PITT) but did not use random assignment of participants.

10.2.11 Simoneau 2008

Reason for exclusion	The study did not involve random assignment of participants to intervention and control conditions.

10.2.12 Duffany 2009

Reason for exclusion	The assessed intervention (CTP, Children's Treatment Program) was not psychoanalytically/psychodynamically informed.

10.2.13 Ghosh Ippen 2011

Reason for exclusion	The participants in the study (75 preschool-aged children) were exposed to multiple traumatic and stressful events mostly relating to exposure to marital violence (as confirmed by their mothers); as such, the study does not meet our inclusion criteria.

10.3 CHARACTERISTICS OF STUDIES AWAITING CLASSIFICATION

10.3.1 Gould 1995

Methods	
Participants	
Interventions	
Outcomes	
Notes	

10.4 EXCLUDED STUDIES

Baker 1987

Baker CR. A Comparison of Individual and Group Therapy as Treatment of Sexually Abused Adolescent Females. Vol. 47 (10-B). Dissertations and Abstracts International, 1987.

Celano 1996

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De Luca 1995

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Duffany 2009

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Homstead 1986

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Lampe 2008

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Sullivan 1992

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Thun D, Sims PL, Adams MA, Webb T. Effects of group therapy on female adolescent survivors of sexual abuse: a pilot study. Journal of Child Sexual Abuse 2002;11(4):1-16.

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10.5 STUDIES AWAITING CLASSIFICATION

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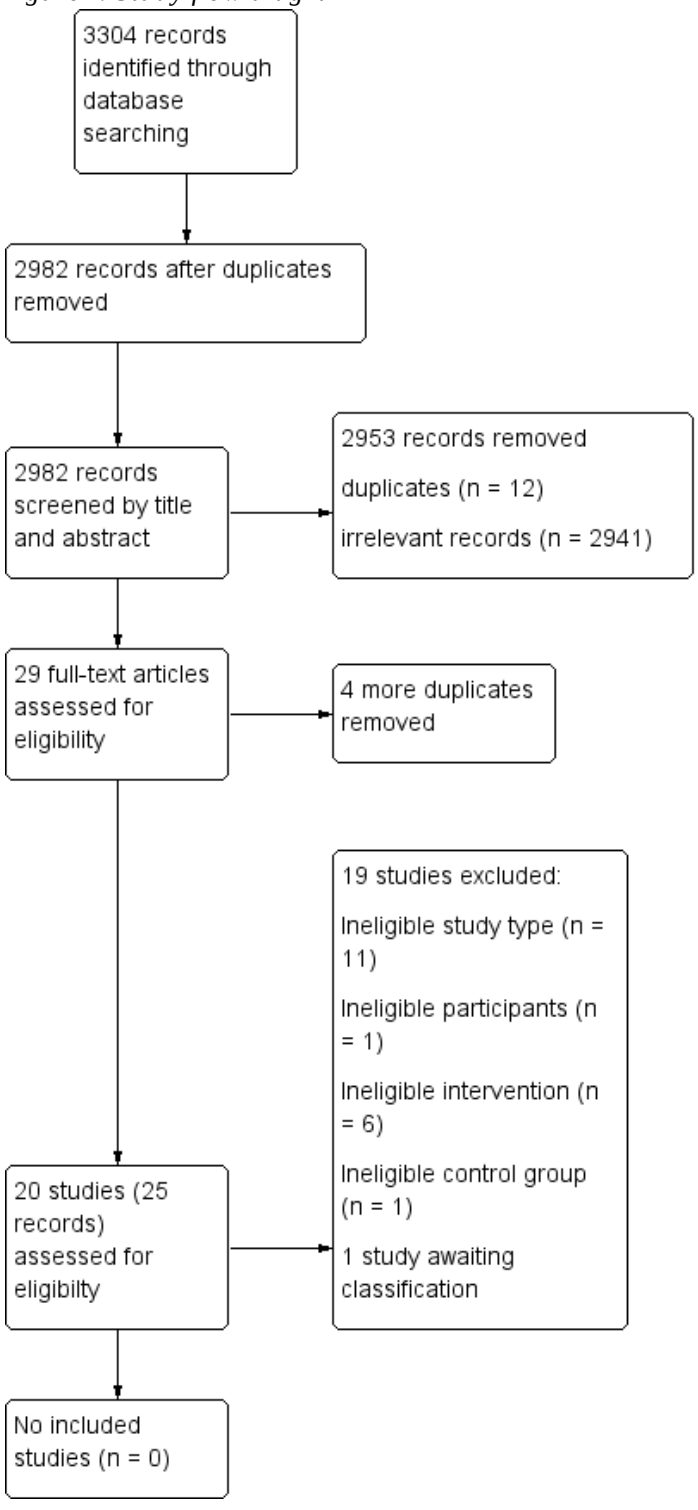
11 Figures

Figure 1: Study flow diagram



12 Sources of support

12.1 INTERNAL SOURCES

- Centre for Gender Violence Research, School for Policy Studies, University of Bristol, UK
- South West London and St Georges Mental Health NHS Trust, UK

12.2 EXTERNAL SOURCES

No sources of support provided

13 Appendices

13.1 1 SEARCH STRATEGIES

Cochrane Central Register of Controlled Trials (CENTRAL) 2013(4) Last searched 9 May 2013 (previously searched November 2009, 17 May 2012)

#1(child* near/5 abuse*)
#2(sex* near/5 abuse*)
#3(incest*)
#4(sex* near/5 offen*)
#5(sex* near/5 child*)
#6MeSH descriptor Incest explode all trees
#7MeSH descriptor Child Abuse, Sexual explode all trees
#8(#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7)
#9MeSH descriptor Psychoanalytic Therapy explode all trees
#10psychoanaly*
#11psychodynamic*
#12child* near/3 analys*
#13MeSH descriptor Psychoanalysis explode all trees
#14MeSH descriptor Psychotherapy explode all trees
#15psychotherap*
#16freud* next therap*
#17freud* next psychotherap*
#18(jung* next therap*) or (jung* next psychotherap*)
#19(klein* next therap*) or (klein* next psychotherap*):ti
#20(winnicott* next therap*) or (winnicott next psychotherap*)
#21(object relations next therap*) or (object relations next psychotherap*)
#22MeSH descriptor Psychotherapy, Group, this term only
#23(group* next therap*) or (group* next technique*) or (group* next psychotherap*)
#24(#9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23)
#25child* or girl* or boy* or schoolchild* or adolescen* or teen* or pre-school* or preschool*
#26(#8 AND #24 AND #25)

Ovid MEDLINE 1946 to May Week 1 2013 Last searched 9 May 2013
(previously searched 17 May 2012)
1 Child Abuse, Sexual/
2 incest/
3 (child$ adj5 abuse$).tw.
4 (sex$ adj5 abuse$).tw.
5 (sex$ adj5 offenc$).tw.
6 (sex$ adj5 offens$).tw.
7 incest$.tw.
8 (sex$ adj5 child$).tw.
9 or/1-8
10 exp Psychoanalytic Therapy/
11 psychoanaly$.tw.
12 psychodynamic$.tw.
13 (child$ adj3 analys$).tw.
14 Psychoanalysis/
15 exp Psychotherapy/
16 psychotherap$.tw.
17 (freud$ adj (therap$ or psychotherap$)).tw.
18 (jung$ adj (therap$ or psychotherap$)).tw.
19 (klein$ adj (therap$ or psychotherap$)).tw.
20 (winnicott$ adj (therap$ or psychotherap$)).tw.
21 (object relations adj (therap$ or psychotherap$)).tw.
22 Psychotherapy, Group/
23 (group adj (therap$ or technique$ or psychotherap$)).tw.
24 or/10-23
25 child/ or adolescent/
26 Child, Preschool/
27 (child$ or girl$ or boy$ or schoolchild$ or adolescen$ or teen$ or pre-school$ or preschool$).tw. (1011292)
28 or/25-27
29 9 and 24 and 28 (2406)
30 randomized controlled trial.pt.
31 controlled clinical trial.pt.
32 randomi#ed.ab.
33 placebo$.ab.
34 drug therapy.fs.
35 randomly.ab.
36 trial.ab.
37 groups.ab.
38 or/30-37
39 exp animals/ not humans.sh.
40 38 not 39

Medline 1950 to current searched 27 November 2009

1 (child$ adj5 abuse$).tw.
2 (sex$ adj5 abuse$).tw.
3 incest$.tw.
4 (sex$ adj5 offenc$).tw.
5 (sex$ adj5 child$).tw.
6 (sex$ adj5 offens$).tw.
7 incest/
8 Child Abuse, Sexual/
9 Incest/
10 or/1-9
11 exp Psychoanalytic Therapy/
12 psychoanaly$.tw.
13 psychodynamic$.tw.
14 (child$ adj3 analys$).tw.
15 Psychoanalysis/
16 exp Psychotherapy/
17 psychotherap$.tw.
18 (freudian adj (therap$ or psychotherap$)).tw.
19 (jungian adj (therap$ or psychotherap$)).tw.
20 (kleinian adj (therap$ or psychotherap$)).tw.
21 (winnicottian adj (therap$ or psychotherap$)).tw.
22 (object relations based adj (therap$ or psychotherap$)).tw.
23 Psychotherapy, Group/ (10123)
24 (group adj (therap$ or technique$ or psychotherap$)).tw.
25 adolescent/ or child/
26 Child, Preschool/
27 (child$ or girl$ or boy$ or schoolchild$ or adolescen$ or teen$ or pre-school$ or preschool$).tw.
28 26 or 27
29 11 or 21 or 17 or 12 or 20 or 15 or 14 or 22 or 18 or 24 or 23 or 13 or 16 or 19
30 28 and 10 and 29
31 randomized controlled trial.pt.
32 controlled clinical trial.pt.
33 randomized.ab.
34 placebo.ab.
35 drug therapy.fs.
36 randomly.ab.
37 trial.ab.
38 groups.ab.
39 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38
40 humans.sh.
41 39 and 40
42 30 and 41

PsycINFO (Ovid) 1806 to April Week 5 2013 Last searched 9 May 2013
(previously searched November 2009, 17 May 2012)
1 Sexual Abuse/
2 Incest/
3 (child$ adj5 abuse$).tw.
4 (sex$ adj5 abuse$).tw.
5 incest$.tw.
6 (sex$ adj5 offenc$).tw.
7 (sex$ adj5 offens$).tw.
8 (sex$ adj5 child$).tw.
9 or/1-8
10 exp Psychotherapy/
11 psychoanaly$.tw.
12 psychodynamic$.tw.
13 psychotherap$.tw.
14 (child$ adj3 analys$).tw.
15 (freud$ adj (therap$ or psychotherap$)).tw.
16 (jung$ adj (therap$ or psychotherap$)).tw.
17 (klein$ adj (therap$ or psychotherap$)).tw.
18 (winnicott$ adj (therap$ or psychotherap$)).tw.
19 (object relations based adj (therap$ or psychotherap$)).tw.
20 Group Psychotherapy/
21 (group adj (therap$ or technique$ or psychotherap$)).tw.
22 or/10-21
23 (child$ or girl$ or boy$ or schoolchild$ or adolescen$ or teen$ or pre-school$ or preschool$).tw.
24 (adolescence 13 17 yrs or childhood birth 12 yrs or preschool age 2 5 yrs or schoolage 6 12 yrs).ag.
25 23 or 24
26 clinical trials/
27 (randomis$ or randomiz$).tw.
28 (random$ adj3 (allocat$ or assign$)).tw.
29 ((singl$ or doubl$ or trebl$ or tripl$) adj3 (blind$ or mask$)).tw.
30 (crossover$ or "cross over$").tw.
31 random sampling/
32 Experiment Controls/
33 Placebo/
34 placebo$.tw.
35 exp program evaluation/
36 treatment effectiveness evaluation/
37 ((effectiveness or evaluat$) adj3 (stud$ or research$)).tw.
38 exp Followup Studies/
39 exp Treatment Outcomes/

40 (clinic$ adj3 trial$).tw.
41 control$.tw.
42 (prospectiv$ adj3 stud$).tw.
43 or/26-42
44 9 and 22 and 25 and 43

CINAHL (EBSCOhost) 1937 to current Last searched 9 May 2013 (previously searched November 2009, 17 May 2012)
S44 S42 and S43
S43 EM > 20091101
S42 S9 and S22 and S38 and S41 2
S41 S39 or S40
S40 AG Child, Preschool: 2-5 years OR Child: 6-12 years OR Adolescent: 13-18 years
S39 (child* or girl* or boy* or schoolchild* or adolescen* or teen* or pre-school* or preschool*)
S38 S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37
S37 TI (evaluat* study or evaluat* research) or AB (evaluate* study or evaluat* research) or TI (effectiv* study or effectiv* research) or AB (effectiv* study or effectiv* research) OR TI (prospectiv* study or prospectiv* research) or AB(prospectiv* study or prospectiv* research) or TI (follow-up study or follow-up research) or AB (follow-up study or follow-up research)
S36 placebo*
S35 crossover* or "cross over*"
S34 (MH "Crossover Design")
S33 (tripl* N3 mask*) or (tripl* N3 blind*)
S32 (trebl* N3 mask*) or (trebl* N3 blind*)
S31 (doubl* N3 mask*) or (doubl* N3 blind*)
Database - CINAHL Plus 27950 Edit S31
S30 (singl* N3 mask*) or (singl* N3 blind*)
S29 (clinic* N3 trial*) or (control* N3 trial*)
S28 (random* N3 allocat*) or (random* N3 assign*)
S27 randomis* or randomiz*
S26 (MH "Meta Analysis")
S25 (MH "Clinical Trials+")
S24 MH random assignment
S23 S9 and S22
S22 S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20 or S21
S21 (object relations based N1 (therap* or psychotherap*))
S20 (winnicottian N1 (therap* or psychotherap*))
S19 (kleinian N1 (therap* or psychotherap*))
S18 (jungian N1 (therap* or psychotherap*))

S17 (freudian N1 (therap* or psychotherap*))
S16 (group N3 (therap* or technique* or psychotherap*))
S15 psychotherap*
S14 (child* N3 analys*) 4
S13 psychodynamic*
S12 psychoanaly*
S11 (MH "Psychoanalysis")
S10 (MH "Psychotherapy+")
S9 S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8
S8 (sex* N5 child*)
S7 sex* N5 offens*
S6 (sex* N5 offenc*)
S5 incest*
S4 (sex* N5 abuse*)
S3 (child* N5 abuse*)
S2 (MH "Incest")
S1 (MH "Child Abuse, Sexual")

Sociological Abstracts (Proquest) 1952 to current Last searched 9 May 2013 (previously searched 18 May 2012)
Searched for:(SU.EXACT("Incest") OR SU.EXACT("Child Sexual Abuse") OR (child* NEAR/5abuse*) OR (sex* NEAR/5 abuse*) OR (incest*) OR (sex* NEAR/5 offenc*) OR (sex* NEAR/ 5child*) OR (sex* NEAR/5 offens*)) AND (SU.EXACT("Psychoanalysis") OR (psychotherap*) OR(psychoanaly*) OR (psychodynamic*) OR (child* NEAR/3 analys*) OR ("freud* therap*") OR("freud* psychotherap*") OR ("jung* therap*") OR ("jung* psychotherap*") OR ("klein*therap*") OR ("klein* psychotherap*") OR ("winnicott* therap*") OR ("winnicott*psychotherap*") OR ("object relations based therap*") OR ("object relations basedpsychotherap*") OR ("group therap*") OR ("group* technique*") OR ("grouppsychotherap*")) AND (SU.EXACT("Children") OR SU.EXACT("Adolescents") ORSU.EXACT("Preschool Children") OR (child* OR boy* OR girl* OR schoolchild* OR adolescen* OR teen* OR pre-school* OR preschool*)) AND ((random* OR crossover* OR placebo* OR assign* OR control* OR trial* OR blind*) OR SU.EXACT("Random Samples"))

Sociological Abstracts (CSA) 1963 to November 2009
Query: (((child* within 5 abuse*) or(sex* within 5 abuse*) or(incest*) or((sex* within 5 offenc*) or (sex* within 5 child*) or (sex* within 5 offens*)) or(DE="incest") or(DE="child sexual abuse")) and((DE="psychoanalysis") or(psychoanaly*) or(psychodynamic*) or(child* within 3 analys*) or(DE="psychotherapy") or(psychotherap*) or((freud* therap*) or (freud* psychotherap*)) or((jung* therap*) or (jung* psychotherap*)) or((klein* therap*) or (klein* psychotherap*)) or((winnicott* therap*) or (winnicott* psychotherap*)) or((object

relations based therap*) or (object relations based psychotherap*))
or((group therap*) or (group* technique*) or (group psychotherap*)))
and((DE="adolescents") or(DE=("children" or "preschool children"))
or(child* or boy* or girl* or schoolchild* or adolescen* or teen* or
pre-school* or preschool*))) and(random* or crossover* or placebo* or
assign* or control* or trial* or blind*)

Social Sciences Citation Index (SSCI) 1970 to 8 May 2013 Last searched 9 May 2013 (previously searched November 2009, 18 May 2012)
6 364 #5 AND #4
5 455,691 TS=(random* OR crossover* OR placebo* OR assign* OR control* OR trial* OR blind*)
4 1,569 #3 AND #2 AND #1
3 434,105 TS= (child* OR boy* OR girl* OR schoolchild* OR adolescen* OR teen* OR pre-school* OR preschool*)
2 70,403 TS= ((psychotherap*) OR (psychoanaly*) OR (psychodynamic*) OR (child*NEAR/3 analys*) OR ("freud* therap*") OR ("freud* psychotherap*") OR ("jung* therap*") OR ("jung* psychotherap*") OR ("klein* therap*") OR ("klein* psychotherap*") OR ("winnicott* therap*") OR ("winnicott* psychotherap*") OR ("object relations based therap*") OR ("object relations based psychotherap*") OR ("group therap*") OR ("group* technique*") OR ("group psychotherap*"))
1 29,890 TS=((child* NEAR/5 abuse*) OR (sex* NEAR/5 abuse*) OR (sex* NEAR/5 offenc*) OR (sex* NEAR/5 child*))

Conference Proceedings Citation Index-SSH Last searched 9 May 2013 (previously searched 18 May 2012). All years searched as not available in 2009
6 #5 AND #4
5 TS=(random* OR crossover* OR placebo* OR assign* OR control* OR trial* OR blind*)
4 #3 AND #2 AND #1
3 TS= (child* OR boy* OR girl* OR schoolchild* OR adolescen* OR teen* OR pre-school* OR preschool*)
2 TS= ((psychotherap*) OR (psychoanaly*) OR (psychodynamic*) OR (child* NEAR/3analys*) OR ("freud* therap*") OR ("freud* psychotherap*") OR ("jung* therap*") OR ("jung* psychotherap*") OR ("klein* therap*") OR ("klein* psychotherap*") OR ("winnicott* therap*") OR ("winnicott* psychotherap*") OR ("object relations based therap*") OR ("object relations based psychotherap*") OR ("group therap*") OR ("group* technique*") OR ("group psychotherap*"))
1 TS=((child* NEAR/5 abuse*) OR (sex* NEAR/5 abuse*) OR (sex* NEAR/5 offenc*) OR (sex* NEAR/5 child*))

LILACS Last searched 9 May 2013 (previously searched November 2009 and 18 May 2012)
Search on : ((Tw abuse$ OR Tw incest$ OR Tw offenc$ OR Tw offens$) OR (Mh "sexualabuse of CHILD" OR Mh "sexual abuse, CHILD" OR Mh "CHILD abuse")) [Words] and (Twpsychoanaly$ OR Tw psychodynamic$ OR Tw psychotherap$ OR Mh "PSYCHOTHERAPY")[Words] and ((Pt randomized controlled trial OR Pt controlled clinical trial OR Mhrandomized controlled trials OR Mh random allocation OR Mh double-blind method ORMh single-blind method) AND NOT (Ct animal AND NOT (Ct human and Ct animal)) OR (Ptclinical trial OR Ex E05.318.760.535$ OR (Tw clin$ AND (Tw trial$ OR Tw ensa$ OR Twestud$ OR Tw experim$ OR Tw investiga$)) OR ((Tw singl$ OR Tw simple$ OR Tw doubl$OR Tw doble$ OR Tw duplo$ OR Tw trebl$ OR Tw trip$) AND (Tw blind$ OR Tw cego$ ORTw ciego$ OR Tw mask$ OR Tw mascar$)) OR Mh placebos OR Tw placebo$ OR (Twrandom$ OR Tw randon$ OR Tw casual$ OR Tw acaso$ OR Tw azar OR Tw aleator$) ORMh research design) AND NOT (Ct animal AND NOT (Ct human and Ct animal)) OR (Ctcomparative study OR Ex E05.337$ OR Mh follow-up studies OR Mh prospective studies ORTw control$ OR Tw prospectiv$ OR Tw volunt$ OR Tw volunteer$) AND NOT (Ct animalAND NOT (Ct human and Ct animal))) [Words]

WorldCat (Theses/Dissertations) Last searched 9 May 2013 (previously searched 18 May 2012)
kw:(sex* abuse* + psychotherap*) | kw:(sex* abuse*+psychoanalys*) | kw:(sex* abuse* +
psychodynamic*)) + (random* | control*| rct| blind*|
experiment*|evaluat*|compar*)
Format-thesis/dissertation

ASSIA (CSA) 1987 to November 2009. Not available to authors or editorial base in 2012 and 2013
(((child* within 5 abuse*) or(sex* within 5 abuse*) or(incest*) or(sex* within 5 offen*) or(sex* within 5 child*) or(DE=("incest" or "father daughter incest" or "mother son incest")) or(DE="child sexual abuse")) and((psychoanalys*) or(psychodynamic*) or(child* within 3 analys*) or(psychotherap*) or((freud* therap*) or (Freud* psychotherap*)) or((jung* therap*) or (jung* psychotherap*)) or((klein* therap*) or (klein* psychotherap*)) or((winnicott* therap*) or (winnicott* psychotherap*)) or((object relations based therap*) or (object relations based psychotherap*)) or((group therap*) or (group technique*) or (group psychotherap*)) or(DE=("psychoanalytic theory" or "catharsis" or "cathexis" or "death instinct" or "electra complex" or "feminist psychoanalytic theory" or "interpersonal theories" or "intrapersonal theories" or "libido theory" or "oedipus complex" or "postoedipal transformations" or "superego" or "transitional objects")) or(DE=("psychoanalytic theory" or "catharsis" or "cathexis" or "death instinct" or "electra complex" or "feminist psychoanalytic theory" or "interpersonal theories" or "intrapersonal theories" or "libido theory" or "oedipus complex" or "postoedipal

transformations" or "superego" or "transitional objects")) or(DE="psychoanalysis") or(DE=("psychotherapy" or "analytical psychotherapy" or "child analytical psychotherapy" or "art therapy" or "behaviour therapy" or "aversion therapy" or "cognitive behaviour therapy" or "covert sensitization" or "selfreevaluation therapy" or "stress inoculation training" or "verbal satiation" or "contingency contracts" or "habit reversal" or "implosive therapy" or "interruption prompting" or "stimulus control" or "subconscious retraining" or "behavioural psychotherapy" or "cognitive behavioural psychotherapy" or "bibliotherapy" or "brief therapy" or "solutions based brief therapy" or "child psychotherapy" or "posttraumatic child therapy" or "psychoanalytic child psychotherapy" or "cognitive psychotherapy" or "countertransference" or "couple therapy" or "systemic couple therapy" or "dialogical psychotherapy" or "drama therapy" or "duo therapy" or "existential psychotherapy" or "experiential psychotherapy" or "experimental psychotherapy" or "family therapy" or "behaviour family therapy" or "brief family therapy" or "cognitive behaviour family therapy" or "contextual therapy" or "developmental family therapy" or "family play therapy" or "medical family therapy" or "multiple family therapy groups" or "structural family therapy" or "systemic family therapy" or "feminist therapy" or "forensic psychotherapy" or "gestalt therapy" or "group psychotherapy" or "analytical group psychotherapy" or "sociotherapy groups" or "forensic group psychotherapy" or "psychodynamic group psychotherapy" or "individual psychotherapy" or "interpersonal psychotherapy" or "milieu therapy" or "mother infant psychotherapy" or "multimodal therapy" or "music therapy" or "primal therapy" or "psychoanalytic supportive psychotherapy" or "psychodrama" or "psychodynamic therapy" or "brief psychodynamic therapy" or "psychosynthesis" or "psychotherapeutic techniques" or "mirroring" or "rational emotive therapy" or "reality therapy" or "social economy therapy" or "supportive psychotherapy" or "therapeutic communities" or "transactional analysis" or "transference" or "self object transference" or "validation therapy"))) and((child* or girl* or boy* or schoolchild* or adolescen* or teen* or pre-school* or preschool*) or(DE="adolescence") or(DE="preschool boys") or(DE="preschool girls") or(DE="preschool children") or(DE="children"))) and((random* or crossover* or placebo* or assign* or control* or trial* or blind*) or(DE=("randomized controlled trials" or "clinical randomized controlled trials" or "cluster randomized controlled trials" or "double blind randomized controlled trials" or "randomized consent design" or "single blind randomized controlled trials" or "urn randomization")))

mRCT Last searched 9 May 2013 (previously searched November 2009 and 18 May 2012)
(sex* abuse AND psychotherap*) OR (sex* abuse AND psychoanaly*)

WHO ICTRP Searched 10 May 2013. Not searched previously
sex abuse AND psychotherapy OR sex abuse AND psychoanalytic

ClinicalTrials.gov Searched 9 May 2013
Searched
Intervention psychotherapy OR psychoanalysis OR psychodynamic
Condition sex abuse
With **Children** selected