A review of individual psychotherapy outcomes for adult survivors of childhood sexual abuse

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Authors' objectives
To conduct a review of individual psychotherapy in adult survivors of childhood sexual abuse, including efficacy and effectiveness.

Searching
PsycLIT and PsycINFO were searched from 1989 to 1999 using the terms 'childhood (or child) sexual abuse', 'treatment or therapy' and 'outcome'. The references of studies that met search criteria (sic) were reviewed. The 12 journals from which eligible studies were identified were handsearched for the previous 12 months.

Study selection
Study designs of evaluations included in the review
The study design was not specified in the inclusion criteria, only that pre and post measures of effect on symptoms should be quantifiable. It was stated that case studies were excluded unless clear and systematic pre- and post-treatment evaluations were conducted using standardised assessment measures. Of the included studies, only one experiential study used a comparison group.

Specific interventions included in the review
Studies of individual psychotherapy, as opposed to group psychotherapy only, were eligible for inclusion. The therapies used in the included studies were as follows.

Cognitive-behavioural: 24 sessions of cognitive restructuring; 26 sessions of cognitive processing. In one study the treatment included both individual and group components.

Experiential: 17.5 sessions on average of therapy with a humanistic perspective, social support network and optional support meeting for family and close friends; 1 to 16 sessions of resolving unfinished business; 12 to 27 sessions of emotionally focused therapy.

Psychodynamic/interpersonal: 16 sessions of cognitive analytic therapy.

Psychoeducational/supportive: 10 sessions based on feminist understanding of childhood sexual abuse.

Participants included in the review
The review concerns adults with a history of child sexual abuse. The inclusion criteria specified that research included studies using clinical samples. Two of the included studies were of treatment seeking victims and two were of referred or recruited victims, while four studies did not describe the source of their samples. Three studies included participants who had experienced other forms of childhood interpersonal trauma as well as sexual abuse. Four studies were of women only.

Outcomes assessed in the review
Studies that reported quantifiable pre and post measures of symptomatology (sic) were eligible for inclusion. Many scales and checklists were used to measure the outcomes in the included studies. These included the Belief Inventory (BI), Beck Depression Inventory (BDI), Posttraumatic Stress Scale (PTSS), Modified Post Traumatic Stress Disorder Symptom scale (MPSS-SR), Clinician Administered PTSD Symptom scale (CAPS), Global Severity Index of the SCL-90-R (GSI), Social Activity and Distress Scale (SADS), General Health Questionnaire (GHQ), Delusions, Symptoms and States Inventory (DSSI), Unfinished Business resolution Scale (UFB), Working Alliance Inventory (WAI), Rosenberg Self-Esteem Scale (RES), Trauma Symptom Checklist (TSC-40), Global Assessment Scale (GAS), Client Perception Scale (CPS), Dissociative Experiences Scale (DES), Structural Analysis of Social Behaviour-Introject
Affiliation subscale (SASB-I-A), Symptom Checklist-90-revised (SCL-90-R), Resolution Scale (RS), Inventory of Interpersonal Problems (IIP), Impact of Events Scale (IES), and Target Complaints Discomfort Scale (TC).

How were decisions on the relevance of primary studies made?
The authors do not state how the papers were selected for the review, or how many of the reviewers performed the selection.

Assessment of study quality
The studies were evaluated by two sets of standards for the evaluation of psychotherapy outcome studies: one for efficacy studies (see Other Publications of Related Interest no.1) and one for effectiveness studies (see Other Publications of Related Interest no.2). The efficacy standards used included: clearly defined target symptoms; reliable and valid measures; use of blind evaluators; assessor training; manual, replicable and specific treatment programmes; unbiased assignment to treatment; and treatment adherence. The effectiveness standards included measures of general functioning and quality of life, and client satisfaction.

The authors do not state how the papers were assessed for validity, or how many of the reviewers performed the validity assessment.

Data extraction
The authors do not state how the data were extracted for the review, or how many of the reviewers performed the data extraction.

The data extracted included participants, findings, and aspects of design appropriate to efficacy and effectiveness studies.

Methods of synthesis
How were the studies combined?
The standardised mean difference method was used to combine the studies. The effect size (ES) was calculated for each study using Cohen's d. Where d was not reported, it was calculated from the means and standard deviations if these were available, otherwise d was calculated from the reported outcome statistics (see Other Publications of Related Interest no.3). The data were synthesised across all four major therapeutic approaches for common outcome measures scales, using weighted and unweighted means.

How were differences between studies investigated?
The studies were grouped according to the four major therapeutic approaches: cognitive-behavioural, experiential, psychodynamic/interpersonal, and psychoeducational/supportive. The only way to evaluate between-study differences in design and methodological strengths and limitations was to examine the descriptive summary of each study in the text.

Results of the review
Eight studies were included: 2 of cognitive-behavioural therapy (n=26), 4 of experiential therapy (n=180), one of psychodynamic/interpersonal therapy (n=7) and one of psychoeducational/supportive therapy (n=65).

The study design, strengths and limitations of each individual study were described in detail. Most studies clearly defined target symptoms and used valid measures, but few provided adequate details of the sample. Most studies also did not conduct blind evaluation. Only one study used a non-treatment control group. In addition, only one study reported reliable measurement of treatment adherence, and only one measured client satisfaction.

One study of cognitive-behavioural therapy (n=11) showed a clinically significant change on BI (d=1.39) and BDI (d=0.89). The other study (n=15) showed a clinically significant change in post-traumatic stress disorder and depression diagnoses.
One experiential therapy study (n=92) showed significant improvement on SADS (d=0.95), GHQ (d=2.34) and DSSI (d=1.58) from pre- to post-treatment based on 59 patients who were evaluable. One study showed improvement on the GSI (d=0.8), UFB (d=1.5) and SASSB-I-A (d=0.45) based on 33 adults, 15% of whom had a history of childhood sexual abuse. One study showed significant improvement on GSI (d=0.89), IES (d=1.09), RS (d=1.86) and SASSB-I-A (d=1.07) based on 33 women, 42% of whom had a history of sexual abuse. One study reported on 22 women in the intervention group (of whom 11 chose to focus on sexual abuse during treatment) and a wait group (delayed treatment) of 24 women (14 of whom chose to focus on sexual abuse). Both groups showed significant improvement on GSI (d=1.03; wait group d=1.23), IES (d=1.37; wait group d=1.20), IIP (d=1.62; wait group d=0.73), TC (d=5.71; wait group d=1.91), RS (d=2.64; wait group d=1.58) and SASSB-I-A (d=1.67; wait group d=1.06) from pre- to post-treatment. The study group maintained their treatment gains at 9 months' follow-up on all scales.

One study of psychodynamic/interpersonal therapy showed improvement on the GSI of the SCL-90-R (d=1.02), BDI (d=1.55), BI (d=1.64), and RES (d=2.44) from pre- to post-treatment based on 7 women. Large effects were reported on all scales at 3 months' follow-up. The changes between post-treatment and follow-up were not significant.

One study of psychoeducational/supportive therapy measured symptoms pre- and post-treatment, and at 6 and 12 months’ follow-up, in 65 women. Improvement was shown in GSI (d=0.47), TSC-40 (d=0.51), PTSS (d=0.44) and for responsibility, shame and self-acceptance on the CPS. The gains were maintained at 6 and 12 months on all scales. The overall functioning (GAS) improved post-treatment, deteriorated at 6 months, and returned to post-treatment levels at 12 months. The DES scale showed improvement only at 12 months’ follow-up.

The ESs (d) for pre- to post-treatment changes were pooled across the studies for the outcome measures of specific symptoms, interpersonal symptoms, trauma symptoms and global symptoms/functioning. The weighted, and unweighted means where applicable, were as follows.

For specific symptoms: BDI, 0.92 and 1.03 (3 studies, n=33); BI, 1.49 and 1.52 (2 studies, n=18); RS, 2.03 and 2.03 (2 studies, n=52); RES, 2.44 (1 study, n=7); DES, 0.18 (1 study, n=65); DSSI, 1.58 (1 study, n=92).

For interpersonal symptoms: IIP, 1.62 (1 study, n=19); SASSB-I-A, 0.98 and 1.06 (3 studies, n=85); SADS, 0.95 (1 study, n=92).

For trauma symptoms: CAPS, 0.82 (1 study, n=15); CPS-responsibility, 0.95 (1 study, n=65); CPS-shame, 1.15 (1 study, n=65); CPS-acceptance, 0.95 (1 study, n=65); IES, 1.19 and 1.22 (2 studies, n=52); MPSS-SR, 1.21 (1 study, n=15); PTSS, 0.44 (1 study, n=65); TSC-40, 0.51 (1 study, n=65); UFB, 1.5 (1 study, n=33).

For global symptoms/functioning: GAS, 0.88 (1 study, n=65); GHQ, 2.34 (1 study, n=92); SCL-90-R, 0.80 and 0.96 (6 studies, n=172).

**Authors' conclusions**

Overall, the data largely supported the conclusion that individual psychotherapy can be effective for adult survivors of childhood sexual abuse.

**CRD commentary**

The review addressed a broad question, which was reflected by the loosely defined inclusion criteria for the participants, intervention, outcomes and study design. Two relevant databases were searched but, overall, the search strategy was not extensive and was inadequate to identify non-English language or unpublished studies. There were no details on how the review was conducted in terms of the study selection, data extraction and validity assessment processes, so the potential for bias is unknown. The methodological quality of the included studies was assessed systematically using relevant criteria, and the characteristics of the included studies were well described in the text. The text was well structured but was lengthy. More information in tables, including the methodological aspects of each study, would have enabled the reader to compare the studies more easily.

The pooling of the effect size (d) was confined to outcomes measured using the same instrument, and the effect size from each individual study was shown. However, the effect sizes from different study designs in different populations...
were pooled, and although differences in effect sizes between the studies were evident, heterogeneity was not assessed. The fact that most of the included studies also had very small samples was not discussed; results based on the statistical significance of pooled data from small heterogeneous studies must be treated with caution. Interpretation of these pooled effect sizes is problematic.

The authors’ fairly confident conclusion is rather inconsistent with their own in-depth critique of the limited strength of the evidence.

**Implications of the review for practice and research**

**Practice:** The authors state that future studies of the type they recommend will assist clinicians in obtaining a more comprehensive understanding of the process involved in treating this population.

**Research:** The authors state several recommendations including continued integration of efficacy and effectiveness methodology, the use of multi-method/multi-rater assessment data, and further investigation of interpersonal variables such as the therapeutic alliance.

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