Child Therapy for the Impacts of Sexual Abuse

A Literature Review from a New Zealand Perspective

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Child sexual abuse has been defined as an event or series of traumatic events of a sexual nature that occur in a child's life (Macdonald, 2006). It is a "substantial social problem which affects large numbers of children, of both sexes, of all ages, and across cultures and social class" (Macdonald, 2006, p. 2). Negative sequelae of child sexual abuse can include depression, anxiety, behavioural problems, and posttraumatic stress disorder (Saywitz, Mannarino, Berliner & Cohen, 2000).

Due to the hidden nature of sexual abuse, estimating its prevalence in children can be highly challenging. New Zealand research has put the overall prevalence of child sexual abuse as occurring in approximately one out of every four girls (23.5%) in urban areas and in almost one out of every three girls (28.2%) in rural areas (Fanslow, 2007). Maori women in New Zealand report higher rates of child sexual abuse than European and other ethnic groups. Prevalence rates are similar for Australian community studies, with 27.5% of all women experiencing sexual abuse as children (Andrews, Gould & Corry, 2002).

The consequences and ripple effects of child sexual abuse can be catastrophic and persistent; hence it is a social problem that requires ongoing intervention. Historically, the psychological treatments for child sexual abuse have been little studied (Feather & Ronan, 2006). The number of empirical studies evaluating available treatments has increased in recent decades; however many studies are methodologically flawed and there is inconsistent evidence to suggest that any one treatment is the superior treatment for all child sexual abuse cases (Skowron & Reinemann, 2005; Feather & Ronan, 2006).

A large proportion of studies are conducted in experimental rather than community settings and others do not include a comparison or non-treatment control group of children (Skowron & Reinemann, 2005). The lack of comparison groups disallows the authors to conclude that positive outcomes are a result of specific treatment components and not the passing of time or the therapeutic environment itself (Finkelhor & Berliner, 1995; Ramchandani & Jones, 2003). An additional concern with experimental studies is their exclusionary criteria – with many barring children with severe mental illnesses, substance misuse problem or any type of intellectual impairment (Ramchandani & Jones, 2003). As intellectual impairment is one of the key risk factors for child sexual abuse, the exclusion of such children means that studies are not always representative of the children seen at community centres (Putnam, 2003). Hence; readers must retain a critical perspective when interpreting the findings of any outcome study in this research area.

The available child sexual abuse outcome studies also tend to support treatments based on cognitive and behaviour therapy principles over non-behavioural treatments (Saywitz et al., 2000; Ramchandani & Jones, 2003). A recent review investigating the interventions available for victims of sexual abuse in the United States of America has found that, according to the Office for Victims of Crime (Saunders, Berliner & Hanson, 2004), Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is the most empirically supported and efficacious treatment for children (Tavkar & Hansen, 2011). However as Saywitz (et al., 2000) put it so aptly:

> This does not mean that behavioural approaches are best for all types of children and all types of problems. These approaches may enjoy the greatest empirical support in part because they are the most frequently studied. They are short term and are among the easiest to manualize, standardize, and therefore utilize in well-controlled treatment trials (p.1043).

Thus, whilst behavioural therapies appear to have the greatest empirical support, further research on other non-behavioural therapies is needed in order to determine the most effective treatment for child sexual abuse. This literature review will first explore the available evidence for behavioural therapies such as CBT and TF-CBT in New Zealand and beyond before exploring the evidence for less studied therapies. A community project used in the Child Advocacy Centres of America will then be discussed as a reference point for the services provided in New Zealand.

New Zealand and Australian Research

Whilst it would be ideal to only review studies of child sexual abuse treatments undertaken in a New Zealand or Australian setting, the profound lack of local research in this area means that this is an impossible task. Only several articles relating to the treatment of sexual abuse for child victims and their families in New Zealand were available.

Feather and Ronan (2006) claim that their clinic-based study – investigating the effectiveness of a manualised, locally developed trauma-focused cognitive behaviour therapy (TF-CBT) programme for multiply abused children diagnosed with PTSD – was the first of its kind in New Zealand. They express how important it is to evaluate the effectiveness of child sexual abuse treatments in clinic-based populations that are representative of the population of children requiring treatment; however, they also stress how challenging this can be in New Zealand where clinics lack resources and client numbers.

In their study, four multiply-abused children diagnosed with PTSD and aged nine to thirteen were recruited from a population of children referred to Child, Youth and Family (CYF) Specialist Services Unit in Auckland. Following referral, the children – along with their parent/caregiver and teacher –

underwent a full assessment. The full battery of assessment measures included: the *Anxiety Disorders Interview Schedule for Children (ADIS)* (Silverman, 1987), the *Children's Post-traumatic Stress Reaction Index (CPTS-RI)* (Frederick, Pynoos & Nader, 1992), the *State Trait Anxiety Inventory for Children (STAIC)* (Speilberger, 1973), the *Children's Depression Inventory (CDI)* (Kovacs, 1981), *The Coping Questionnaire (CQ)* (Kendall et al., 1992), the *Child Behaviour Checklist/4-18 Parent Form (CBCL/4-18)* (Achenbach, 1991) and the *Child Behaviour Checklist – Teacher Report Form (TRF)* (Achenbach, 1991). The children completed the full battery of measures again at post-treatment, and at a follow-up of 3 months, 6 months and 12 months.

The 16-session TF-CBT programme (Feather & Ronan, 2004) was carried out at the CYF Specialist Services Unit and included a 3-session parent/caregiver option. The programme consisted of four key phases: Psychosocial strengthening, coping skills (including "The STAR Plan" (Kendall et al, 1990)), trauma processing, and special issues and completion of therapy. Results show that, from baseline through to 12-month follow up, average posttraumatic stress symptoms (CPTS-RI scores) decreased and average self-perceived coping (CQ scores) increased. However, the large variation between participant scores (such as in the STAIC and CDI), as well as the post-treatment booster sessions needed for the two younger participants, suggests that TF-CBT may not have the same degree of effectiveness from one child to the next.

An additional concern with this study lies within the characteristics of the small number of participants. Firstly, the children had a wide range of abuse histories, with only one child experiencing sexual abuse. The researchers deny that the varying abuse histories are a limitation to the study. Instead, they insist that the children are typical of those referred to clinical settings and that they highlight the fact that sexual abuse seldom occurs in isolation of other forms of abuse (Skowron & Reinemann, 2005). Secondly, all four children identified as New Zealand Europeans, meaning that the findings cannot be generalised to children of other cultures, for example Maori and Pacific Islanders.

Despite these limitations, the study does provide useful information on appropriate treatments for multiple child abuse cases and the measures used to assess treatment effectiveness. Furthermore, it is one of the only child abuse outcome studies carried out in a real-life New Zealand setting and therefore helps to guide local clinical practice.

The same manualised 16 session TF-CBT program developed by Feather and Ronan (2004) for children with PTSD resulting from sexual abuse has been evaluated in a number of more recent studies. Feather, Ronan, Murupaenga, Berking and Crellin (2009) evaluated the program using two

Maori and two Samoan children in New Zealand. The results showed that the program was effective in reducing PTSD symptoms and increasing self-perceived coping amongst children of other cultures.

Another study investigated the effectiveness of the TF-CBT program (Feather & Ronan, 2004) when administered by different therapists (Feather & Ronan, 2009). In one situation the program was delivered by the author of the treatment manual and in the other situation the program was delivered by two therapists working in a specialist child protection clinic in New Zealand. The children were eight, 9-13 year olds with multiple abuse histories (including sexual abuse) that had also been diagnosed with PTSD. The children came from a range of different cultures including New Zealand European, Eastern European, North African, South American, Maori and Samoan. The children were assessed with the aforementioned battery of measures used by Feather and Ronan (2006) before treatment, after treatment and at a 3- and 6-month follow up.

All children, regardless of who the program was delivered by, showed an overall decrease in PTSD symptoms and an overall increase in coping, and this was maintained at follow-up. The results confirm the flexibility and effectiveness of this locally developed TF-CBT program across a range of cultures present in New Zealand. However, the study is not without methodological limitations. Firstly, those children with primarily a history of sexual abuse as well as those children with serious mental health concerns may have been excluded from the study entirely. Secondly, there is missing data for some children - highlighting the challenges involved in conducting research in a clinical setting. These limitations emphasise how important it is to maintain a critical perspective when interpreting the results of outcome studies conducted with victims of child sexual abuse.

There are also several sexual abuse outcome studies conducted in Australia that deserve a mention here. King (et al., 2000) investigated the effectiveness of involving a parent or caregiver in the cognitive-behavioural treatment of sexually abused children diagnosed with PTSD. The children were aged 5 to 17 years and most had experienced multiple forms of sexual abuse. Ethnicity was not recorded. The children were randomly assigned to one of three conditions: child-only CBT, family CBT, or wait list control. The child-only CBT consisted of 20 weekly 50-minute sessions aimed at reducing PTSD symptoms, and this took place in the Children's Support Centre which was established as part of the study. The family CBT saw the non-offending mother also receive 20 weekly individual sessions aimed at providing her with skills for child behaviour management and parent-child communication. Self-report measures for the child were: the *ADIS* (Silverman, 1987), the *CQ* (Kendall et al., 1992), the *CDI* (Kovacs, 1981), the *Revised Children's Manifest Anxiety Scale (R-CMAS)* (Reynolds & Richmond, 1978) and the *Fear Thermometer for Sexually Abused Children* (Kleinknecht & Bernstein, 1988). Parents completed the *CBCL* (Achenbach, 1991).

Results showed that, compared to the wait-list group, treated children had significantly fewer PTSD symptoms at post-treatment assessment and follow-up. A significant improvement was also found in the Fear Thermometer scale for the family CBT compared to the child-only condition. Interestingly, no significant differences were found in any other child or parent self- reports between the child-only CBT and family CBT conditions at post-treatment or follow-up. The findings suggest that treatment is definitely beneficial over no-treatment. However, there was no suggestion that non-offending parent involvement improves treatment outcomes in sexually abused children. The authors suggest that their small sample size as well as the sexual abuse history of the mothers themselves may have produced such results.

It seems this may be the case, as a number of other studies have shown the importance of involving family in the therapeutic process; with Cohen and Mannarino (1998a) noting that caregiver involvement and support was the most salient predictor of positive therapeutic outcomes for young children. An overseas study by Deblinger, Lipmann and Steer (1996) examined parent participation in a 12-week cognitive behavioural intervention designed to treat symptoms of PTSD. The 100 participants were aged 7-13 and were mostly of Caucasian ethnicity. They were randomly assigned to one of three conditions: mother only, child only, or mother and child together. Results showed that having the mother involved in therapy significantly increased effective parenting skills and significantly reduced child depression scores and externalizing behaviours.

Further research on family involvement comes from Bagley and LaChance (2000) who have done a two-year follow-up study on a family intervention for 11 year old female victims of sexual abuse and their non-offending parent. The Canadian programme was based on Giarretto's Child Sexual Abuse Treatment Program [CSATP], and involved on average 78 hours of individual therapy, 37 hours dyadic therapy with mother and sibling, 32 hours of group therapy with other victims and 14 hours of family therapy including siblings. Two years later, and in comparison to an untreated control group, the treated children showed higher self-esteem as well as less depression and problem behaviours (for example delinquency and self-harm). However, it remains unclear whether positive treatment outcomes in this study are caused by family involvement or the therapeutic process in itself.

Another prominent Australian child sexual abuse study is one by Nurcombe, Wooding, Marrington, Bickman and Roberts (2000). This article describes treatment programs for child sexual abuse designed by The University of Queensland in conjunction with the organisation Protect All Children Today (PACT). The treatments compared are an 18-week, manualised CBT program and an 18-week, manualised family therapy program. Participants are male and female victims of sexual abuse, aged

6-16 years of age, who are recruited through police or child protection services in Queensland. The CBT program consists of three 6-week phases: the Relaxation, Reframing and Stress Management phase (child and parent together), the Resolving Anxiety and Depression phase (child and parent separate) and the Resolving Residual Problems phase (child and parent reunite). The family therapy program also has three 6-week phases: the Relaxation, Reframing and Stress Management phase, the Parenting Issues and Family Functioning phase and the Application and Consolidation phase (in all of which the child and parent remain together). Though the two treatment programs are described in depth, no actual evidence exists as to which treatment produced greater results in the abused children. The authors merely predict that the CBT program will be superior due to its use of certain techniques, such as graded imaginal exposure, that directly examine any traumatic memories the child may have.

There is a dearth of high quality outcome studies evaluating the effectiveness of psychological treatments for child sexual abuse in New Zealand and Australia, thus we must look to the evidence emerging from other parts of the world to inform our local clinical practice. However, when using overseas studies as a reference point for the services provided to children here in New Zealand we must keep in mind the different ethnicities and socio-economic status' of the participants used as well as the different contexts in which treatment is carried out.

Non-New Zealand Research

Skowron and Reinemann (2005) were the first non-New Zealand researchers to quantitatively review interventions (including CBT) for maltreated children. Seven of the studies reviewed related specifically to child sexual abuse. Celano, Hazzard, Webb and McCall (1996) compared a structured behaviour therapy to a comparison therapy for sexually abused African American and Caucasian girls aged 8 to 13, along with their non-offending female caregivers. The behaviour therapy was based on Finkelhor and Browne's (1985) traumagenic model targeting self-blame, betrayal, traumatic sexualisation, and powerlessness. The comparison therapy involved unstructured psychotherapy or 'treatment-as-usual'. Both of the 8-week, child and parent interventions resulted in decreased child posttraumatic stress symptoms and traumagenic beliefs, as well as increased overall psychosocial functioning in the child. However, the structured behaviour therapy was superior in increasing caregiver support of the child and in decreasing caregiver self-blame.

Cohen and Mannarino (1996) compared a cognitive-behavioural therapy (CBT) to a non-directive supportive therapy (NST) amongst sexually abused Caucasian and African American children aged 3-6. The participants, along with their non-offending caregivers, underwent 12 individual sessions of

either therapy. Due to the young age of the participants, only one child self-report measure was included: the pictorial *Preschool Symptom Self-Report (PRESS*) (Martini, Strayhorn & Puig-Antich, 1990). Parents completed the CBCL-Parent Version (Achenbach & Edelbrock, 1983) and *the Child Sexual Behaviour Inventory (CSBI)*. Results show that the CBT was superior in improving symptomatology on most outcome measures from pre-treatment through to post-treatment, particularly in the CSBI. The findings support the effectiveness of CBT over NST for pre-school aged girls and boys and their parents. A similar study was undertaken by Cohen and Mannarino (1998b) in older children aged 7-14 comparing sexual-abuse specific CBT with NST. Results show that the 12-session CBT program was more effective than the NST program in improving child depression scores, child social competence and in treating sexually inappropriate behaviours.

In the years following the review by Skowron and Reinemann (2005) a number of overseas outcome studies comparing the effectiveness of CBT-like interventions with control interventions were published. Key studies will be reviewed here.

Cohen, Deblinger, Mannarino and Steer (2004) investigated the effects of a trauma-focused cognitive-behavioural therapy (TF-CBT) and a supportive child-centred therapy (CCT) on 229 8 to 14 year-old victims of sexual abuse. The children, who also had PTSD, were recruited from a metropolitan and a suburban outpatient clinic; hence the sample was considered by the authors to be representative of the population seen in practice. The children were assessed before and after treatment using: the *K-SADS-PL* (Kaufman et al., 1996), the *CDI* (Kovacs, 1981), the *STAIC* (Spielberger, 1973) and the *Children's Attributions and Perceptions Scale (CAPS)* (Mannarino et al., 1994 as cited in Cohen et al., 2004). Parents, who were also involved in the therapy, were assessed with: the *K-SADS-PL*, the *CBCL* (Achenbach, 1991), the *CSBI* (Friedrich et al., 1992), the *BDI* (Beck et al., 1996), the *Parent's Emotional reaction Questionnaire (PERQ)* (Mannarino & Cohen, 1996), the *Parent Support Questionnaire* (Mannarino & Cohen, 1996) and the *Parenting Practices Questionnaire (PPQ)* (Strayhorn & Weidman, 1998 as cited in Cohen et al., 2004). Compared to the CCT condition, children in the TF-CBT condition showed significant improvements in the measures of PTSD, depression, shame and behaviour problems. Parents in the TF-CBT condition also showed improvements in their own depression and distress as well as their effective parenting skills and support for their child. This study builds on the evidence in support of TF-CBT for sexually abused children suffering from PTSD; however the specific components of the TF-CBT that contribute most to the positive outcomes of the therapy remains unclear.

The same authors carried out a 6 and 12-month follow-up of this study in 2006. At both 6 and 12 months later, the TF-CBT group showed significantly less PTSD symptoms and less shame than the

CCT group. Parents who participated in the TF-CBT also showed less abuse-related distress than the parents in the CCT group. Finally, the number of traumas experienced by the child and their level of depression prior to treatment was positively correlated to the PTSD symptoms following treatment for the CCT but not the TF-CBT group.

Another study that provides evidence in support of the efficacy and durability of TF-CBT was carried out by Cohen, Mannarino and Knusden (2005). This study compared TF-CBT to a non-directive supportive therapy (NST). Participants were 82, 8 to 15 year-olds referred from a number of community organisations to an urban outpatient clinic. Over one-third of the participants were African American. The children were assessed against reputable measures: the *CDI,* the *CSBI,* the *STAIC*, the *CBCL,* and the *Trauma Symptom Checklist for Children (TSC-C)* (Briere, 1995 as cited in Cohen et al., 2005). Each parent and each child received 12, 45-minute sessions of the therapy they were randomly assigned to. From before treatment to 6-month follow-up, participants who received the TF-CBT therapy showed significantly larger improvements on the *STAIC* scales as well as the anxiety, depression, sexual problems and dissociation factors of the *TSCC.* At 12-month follow up, the TF-CBT group also showed significantly larger improvements in PTSD symptoms and dissociation. The findings suggest that a therapy in which a victim and his/her parents direct the session and create their own strategies for managing behavioural problems may not be as effective as one in which strategies and skills are taught and advice is given.

Overall, CBT and TF-CBT has been shown to be efficacious for child victims of sexual abuse (Tavkar & Hansen, 2011). Paul, Gray, Elhai, Massad and Stamm (2006) note that such therapy should reduce shame, self-blame, depression, behaviour problems, powerlessness, and sexualised behaviours and increase social skills and knowledge about body-safety. Whilst TF-CBT is normally an individual therapy, it's effectiveness as a group therapy has also been investigated. For some, group therapy in young children is not advisable, with many psychologists stressing the need for detailed psychological and abuse histories and standardised measures to assess the client's appropriateness for group treatment (See Wolfe, 2006, as cited in Tavkar and Hansen, 2011). However, for others, group treatment is the treatment of choice.

Trowell (et al., 2002) compared an individual psychodynamic therapy to group psychoeducation. The participants were 71 sexually abused girls aged 6 to 14 years old. Whilst both groups showed improvements in symptoms and functioning, there was no significant difference between the two groups. Individual psychoanalytic treatment did result in significantly larger reductions in PTSD symptoms than the group therapy. However, the difference in length of treatments (individual

treatment was 30 sessions; group treatment was 18 sessions) may have influenced the results (Taylor & Chemtob, 2004).

Deblinger, Stauffer & Steer (2001) compared group CBT with group supportive therapy for young children, aged 2 to 8, and their non-offending mothers. The 44 participants were recruited from families referred to the Regional Child Abuse Diagnostic and Treatment Centre in New Jersey. Two-thirds of the children identified as 'White'. The children were measured for PTSD symptoms as well as assessed using the *CBCL,* the *CSBI-3* and the *What If Situations Test (WIST)* – a test that examines the child's ability to assess danger in certain abusive situations (Sarno & Wertele, 1997, as cited in Deblinger et al., 2001). Each randomly organised group (CBT parent, CBT child, supportive therapy parent, and supportive therapy child) met for 11 1 hour and 45 minute sessions. The post-treatment results suggest that young victims of sexual abuse and their mothers benefit from being involved in group therapy whether it is CBT or supportive. However, the results show a greater improvement for those in the CBT group compared to the supportive therapy group; mothers show greater reductions in intrusive thoughts and negative parental emotions, and children show greater improvement in their knowledge about body safety.

Group treatment can be particularly helpful for adolescent victims by the way it targets feelings of isolation and stigmatisation and strengthens peer relationships (Tavkar & Hansen, 2011). A literature review by Avinger and Jones (2007) looked at a range of group therapies for sexually abused girls aged 11-18. Both the TF-CBT and the multidimensional treatment models evaluated reduced PTSD symptoms. The children in the psychodrama group showed decreases in depression levels. The groups that included sex education as a component of therapy showed decreased shame and guilt in the girls. Meanwhile, all groups showed improvements in self-esteem, whilst none of the groups showed reductions in problem behaviours. Although these findings are interesting, it is important to consider that only four of the studies reviewed included comparison groups, and that there were disparities in the lengths and settings of the treatments evaluated. Overall, group therapy for victims of child sexual abuse is understudied and there is insufficient evidence to determine its effectiveness for children of different ages, cultures and abuse histories.

Unfortunately, many modes of therapy for child victims of sexual abuse that are not based on CBT are also understudied and hence are not well proven (Ramchandani & Jones, 2003). One such mode of therapy is Eye Movement Desensitisation and Reprocessing (EMDR; Shapiro 1995). This individual intervention is based on the "adaptive cognitive network theories of emotion and learning...accommodation and assimilation... [and is] used to address traumatic memories and PTSD symptoms typically in two to three sessions...[It involves] facilitating the blocked processing of the

traumatic memory; promoting more adaptive cognitions...;and installing alternative positive cognitions, adaptive behaviours and coping strategies" (Tavkar & Hansen, 2011; pp. 192; see also Clayton, 2011). Chemtob, Nakashima, Hamada and Carlson (2002) have attempted to demonstrate the efficacy of EMDR in 32 Hawaiian children (aged 6-12) as a treatment for PTSD symptoms. Compared to a wait-list control group, children in the EMDR group showed a large reduction in PTSD symptoms. However, the lack of a comparison treatment group makes it unclear whether the positive treatment outcomes are due to the treatment components or treatment in general – as is the case for so many similar studies (Taylor & Chemtob, 2004).

EMDR has also been compared to CBT in 14 sexually abused Iranian girls (Jaberghaderi, Greenwald, Rubin, Zand & Dolatabadi, 2004). In this study the girls, who were aged 12-13 years old, were randomly assigned to 12 sessions of either therapy. Post-traumatic stress symptoms and problem behaviours were assessed prior to treatment and 2 weeks following treatment. Both modes of therapy were effective in significantly reducing stress symptoms and problem behaviours; however, the EMDR had larger effect sizes for each outcome measured. The findings tell us that both CBT and EMDR are effective treatments for sexual abuse, and that EMDR has the potential to be superior. Unfortunately, the lack of a long-term follow-up in this study reduces the strength of the evidence in favour of EMDR.

The final therapy for sexual abuse survivors that I will look at is Cognitive processing therapy (CPT). According to Chard (2005), CPT combines information processing, developmental and self-trauma theories and is focused on the functions that fear processing, attachment and cognitions play in maintaining symptoms of distress. Compared to a wait-list control, 17 weeks of CPT was found to reduce trauma-related symptoms, and this was maintained for at least one year following treatment (Chard, 2005). However, the participants of this study were adult victims of child sexual abuse. More research is needed to determine the effectiveness of this promising treatment in recently abused children; however to my knowledge no evaluation of CPT in children has been conducted since Chard's (2005) study.

Project SAFE

Project SAFE (Sexual Abuse Family Education) is a programme that was developed for victims of child sexual abuse in 1996 and it has been used as an on-site treatment programme at various Child Advocacy Centres (CAC's) in America since the year 2000. Tavkar and Hansen (2011) describe Project SAFE as primarily a cognitive-behavioural treatment program that also includes important group and family interventions. The four manualised cognitive-behavioural treatments available under Project

SAFE allow greater ability to triage care based on the presenting needs of the children and their families. The treatment pathways will be briefly described here.

The first treatment (a group therapy for the victim and their non-offending caregiver) was designed to address: the self, relationships and sexual development. There are two groups catering to different ages: child victims (ages 7-12) and adolescent victims (ages 13-18). The 12-week programme involves separate youth and parent groups that meet for 90-minute sessions. The sessions focus on: psychoeducation, regulation of feelings, cognitive restructuring, relaxation, disclosure and prevention of further abuse (Tavkar & Hansen, 2011). The second treatment option involves a group treatment for non-abused siblings. This 6-week treatment runs parallel to the above group therapy for victims and covers similar topics. The third treatment option is a crisis intervention called the Project SAFE Parent Support and Education Session (PSES) that helps caregivers understand and cope with the difficulties following disclosure of sexual abuse. This treatment is flexible and individualised. The fourth and final treatment on offer from America's Project SAFE is the Brief Family Intervention that provides short-term, 1 hour sessions of individual and family counselling for the victim and his or her non-offending caregiver (Tavkar & Hansen, 2011).

Project SAFE has demonstrated its effectiveness as a community-based intervention in The United States of America. Parents have been shown to report improvements in child behaviours, increased body knowledge, and reduced anxiety, post-traumatic stress symptoms and maladaptive abuse attributions for three months following group treatment (Hsu, 2003; Campbell et al., 2006, as cited in Tavkar & Hansen, 2011). The evidence in support of Project SAFE suggests that a similar community-based programme that combines CBT, group and family therapy could be effective in New Zealand.

Conclusion

Unfortunately, studies investigating the effectiveness of real life programmes such as Project SAFE are uncommon. As Putnam (2003) has said, "[Future research] needs large-scale "effectiveness"...trials with longitudinal follow-up conducted in community settings to determine how well these models work in the real world" (p.276). Almost ten years later, the need for more community-based research, particularly in a New Zealand setting, is still apparent. Furthermore, "the [previous] empirical support for abuse-specific CBT must be viewed in the context of a dearth of information about the efficacy of other treatments" (Saywitz et al., 2000, p.1045); hence future research must also look past CBT to other, less studied therapies. Finally, future research must strive to be methodologically sound; studies must always include a control or comparison treatment group

so that outcomes in abused children can be attributed to a specific therapy and not simply to the passage of time or the therapeutic process in itself.

Overall, child sexual abuse is a social problem that is highly challenging to deal with; both in prevention and in treatment for child victims. Due to the heterogeneity of the impacts of sexual abuse, as well as the methodological flaws plaguing recent studies, we currently do not know of a psychological treatment that is effective for children of all ages, cultures, sexes and socio-economic status'. What we do know, however, is that the treatments currently showing the most promise are behavioural therapies in the form of CBT and TF-CBT. We also know that involving a non-offending parent or caregiver in the therapeutic process is highly beneficial. Finally, it is becoming clear that the lack of evidence for other therapies such as Eye Movement Desensitisation and Reprocessing (EMDR), Cognitive Processing Therapy (CPT) and many forms of group therapy may simply be due to the fact that such treatments are not as popular to study. There is a long way to go before the perfect treatment for child sexual abuse is found; but in reality this can only be achieved through extensive community-based research of all therapies, but particularly those currently understudied.

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