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**A comparison of two programmes for victims of Child sexual abuse:
A treatment outcome study**

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ABSTRACT

This study aimed to evaluate the comparative effectiveness of individual therapy and combined individual and group therapy in the treatment of the psychological sequelae of child sexual abuse. The Child Behaviour Checklist (CBCL), the Youth Self Report form (YSR), the Childhood Depression Inventory (CDI) and the Trauma Symptom Checklist for Children (TSCC) were administered before treatment and 6 months later to a group of 20 young people who participated in individual therapy (IT) programmes and to a group of 18 young people who participated in programmes that involved combined individual and group therapy (IGT). For both types of programmes statistically significant improvement occurred on the following scales: the total problems, internalising problems, externalising problems, withdrawn, somatic complaints, anxious/depressed, social problems, attention problems and aggressive behaviour problems CBCL scales; the total depression, interpersonal problems and anhedonia CDI scales; and the depression and anger TSCC scales. The only scale for which one therapy programme led to greater improvement than another, was the CDI ineffectiveness scale. The IGT programme led to a reduction in the mean CDI ineffectiveness score, whereas a slight increase in the mean ineffectiveness score occurred in the IT group. There were no significant differences in the rates of clinically significant improvement associated with the two treatments and no major differences between cases who improved and those that did not improve over the course of therapy. From this study it may be concluded that after 6 months, individual therapy and combined individual and group therapy were equally effective in the treatment of the psychological sequelae of child sexual abuse.

INTRODUCTION

Child sexual abuse (CSA) is a widespread problem in Ireland (Kennedy et al., 1990; MacIntyre and Carr, 1999a, 2000; McKeown and Gilligan, 1991; O'Reilly and Carr, 1999). Children who are victims of CSA may show a range of adjustment difficulties including behaviour problems and personal distress; interpersonal and relationship difficulties within the peer group; and a variety of problems within the family, school and wider social network (MacIntyre and Carr, 1999b, 2000). For about two thirds of young people these difficulties are transient, but in a fifth of cases clinically significant long-term problems develop which persist into adulthood (Kendall-Tackett et al., 1993). In view of this, the development of effective treatment programmes to ameliorate the sequelae of CSA is imperative. Ideally such programmes should address intrapsychic psychological difficulties through individually based child-focused interventions; peer-related interpersonal problems through group-based interventions; and difficulties within the family and wider social network through family therapy and systemic interventions (Stevenson, 1999; Wolfe and Wekerle, 1993; Carr, 1999, 2000a). It would be expected that some programmes might be more effective than others for young people with particular constellations of difficulties and that programmes that combined two or more therapeutic modalities might be more effective than more narrowly focused programmes.

Extensive literature reviews confirm that treatment outcome research to evaluate the comparative effectiveness of various intervention programmes to ameliorate the sequelae of CSA is in its infancy (Finkelhor and Berlinger, 1995; Reeker et al., 1997; Stevenson, 1999; Tourigny, 1997). Individual, group and family based therapies have all been shown to have positive effects for some, but not all CSA cases. However, with some notable exemplary exceptions (Cohen and Mannarino, 1996a, 1996b, 1998a, 1998b; Deblinger et al., 1996; Monck et al., 1996), most studies are fraught with methodological difficulties. These include the lack of control or comparison groups, inadequate matching of groups on baseline variables, failure to use psychometrically robust assessment instruments, use of inexperienced therapists, inadequate follow-up periods and failure to adequately analyse data by examining both statistically and clinically significant improvement rates and base-line factors related to improvement. In the present study we attempted to avoid some of these methodological shortcomings. We set out to investigate the comparative effectiveness of two treatment programmes and to address the following three specific questions:

1. Six months after the onset of treatment, is there a statistically significant difference between the mean scores (on psychometrically robust measures) of a group of sexually abused children and young people who received individual therapy and a matched group that received a combined programme of individual and group therapy?
2. Six months after the onset of treatment, is there a difference between the proportions of cases that show clinically significant improvement, when a comparison is made between a group of sexually abused young people who received individual therapy and a matched group that received a combined programme of individual and group therapy?
3. Do cases that show clinically significant improvement six months after the onset of treatment differ from those that do not improve on a range of baseline variables?

METHOD

DESIGN

A two group, repeated measures, comparative design was used in this study to evaluate the effects of two different treatment programmes on CSA-related psychological adjustment problems. In one programme children received individual therapy only (IT) and in the other, children received combined individual and group therapy (IGT). Cases were assessed before treatment (at time 1) and approximately 6 months later (at time 2) with a range of psychometric instruments to evaluate psychological adjustment. While cases were not randomly assigned to treatment programmes, the two groups were comparable on many baseline variables. A design which entailed a single 6 month follow-up time frame was used because of resource constraints although it is acknowledged that a design which included pre and post-treatment assessment with a longer follow-up period of 12 or 14 months would have been preferable.

Insert Tables 1,2 and 3 here

PARTICIPANTS

Thirty-eight young people consented to participate in this study, 20 in the IT group and 18 in the IGT group. From Tables 1-3 it is clear that the groups were remarkably similar in terms of demographic characteristics, abuse related experiences and disclosure related experiences. It is noteworthy that participants were predominantly female. It is also worth mentioning that there was near-significant trend ($p=.07$) for more members of the IGT group to have suffered penetrative abuse compared with the IT group (61% vs 25%). Participants were drawn from eight urban and rural services for sexually abused children and adolescents. Participants were included in the study if their disclosure of sexual abuse was confirmed by a specialist multidisciplinary assessment team, if they were between 8 and 18 years of age, and if their non-abusive parent gave written consent.

INSTRUMENTS

For all cases, clinicians complete a comprehensive clinical information protocol which allowed demographic information, abuse-specific variables and disclosure related information to be routinely coded. Clinician's obtained this information from multiple sources including interviews with parents, children and other involved professionals. Information set out in Tables 1-3 is based on the clinical information protocol. The following instruments were used to assess the psychological adjustment of children before and after treatment:

- The Child Behaviour Checklist (CBCL, Achenbach, 1991a)
- The Youth Self Report Form (YSR, Achenbach, 1991b)
- The Children's Depression Inventory (CDI, Kovacs, 1992)
- The Trauma Symptom Checklist for Children (TSCC, Briere, 1996)

The Child Behaviour Checklist (CBCL)

This 113 item inventory was completed by parents to give a description of their children's behaviour problems (Achenbach, 1991a). The CBCL yields scores on 3 broad band and 8 narrow band scales. The total problem scale, the externalizing behaviour problem scale and the internalizing behaviour scale are broad band dimensions. The narrow band scales are: withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behaviour, and aggressive behaviour. CBCL items describe problem behaviours that children between 4 and 18 years may exhibit. A three point response format is used for

each item: 0=not a problem, 1=sometimes a problem, 2=often a problem. Raw scores are converted to T-scores with a mean of 50 and a standard deviation of 10. T-scores above a clinical cut-off of 63 on the broad band scales are indicative of clinically significant problems. The CBCL scales have high internal consistency and test-retest reliability with reliability coefficients ranging from .7-.9 (Achenbach, 1991a) and good discriminative validity with a sensitivity of 60% and a specificity of 73% for DSM-III-R diagnoses (Kasius et al.,1997). In a recent epidemiological study of psychopathology in Irish children and adolescents as measured by the CBCL, 13-15 year olds did not differ from their American counterparts on the total problem score (Fitzpatrick and Deehan, 1999).

Youth Self Report Form (YSR)

The YSR is the self-report version of the CBCL (Achenbach, 1991b). This 112-item inventory has been designed to obtain 11-18 year-olds reports of their competencies and problems in a standardized form. The structure of this questionnaire and response format are identical to those of the CBCL, yielding scores on 3 broad band and the 8-narrowband scales. The reliability and validity of the YSR has been established (Achenbach, 1991b). Internal consistency and test-retest reliability coefficients have been found to range from .7-.9 and the mean scores of clinical and community samples have been found to differ from each other at a high level of statistical significance ($p<.01$).

The Children's Depression Inventory (CDI)

The CDI is a 27 item self-rated symptom oriented scale for school-aged children and adolescents aged between 7 and 17 years (Kovacs,1992). It yields a total depression score and scores on the following 5 scales: negative mood, interpersonal difficulties, ineffectiveness, anhedonia and negative self-esteem. This measure of childhood depression is based on the Beck Depression Inventory, a widely used instrument for assessing depression in adults (Beck and Steer, 1987). The CDI includes items relating to a broad range of depressive symptomatology. Each item consists of three statements which describe symptoms at different levels of severity. Items are scored 0, 1, or 2. The respondent is instructed to select the choices for each item that best describes them over the preceding two weeks. The CDI has been found to have good test-retest reliability, high internal consistency reliability and good validity (Kovacs, 1992). Reliability coefficients range from .7-.9 and CDI scores have been

found to correlate significantly ($p < .01$) with other self-report and interview measures of depression in children and adolescents.

The Trauma Symptom Checklist for Children

The TSCC is a 54-item self-report questionnaire designed to assess children's responses to trauma across a number of symptom areas (Briere, 1996). It yields scores on the following 10 clinical scales: anxiety, depression, anger, posttraumatic stress, dissociation, overt dissociation, fantasy dissociation, sexual concerns, sexual preoccupation and sexual distress. In addition the TSCC yields scores on two response-distortion indices: the under-response and hyper-response scales which allow for the detection of extreme minimisation or exaggeration of symptoms. TSCC items describe thoughts, feelings or behaviours that children may exhibit in response to sexual trauma. A four point response format is used for each item: 0=never, 1=sometimes a problem, 2=lots of times, 3=almost all the time. The clinical scales of the TSCC have been found to have high internal consistency reliability good validity (Briere, 1996). For the clinical scales internal consistency reliability coefficients range from .8 to .9. The TSCC depression, anxiety and post traumatic stress scales have been found to correlate significantly ($r = .8$) with self-reported internalising symptoms, whereas TSCC anger, dissociation and sexual concerns scales have been found to correlate most strongly with self-reported externalising behaviour problems ($r = .6-.7$).

PROCEDURE

All 8 of the agencies involved in the study independently received ethical approval from their respective ethics committees for their participation in this multi-site treatment evaluation project. Prior to therapy, participants and their parents signed consent forms after they had been briefed about the nature of the study. Clients completed the CBCL, YSR, CDI and TSCC before treatment (at time 1) and approximately six months later (at time 2). In the majority of cases, treatment had been completed at time 2.

The professionals who conducted the therapy at the 8 agencies were highly experienced, had advanced training in the fields of child protection and therapy, and came from a range of disciplines including child psychiatry, clinical psychology, psychotherapy, and social work.

The therapy programmes evaluated in this study were not standardised or manualized. They did, nevertheless, represent current clinical practice within an Irish context. Therapy was predominantly integrative and based on principles drawn from individual and group therapy practices within the broad traditions of psychodynamic psychotherapy, client-centred therapy, and cognitive-behaviour therapy. However, the way in which practices from these traditions were integrated varied from case to case, and from clinician to clinician. Despite this variability in clinical practice, certain core features characterized the type of therapy offered to participants within the study.

Within individual therapy programmes, all therapists provided clients with a supportive therapeutic relationship within which to process the psychological sequelae of CSA and within which to develop self-protective insights and skills to prevent further abuse.

Group therapy programmes also provided children with these factors. However, the interpersonal context unique to group therapy, also provided children with a forum within which they could experience peer support and achieve a realisation that their CSA experiences were shared by others. Group therapy programmes, in addition, offered a context within which children could receive ongoing interpersonal feedback from peers about their behaviour and experiences, a factor that was not available within individual therapy.

Participants in the IGT group received an average of 20 hours of therapy each while those in the IT group on average received 18 hours of therapy each.

RESULTS

Complete data sets were obtained for 12 of the 20 cases in the IT group and only 2 of the 18 cases in the IGT group. In the remaining cases there were incomplete data sets, with some cases having some questionnaires completed with others missing.

MISSING DATA

Here is a breakdown of the data that were collected. There were CBCLs at Time 1 and Time 2 for 19 cases in the IT group and 9 cases in the IGT group. There were YSRs at Time 1 and Time 2 for 16 cases in the IT group and 12 cases in the IGT group. There were CDIs at Time 1 and Time 2 for 19 cases in the IT group and 11 cases in the IGT group. There were TSCCs at Time 1 and Time 2 for 19 cases in IT group and 15 cases in the

IGT group. In the analyses reported below, no substitutions were made for missing data, and Ns involved in all analyses are noted in Tables 4,5, 6 and 7.

Insert Tables 4,5 and 6 here

CHANGES IN GROUP MEAN SCORES

To examine statistically significant changes in mean scores from time 1 to time 2 for both groups, 2x2, one-between, one-within, mixed model ANOVAs were conducted for scores on all scales from the CBCL, YSR, CDI and TSCC. In these analyses Therapy was the between group factor with two levels (IT and IGT) and Time was the within group factor with two levels (time 1 and time 2). Because of the large number of analyses involved in this study, there is an increase risk of Type 1 error (erroneously accepting the presence of a significant effect based on the results of a statistical test). To avoid Type 1 error, only results significant at $p < .01$ were considered statistically significant. Differences which occurred at $p < .05$ were noted, but were interpreted with caution.

Child Behaviour Checklist

Means, standard deviations and results of 2x2 mixed model ANOVAs on CBCL scale scores are presented in Table 4. No significant Therapy X Time effects were observed, indicating that the two therapy programmes did not differ in their impact on CBCL scale scores. However, significant Time effects were observed for the following CBCL scales: total behaviour problems, internalising behaviour problems, externalising behaviour problems, withdrawn, somatic complaints, anxious-depressed, social problems, attention problems, and aggressive behaviour. In all instances, both forms of therapy led to significant reductions in behaviour problems from time 1 to time 2. All of these effects were significant at $p < .01$, except that for externalizing behaviour problems which was significant at $p < .05$. This result should be interpreted cautiously.

Youth Self Report Scale

No significant Therapy X Time effects were observed on any of the YSR scales indicating that the two therapy programmes did not differ in their impact on YSR scale scores. Also, no significant Time effects were observed, indicating that the two therapy programmes did not lead to improvements on any of the YSR scales.

Children's Depression Inventory

Means, standard deviations and results of 2x2 mixed model ANOVAs for CDI scales are presented in Table 5. A significant Therapy x Time effect was found for scores on the ineffectiveness scale. An inspection of the means shows that a reduction in the mean score for ineffectiveness occurred in the IGT group whereas a slight increase in ineffectiveness occurred in the IT group. Thus, the combined programme of individual and group therapy had a more pronounced impact in ameliorating ineffectiveness than the programme of individual therapy alone. Significant Time effects were found for the CDI total depression score, and scores on both the interpersonal problems and anhedonia scales. While the effect for CDI total depression scores was significant at $p < .01$, those for the interpersonal problems and anhedonia scales were only significant at $p < .05$, and so should be interpreted cautiously.

Trauma Symptom Checklist for Children

Means, standard deviations and results of 2x2 mixed model ANOVAs for TSCC scales are presented in Table 6. No significant Therapy X Time effects were observed, indicating that the two therapy programmes did not differ in their impact on TSCC subscale scores. Time effects were found for the TSCC depression and anger scales, with significant reductions on these scales occurring from Time 1 to Time 2. The time effect for the TSCC anger scale was significant at $p < .01$, but that for the TSCC depression scale was only significant at $p < .05$, and so should be interpreted cautiously.

Insert Table 7 here

CLINICALLY SIGNIFICANT IMPROVEMENT

Cases in each group were classified as improvers or non-improvers on the basis of their status with respect to the clinical cut-off score for main scales from the CBCL, the YSR, the CDI and the TSCC. For the total behaviour problems, internalizing behaviour problems and externalizing behaviour problem scales of the CBCL and the YSR the clinical cut-off was a T-score of 63. A clinical cut-off score of 65 was used for the total CDI depression scale and the following TSCC scales: anxiety, depression, anger, posttraumatic stress, dissociation, overt dissociation, fantasy dissociation. For the sexual concerns, sexual preoccupation, and sexual distress TSCC scales a clinical cut-off score of 70 was used.

Two sets of analyses were conducted to investigate differences in improvement rates across the IT and IGT groups. In both sets of analyses cases were classified as improvers if their scores were above the clinical cut-off score at time 1 and below the clinical cut-off at time 2. In the first set of analyses, all other cases for whom there were data on the variable which formed the basis of the analysis were classified as non-improvers, regardless of whether they were above or below the clinical cut-off score at time 1. Whereas in the second set of analyses, only cases who were above the clinical cut-off score at both time 1 and time 2 were classified as non-improvers. In effect the first set of analyses addressed the question: How many cases out of all those for whom there were data on a given variable improved? The second set of analyses address the question: How many cases out of all those for whom there were data on a given variable, and who showed clinically significant problems on that variable at time 1, improved? The second set of analyses is probably a more powerful test of treatment effectiveness.

The results of both of these sets of analyses are presented in Table 7. Chi square tests or, where frequencies were below 5, Fishers Exact probability tests, showed that there were no significant intergroup differences in the distribution of improvers and non-improvers across IT and IGT groups.

The total score on the CBCL is probably the best overall index of behavioural adjustment in the assessment battery used in this study, so it is worthwhile commenting on rates of clinically significant improvement on this scale. Of those cases who were above the clinical cut-off T-score of 63 at time 1, only 20% of cases in the IGT group were clinically improved at time 2 compared with more than twice as many (46%) from the IT group.

COMPARISON OF IMPROVERS AND NON-IMPROVERS

In order to determine the variables on which cases that benefited from treatment differed from those that did not, irrespective of type of therapeutic intervention, improvers and non-improvers were compared on demographic, abuse-related and disclosure-related characteristics and on pretreatment scores on the CBCL, YSR, CDI and TSCC. Independent t-tests were used to assess the statistical significance of intergroup differences on interval scale variables, while chi square tests were used for categorical data and Mann Whitney U test were used for ordinal data. For these analyses there were 8 responders and 23 non-responders. Responders were those cases whose scores were above the clinical cut-off on the CBCL total problem scale at time 1 and below this cut-off at time 2. Non responders scored above the clinical cut-off at both time 1 and time 2 on the total problem scale of the CBCL. Across over 70 descriptive variables included in this set of analyses, none of the differences between responders and non-responders were significant at $p < .01$.

DISCUSSION

In answer to the three questions addressed in this study the following conclusions were reached. With respect to the first question concerning the differential effects of the two treatment programmes on group mean scores, in only one instance was such a difference found. The only scale on which one therapy programme led to greater improvement than another was the CDI ineffectiveness scale. A reduction in the mean score for ineffectiveness occurred in the group that participated in individual plus group therapy, whereas a slight increase in ineffectiveness occurred in the group that received individual therapy. However, for both individual and individual plus group therapy conditions scores on a range of CBCL, CDI and TSCC scales decreased significantly from Time 1 to Time 2. These included the CBCL total behaviour problems, internalising behaviour problems, externalising behaviour problems, withdrawn, somatic complaints, anxious-depressed, social problems, attention problems, and aggressive behaviour scales; the CDI total depression, interpersonal problems and anhedonia scale; and the TSCC depression and anger scales.

In answer to the second question concerning differences in rates of clinically significant improvement for the two therapy programmes, it was found that the rates of improvement for both therapy programmes were not significantly different. However, it is worth noting that using the CBCL total score as the criterion variable, compared with the IGT group, twice as many cases in the IT group improved (20% vs 46%). With larger

numbers of participants in the study, this difference in rates of clinically significant improvement would have reached statistical significance.

In answer to the third question concerning differences between cases who showed clinically significant improvement and those that did not, it was found that improvers and non-improvers did not differ significantly on a wide range of baseline variables.

The broad findings that both treatments were effective and did not differ markedly in their degree of effectiveness is consistent with the results of major reviews of the CSA treatment outcome literature (Finkelhor and Berlinger, 1995; Reeker et al., 1997; Stevenson, 1999; Tourigny, 1997). Reeker et al. (1997) estimated that the average effect size (based on the difference between pre and post treatment means rather than treatment and control group post-treatment means) of group treatments for sexually abused children to be $d = .79$. In the present study, for the effect size (based on pre and post treatment CBCL total scores) for individual therapy was $d = .79$ and for combined individual and group therapy was $d = .70$. Thus, the programmes investigated in this study were as effective as many other group therapy programmes for CSA victims. Meta-analyses of individual, group and family therapy outcome studies for routine child and adolescent psychological difficulties yield effect sizes between $d = .5$ and $d = .8$ (Carr, 2000b). Thus, the extent of the impact of both therapy programmes investigated in this study on the behavioural sequelae of sexual abuse was comparable to the impact of individual group and family therapy on routine child and adolescent mental health problems.

This study had a number of methodological strengths. We carefully matched the two groups on baseline variables; used psychometrically robust assessment instruments; collected follow-up data after there has been an adequate time period for treatment to have a beneficial effect; involved highly experienced therapists in the study (rather than post-graduate novices); and the young people who participated in therapy were cases with pronounced difficulties referred for treatment through the usual professional channels (rather than solicited through media announcements).

However, this study was not without methodological shortcomings. First, there was the absence of a no-treatment control group, so we cannot be certain that the gains made were not due simply to the passage of time, although the similarity of our effect sizes to those from major psychotherapy meta-analyses, makes us doubt that the passage of time alone can explain the beneficial effects of therapy. Second, cases were not randomly assigned to treatment conditions, so we cannot be completely certain that some unknown extraneous

variable accounts for the intergroup difference that was found for the CDI ineffectiveness scale. The fact the groups were so well matched on baseline variables suggests that this was not the case. Third, the small initial numbers of participants and moderate amount of missing data reduced the power of the statistical analyses to detect intergroup differences. This is a significant shortcoming. We have already noticed that with larger numbers we may have found significantly greater improvement rates in the individual therapy condition. Fourth, clearly defined treatment programmes with guidelines or manuals and integrity checks for therapist adherence to guidelines or manuals were not used. Thus, we can only draw conclusions about the comparative effectiveness of the programme structures (individual therapy versus individual plus group therapy) rather than the content and procedures of the programmes compared. However, it is important to emphasize that these two programmes are representative of current best practice in Ireland in this field, since the therapy was conducted by expert therapists at recognized centres of clinical excellence. Finally, since participants were predominantly female, our results are generalizeable only to the population of female victims of child sexual abuse.

Further treatment outcome studies that overcome the methodological shortcomings of the present investigation are required.

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Table 1. Demographic characteristics

Variable		Individual Therapy (N=20)	Individual Group Therapy (N=18)	t or Chi Square or Z
Age				
	M	12.6y	12.7y	t 0.20
	SD	2.2y	2.3y	
	Range			
	4-5 yrs	0.0%	0.0%	
	6-11 yrs	40.0%	55.6%	
	12-17 yrs	60.0%	44.4%	
Gender				X 0.14
	male	15.0%	0.0%	
	female	85.0%	100.0%	
Social Class				Z 0.77
	1	5.0%	0%	
	2	0.0%	5.9%	
	3	30.0%	17.6%	
	4	15.0%	29.4%	
	5	10.0%	17.6%	
	6	15.0%	17.6%	
	7	25.0%	11.8%	
Birth Order				Z 0.43
	eldest	25.0%	28.6%	
	2 nd	25.0%	21.4%	
	3 rd	25.0%	21.4%	
	4 th	5.0%	21.4%	
	5 th	5.0%	0.0%	
	6 th	10.0%	7.1%	
	<7 th	5.0%		
No. of fathers in family				X 0.53
	1	85.0%	87.5%	
	2	15.0%	12.5%	
	3			
	4			
Custody Access Issues		5.0%	0.0%	0.31
Child's Legal Status				X 0.37
	family care	100.0%	94.4%	
	voluntary care	0.0%	5.6%	
Marital Status (mother)				X 0.82
	married	50.0%	55.6%	
	single/separated	50.0%	38.9%	
	divorced	0.0%	0.0%	
	widowed	0.0%	5.6%	
Marital Status (father)				X 0.74
	married	45.0%	58.8%	
	single/separated	50.0%	41.2%	
	unknown	5.0%		
Criminal Record (father)				X 0.54
	no	72.2%	77.8%	
	yes	5.6%	0.0%	
	unknown	22.3%	22.2%	

Criminal Record (mother)				X	0.05
no	90.0%	83.3%			
yes	0.0%	0.0%			
unknown	10.0%	16.7%			
History of Violence (father)				X	0.21
none	52.6%	38.9%			
marital violence	31.6%	27.8%			
indecent assault of children	5.3%	5.6%			
neglect	5.3%	22.2%			
violence towards adults	0.0%	5.6%			
unknown	5.3%	0.0%			
History of Violence (mother)				X	0.05
none	90.0%	77.8%			
neglect	5.0%	16.7%			
marital violence	0.0%	5.6%			
unknown	5.0%	0.0%			
Previous psychological treatment	45.0%	33.3%		X	0.41
Did not complete Stay Safe Programme	30.0%	-----			
Not attending school	0.0%	7.1%		X	0.41

Note:* p<0.05. **p<0.01. t=result of t-test. X = chi square. z = z derived from Mann Whitney U test. Cases were assigned to socio-economic groups on the basis of occupation with O'Hare, Whelan Cummins (1991) scale.

Table 2. Abuse-related characteristics

Variable	Individual Therapy (N=20)	Individual Group Therapy (N=18)	Chi Square
Relationship of Perpetrator			0.29
neighbour	20.0%	5.6%	
multiple perpetrators	20.0%	5.6%	
sibling	15.0%	5.6%	
biological parent	10.0%	33.3%	
family friend	10.0%	22.2%	
child's own friend	10.0%	0%	
stranger	10.0%	0%	
uncle	5.0%	16.7%	
cousin	0.0%	5.6%	
co-hab. parent	0.0%	5.6%	
Perpetrator living in same home			0.61
no	75.0%	50.0%	
yes	25.0%	50.0%	
Gender of Perpetrator			0.63
male	95.0%	100.0%	
Age of Perpetrator			0.45
adult	65.0%	72.2%	
adolescent	35.0%	22.2%	
child	0.0%	5.6%	
Type of Abuse			0.07
contact-penetrative abuse	25.0%	61%	
contact non penetrative	40.0%	5.6%	
contact-attempted penetrative abuse	30.0%	22.2%	
non-contact	5.0%	11.1%	
Chronicity of Abuse			0.55
less than 1 year	38.9%	47.1%	
1 to 2 years	27.8%	5.9%	
2 to 3 years	22.2%	17.6%	
more than 3 years	11.1%	29.4%	
Strategies to Achieve Compliance			0.51
coercive-violent	45.0%	50.0%	
coercive-non violent	45.0%	44.4%	
grooming/reward	10.0%	5.6%	
Physical Findings			0.05
medical refused	10.0%	0.0%	
no medical done	40.0%	25.0%	
definite positive	10.0%	43.8%	
none	30.0%	25.0%	
uncertain	10.0%	6.3%	
Sexualised Behaviour Exhibited			0.13
none/age appropriate	90.0%	72.2%	
yes	10.0%	27.8%	
Child Previous Victim of Abuse			0.49
no	80.0%	72.2%	
yes	10.0%	11.1%	
unknown	10.0%	16.7%	
Mother History of Abuse			0.14
no	20.0%	22.2%	
yes	45.0%	16.7%	
unknown	35.0%	61.1%	
Father History of Abuse			0.31
no	50.0%	22.2%	
yes	5.0%	0.0%	
unknown	45.0%	77.8%	

Table 3. Disclosure-Related Characteristics

Variable	Individual Therapy (N=20)	Individual GroupTherapy (N=18)	Chi Square
Reason for Referral			0.10
purposeful disclosure by child	65.0%	61.1%	
accidental disclosure by child	15.0%	11.1%	
disclosure by sibling	20.0%	11.1%	
disclosure by other child	0.0%	11.1%	
abuse overheard by third party	0.0%	11.1%	
concern	0.0%	5.6%	
Initial disclosure to whom			0.85
parent	45.0%	66.7%	
sibling	20.0%	5.6%	
professional	15.0%	11.1%	
friend - child	10.0%	16.7%	
friend - adult	5.0%		
Gender child initially disclosed to			0.38
female	90.0%	100.0%	
male	10.0%		
Parents supportive of child			0.32
mother	90.0%	100.0%	
father	76.5%	72.7%	
Parent's non-supportiveness of perpetrator			0.59
mother	75.0%	88.9%	
father	76.5%	72.7%	
Perpetrators stance on abuse			0.74
unknown	35.0%	33.3%	
denial	35.0%	20.0%	
admits part of the abuse	5.0%	6.7%	
admits abuse in full	25.0%	40.0%	
Other children victims			0.11
yes	45.0%	27.8%	
no	40.0%	27.8%	
unknown	15.0%	44.4%	
Household changes post disclosure			0.06
none	85.0%	61.1%	
perpetrator left	15.0%	22.2%	
child removed	3.8%	16.7%	
Number of moves of child post disclosure			0.25
none	85%	83.3%	
1	10%	16.7%	
2	0%	0.0%	
3	0%	0.0%	
4	5%		

Table 4. Changes in CBCL scale scores over the course of treatment

		Type of Therapy				ANOVA		
		Individual Therapy (N=19)		Individual Group Therapy (N=9)		Therapy	Time	Therapy X Time
		T1	T2	T1	T2			
CBCL Total Score	M	66.64	58.55	66.50	59.00	0.61	20.38 **	2.64
	SD	10.22	11.24	10.71	4.24			
CBCL Internalising T	M	69.09	59.64	64.50	58.00	0.48	17.77 **	2.86
	SD	13.32	12.60	3.54	4.24			
CBCL Externalising T	M	59.27	54.09	61.50	55.00	0.30	05.97 *	2.44
	SD	6.33	9.85	6.36	1.41			
Withdrawn	M	66.45	58.36	61.50	55.50	0.28	08.99 **	0.30
	SD	13.52	9.17	2.12	2.12			
Somatic Complaints	M	66.36	60.91	74.50	64.50	0.41	10.24 **	0.01
	SD	13.35	7.46	2.12	19.09			
Anxious/Depressed	M	70.27	60.82	57.00	68.50	0.04	13.16 **	3.98
	SD	14.49	13.44	1.41	2.12			
Social Problems	M	62.45	58.73	59.50	55.50	0.47	10.76 **	0.07
	SD	8.49	9.94	2.12	7.78			
Thought Problems	M	62.91	56.45	56.50	58.50	0.03	03.52	0.47
	SD	9.44	7.39	9.19	12.02			
Attention Problems	M	64.45	58.09	61.00	55.50	0.85	12.71 **	0.20
	SD	9.89	7.20	1.41	2.12			
Delinquent Behaviour	M	60.55	58.18	63.50	53.50	0.52	02.53	0.00
	SD	11.24	7.07	3.54	3.54			
Aggressive Behaviour	M	57.55	55.18	60.00	55.00	1.40	07.19 **	0.08
	SD	5.75	6.01	7.07	.00			

Note: F values are from 2 X 2 Therapy (Individual, Individual Group) X Time (Time 1, Time 2) ANOVAs.

*p <.05. **p<.01

Table 5. Changes in Children's Depression Inventory scale scores over the course of treatment

		Type of Therapy				ANOVA		
		Individual Therapy (N=19)		Individual Group Therapy (N=11)		Therapy	Time	Therapy X Time
		T1	T2	T1	T2			
CDI Total Score	M	50.80	47.58	54.00	46.45	0.58	6.92 **	3.62
	SD	12.40	10.02	14.21	10.90			
Negative Mood	M	49.65	47.47	53.18	49.09	0.99	1.14	0.68
	SD	11.07	9.76	14.79	10.90			
Interpersonal Problems	M	50.30	47.21	57.27	50.73	2.71	5.34 *	1.68
	SD	10.01	7.83	16.64	10.26			
Ineffectiveness	M	48.65	49.47	54.45	44.91	0.16	2.39	7.06 **
	SD	11.76	11.85	15.46	9.13			
Anhedonia	M	52.75	47.42	51.27	46.36	0.05	6.77 *	0.04
	SD	11.68	8.28	10.22	9.07			
Negative Self-esteem	M	49.60	48.05	50.82	47.91	0.20	0.44	0.59
	SD	11.49	9.25	14.32	8.34			

Note: F values are from 2 X 2 Therapy (Individual, Individual Group) X Time (Time 1, Time 2) ANOVAs.

*p <.05. **p<.01

Table 6. Changes in Trauma Symptom Checklist for Children scale scores over treatment

		Type of Therapy				ANOVA		
		Individual Therapy (N=19)		Individual Group Therapy (N=15)		Therapy	Time	Therapy X Time
		T1	T2	T1	T2			
Anxiety	M	55.09	48.73	65.00	51.00	0.00	3.22	0.01
	SD	12.04	11.40	24.04	22.63			
Depression	M	50.36	42.36	57.50	50.50	0.21	5.03 *	1.34
	SD	9.79	6.64	28.99	20.51			
Anger	M	46.55	44.64	51.00	53.50	1.53	7.09 **	2.97
	SD	7.69	8.45	22.63	26.16			
Post Traumatic Stress	M	53.64	48.64	59.50	53.50	0.43	2.85	0.09
	SD	6.68	7.72	24.75	26.16			
Dissociation	M	52.45	49.09	56.50	50.50	0.01	2.14	0.66
	SD	9.44	10.73	21.92	20.51			
Overt Dissociation	M	53.27	49.18	56.50	51.50	0.07	2.92	0.82
	SD	10.04	9.97	20.51	20.51			
Dissociation - Fantasy	M	50.27	49.36	54.50	47.00	0.04	0.47	0.31
	SD	7.89	10.15	19.09	15.56			
Sexual Concerns	M	53.55	47.00	57.00	57.00	3.14	1.76	0.75
	SD	22.31	8.83	29.70	29.70			
Sexual Preoccupation	M	51.55	43.00	40.00	37.00	3.10	1.85	2.32
	SD	19.41	4.82	4.24	.00			
Sexual Distress	M	56.82	56.09	75.50	75.50	1.77	.66	0.32
	SD	21.58	16.97	48.79	48.79			

Note: F values are from 2 X 2 Therapy (Individual, Individual Group) X Time (Time 1, Time 2) ANOVAs.

*p <.05. **p<.01

Table 7. Clinically Significant Change

Improvement Index	Individual Therapy	Individual Group Therapy	P
Improved on CBCL Total from T1 to T2 for all cases	30% (6/20)	18.18% (2/11)	.39
Improved on CBCL Total from T1 to T2 for cases above cut-off at T1	46% (6/13)	20% (2/10)	.31
Improved on CBCL Int from T1 to T2 for all cases	25% (5/20)	11.11% (1/9)	.28
Improved on CBCL Int from T1 to T2 for cases above cut-off at T1	38.46% (5/13)	14.29% (1/7)	.18
Improved on CBCL Ext from T1 to T2 for all cases	10% (2/20)	44.44% (4/9)	.23
Improved on CBCL Ext from T1 to T2 for cases above cut-off at T1	25% (2/8)	66.67% (4/6)	.43
Improved on YSR total from T1 to T2 for all cases	12.5% (2/16)	20% (2/10)	.66
Improved on YSR total from T1 to T2 for cases above cut-off at T1	40% (2/5)	66.67% (2/3)	.71
Improved on YSR Int from T1 to T2 for all cases	12.5% (2/16)	20% (2/10)	.50
Improved on YSR Int from T1 to T2 for cases above cut-off at T1	66.67% (2/3)	66.67% (2/3)	.40
Improved on YSR Ext from T1 to T2 for all cases	6.25% (1/16)	10% (1/10)	.63
Improved on YSR Ext from T1 to T2 for cases above cut-off at T1	50% (1/2)	33.33% (1/3)	.70
Improved on CDI Total from T1 to T2 for all cases	5.26% (1/19)	-- (0/11)	.30
Improved on CDI Total from T1 to T2 for cases above cut-off at T1	100% (1/1)	-- (0/11)	.33
Improved on TSCC Anxiety scale from T1 to T2 for all cases	20% (4/20)	6.67% (1/15)	.39
Improved on TSCC Anx. from T1 to T2 for cases above cut-off at T1	75% (3/4)	50% (1/2)	.60
Improved on TSCC Depression scale from T1 to T2 for all cases	10% (2/20)	-- (0/15)	.30
Improved on TSCC Dep. from T1 to T2 for cases above cut-off at T1	100% (2/2)	--	.33

Improved on TSCC Anger scale from T1 to T2 for all cases	— (0/20)	6.67% (1/15)	.44
Improved on TSCC Anger from T1 to T2 cases above cut-off at T1	-	50% (1/2)	-
Improved on TSCC -PTS scale from T1 to T2 for all cases	5% (1/20)	-	.57
Improved on TSCC -PTS from T1 to T2 cases above cut-off at T1	100% (1/1)	-	-
Improved on TSCC Dissociation scale from T1 to T2 for all cases	15% (3/20)	-	.32
Improved on TSCC Dissociation from T1 to T2 cases above cut-off at T1	66.7% (2/3)		.40
Improved on TSCC Overt Dissociation scale from T1 to T2 for all cases	15% (3/20)	-	.32
Improved on TSCC Overt Diss. from T1 to T2 cases above cut-off at T1	66.7% (2/3)	-	.30
Improved on TSCC Dissociation-Fantasy from T1 to T2 for all cases	5% (1/20)	6.67% (1/15)	.70
Improved on TSCC Diss-Fantasy from T1 to T2 for cases above cut-off at T1	100% (1/1)	100% (1/1)	-
Improved on TSCC Sexual Concerns from T1 to T2 for all cases	25% (3/20)	5.56% (1/18)	.42
Improved on TSCC Sexual Concerns from T1 to T2 for cases above cut-off at T1	100% (3/3)	20% (1/5)	.07
Improved on TSCC Sexual Preoccupation from T1 to T2 for all cases	5% (1/20)	-	.57
Improved on TSCC Sexual Preoc. from T1 to T2 for cases above cut-off at T1	100% (1/1)	-	.33
Improved on TSCC Sexual Distress from T1 to T2 for all cases	20% (4/20)	16.67% (3/18)	.50
Improved on TSCC Sexual Distress from T1 to T2 for cases above cut-off at T1	80% (4/5)	42.86% (3/7)	.38

Note: CBCL Ext = Child Behaviour Checklist Externalising behaviour problem scale on which the clinical cut-off is a T score of 63. CBCL Int = Child Behaviour Checklist Internalising behaviour problem scale on which the clinical cut-off is a T score of 63. T1 = Time 1 before treatment. T2 = Time 2 after treatment. P values are from either chi square or Fishers Exact probability test.