Treatment of Adult Women Sexually Abused as Children

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Clinical Problem

Child sexual abuse (CSA) is a serious international public health problem, broadly defined as the use of a child for sexual stimulation by an adult or another child who, by either age or development, is in a position of trust or power (Finkelhor, 1997; WHO, 1999). CSA is an adverse experience, not a disorder, disease, or diagnosis (Putnam, 2003). It is diverse in terms of its characteristics (e.g., intra- and extra-familial abuse, contact and non-contact activities) and tends to involve particular interpersonal features that can impact on development in distinct ways compared with other types of child maltreatment (e.g., sexual trauma, boundary violations, betrayal, secrecy; Fergusson, Boden, & Horwood, 2008; Noll, 2008).

Although CSA does not always result in clinically significant negative outcomes, there is consistent evidence of a wide range of adverse but relatively non-specific mental health effects in childhood that may extend into adulthood, even after sociodemographic variables, subsequent interpersonal victimization, and childhood physical abuse are accounted for (Briere & Elliott, 2003; Fergusson et al., 2008; Jonas et al., 2011; Jumper, 1995; Owens & Chard, 2003; see Maniglio, 2009, for a recent meta-analytic review). Efforts to identify causal links between CSA and psychopathology have been hampered by the quality and inconsistency of studies in the area, making it difficult for professionals to make sense of and be clearly guided by the literature (Maniglio, 2009). However, the complexity of the abuse experience is extraordinarily difficult to capture in research. The effects of CSA usually constitute a dynamic sequence of interrelated consequences that are influenced by both pre- and post-abuse circumstances as well as characteristics of the abuse itself (Briere & Jordan, 2009). For example, the negative

family environments experienced by many CSA survivors can themselves significantly influence the development of later psychopathology (Bhandari, Winter, Messer, & Metcalfe, 2011; Briere & Elliot, 1993; Rind, Tromovitch, & Bauserman, 1998). Research has started to examine the complex relationships between CSA, contextual factors, and adult mental health (see Briere & Jordan, 2009, for a review).

Prevalence

Prevalence data vary depending on the way CSA is operationally defined, the characteristics of the sample studied, and differences in research methodology. However, a recent meta-analysis of the prevalence of CSA in adults using 65 articles from 22 countries reported that 19.7% of women had experienced sexual abuse prior to the age of 18 (Pereda, Guilera, Forns, & Gómez-Benito, 2009). Life course following CSA can include effects that can be continuous, solitary, and/or a combination of outcomes. Children as well as adults can experience temporary, discontinuous, or "sleeper" effects that remain undetected but emerge at key times in a person's life or in new situations.

Diversity

As noted above, both the experience and effects of CSA are inherently diverse, making for a wide and complex range of adverse outcomes that can have major implications for treatment. A history of CSA is more prevalent in women, and some research indicates that it is associated with higher rates of psychopathology in women (Jonas et al., 2011; MacMillan et al., 2001; Molnar et al., 2001). CSA is one of the most common manifestations of violence around the world. While CSA does not discriminate by ethnicity, culture, age, disability, sexual orientation, or spiritual background, these factors can influence the expression of CSA sequelae (e.g., religious beliefs, cultural norms and practices) and, by implication, decisions regarding appropriate treatment.

Empirically Supported Treatments

Although psychotherapy outcome research for adult survivors of CSA has been conducted for more than 25 years, no treatments have been identified as empirically supported (Draucker & Martsolf, 2006). This is probably at least in part due to the fact that many studies treat survivors of CSA, with all of the complex effects and pathways to and from abuse that that entails, while relatively few focus their treatment efforts at specific effects, such as post-traumatic stress disorder (PTSD). However, psychological treatments are effective in reducing symptoms and improving outcomes for adults who were sexually abused as children (Kessler et al., 2003; Martsolf & Draucker, 2005). Group, couple, and individually-focused treatments have been studied, with the vast majority of research on group approaches. Treatment modalities have ranged from single-theory focused treatments (e.g., CBT, EMDR, emotion-focused), to multi-disciplinary, insight and/or experiential, combination, or eclectic treatments.

Most attempts to synthesise the outcome research using meta-analysis have been limited to single approaches, used flawed methodologically, or not considered the multitude of factors that might account for the variability in treatment outcome (Callahan et al., 2004; de Jong & Gorey, 1996; Peleikis & Dahl, 2005; Price, Hilsenroth, Petretic-Jackson, & Bonge, 2001). A recent meta-analysis by Taylor and Harvey (2010) addressed these issues. Overall treatment effects, regardless of approach used, were moderate for PTSD/trauma symptoms (g = 0.72-0.77), internalising symptoms (g = 0.68-0.72), externalising symptoms (g = 0.41-0.53), self-esteem (g = 0.56-0.58), and global functioning (g = 0.57-0.60), and inconsistent for interpersonal functioning. Effects were largely maintained at follow-up, although few studies provided follow-up data.

However, different characteristics of therapy moderated the effectiveness of treatments depending on the symptom domain or outcome being measured, and some of

these variables were based on stronger evidence than others. The degree of effectiveness differed according to clinician variables (e.g., experience, discipline), the nature of treatment (e.g., structure, modality, treatment approach, length of treatment), client variables (e.g., presenting condition, nature of abuse), and contextual factors (e.g., inpatient/outpatient, inclusion of out-of-session work) (Taylor & Harvey, 2010). For PTSD/trauma symptoms, individual therapy approaches were associated with better outcomes (g = 1.04-1.17) than couple-based approaches (g = 0.37-0.61). At the time, only one study of group therapy had been conducted targeting trauma symptoms, but more studies have since been published, some more rigorous than others, showing beneficial effects of group therapy for trauma symptoms following CSA (e.g., Classen et al., 2011). Additional studies supporting individual (e.g., Elklit, 2009; Talbot et al., 2011) and combined approaches (e.g., DBT: Steil et al., 2011) for trauma symptoms have also been reported. Trauma outcomes improved when therapy included out-of-session work. Alternatively, the treatment of issues related to self-esteem responded well to semi-structured interventions delivered by experienced practitioners. No clear moderating differences were found when treating externalising symptoms, interpersonal functioning, global symptoms (Taylor & Harvey, 2010). Furthermore, no differences were found between therapeutic approaches for the different outcome domains, with the exception of cognitive behavioural therapies having better outcomes for internalising symptoms such as anxiety and depression.

Future Research

Characteristics of each woman and her abuse experience are likely to also function as moderators of treatment outcome, but clearer analysis of these influences in meta-analysis will not be possible until researchers report this information systematically (Taylor & Harvey, 2010). Furthermore, women with CSA histories more often than not

experience a constellation of abuse-related effects as opposed to isolated outcomes, and more advanced meta-analytic techniques are needed to evaluate outcomes for various abuse and effect profiles (Taylor & Harvey, 2010). This is particularly important considering the multifaceted etiology of the effects of child sexual abuse (Briere & Jordan, 2009).

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