Review: psychological therapies can improve psychological symptoms in children who have been sexually abused

Ramchandani P, Jones DPH. Treating psychological symptoms in sexually abused children: from research findings to service provision. *Br J Psychiatry* 2003;**183**:484–90.

Q What are the effects of psychological therapies in children who have been sexually abused?

METHODS

Design: Systematic review with narrative synthesis.

Data sources: MEDLINE, PsychLIT, CINAHL, and Cochrane Controlled Trials Register searched, plus hand searches of five journals (1997–2002), bibliographies, and reviews. Authors and other experts were contacted. Unpublished sources were explored, including three PhD theses.

Study selection and analysis: Eligible studies included randomised controlled trials of interventions to treat the behavioural and psychological effects of sexual abuse. Relevant outcome measures were required. Trial quality was assessed using the 5 point Jadad scale. Due to trial heterogeneity, meta-analysis was not possible.

Outcomes: Behavioural or psychological effects of abuse (25 different scales used among the 12 trials).

MAIN RESULTS

Twelve trials from three countries met inclusion criteria. Trials scored low on quality, averaging 2.2 out of 5 on the Jadad score. The trials generally included children experiencing recent sexual abuse and excluded children with significant learning problems. Different types of therapy were examined, with cognitive-behavioural therapy (CBT) being studied the most. CBT appeared to be the most beneficial, particularly for younger children receiving 12 therapy sessions with their non-abusing parent or carer. Little consistent evidence favoured group versus individual therapy.

CONCLUSIONS

Some therapies have shown benefit for sexually abused children. Most studies found CBT effective. Overall, the evidence in this field is sparse. Limitations exist with respect to replication of studies, generalisability, predictions of which children will benefit and which treatment components are effective, and long term effects of therapy.

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Commentary

Twenty five years ago child sexual abuse (CSA) was regarded as rare. Recent international data show that lifetime prevalence rates of CSA is between 7% and 36% for women and 3% and 29% for men.^{1 2} Female to male ratios are typically between 1.5:1 and 3:1. CSA is associated with an increased risk, an earlier age of onset and more adverse course of depression, suicide attempt, impulsivity, substance abuse, and post-traumatic stress disorder.³

Treatment of sexually abused children has increasingly been studied. The review of Ramchandani and Jones extracts critical treatment recommendations that could be easy to generalise: to involve a non-abusing parent in the treatment, to offer a psychosocial intervention in all the cases (symptomatic and non-symptomatic) and to offer abuse focused cognitive behaviour therapy (CBT) to symptomatic youth. It is important also to emphasise their proposition to focus on outreach and active methods of keeping children and families involved with therapeutic treatment, as dropout from treatment is a concern in this population.

Given the absence of evidence for treatment improving non-symptomatic children, Ramchandani and Jones recommend focusing on symptomatic children. However, as they mention, most of the reviewed studies have been relatively brief, with short term follow up, and therefore do not inform us of the long term impact of treatment in symptomatic or non-symptomatic children. Additionally, the present research can only report symptom measures as these are the only outcomes that have been used. It is worth considering, at least for long term outcomes, if measures of adjustment would be more appropriate. Another source of concern is how to take into account the 10%–20% of children who are asymptomatic and will later deteriorate, a phenomenon called the “sleeper” effect.³ One way to address this could be, as proposed by the authors, to offer services with a long term orientation, that is not only short term symptom driven approaches but also treatment for those who present themselves at later dates or who present durable problems.

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