Simon Fraser University
Faculty of Health Sciences
Children's Health Policy Centre

Preventing and Treating Childhood Sexual Abuse

A Research Report Prepared For Child and Youth Mental Health British Columbia Ministry of Children and Family Development

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Preamble

The Children's Health Policy Centre (CHPC) in the Faculty of Health Sciences at Simon Fraser University prepared this report at the request of the British Columbia (BC) Ministry of Children and Family Development (MCFD). Our goal was to summarize the best currently available research evidence in order to inform policy and practice for preventing and treating childhood sexual abuse. This report is one in a series of reports prepared in support of MCFD's *Child and Youth Mental Health Plan for British Columbia.*[1] Our reports are intended as a resource for policy-makers, practitioners, families and community members. The complete series of reports produced for MCFD is available on our website at www.childhealthpolicy.sfu.ca.

About the Children's Health Policy Centre

Located in the Faculty of Health Sciences at Simon Fraser University, we are a research group dedicated to integrating research and policy to improve children's health. We particularly focus on children's social and emotional development, or *children's mental health,* as one of the most important investments society can make. We conduct research on the policy process and research relevant for informing policy-making: addressing determinants of health; preventing problems where possible; promoting effective treatments and services; and monitoring our collective progress towards improving the lives of all children. In turn, partnerships with policy-makers inform our research. We also provide education on health policy, children's mental health and population health. Our work supports and complements the vision of the Faculty of Health Sciences to integrate research and policy for public and population health locally, nationally and globally.

Executive Summary

Childhood sexual abuse is defined as a diverse array of sexual activities perpetrated against children, not a diagnosis or disorder. Reported rates of childhood sexual abuse vary widely with estimates ranging from 5-25%.[2] Children who have been sexually abused constitute a heterogeneous group with diverse experiences and outcomes. No distinct collection of symptoms is exclusively associated with sexual abuse. The majority of sexually abused children display moderate to serious symptoms at some point after their abuse experience. Experiences of childhood sexual abuse are associated with as many as 60 different outcomes. Symptoms of posttraumatic stress and sexual behaviour problems are particularly common, although up to 40% of sexually abused children display few or no symptoms. Both prevention and treatment are important elements of a public policy response to childhood sexual abuse. There is sufficient research evidence on prevention and treatment such that systematic reviews are available on both. Therefore, this report summarized findings from systematic reviews completed over the past 10 years. To be included, reviews had to meet a high standard involving an explicit focus on childhood sexual abuse along with a description of the search strategy and the criteria used to select original studies for detailed review.

Findings

- Three prevention reviews met criteria. A diverse range of programs focusing on children was found to increase children's knowledge and self-protection skills. However, none of the reviews were able to assess whether program participation reduced actual rates of childhood sexual abuse.

- Four treatment reviews met criteria. None specifically addressed children without mental health symptoms. Cognitive-behavioural therapy (CBT) was shown to be effective in treating common outcomes associated with childhood sexual abuse, including emotional and behavioural problems.

Recommendations

- Preventing childhood sexual abuse is a priority. New research is needed on strategies for preventing adults and older children from becoming perpetrators.
- Prevention programs are effective in increasing children's knowledge and self-protection skills. Negative effects such as fear or anxiety are not associated with program participation, as evidenced by studies to date. Given the benefits, continued investments in prevention programs are warranted. New research measuring the impact of prevention programs on actual rates of childhood sexual abuse should also be undertaken.
- Prevention programs should include high levels of participation, such as role-playing and behavioural skills training. Programs should be of sufficient duration (no less than one hour and three separate sessions) to provide enough time for children to learn and integrate self-protection skills regardless of their age and developmental level. Repeating programs at regular intervals may help to ensure that positive effects do not diminish over time.
- Up to 40% of sexually abused children may display few or no symptoms. Although caution is needed to avoid an exaggerated focus where children may not be in distress, it is important to monitor the mental health needs of children without symptoms because 10-20% of these children will go on to develop mental health symptoms or coping problems. Therefore, educational interventions to prevent further victimization, to clarify and normalize feelings and to educate parents may be helpful. Teaching coping strategies and fostering social competencies, such as making and sustaining friendships, may be beneficial in promoting resilience.
- For sexually abused children who are experiencing emotional and behavioural problems, treatment should be modeled after the CBT interventions described in this review. Involving non-offending parents is helpful. Adequate resolution of child protection issues and prevention of re-abuse is crucial.
- Where research evidence is lacking, prevention and treatment interventions should be modeled after the principles and key elements of approaches supported by research; interventions proven ineffective should not be employed. Outcome evaluations of any new prevention and treatment strategies should be conducted. Approaches not supported by the best available research evidence should be carefully evaluated.

1. Introduction

1.1 What is Childhood Sexual Abuse?

Childhood sexual abuse is defined as a diverse array of sexual activities perpetrated against children, not a diagnosis or disorder. Within the spectrum of sexual abuse, there is a distinction between *contact* and *non-contact* abuse. Contact abuse includes acts such as intercourse or oral-genital contact. Non-contact abuse comprises behaviours such as exposing children to adult sexual activity or inducing children to act sexually with each other.

Reported rates of sexual abuse vary widely. This variance is mainly due to methodological issues such as how sexual abuse is defined and which populations are surveyed.[3] A nationally representative cross-sectional sample of American children aged 2-17 years found 1 in 12 children had been sexually victimized (defined as exposure to sexual assault, attempted rape, flashings, sexual harassment or statutory sexual offenses) in the study year.[4] Retrospective prevalence surveys with adults conducted in the United States and Canada found 20–25% of women and 5-15% of men had experienced contact sexual abuse.[2] Notably, sexual abuse may be underreported because it is often associated with secrecy.[5]

Childhood sexual abuse occurs across all socioeconomic, educational, racial and ethnic groups.[6] Known risk factors for childhood sexual abuse include: being female; being 12 years or older; or having a physical disability.[7] Parental absence or impairment are also risk factors.[7] Regarding abuse perpetration, parents and step-parents are the abuser for 6-16% of cases.[8] Abuse by any relative comprises more than one-third of cases.[8] Abuse by strangers accounts for a relatively small proportion of cases, approximately 5-15%.[8] The majority of abusers are male.[9] Many perpetrators have a history of childhood maltreatment[9] and significant personality disturbances.[10] Juvenile sexual offenders represent up to 40% of offenders.[8] These youth often have high rates of non-sexual juvenile offending, impaired social skills, academic and behavioural problems, and family environments characterized by conflict and instability.[10]

Children who have been sexually abused constitute a heterogeneous group with diverse experiences and outcomes.[7] Factors influencing outcomes include: the child's age and gender; the perpetrator's age and gender; the type of relationship between child and perpetrator; and the type, frequency and duration of the abuse experience.[7] Specifically, abuse perpetrated by a parent or step-parent and abuse involving physical force or more prolonged or invasive contact may be related to greater negative impact.[6] Moreover, parental emotional distress, lack of maternal support and maternal depression appear to exacerbate emotional and behavioural disturbances in sexually abused children.[6] Individual differences in coping strategies at different points in development can also impact outcomes.[7]

The majority of sexually abused children display moderate to serious symptoms at some point after their abuse experience.[7] Experiences of childhood sexual abuse are associated with as many as 60 different outcomes.[11] For example, approximately one-half of sexually abused children may meet diagnostic criteria for posttraumatic stress disorder (PTSD) while one-third may display sexual behaviour problems.[12] Additional psychological symptoms can include: anxiety,[6,13] depression,[6] substance abuse,[11] dissociation,[13] social withdrawal,[6] anger[6] and low self-esteem.[13] Childhood sexual abuse experiences are also linked to behavioural problems including: school difficulties,[6] prostitution,[7] early pregnancy,[7] antisocial behaviour,[13] and suicide attempts.[11,13] Physical symptoms associated with childhood sexual abuse include: headaches,[6] stomach aches,[6] sleep difficulties[6] and increased sympathetic nervous system activity.[7] Within the diverse range of clinical presentations for child victims, there is no distinctive collection of symptoms that is exclusively associated with sexual abuse.[13] The few studies documenting children's symptom patterns over time reveal a general pattern of improvement for most children.[8] Additionally, up to 40% of sexually abused children display few or no symptoms.[14] For such children, the possibility of delayed symptoms should be recognized.[15]

1.2 Prevention and Treatment Issues

Childhood sexual abuse is a serious violation of children's rights. Accordingly, all adults share a collective ethical responsibility to ensure that the prevention of abuse is a priority. This may be achieved through prevention programs aimed at enhancing protective factors or mitigating risk factors in order to reduce the number of children experiencing sexual abuse. Prevention programs may be either *universal* or *targeted*. Universal programs are directed at entire populations while targeted programs are directed to children identified as high-risk based on factors such as family history.[16] Both universal and targeted prevention programs have advantages and disadvantages.[17] Universal programs avoid isolating or labelling particular children but may be unnecessarily expensive. Targeted programs can be more efficient but present the difficult challenge of accurately identifying children at risk. Targeted programs may also expose identified children to labelling and stigma. The optimal mix of universal and targeted prevention programs needs to be determined according to local needs.[17]

Prevention and treatment fall on a continuum of interventions to address outcomes associated with childhood sexual abuse. While many researchers and professionals believe the major emphasis should be on prevention,[18] treatment is also crucial for children who have established symptoms related to abuse experiences. Treatment aims to reduce the duration, severity and impairment associated with the abuse experience, as well as to prevent recurrence of abuse. Treatment focuses on individuals or small groups rather than on populations. As with prevention, there are trade-offs. Treatment provides much-needed support to children and families and can alleviate symptoms through a specific focus on those who are most severely affected. However, treatment programs are costly, may result in labelling and associated stigma, and cannot reach all children in need.[17]

1.3 Purpose of this report

This report was requested by MCFD in order to inform policies and programs for preventing and treating childhood sexual abuse. This report is one in a series of reports prepared by the Children's Health Policy Centre (CHPC) in support of MCFD's *Child and Youth Mental Health Plan for British Columbia*.[1] Our reports are intended as a resource for policy-makers, practitioners, families and community members. The complete series of reports produced for MCFD is available on our website at www.childhealthpolicy.sfu.ca.

2. Methods

Using Medline, PsycINFO, and the Cochrane Database of Systematic Reviews, we searched for systematic reviews published in English from January 1994 to November 2005 on the prevention and treatment of sexual abuse in children aged 0-18 years. Reviews were included that examined *efficacy* (can this intervention work in ideal settings?) and if possible, *effectiveness* (does this intervention work in usual settings?). The search terms were *sexual abuse, child abuse, pedophilia* or *date rape*. All abstracts identified through these searches were assessed and relevant reviews were retrieved. Using the criteria outlined in Table 1 below, each review was then evaluated by two assessors. Additionally, the reference sections of accepted articles were hand-searched to identify additional reviews. Any disagreements about which articles to include were resolved by consensus among two or more authors.

TABLE 1. Criteria for Evaluating Research Articles*

Basic Criteria
· Articles published in English about children aged 0-18 years
· Articles on topics relevant to children's mental health
Systematic Reviews
· Clear statement of relevant topic
· Clear description of the methods including sources for identifying literature reviewed
· Clear statement of criteria used for selecting articles for detailed review
· At least two studies reviewed met criteria (below) for assessing original studies
Original Studies
· Clear descriptions of participant characteristics, study settings and interventions
· Random allocation of participants to intervention and comparison groups
· Maximum drop-out rates of 20% post-test
· Follow-up of six months after post-test
· For treatment studies, diagnostic "gold" standards used
· For medication studies, double-blind placebo-controlled procedures used
· Both statistical and clinical significance assessed and reported at post test

*Adapted from Evidence-Based Mental Health (2006).[19]

3. Findings

3.1 Summary

A total of 40 reviews were retrieved. Of these, three prevention reviews and four treatment reviews met our inclusion criteria. The findings on prevention and treatment are summarized in Tables 2 and 3 respectively. The reviews mainly focused on randomized controlled trials (RCTs), though other research methodologies were considered including quasi-randomized and non-randomized controlled studies, multiple baseline investigations and case reviews. Where possible, only findings from the RCTs are presented due to concerns about biases introduced when other methods are employed. Three reviews used a meta-analytic approach, pooling data from the reviewed articles. The remainder summarized data from included studies. All reviews focused on children. However, one treatment review did not indicate specifically the age of the children involved in the original research studies. In all cases, findings are only reported on measures directly related to mental health outcomes in children.

3.2. Prevention

Prevention programs were addressed in the three systematic reviews that met criteria.[16,20,21] Most programs assessed were universal in format. Two of the reviews focused exclusively on school-based prevention programs.[16,20] These programs were diverse regarding: ages of children; elements (e.g., film presentations, behavioural training, role plays, verbal instruction); professions of program leaders (e.g., police officers, teachers, mental health professionals); and length (e.g., from 25 minutes to six hours). Programs typically focused on education about sexual abuse concepts such as "body ownership," recognizing abusive situations and self-protection skills. Across all three reviews, prevention programs were effective in improving children's prevention-related knowledge and skills.[16,20,21] Retention of skills and knowledge was demonstrated in follow-up periods.[21] One review found programs which used active participation and behavioural skills training produced the best outcomes.[20] Program length was related to effectiveness. Specifically, programs using more than three sessions[20] and programs longer than one hour[16] were more effective than shorter programs. Two reviews found younger children received greater benefit from program participation than older children.[16,20] None of the reviews assessed whether program participation actually reduced rates of sexual abuse.

TABLE 2. Preventing Childhood Sexual Abuse

Author(s)	Scope	Studies Included	Main Findings
Davis & Gidycz (2000)[20]	*Population:* Children aged 3-13 years *Inclusion criteria:* Studies evaluating school-based sexual abuse prevention programs published 1975-1996	13 RCTs (13 of 27 studies)△	• Program impact on sexual abuse rates not assessed • Prevention programs significantly improved children's knowledge and skills • Programs using active participation and behavioural skills training (e.g., modeling, rehearsal and reinforcement procedures) produced best outcomes • Programs using 3 or more sessions were significantly more effective than programs with fewer sessions, independent of total program hours • Children in preschool and early elementary school benefited most from prevention programs
MacMillan, MacMillan, Offord, Griffith, & MacMillan (1994)[21]	*Population:* Children up to 18 years *Inclusion criteria:* Studies on sexual abuse primary prevention programs published 1979-1993	14 RCTs (14 of 19 studies)	• Program impact on sexual abuse rates not assessed • Prevention programs significantly improved children's knowledge and skills • No negative effects, such as fear or anxiety, were associated with program participation
Rispens, Aleman, & Goudena (1997)[16]	*Population:* Children aged 3-12 years *Inclusion criteria:* Update of Macmillan et al (1994)[21] review; additional studies published 1993-1996	At least 10 RCTs (10 of 16 studies)△	• Program impact on sexual abuse rates not assessed • Prevention programs were effective in teaching sexual abuse concepts and self-protection skills; programs including explicit training in self-protection skills were more effective than programs teaching sexual abuse concepts • Programs 1 or more hours long were more effective than shorter programs • Children younger than 5.5 years benefited more than older children; this difference faded during follow-up

△ Indicates meta-analysis

3.3. Treatment

Treatments for the common outcomes associated with childhood sexual abuse (such as anxiety, depression and sexually inappropriate behaviours) were addressed in the four systematic reviews that met criteria.[6,7,11,13] Two of the reviews had an exclusive focus: one on CBT[6] and the other on group therapies.[11] By contrast, the other two reviews did not focus exclusively on any one treatment format.[7,13]

Strong support was found for using CBT in treating emotional and behavioural problems associated with childhood sexual abuse experiences. CBT interventions typically incorporated a number of treatment components including cognitive reframing, thought stopping, positive imagery, relaxation training and problem solving. Non-offending parents were often included in treatment. Overall, CBT decreased behavioural problems, including sexually inappropriate behaviours, and reduced symptoms of mental health problems, such as depression and PTSD.[6,7,13] Moreover, CBT was found to be more effective than other forms of psychological treatments such as nondirective supportive psychotherapy.[6,13] Encouraging results regarding the maintenance of CBT treatment effects were found at one-year follow-up.[6] The empirical support for other therapy modalities, such as play therapy or sex education group therapy, was less compelling.[13]

The findings regarding treatment format were more equivocal. Group treatments using a variety of theoretical orientations (including CBT, play, drama and art therapies) were effective in treating a number of mental health outcomes.[11] However, the data from which these conclusions were drawn included studies that did not use RCTs. In the one study using RCT methods, older girls who received individual treatment had greater improvements than those who received group treatments.[13] Authors reported advantages for both individual and group treatments. Individual treatments offered increased privacy; however, group treatments were more cost-effective, less labour-intensive and therefore better able to reach more children.[11]

TABLE 3. Treating Childhood Sexual Abuse

Author(s)	Scope	Studies Included	Main Findings
King, Tonge, Mullen, Myerson, Heyne, & Ollendick (1999)[6]	*Population:* Children aged 3-16 years* *Inclusion criteria:* Studies of CBT for sexually abused children published 1980-1999	4 RCTs◊ (4 of 9 studies)	• CBT reduced behaviour problems including sexually inappropriate behaviours, reduced internalizing problems such as depressive and PTSD symptoms, and increased social competence
Putnam (2003)[7]	*Population:* Children of unspecified age *Inclusion criteria:* Empirical studies on childhood sexual abuse published after 1989	6 RCTs◊ (6 of 7 studies)	• CBT reduced internalizing problems such as depressive and PTSD symptoms, and reduced externalizing problems including sexually inappropriate behaviours • Abuse-focused CBT, often including the non-offending parent, was the best-documented and most effective treatment for childhood sexual abuse
Reeker, Ensing, & Elliott (1997)[11]	*Population:* Children aged 3-17 years *Inclusion Criteria:* Articles examining the effectiveness of group treatments for sexually abused children published 1987-1996	2 RCTS (2 of 15 studies)◊	• Theoretically diverse group treatments (including integrated™, cognitive-behavioural, drama and play therapies) reduced anxiety, depression, sexualized behaviours and conduct problems • No significant differences found in effectiveness based on participant age or gender, although trends indicated larger effect sizes for female-only groups • Studies conducted in clinic settings were more effective than those in research settings
Stevenson (1999)[13]	*Population:* Children aged 2-19 years✪ *Inclusion criteria:* Empirical studies on child abuse and neglect published after 1981	8 RCTs◊ (8 of 34 studies)	• Diverse treatments (including structured groups, individual and group play, group sex education) produced better outcomes (less negative affect anxiety and misbehaviour as well as improved self-concept, self-mastery, self-esteem and sexual awareness) than no treatment • Group CBT with young children significantly reduced behaviour problems compared to nondirective supportive psychotherapy • Older girls receiving individual treatment had greater improvements in self-esteem than those in group treatment; no differences were found for depression or anxiety outcomes

* When findings limited to RCT data, age range for included studies is preschool to 14 years.
◊ Reported main findings include only RCT data.
△ Indicates meta-analysis
✦ Integrated therapy defined as including combinations of techniques such as psychoeducation, art therapy, play therapy, role plays, problem solving, puppet work, writing exercises, exploration of feeling and abuse experience, and behaviour management.
✪ When findings limited to RCT data, age range for included studies is 4-17 years.

4. Discussion

Of the 40 reviews assessed, three prevention and four treatment reviews met our inclusion criteria. While most of the prevention programs assessed in the three reviews were effective in improving children's knowledge and skills regarding sexual abuse prevention, none assessed the impact of participation on actual rates of sexual abuse. Prevention knowledge and behavioural skill gains were typically made across programs with varied content and formats. However, most prevention programs focused on sexual abuse concepts and self-protection skills training. One review found that programs using active participation and behavioural skills training produced the best outcomes. Longer programs, both in duration and in number of sessions, were associated with better outcomes.

Regarding treatment, there was strong evidence supporting the use of CBT. Both individual and group CBT improved emotional and behavioural symptoms including: fewer sexually inappropriate behaviours; fewer depressive, internalizing and PTSD symptoms; and greater social competence. Moreover, the evidence suggests that these gains were lasting with treatment effects continuing at one-year follow-up. Abuse-focused CBT, coupled with similar treatment for the non-offending parent, was assessed as being the most effective treatment for symptoms associated with childhood sexual abuse documented to date. These findings align with the current practice guidelines such as *Child Physical and Sexual Abuse: Guidelines for Treatment,* which is a widely-used guide for treating child victims of sexual abuse.[12] There was less compelling research evidence regarding the management of the mental health needs of children who display few or no symptoms following experiences of sexual abuse. None of the reviewed RCTs specifically included children without mental health symptoms.

There were several limitations in the prevention and treatment reviews on childhood sexual abuse. The evidence showed prevention programs improve knowledge and skills under experimental conditions; however, it remains to be established how effective these programs are in usual settings. It is also critical to evaluate whether prevention programs can also reduce actual rates of sexual abuse in children. To facilitate this, new research is needed using valid and reliable measures of sexual abuse rates and outcomes in populations. Most importantly, prevention efforts need to include strategies for stopping perpetrators from offending against children rather than focusing solely on child victims themselves. Methodological improvements would also benefit the field. Much literature assessed for this review appeared to lack control groups, to lack random allocation and to employ small sample sizes. However, despite these limitations, it was encouraging that sufficient high-quality reviews were found to suggest there *is* empirical support for using certain prevention and treatment programs to assist children.

5. Recommendations

- Preventing childhood sexual abuse is a priority. New research is needed on strategies for preventing adults and older children from becoming perpetrators.
- Prevention programs are effective in increasing children's knowledge and self-protection skills. Negative effects such as fear or anxiety are not associated with program participation, as evidenced by studies to date. Given the benefits, continued investments in prevention programs are warranted. New research measuring the impact of prevention programs on actual rates of childhood sexual abuse should also be undertaken.
- Prevention programs should include high levels of participation, such as role-playing and behavioural skills training. Programs should be of sufficient duration (no less than one hour and three separate sessions) to provide enough time for children to learn and integrate self-protection skills regardless of their age and developmental level. Repeating programs at regular intervals may help to ensure that positive effects do not diminish over time.
- Up to 40% of sexually abused children may display few or no symptoms. Although caution is needed to avoid an exaggerated focus where children may not be in distress, it is important to monitor the mental health needs of children without symptoms because 10-20% of these children will go on to develop mental health symptoms or coping problems. Therefore, educational interventions to prevent further victimization, to clarify and normalize feelings and to educate parents may be helpful. Teaching coping strategies and fostering social competencies, such as making and sustaining friendships, may be beneficial in promoting resilience.
- For sexually abused children who are experiencing emotional and behavioural problems, treatment should be modeled after the CBT interventions described in this review. Involving non-offending parents is helpful. Adequate resolution of child protection issues and prevention of re-abuse is crucial.
- Where research evidence is lacking, prevention and treatment interventions should be modeled after the principles and key elements of approaches supported by research; interventions proven ineffective should not be employed. Outcome evaluations of any new prevention and treatment strategies should be conducted. Approaches not supported by the best available research evidence should be carefully evaluated.

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