

COGNITIVE-BEHAVIOURAL TREATMENT OF SEXUALLY ABUSED CHILDREN: A REVIEW OF RESEARCH

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Abstract. Child sexual abuse is a prevalent form of child maltreatment that frequently occasions severe disturbance including posttraumatic stress disorder. This review focuses on recent cognitive-behavioural treatment initiatives designed specifically for sexually abused children, and the extent to which they are empirically supported. Our review draws on case studies, open clinical trials, multiple baseline investigations and randomized clinical trials. At first glance, the research findings are encouraging for the efficacy and acceptability of cognitive-behaviour therapy. However, more conservative conclusions are reached when stringent criteria are applied regarding evidentiary support for psychosocial interventions. Directions for future research are also explored.

Keywords: Sexual abuse, child, posttraumatic stress disorder, treatment.

Introduction

The sexual abuse of children is a major societal problem because of its high prevalence and devastating impact on the victimized child (Deblinger, McLeer, & Henry, 1990; Gorey & Leslie, 1997). Girls are especially at risk of sexual abuse. On the basis of community-retrospective studies, it has been estimated that as many as 54% of girls and 18% of boys experience sexual abuse before the age of 18 (Anderson, Martin, Mullen, Romans, & Herbison, 1993; Fleming, 1997; Russell, 1984). Although methodological limitations are acknowledged with these studies (Gorey & Leslie, 1997), it is nonetheless clear that child sexual abuse has a high prevalence and occurs across all

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socioeconomic, educational, racial and ethnic groups (see reviews by Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Massoth, 1986; Green, 1993).

Children who have been sexually abused often exhibit elevated anxiety, depressive symptomatology, inappropriate sexual behaviour, nightmares, social withdrawal, sleep difficulties, anger, shame/guilt and school problems (Alter-Reid et al., 1986; Kendall-Tackett, Williams, & Finkelhor, 1993; Wolfe & Birt, 1995). Physiological symptoms, such as headaches and stomachaches, may also be part of the sequelae of child sexual abuse (Kimerling & Calhoun, 1994). For most child victims, these emotional and behavioural symptoms also continue to manifest themselves for many years (Carlson, Furby, Armstrong, & Shlaes, 1997; Oates, O'Toole, Lynch, Stein, & Cooney, 1994). In other words, trauma-related disturbance should not be dismissed as something that is short-lived and clinically unimportant.

Quite a few of these symptoms will be recognized as being characteristic of post-traumatic stress disorder (PTSD). The *Diagnostic and statistical manual of mental disorders* (DSM-IV) specifies the following criteria for a diagnosis of PTSD: (a) the person has experienced or witnessed a traumatic event(s) that elicited intense fear, helplessness or horror; (b) persistent reexperiencing of the traumatic event, such as in distressing memories or dreams about the event; (c) persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness; and (d) persistent symptoms of increased arousal such as sleep disturbance, irritability or difficulties in concentration (American Psychiatric Association, 1994). Developmental considerations are noted for several of the criteria. Thus, PTSD in young children may be experienced through "childhood" ways such as disorganized or agitated behaviour and repetitive play or drawings in which aspects of the trauma are expressed. Recent studies confirm that on clinical evaluation a large proportion of sexually abused children meet diagnostic criteria for PTSD (e.g., Kiser et al., 1988; McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988; Merry & Andrews, 1994). Consequently, PTSD formulations of the impact of child sexual abuse have become quite prominent in the literature (Wolfe & Birt, 1995; Wolfe, Gentile, & Wolfe, 1989).

The etiology and maintenance of PTSD or emotional/behavioural problems in sexually abused children is not fully understood, although it is likely that many interactive factors are involved (Carlson et al., 1997; Wolfe & Birt, 1995). In relation to abuse characteristics, many studies suggest that abuse perpetrated by a parent/step-parent and abuse involving physical force and/or more invasive contact may be related to an increased negative impact (e.g., Conte & Schuerman, 1987; Friedrich, Urquiza, & Beilke, 1986; McLeer et al., 1988). Cognitive factors such as the child's perception of the abuse and attributional style also appear to be important in the development of guilt, self-blame and faulty attributions (Wozencraft, Wagner, & Pellegrin, 1991). Further, the family context has been shown to be a critical influence on post-abuse adjustment. In particular, researchers have found that parental emotional distress, lack of maternal support and maternal depression appear to exacerbate emotional and behavioural disturbances in sexually abused children (Anderson, Bach, & Griffith, 1981; Tufts, 1984).

Clearly, empirically supported psychological interventions are urgently required by mental health professions responsible for the management of sexually abused children exhibiting emotional/behavioural difficulties or PTSD (O'Donohue & Elliot, 1992).

Cognitive-behavioural treatments, incorporating exposure and cognitive therapy, have been found to be effective in the treatment of adult trauma sufferers, particularly rape victims and Vietnam combat veterans (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991; Keane, Fairbanks, Caddell, & Zimering, 1989). Given the empirically demonstrated success of these interventions with adults suffering from PTSD, it is logical that cognitive-behavioural interventions be specifically designed for sexually abused children. We now review recent cognitive-behavioural treatment initiatives for sexually abused children and the extent to which these programs are empirically supported. Although a number of excellent reviews have been published on the psychological treatment of sexually abused children (Finkelhor & Berliner, 1995; O'Donohue & Elliot, 1992; Reeker, Ensing, & Elliot, 1997), this is the first review of research on cognitive-behaviour therapy with this clinical population.

Clinical and research support

While randomized clinical trials are rightfully considered the “gold standard” of treatment outcome research (Finkelhor & Berliner, 1995), we decided to include studies representative of the broad range of research methodologies employed in clinical settings. Hence, our review of cognitive-behaviour therapy and sexually abused children includes case studies, open clinical trials, multiple baseline design investigations and randomized clinical trials. Relevant published articles were located through searching the computerized database PsychInfo (1980–1999). We also examined selected peer-review journals known to publish treatment evaluation studies on sexually abused children (e.g., *Child Maltreatment* and *Journal of the American Academy of Child and Adolescent Psychiatry*). Conference proceedings and dissertations were excluded.

Case studies

Several controlled single case investigations attest to the usefulness of behavioural and cognitive procedures in the treatment of sexually abused children (see review by O'Donohue & Elliot, 1992). For example, Becker, Skinner and Abel (1982) conducted a controlled single case investigation with a 4-year-old girl. The child was an incest victim and exhibited a range of emotional and behavioural problems. Of particular concern, she had lost 20% of her body weight, was refusing to eat meals, engaged in self-injurious behaviours and exhibited phobic reactions. A contingency management program implemented by the mother was effective in reducing self-injurious and phobic behaviour and in dealing with her potentially life threatening eating habits. A 2-month follow-up assessment indicated that the treatment-produced improvements remained stable.

Kolko (1986) reported social-cognitive skills training with an 11-year-old who had a history of sexual abuse. The boy was placed on an inpatient psychiatric facility after sexually abusing a young girl. He was socially withdrawn and aggressive towards children and adults. Social-cognitive skills training produced clinically significant improvement on the targeted behaviours (e.g., eye contact and physical gestures). The use of a multiple baseline design across behaviours demonstrated a functional relationship

between social-cognitive skills training and therapeutic gains. A 1-year follow-up indicated maintenance of treatment gains. While discussions of treatment research tend to focus on child victims, this particular case study serves to remind us of societal and family needs in relation to the perpetrators of sexual abuse.

Open clinical trials

We identified two open clinical trials of interest to our review (Deblinger et al., 1990; Stauffer & Deblinger, 1996). In the initial study, Deblinger et al. evaluated the efficacy of a cognitive-behavioural treatment program designed for sexually abused children suffering from PTSD. Assessment of PTSD relied on a structured clinical interview. Nineteen girls who suffered contact sexual abuse and met DSM-III-R criteria for PTSD were included in the study. Subjects ranged in age from 3 to 16 years. Individual treatment was provided to both the child and non-offending primary caregiver in 12 sessions. Therapy sessions with the child incorporated, for example, coping skills training, graduated exposure to help confront abuse-related thoughts and memories, and prevention skills training. Therapy sessions with parents focused on strengthening parent-child communication skills and behaviour management skills. Assessment tools included a structured clinical interview with the child and parents to assess PTSD symptomatology. Parents completed the Child Behavior Checklist (Achenbach & Edelbrock, 1983). Children aged 6 years or older completed the State-Trait Anxiety Inventory for Children (Spielberger, 1973) and Children's Depression Inventory (Kovacs, 1985). These measures were taken twice before intervention in order to demonstrate the stability of the various symptoms. The measures were repeated again at posttreatment. Results showed significant improvements on all measures. Further, none of the children met diagnostic criteria for PTSD following treatment.

A subsequent investigation involved a much broader clinical evaluation of the impact of group cognitive-behaviour therapy on 19 nonoffending mothers and their sexually abused children (Stauffer & Deblinger, 1996). The cognitive-behavioural intervention package was similar to that used in the Deblinger et al. (1990) trial, except intervention was administered to families on a group basis. Separate group sessions were organized for the children and parents over an 11-week period (1 session per week). This investigation evaluated changes in the following dependent variables across initial contact, pretreatment, posttreatment and 3-month follow-up assessment points:

- (a) General parental distress as measured by the Symptom Checklist-90-Revised (Derogatis, 1983).
- (b) Parental distress related directly to the abuse as measured by the avoidance and intrusive thoughts subscales of the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979).
- (c) Parents' reports of children's overall behaviour functioning as measured by the Child Behavior Checklist (Achenbach & Edelbrock, 1983).
- (d) Parents' reports of children's sexualized behaviours as measured by the Child Sexual Behavior Inventory (Friedrich et al., 1992).
- (e) Parents' reports of their interactions with their children, including behaviour management strategies and abuse-related discussions/interactions as measured by the Parenting Practices Questionnaire (Strayhorn & Weidman, 1988).

Cognitive-behavioural therapy groups resulted in significant improvements on the various measures of maternal and child symptomatology, as well as improvements in self-reported parenting practices. More specifically, mothers experienced lower levels of general distress, less avoidance of abuse-related thoughts and feelings, and more appropriate responses to their children's behaviour and abuse-related issues following participation in the group program. The improvements achieved during treatment were maintained at 3-month follow-up. Overall, the results of these open trials are definitely encouraging for the efficacy of cognitive-behaviour therapy and signal the need for controlled investigations.

Multiple baseline design investigations

Our search located only one study in this category (Farrell, Hains, & Davies, 1998). The researchers examined the effectiveness of a cognitive-behavioural intervention with four sexually abused children exhibiting PTSD, using a multiple baseline design across subjects. Participants (3 girls, 1 boy; age: 8–10 years) were assessed for PTSD symptomatology in a clinical interview using the Childhood Posttraumatic Stress Disorder Reaction Index (Frederick, Pynoos, & Nader, 1992). Assessment also included self-report measures of anxiety and depression (Revised Children's Manifest Anxiety Scale; Reynolds & Richmond, 1978; Reynolds Child Depression Scale; Reynolds, 1989; respectively). Children were assessed before and after treatment, and at a 3-month follow-up. In addition, these instruments were administered during baseline and prior to each treatment session. Treatment was confined to individual therapy sessions with the child only (10 weeks, 9 sessions). The treatment package contained educational components, self-monitoring, relaxation training, cognitive-restructuring, role-playing, and *in vivo* practice of skills. All four participants reported decreases in their PTSD symptomatology. The three participants who had elevated levels of depression and anxiety during baseline showed decreases with treatment. Although the results of this multiple baseline across subject investigation suggest that cognitive-behavioural techniques can be effective in the treatment of sexually abused children, randomized clinical trials afford a more robust empirical evaluation.

Randomized clinical trials

Four randomized clinical trials were identified in our search (Berliner & Saunders, 1996; Cohen & Mannarino, 1996a, 1998; Deblinger, Lippmann, & Steer, 1996). Cohen and Mannarino (1996a) report a controlled investigation on the efficacy of cognitive-behaviour therapy for sexually abused preschool children exhibiting emotional and behavioural symptomatology. Eighty-six sexually abused preschool-aged children (58% girls, 42% boys) and their parents were recruited for the investigation. Families were randomly assigned to either cognitive-behavioural therapy or nondirective supportive therapy. Treatment consisted of 12 individual sessions for both the child and parent. The cognitive-behaviour therapy condition incorporated cognitive reframing, thought-stopping, positive imagery, contingency reinforcement, parent management training and problem solving. Designed to control for the nonspecific aspects of intervention, the nondirective supportive therapy condition emphasized the expression of feelings

and consolidation of the therapeutic bond. Each of the treatment conditions was monitored for integrity with the therapeutic model through intensive training and supervision, use of treatment manuals, and review of audiotaped sessions. Of the 86 initial participants, 67 completed the entire treatment (13 dropouts, 6 removed from study).

Parents completed the Child Behavior Checklist (Achenbach & Edelbrock, 1983), the Child Sexual Behavior Inventory (Friedrich et al., 1992), and the Weekly Behavior Report (Cohen & Mannarino, 1996c) in order to measure a variety of emotional and behavioural symptoms. Children completed a self-report inventory on affective symptoms: the Preschool Symptom Self-Report (Martini, Strayhorn, & Puig-Antich, 1990). These measures were taken before and after invention. Results indicated that cognitive-behaviour therapy was the superior intervention. Whereas the nondirective supportive therapy condition was associated with few significant changes in symptomatology, cognitive-behaviour was significantly more effective in improving total behaviour problems, internalizing symptoms and sexually inappropriate behaviours. However, improvements were confined to the parent-completed measures; there were no significant changes on the self-report measure of affective symptoms. Given the problems of self-report measures for children at such a young age, these particular findings are not surprising. Parent reports would seem to be more valid for the purposes of the treatment outcome study. The superior efficacy of cognitive-behaviour therapy was maintained at 6- and 12-month follow-ups (Cohen & Mannarino, 1997).

Cohen and Mannarino (1998) also conducted a study of similar design with older sexually abused children. Abused children aged 7–14 were randomly assigned to receive either abuse-specific cognitive-behaviour therapy or nondirective supportive therapy. Cognitive-behavioural intervention with the child focused on abuse-related depression, anxiety and behavioural difficulties whilst parents were assisted in relation to their own emotional distress, improving support for the child and behavioural management difficulties. Treatment manuals were developed for each of the conditions and high levels of therapist compliance were found in checks for protocol adherence. Of the 82 subjects recruited for the study, 49 completed the trial. The following instruments were used to assess symptomatology at pre- and posttreatment: Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983), State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973), Children's Depression Inventory (CDI; Kovacs, 1985) and the Child Sexual Behavior Inventory (CSBI; Friedrich et al., 1992). Results showed that substantially more cognitive-behaviour therapy participants experienced clinically significant improvements on the CDI, CSBI, CBCL Social Competence scale, and CBCL Behaviour Profile Total scales. As with their first investigation, child participants were not assessed for PTSD.

Deblinger et al. (1996) examined the differential effects of child and mother participation in a cognitive-behavioural intervention designed for sexually abused children. The children (83% girls, 17% boys) were 7 to 13 years of age. About three-quarters of the children met DSM-III-R diagnostic criteria for PTSD as assessed on the Schedule for Affective Disorders and Schizophrenia for School-Age Children (Orvaschel, Puig-Antich, Chambers, Tabrizi, & Johnson, 1982). The other children had a total of at least three PTSD symptoms, including at least one symptom of avoidance or reexperiencing phenomenon. Such children were included on the grounds that they "might develop the full-blown disorder with time" (p. 312). Families were randomly assigned to one of

three cognitive-behavioural treatment conditions – child only, mother only, or child plus mother – or to a community control condition. Of the 100 sexually abused children recruited for the study, there were 90 completers.

Pre- and posttreatment assessments involved a range of measures including PTSD symptomatology as determined by clinical interview, self-reports of anxiety and depression, parent ratings on a child behaviour checklist and parent reports of family interactions and parenting practices. In general, results support the superior efficacy of the cognitive-behavioural intervention conditions over the community control condition. Differential treatment effects were also reported by the researchers. In particular, significantly greater reductions in overall PTSD symptomatology were achieved in those treatment conditions in which there was child participation (i.e., child only and child plus parent). Conversely, mother participation in treatment (i.e., parent only and child plus parent) was associated with significantly greater reductions in their children's externalizing behaviour and greater improvements in their own parenting skills. The mothers' direct involvement in the treatment conditions was also associated with the children reporting less depression. Of all of these changes, however, only the finding with respect to externalizing behaviour was found to be clinically significant.

Berliner and Saunders (1996) report a randomized clinical trial on the efficacy of adjunctive cognitive-behavioural procedures in the group treatment of sexually abused children. Eighty sexually abused children (age: 4–13 years; 90% girls) formed the final sample; "PTSD was the chart diagnosis in 81% of cases" (p. 297). Further details are not provided on PTSD diagnostic status. Children were randomly assigned to comparison or index treatment groups. The comparison treatment groups involved conventional sexual abuse treatment in which abuse-related issues were dealt with in structured sessions involving instructions, games, activities and role play. The index groups incorporated conventional treatment plus self-instructional training (mainly instruction in relaxation and cognitive strategies) and gradual exposure to anxiety provoking tasks (e.g., drawing a picture of the abuse experience, speaking aloud to members of the group about the abuse). The groups were led by two co-therapists and lasted 10 weeks. There was also an accompanying parent support group for parents of all children undergoing treatment. Treatment manuals were developed for each of the conditions.

Children were assessed on a battery of parent rating and self-report instruments before treatment, immediately after treatment, and 1 and 2 years after treatment. Both comparison and index treatment groups improved significantly on the outcome measures including the Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978), Fear Survey Schedule for Children–Revised (Ollendick, 1983), Sexual Abuse Fear Evaluation Scales (Wolfe & Wolfe, 1986), Children's Depression Inventory (Kovacs, 1985); Child Behavior Checklist–Parent Version (Achenbach & Edelbrock, 1983), and Child Sexual Behavior Inventory (Friedrich et al., 1992). However, the index treatment groups did not exhibit greater improvement over time than the comparison groups on any of the outcome measures. Thus, the addition of self-instructional training and gradual exposure failed to improve the efficacy of intervention for the sexually abused children.

The researchers offer several possible explanations for the results of their investigation. First, although nearly all of the child victims had a PTSD diagnosis, these children had surprisingly low pretreatment levels of self-reported fear and anxiety. In

other words, floor effects on key measures may have prevented any demonstration of treatment superiority for self-instructional training and graduated exposure. Second, the treatments may not have been meaningfully different with elements of self-instructional training and gradual exposure present in both treatment programs. Third, it may be that a supportive, abuse-specific treatment is sufficient for moderate levels of fear and anxiety. Both treatments emphasized coping with the aftermath of sexual abuse. This “may have produced an increased sense of self-efficacy and obviated the need for specific anxiety management techniques for most of the children” (Berliner & Saunders, 1996, p. 305).

Empirical status of cognitive-behaviour therapy programs for sexually abused children

From the little research that has been conducted, cognitive-behaviour therapy appears at first glance to be an efficacious intervention for sexually abused children. Treatment evaluations have been performed on child and adolescent victims suffering from PTSD or PTSD symptomatology. Typically, cognitive-behavioural intervention programs are multi-component and involve the child victim and non-offending parents. As a result of cognitive-behaviour therapy, children show improvements on PTSD symptomatology, self-reports of anxiety and depression, and parent-completed problem behaviour checklists. In other words, there appear to be marked clinical reductions in emotional and behavioural symptomatology for the child at posttreatment. Further, it would appear that parents also become less stressed, anxious and depressed over the course of treatment. Three to 24 month follow-ups have also yielded encouraging results for the stability of treatment effects (Berliner & Saunders, 1996; Cohen & Mannarino, 1997; Stauffer & Deblinger, 1996).

As well as having empirical support, our intervention strategies must also be acceptable to clients and society (Kazdin, 1977; Wolf, 1978). Researchers have examined this issue in their evaluations of the cognitive-behavioural treatment programs for sexually abused children. For example, acceptability of treatment was examined in the clinical trial with sexually abused preschool-aged children (Cohen & Mannarino, 1996a). All parents completed a consumer satisfaction questionnaire at the end of their treatment. Caregivers indicated high levels of satisfaction with important aspects of the cognitive-behavioural program. Deblinger et al. (1996) also examined caregiver satisfaction in their treatment evaluation. High levels of satisfaction were expressed by the mothers whose children or themselves had participated in group cognitive-behaviour therapy. Interestingly, this level of satisfaction was significantly greater than that indicated by their caregiver counterparts in the community control condition. Thus, as well as having demonstrated benefits on standardized measures, cognitive-behavioural strategies are perceived in a positive light by caregivers.

On the other hand, more sobering conclusions are reached when stringent criteria are applied regarding evidentiary support for psychosocial interventions. Rather than drawing general conclusions about the empirical status of cognitive-behaviour therapy for sexually abused children, it can be argued that it is more appropriate scientifically to focus on *specific* cognitive-behavioural intervention programs. As shown in our review, there is considerable heterogeneity in the content and targeted clientele across cognitive-behavioural treatment programs for sexually abused children (cf., Berliner &

Saunders, 1996; Cohen & Mannarino, 1996a; Deblinger et al., 1996). As a result of these kinds of issues, the American Psychological Association's Division 12 (Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1996; Task Force, 1995) put forth guidelines for the determination of experimental, probably efficacious and well established treatments. We now outline the most recent criteria for empirically supported treatments (Lonigan, Elbert, & Johnson, 1998). Since the relevant intervention literature does not include a large number of single case design experiments, only criteria related to between-group studies are outlined.

For a cognitive-behavioural intervention program to be classified as well established, there must be at least two good between-group design experiments demonstrating efficacy in one of the following ways: (a) superior to pill or psychological placebo or to another treatment, or (b) equivalent to an already established treatment in experiments with adequate statistical power ($n \geq 30$ per group). For a between-group design to be considered "good" (i.e., well designed), there must be random assignment to the comparison groups. Also, it is preferable that experiments be conducted in accordance with a treatment manual. Sample characteristics must be detailed by researchers, and intervention effects must be demonstrated by at least two different investigators or investigatory teams. For an intervention to be viewed as probably efficacious, either two experiments must demonstrate that the intervention is more effective than a wait-list condition or one or more experiments must meet all criteria for a well-established treatment, except for the requirement that treatment effects be shown by two different research teams (Lonigan et al., 1998).

Cohen and Mannarino's (1996a) first experiment found the index cognitive-behaviour therapy program for sexually abused preschool children to be effective and superior to a psychological placebo (nondirective supportive therapy). As already noted, the investigatory team observed randomization, had an adequate sample size, documented sample characteristics, and followed treatment manuals in both conditions. Also, treatment-related improvements were demonstrated to have clinical significance. Clearly, the study meets most criteria for a well-established classification. Of similar design, Cohen and Mannarino's (1998) second experiment with sexually abused school-aged children also meets many of the criteria for this particular cognitive-behavioural therapy program to be classified as well-established. However, until independent replications have been reported the intervention packages are deemed to have probably efficacious status.

Similarly, the Deblinger et al. (1996) trial meets many of the criteria (e.g., randomization, specification of client characteristics, use of therapy manuals) for a well established classification. The cognitive-behavioural program for sexually abused children was in general more effective than a community control, and we noted differential treatment effects in terms of child and mother participation in cognitive-behaviour therapy. On the other hand, there were some reservations about the extent to which the findings are clinically meaningful. Also, since independent replication has yet to be reported, this particular cognitive-behavioural treatment program must at best be deemed to have probably efficacious status. In addition to these experiments, our review identified another randomized trial but it failed to show empirical support for the efficacy of cognitive-behavioural strategies (Berliner & Saunders, 1996). More

specifically, adjunctive stress-inoculation training and graded exposure did not improve the efficacy of a conventional treatment program. Given the infancy of research on cognitive-behaviour therapy programs for sexually abused children, our conclusions regarding evidentiary support are hardly surprising.

Future clinical and research directions

Although the Task Force framework on empirically supported treatments is by no means infallible or beyond any possible criticism (see Kazdin & Kendall, 1998; Weisz & Hawley, 1998), it is clear that additional studies are required on the efficacy of the cognitive-behaviour therapy programs for sexually abused children. In the language of the Task Force, replications by other investigatory teams are required before the programs of Cohen and Mannarino (1996a) and Deblinger et al. (1996) can be regarded as having well-established treatment status. We now highlight several additional issues for future research on the cognitive-behavioural treatment of sexually abused children.

First, much of the treatment outcome research is predicated on the assumption that PTSD is the best conceptualization of the disturbance that occurs in the aftermath of sexual abuse. However, any treatment enquiry requires reliable and valid diagnostic evaluations in order to establish that the participants actually have PTSD or high levels of PTSD symptomatology. This is an issue that should be better addressed in future years, particularly in the light of the recent advances in diagnostic interviewing with emotionally distressed children. Of the many structured diagnostic interview schedules that are now available, we recommend the Anxiety Disorders Interview Schedule for Children (ADIS-C, Silverman & Nelles, 1988) for the diagnosis of PTSD and any comorbid disorders. A DSM-IV version is available with separate child and parent interviews (ADIS-C and ADIS-P, respectively). The ADIS-C/P is recommended because of its specialist nature, attention to developmental considerations and promising reliability and validity in the diagnosis of childhood anxiety disorders (Rapee, Barrett, Dadds, & Evans, 1994; Silverman, 1994). Of course, very young sexually abused children represent a special challenge diagnostically and it may be that researchers will have to continue to rely on other measures of emotional and behavioural disturbance as was the case in the clinical trial with preschool-aged children (Cohen & Mannarino, 1996a).

Second, given that sexually abused children are not equally responsive to cognitive-behaviour therapy, more research is needed on the factors that mediate treatment outcome. Cohen and Mannarino (1996b) examined the role of demographic, developmental and familial mediating factors in their clinical trial with sexually abused preschool children. A strong relationship was found between parental emotional distress and child outcome measures. This finding would not be surprising to clinicians experienced in the treatment of sexually abused children and their parents, and it is consistent with studies that have shown parental distress and depression to be strong factors in initial symptom formation and in symptom maintenance (e.g., Kinard, 1995). The researchers speculated that their findings were “. . . in part due to modeling, in that the child may learn fewer adaptive coping behaviors from a parent who is having difficulty coping with his or her own emotional distress. It is very likely that such a parent would be less emotionally and/or physically available to provide needed emotional support. It is

also possible that a biological factor may play a role in coping style or capacity, such that the ability to recover from emotional stress is in part genetically transmitted" (Cohen & Mannarino, 1966b, p. 1408). Clearly, further research is required on the predictors of treatment outcome with parental distress/psychopathology and child-parent interactions being especially important foci.

Third, building on the above research findings, it should be clinically possible to strengthen cognitive-behavioural interventions with sexually abused children and their parents. Although parents are usually involved in treatment, the child's disturbance has always remained the primary focus of intervention (i.e., child-focused intervention). Treatment undertaken with the child and parent, such as communication skills training and behaviour management skills training, is almost exclusively in a child-focused context. Similar to Finkelhor and Berliner (1995), we believe that it is logical to broaden the scope of intervention so as to also address parental distress and psychopathology (i.e., parent-focused intervention). This broadening of treatment is consistent with the recognition of parental distress/psychopathology as a significant factor in the aetiology and maintenance of PTSD in sexually abused children. Our own clinical experience suggests that cognitive-behavioural strategies are useful in helping parents of sexually abused children deal with their own stress and anxiety/depression. However, whether such adjunctive cognitive-behavioural treatment for parental problems actually improves the efficacy of child-focused intervention remains to be determined in a careful trial. This suggested clinical and research direction is consistent with the "high push", family-wide cognitive-behavioural intervention approach now recommended in the management of childhood anxiety disorders (Barrett, Dadds, Rapee, & Ryan, 1996; Ginsburg, Silverman, & Kurtines, 1995; Kendall et al., 1992).

Conclusions

We reviewed the clinical and research support for the efficacy of cognitive-behaviour therapy in the treatment of sexually abused children exhibiting PTSD or emotional/behavioural problems. Contrary to the fears of some clinicians about the use of such direct or abuse-confronting interventions, the available evidence would suggest that sexually abused children and their caregivers benefit quite remarkably from cognitive-behaviour therapy. However, it would be premature to extol the positive benefits of cognitive-behaviour therapy at this stage of treatment research. Cognitive-behavioural intervention programs have been shown to be efficacious and acceptable in carefully controlled trials, but independent replication is essential before it can be confidently asserted that we have empirically validated psychological treatment programs that will truly benefit sexually abused children and the broader community (school and families). The recently published guidelines for empirically supported psychological treatments should prove helpful to researchers working in this field. A theoretical and clinical argument was also mounted for the development and evaluation of adjunctive parent-focused interventions in future treatment research.

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