Best Evidence Summaries of Topics in Mental Healthcare

BEST *in* MH *clinical question-answering service*

Question

'In children that have been sexually abused, what is the most effective psychological therapy in reducing short and/or long term trauma?'

Clarification of question using PICO structure

Patients: Children and adolescents who have been sexually abused
Intervention: Any psychological therapy
Comparator: Any other psychological therapy
Outcome: Reduction in short and long term trauma

Clinical and research implications

Due to methodological limitations of the included studies, no definite clinical implications could be made from the available evidence. The current evidence does suggest that Cognitive Behavioural Therapy (CBT) is an effective treatment for children who have been sexually abused. One randomised controlled trial reported an effective CBT treatment specific to preschool children and their non-offending parents.

The authors of the included studies reported that additional well-controlled and empirically based treatment outcome studies are needed and that research should continue to identify therapy ingredients that are critical to successful outcomes. Another suggested that research should examine children presenting co-morbid conditions, the role of parental involvement and the degree of trauma focus necessary to produce optimal outcomes across domains. It was also suggested that it is important to develop, identify and utilise psychometrically sound instruments designed for young children.

What does the evidence say?

Number of included studies/reviews (number of participants)
Three RCTs (Cohen 1996; Deblinger 2001; Deblinger 2011) and two follow-up studies (Cohen 1997; Mannarino 2012) met the inclusion criteria for this BEST summary.

Main Findings
One randomised trial compared the effectiveness of cognitive-behavioural therapy adapted for sexually abused pre-school children (CBT-SAP) with nondirective supportive therapy (NST) (Cohen 1996). After 12 therapy sessions, children who received CBT-SAP had better scores for all outcomes;

more than half of which were statistically significant. A one year follow-up of this study demonstrated lasting effects (Cohen 1997).
Another randomised trial compared supportive group therapy and cognitive behavioural group therapy for young children (two to eight years of age) and their non-offending mothers (Deblinger 2001). After therapy, eight out of 11 measures evaluated were improved in participants who received gruop CBT. Mothers who participated in cognitive behavioural groups reported significantly greater reductions at post-test in their intrusive thoughts and their negative parental emotional reactions regarding the sexual abuse, compared with mothers who received supportive therapy. In addition, the authors reported that the children treated with CBT demonstrated a significantly greater improvement in their knowledge regarding body safety skills at post-test compared with children who received supportive therapy.

A further study by Deblinger (2011) evaluated the effects of Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) with or without a trauma narrative (TN) component delivered in 8 versus 16 sessions to children (4-11 years of age) and their non-offending parents. The authors evaluated 14 outcome measures, and found that TF-CBT was generally effective. Some differential responses were, however, found across groups depending on the outcome evaluated. For example, parents in the 16 No TN group reported significantly greater improvements in parenting practices than those assigned to the Yes TN groups. Children who were treated without the TN component were rated by their parents as having less severe externalising behaviour problems than those who were treated with the TN component. In addition, parents in the 8 Yes TN group described less abuse-specific emotional distress after treatment than the parents in the 8 No TN group. Regardless of treatment length, the levels of abuse-related fear were less for the children who had been assigned to the Yes TN groups. Similarly, the children assigned to the 8 Yes TN group reported significantly less anxiety as compared to children assigned to the 8 No TN group. With respect to post-traumatic stress disorder (PTSD) symptoms, longer length of treatment was associated with a decrease in the number of avoidance and re-experiencing symptoms. The authors noted, however, that the addition of eight more sessions yielded a decrease in approximately only one PTSD symptom. A follow-up of this study demonstrated that the significant improvements were sustained at 6 and 12 months after treatment (Mannarino 2012). In addition, two of the measures (child self-reported anxiety and parental emotional distress) showed improvements at 12-months follow-up.

Authors Conclusions
Cohen (1996) concluded that there is strong preliminary evidence for the effectiveness of a specific cognitive-behavioural treatment model (CBT-SAP) for sexually abused preschool children and their parents and that this reduction was maintained a year after treatment (Cohen 1997).

Deblinger (2001) concluded that their findings support the growing body of evidence suggesting CBT group therapy is effective.

Deblinger (2011) concluded that TF-CBT, regardless of the number of sessions or the inclusion of a TN component, was effective in improving participant symptomatology as well as parenting skills and the children's personal safety skills. The eight session condition that included the TN component seemed to be the most effective and efficient means of ameliorating parents' abuse-specific distress as well as children's abuse-related fear and general anxiety. On the other hand, parents assigned to the 16 session, no narrative condition reported greater increases in effective parenting practices and fewer externalising child behavioural problems at post-treatment. The authors also

noted, however, that the findings should be interpreted with caution. The follow-up study by Mannario (2012) confirmed TF-CBT had a positive effect over time but the differences between the four conditions at post-treatment were not sustained.

Reliability of conclusions/Strength of evidence

As might be expected, all of the studies had high attrition rates, and many of the studies had small sample sizes. This and other methodological limitations undermine the reliability of the results and hence the conclusions made from them are uncertain.

What do guidelines say?

NICE (2005)

"The evidence base from which to draw conclusions about the treatment of children under 7 years old suffering from PTSD is sparse. The lack of agreement on and use of a common set of measures is particularly of concern for studies of PTSD in very young children and adds to the difficulties of interpreting an extremely limited data-set. All treatments need to be adapted to accommodate young children's less mature ways of thinking about their world, and often clinicians will use play materials and drawings to help children focus on what happened to them and how they feel. However, there is a lack of high-quality (randomised controlled trial) evidence that specific types of play therapy or art therapy have therapeutic value in treating PTSD in young children." (pp.114)

"Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused cognitive-behavioural therapy adapted appropriately to suit their age, circumstances and level of development. Where appropriate, families should be involved in the treatment of PTSD in children and young people. However, treatment programmes for PTSD in children and young people that consist of parental involvement alone are unlikely to be of any benefit for PTSD symptoms. The duration of trauma-focused psychological treatment for children and young people with chronic PTSD should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are usually necessary (for example, 90 min). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person. Drug treatments should not be routinely prescribed for children and young people with PTSD. When considering treatments for PTSD, parents and, where appropriate, children and young people should be informed that, apart from trauma-focused psychological interventions, there is at present no good evidence for the efficacy of widely used forms of treatment of PTSD such as play therapy, art therapy or family therapy." (pp. 115)

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REFERENCES

Guidelines

National Institute for Health and Care Excellence (2005) Post-traumatic stress disorder. The management of PTSD in adults and children in primary and secondary care. CG26. London: National Institute for Health and Care Excellence
http://www.nice.org.uk/nicemedia/live/10966/29772/29772.pdf

RCTs

Cohen, J.A. and Mannarino, A.P. (1996) A Treatment Outcome Study for Sexually Abused Preschool Children; Initial Findings. *Journal of American Academy of Child and Adolescent Psychiatry 5* **(1)** pp. 42-50.

Cohen, J.A. and Mannarino, A.P. (1997) A Treatment Outcome Study for Sexually Abused Preschool Children; Outcome during a One-year Follow Up. *Journal of American Academy of Child and Adolescent Psychiatry 36* **(9)** pp. 1228-1235.

Deblinger, E., Mannarino, A.P., Cohen, J.A., Runyon, M.K. and Steer, R.A. (2011) Trauma- focused Cognitive Behavioural Therapy for Children: Impact of The Trauma Narrative and Treatment Length. *Depression and Anxiety 28*. pp.67–75.

Deblinger, E., Stauffer, L.B. and Steer, R.A. (2001) Comparative Efficacies of Supportive and Cognitive Behavioral Group Therapies for Young Children Who have been Sexually Abused and their Nonoffending Mothers. *Child Maltreatment 6* pp. 332-343.

Mannarino, A.P., Cohen, J.A., Deblinger, E., Runyon, M.K. and Steer, R.A. (2012) Trauma-Focused Cognitive-Behavioral Therapy for Children : Sustained Impact of Treatment 6 and 12. *Child Maltreatment 17***(3)** pp. 231-241

Results

RCTs/DTAs

Author (year)	Inclusion criteria	Number of participants	Summary of results	Risk of bias
Cohen and Mannarino (1996)	*Patient*s: Male and female 3-6 year olds, mean age of 4.68 years. Most recent sexual abuse no more than 6 months before referral to the study. *Intervention*: Cognitive-behavioural therapy adapted for sexually abused pre-school children (CBT-SAP) – structured, short-term treatment model for sexually abused preschool children and their parents. *Comparison*: NST – Nondirective support therapy, not specific to sexual abuse. *Outcome*: Symptom reduction – displaying of sexually inappropriate behaviour. Child measures; The Preschool Symptom Self-Report (Martini et al 1990). Parents measures: CBCL-Parent Version (Achenbach and Edelbrook 1983). Each group received 12 sessions that were one and a half hours long.	N = 86 (n = 67 included in the analyses)	At post-treatment, children who received CBT-SAP had significantly better scores for Behaviour Profile-Total (BPT) ($p<0.01$), Internalizing (Int) ($p<0.002$), Child Sexual Behaviour Inventory (CSBI) ($p<0.05$), and Weekly Behavioural Record - Total ($p<0.05$) compared to children who received NST. Scores were also better in children who received CBT-SAP for Social Competence (Soc), Externalizing (Ext), and Weekly Behavioural Record – Types, but the results did not reach statistical significance. There was no significant difference between the groups for Preschool Symptom Self-Report (PRESS).	High
Cohen and Mannarino (1997)	*Patient*s: Male and female 3-6 year olds, mean age of 5 years 9 months. Most recent sexual abuse no more	N = 43	One year follow-up of Cohen (1996) study. Repeated-measures analyses were used to assess group	High

	than 6 months before referral to the study. *Intervention*: CBT-SAP – structured, short-term treatment model for sexually abused preschool children and their parents. *Comparison*: NST – Nondirective support therapy, not specific to sexual abuse. *Outcome*: Symptom reduction – displaying of sexually inappropriate behaviour. Child Behaviour Checklist – Parent Checklist (Achenbrach and Edelbrock 1983), WBR (Cohen and Mannarino 1996c).		changes. These analyses revealed significant changes on all instruments, with a main effect for time on all measures (as reported above). There were significant group by time interactions on three of the four broad-band CBCL scales (Behaviour Profile Total, Internalizing, and Externalizing) and on both WBR scales (Type and Total), with the CBT-SAP group improving significantly more on these measures over time than the NST group.	
Deblinger et al. (2011)	*Patient*s: Male and female sexually abused children 4-11 years, mean age of 7.7 years, displaying at least 5 PTSD symptoms. *Intervention*: Trauma-focussed cognitive behavioural therapy inclusive of trauma narrative (TN). *Comparison*: Trauma-focussed cognitive behavioural therapy not inclusive of trauma narrative. *Outcomes*: The presence (reduction of) of DSM-IV-TR PTSD symptoms. The number of symptoms representing reexperiencing, avoidance and hypervigilance was summed.	N = 210 (n = 179 included in the analyses)	*Parent reported outcomes*: Parents who were assigned to No TN conditions described significantly greater improvements on their PPQ scores than the parents who were assigned to Yes TN conditions ($p<0.05$). Parents in the 16 No TN condition described higher levels of effective parenting practices as compared to parents in the Yes TN conditions ($p<0.05$). The children who had received the No TN conditions were also rated by their parents as having fewer CBCL externalising problems than the children assigned to the Yes TN conditions ($p<0.01$). With respect to the PERQ, parents who were assigned to the 8 Yes TN group described themselves as being less emotionally upset by the abuse than did the parents who were assigned to the 8 No TN group at the post-treatment assessment ($p<0.05$). *Child reported outcomes*: Children who had received the TN component described less fear associated with thinking	Unclear

	Outcomes; Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version, Parent; Beck Depression Inventory-II, Child Behavior Checklist, Child Sexual Behavior Inventory, Parent Emotional Reaction Questionnaire, Parent Practices Questionnaire. Child; The Children's Depression Inventory, Fear Thermometer, Multidimensional Anxiety Scale for Children, The Shame Questionnaire, What If Situations Test.		or talking about the abuse as compared to the children in the No TN conditions ($p<0.001$). Furthermore, on the MASC, children assigned to the 8 Yes TN condition reported less anxiety at post-treatment as compared to children assigned to the 8 No TN condition ($p<0.001$). Children who received 16 sessions were rated as having fewer symptoms of re-experiencing and avoidance at post-treatment than those who received 8 sessions ($p<0.01$ for both). No differences were found across the treatment conditions for the following outcomes: K-SADS hypervigilance, CBCL internalising, CSBI, BDI-II, CDI, Shame, and WIST Skills (see paper).	
Deblinger et al. (2001)	*Patient*s: Non-offending maternal care providers (e.g. mother, grandmother) and their children, male and female aged 2-8 years, mean age 5.45 years. *Intervention*: Cognitive behavioural group therapy. *Comparison*: Supportive counselling. *Outcome*: To assess the therapeutic gains made by children and their parents after therapy. For maternal carers; Miller Behaviour style Scale (Miller 1990), SCL-90-R Posttraumatic Symptom Scale (Derogatis 1983), IES, Parent Emotional Reaction Questionnaire, Social Support Questionnaire, Therapy Satisfaction Questionnaire. For children; PTSD	N = 67 (n=44 included in the analyses)	Repeated measures MANOVAs (time / time x group) demonstrated that mothers who participated in the cognitive behavioural groups reported significantly greater reductions in Impact of Events-Intrusive Thoughts ($p<0.05$) and Parent Emotional Reaction Questionnaire ($p<0.001$) compared with women who participated in the support groups. In addition, children treated with CBT demonstrated greater improvement in their knowledge regarding body safety skills at post-test than did children who received supportive therapy (What If Situations Test, $p<0.05$)). Significant differences between groups were not reported for the following outcomes: SCL-90-R Post-Traumatic Stress subscale, Impact of Events-Avoidance of Thoughts, Social Support-Emotional subscale, Social Support-Problem-Solving subscale, Parental Practices Questionnaire, Post-traumatic Stress Symptoms Scale, Child Behaviour Checklist, and Child Sexual Behaviour Inventory.	Unclear

	scale, Child Behaviour Checklist, Child Sexual Behaviour Inventory, What If Situations Test. The parents' and children's groups met for a total of 11 sessions for 1 hour and 45 min each session. The CBT group met for an additional 15 min each week for a joint parent and child activity session.			
Mannarino (2012)	*Patient*s: Sexually abused male and female 4-11 year olds, mean age at admission of 7.60 years. *Intervention*: Trauma-focussed cognitive behavioural therapy inclusive of trauma narrative. *Comparison*: Trauma-focussed cognitive behavioural therapy not inclusive of trauma narrative. *Outcome*: A reduction of DSM-IV-TR PTSD symptoms, whether gains made post-treatment would be maintained at 12 month follow up and if this was influenced by clinical or background characteristics of the child. Outcome measures; Schedule for affective disorders and schizophrenia for school-age children-present lifetime version (Kaufman et al 1997). For parents; Beck Depression Inventory (Besk, Steer and Brown 1996), Child Behaviour Checklist (Achenback 1991), Child	N = 158	Six month and one year follow-up of Deblinger (2011) study. Overall significant improvements across 14 outcome measures that had been reported at post-treatment (see above) were sustained 6 and 12 months after treatment, and on two of these measures (child self-reported anxiety and parental emotional distress) there were additional improvements at the 12-month follow-up. Although all four groups continued to improve, the differences between the four conditions at post-treatment were not sustained at 6- and 12-month follow-up.	High

	Sexual Behaviour Inventory (Friedrich et al 1992), Parent Emotional Reaction Questionnaire (Cohen and Marrarino 1996), The Parent Practices Questionnaire (Strayhorn and Weidman 1988). For children; Children's Depression Inventory (Koracs 1992), Fear Thermometer (Hernsen and Bellack 1988), Multidimensional Anxiety Scale for children (March et al 1997), Shame Questionnaire (Feiring, Taska and Lewis 1999), What If Situations Test (Carno and Wurtele 1997).			

Risk of Bias:

RCTs

Study	RISK OF BIAS					
	Random allocation	Allocation concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective Reporting
Cohen 1996	☺	?	NA	☺	☹	?
Cohen 1997	☺	?	NA	☺	☹	☺
Deblinger 2011	?	?	☺ personnel	☺	☹	?
Deblinger 2001	?	?	NA	☺	☹	?
Mannarino 2012	?	?	☺ personnel	☺	☹	?

☺Low Risk ☹High Risk ? Unclear Risk

Search Details

Source	Search Strategy	Number of hits	Relevant evidence identified
SRs and Guidelines			
NICE	Child Sexual Abuse	86	1
DARE	(child* ADJ5 abuse*) IN DARE 80 2 (sex* ADJ5 abuse*) IN DARE 50 3 (incest*) IN DARE 1 4 (sex* ADJ5 offence*) IN DARE 6 5 (sex* ADJ5 child*) IN DARE 37 6 (sex* ADJ5 offense*) IN DARE 11 7 (child*) IN DARE 4468 8 (infant*) IN DARE 1762 9 (teenage*) IN DARE 50 10 (adolescen*) IN DARE 1962 11 (pre-school*) IN DARE 63 12 (preschool*) IN DARE 779 13 (baby) IN DARE 400 14 (babies) IN DARE 495 15 MeSH DESCRIPTOR Child Abuse, Sexual EXPLODE ALL TREES 21 16 MeSH DESCRIPTOR Sex Offenses EXPLODE ALL TREES 36 17 MeSH DESCRIPTOR Sex Offenses EXPLODE ALL TREES 36 18 MeSH DESCRIPTOR Incest EXPLODE ALL TREES 0 19 MeSH DESCRIPTOR Child Abuse EXPLODE ALL TREES 50 20 MeSH DESCRIPTOR Sex Offenses EXPLODE ALL TREES 36 21 MeSH DESCRIPTOR Child Abuse, Sexual EXPLODE ALL TREES 21 22 MeSH DESCRIPTOR Child EXPLODE ALL TREES 3199 23 MeSH DESCRIPTOR Child, Preschool EXPLODE ALL TREES 1571 24 MeSH DESCRIPTOR Infant EXPLODE ALL TREES 1993 25 MeSH DESCRIPTOR Adolescent EXPLODE ALL TREES 3084	112	0

	26 MeSH DESCRIPTOR Adolescent Psychology EXPLODE ALL TREES 16 27 MeSH DESCRIPTOR Adolescent Psychiatry EXPLODE ALL TREES 7 28 #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 9138 29 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 134 30 #28 AND #29		
Primary studies			
CENTRAL	#1 MeSH descriptor: [Child Abuse, Sexual] explode all trees 165 #2 MeSH descriptor: [Child Psychology] 225 #3psychotherap*7487 #4psycholog*56570 #5#2 or #3 or #459209 #6#1 and #5 146	129	
PsycINFO	1. PsycINFO; CHILD ABUSE/; 21592 results. 2. PsycINFO; SEXUAL ABUSE/; 15539 results. 3. PsycINFO; child*.ti,ab; 489670 results. 4. PsycINFO; 2 AND 3; 10795 results. 5. PsycINFO; (child* AND sex* AND abuse*).ti,ab; 15144 results. 6. PsycINFO; (child* AND sex* AND trauma*).ti,ab; 4457 results. 7. PsycINFO; (child* AND sex* AND maltreat*).ti,ab; 1426 results. 8. PsycINFO; CHILD PSYCHOTHERAPY/; 5056 results. 9. PsycINFO; psychotherapy.ti,ab; 68050 results. 10. PsycINFO; (psychological AND therap*).ti,ab; 24508 results. 11. PsycINFO; desensitiz*.ti,ab; 5160 results. 12. PsycINFO; (therapeutic oR psychological).ti,ab; 327570 results. 13. PsycINFO; 1 OR 4 OR 5 OR 6 OR 7; 28271 results. 14. PsycINFO; 8 OR 9 OR 10 OR 11 OR 12; 380225 results. 15. PsycINFO; 13 AND 14; 5886 results. 16. PsycINFO; 15 [Limit to: (Methodology 2000 Treatment Outcome/Clinical Trial)]; 50 results.	50	
Embase	17. EMBASE; CHILD ABUSE/; 21709 results.	151	

	18. EMBASE; CHILD SEXUAL ABUSE/; 6117 results. 19. EMBASE; (child* AND sex* AND abuse*).ti,ab; 10100 results. 20. EMBASE; (child* AND sex* AND trauma*).ti,ab; 3400 results. 21. EMBASE; (child* AND sex* AND maltreat*).ti,ab; 934 results. 22. EMBASE; CHILD PSYCHOTHERAPY/; 14002 results. 23. EMBASE; CHILD PSYCHOLOGY/; 17494 results. 24. EMBASE; psychotherapy.ti,ab; 33292 results. 25. EMBASE; (psychological AND therap*).ti,ab; 25886 results. 26. EMBASE; desensitiz*.ti,ab; 25610 results. 27. EMBASE; (therapeutic oR psychological).ti,ab; 881523 results. 28. EMBASE; 17 OR 18 OR 19 OR 20 OR 21; 31106 results. 29. EMBASE; 22 OR 23 OR 24 OR 25 OR 26 OR 27; 956698 results. 30. EMBASE; 28 AND 29; 4373 results. 31. EMBASE; 30 [Limit to: (Clinical Trials Clinical Trial or Randomized Controlled Trial or Controlled Clinical Trial or Multicenter Study)]; 151 results.		
MedLine	33. MEDLINE; CHILD ABUSE/; 16355 results. 34. MEDLINE; CHILD SEXUAL ABUSE/; 7937 results. 35. MEDLINE; (child* AND sex* AND abuse*).ti,ab; 7994 results. 36. MEDLINE; (child* AND sex* AND trauma*).ti,ab; 2555 results. 37. MEDLINE; (child* AND sex* AND maltreat*).ti,ab; 775 results. 38. MEDLINE; CHILD PSYCHOTHERAPY/; 0 results. 39. MEDLINE; CHILD PSYCHOLOGY/; 11824 results. 40. MEDLINE; psychotherapy.ti,ab; 23663 results. 41. MEDLINE; desensitiz*.ti,ab; 22150 results. 42. MEDLINE; (therapeutic oR psychological).ti,ab; 660715 results. 43. MEDLINE; 33 OR 34 OR 35 OR 36 OR 37; 25963 results. 45. MEDLINE; (trauma AND therapy).ti,ab; 10725 results. 46. MEDLINE; (child adj5 therapy).ti,ab; 1835 results. 47. MEDLINE; 39 OR 40 OR 41 OR 42 OR 45 OR 46; 721389 results. 48. MEDLINE; (child adj5 psychotherap*).ti,ab; 440 results.	128	

	49. MEDLINE; 39 OR 40 OR 41 OR 42 OR 45 OR 46 OR 48; 721413 results. 50. MEDLINE; 43 AND 49; 3062 results. 51. MEDLINE; 50 [Limit to: (Publication Types Clinical Trial or Controlled Clinical Trial or Randomized Controlled Trial)]; 128 results.		
Summary	**NA**	**NA**	

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