Meta Analysis of Trauma Focused Cognitive Behavior Therapy for Reducing Child Sexual Behaviour in Sexually Abused Children

Andini Damayanti
Universitas Airlangga
andini.damayanti-2019@psikologi.unair.ac.id

Ike Herdiana
Universitas Airlangga
ike.herdiana@psikologi.unair.ac.id
(corrersponding author)

Ilham Nur Alfian
Universitas Airlangga
Ilham.nuralfian@psikologi.unair.ac.id

Rahkman Ardi
Universitas Airlangga
rahkman.ardi@psikologi.unair.ac.id

Abstract

Child sexual abuse is known to cause adverse effects for its victims, one of them is problem sexual behavior. Problem sexual behavior is sexually oriented behavior done by child aged 12 years or younger and it is developmentally inappropriate or could be harmful for themselves and others. One of the longer term effect is the victim may become sexual offenders if not treated seriously. One of the intervention that can treat problem sexual behavior is *Trauma Focused Cognitive Behaviour Therapy* or TF-CBT. This review aims to determine the effectivity of TF-CBT by using meta analysis. The studies are collected from *Science Direct, ProQuest, Sage Journal, Springer Link, Scopus,* EBSCO and several *repository.* The inclusion criteria used are the studies must be RCT, subjects are child victim of sexual abuse who showed problem sexual behavior, the behavior is measured with CSBI (*Child Sexual Behavior Inventory)* and used TF-CBT as intervention. The result shows that the use of TF-CBT may not be effective for decreasing problem sexual behavior. There are some factors that affect the effectivity of TF-CBT, such as participant's age, cognition, intensity of trauma and other psychological disorders. However, TF-CBT is potential for decreasing problem sexual behavior because it is directive and uses various behavioral strategies.

Keywords: CBT, cognitive behaviour therapy, child sexual abuse, problem sexual behavior,
trauma focused cognitive behaviour therapy, TF-CBT

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Introduction

Child sexual abuse is involvement of child on sexual activity without their understanding or the involvement of underage child hence they can't give their consent. It also violates law and social norms (World Health Organization, 1999). Prevalence of child sexual abuse around the world

is approximated to be about 118 out of 1000 children (Stoltenborgh, Bakermans, Kranenburg, Alink, & van Ijzendoorn, 2014). In Indonesia, the prevalence of child sexual abuse also increased. According to Sistem Informasi Online Perlindungan Perempuan dan Anak, there were 1.975 cases in 2015. In 2016, it became 6.280 cases (Pinandhita, 2020).

Child sexual abuse causes various negative effects, whether in short or long term (Maniglio, 2009; Lalor & McElvaney, 2010; Sanchez-Meca, Rosa-Alcazar, & Lopez-Soler, 2011). One of the effects of child sexual abuse is problem sexual behavior. Problem sexual behavior is defined as age-inappropriate sexual behavior, related to sexual organ and potentially harmful for oneself or another. This definition is suitable for child under age 12 years old (Chaffin, et al., 2008 in Mesman, et al., 2019). The examples are tendency to have age-inappropriate knowledge about sex, masturbation, seductive toward others, drawing and watching pornography, seeking sexual stimulation and inviting others to have sex with them (Kendall-Tackett, et al., 1993; Mesman, et al., 2019; Uyun, 2015).

Problem sexual behavior can be explained by various factors, one of them is history of sexual abuse. Problem sexual behavior is considered as one of the distinctive characteristics that defined child victims of sexual abuse (Cash, 2001; Kendall-Tackett, et al., 1993). Approximately 62-95% of children with problem sexual behavior had history of sexual abuse. So, history of sexual abuse is considered as primary predictor of problem sexual behavior (Wamser-Nanney & Campbell, 2019). Research by Ensink et al (2018) explained that 48,7% of child victims of sexual abuse showed persistent problem sexual behavior until 2 years after intervention. Meanwhile, Carpentier, Silovsky & Chaffin (2006) explained that 2-10% child with problem sexual behavior would engage in sexual abuse 10 years later, as perpetrator.

Several interventions have been conducted to reduce problem sexual behavior, such as CBT, TF-CBT, psychoanalytic, humanistic, support therapy, play therapy or combination of several methods. (St.Amand, Bard, & Silovsky, 2008; Sanchez-Meca, et al., 2011; Narang, Schwannauer, Quayle, & Chouliara, 2019). CBT and TF-CBT become the most researched form of interventions so far (St.Amand, et al., 2008; Sanchez-Meca, dkk., 2011).

Meanwhile, according to Cohen, Deblinger, Mannarino and Steer (2004 in St. Amand, dkk., 2008), TF-CBT is more effective in reducing problem sexual behavior compared to humanistic therapy (Cohen's d TF-CBT 0,46 > Cohen's d humanistik 0,29). Cohen and Mannarino's research (1996 in St. Amand, dkk., 2008) also shows that sexual abuse specific CBT is more effective than supportive therapy (Cohen's d SAS-CBT 0,73 > Cohen's d ST 0,39).

Nevertheless, there hasn't been any conclusion on which intervention is the most effective to reduce problem sexual behavior. Based on our research in selected databases, we have not found any published systematic review on effecitivity of TF-CBT in reducing problem sexual behavior. Whereas, TF-CBT itself is one of the most researched interventions for child sexual abuse. (Cohen, Berliner & Mannarino, 2010; St.Amand, dkk., 2008). It shows that TF-CBT has potential to be the most effective method for reducing problem sexual behavior. Therefore, this paper aims to analyze and evaluate the effectivity of TF-CBT compared to other interventions for reducing problem sexual behavior.

We hope that this paper can strengthen theoretical foundation on problem sexual behavior in children. Other than that, we also hope that this paper can serve as an update for previous meta analysis which had been done 8-12 years ago. Professionals such as psychologist and psychiatrist can also benefit from understanding the use of TF-CBT and its effectivity.

Methods

Research Design

This research use systematic review to determine the effectivity of TF-CBT in reducing problem sexual behavior. To be included in the systematic review the study had to have the predetermined criteria of inclusion. Researchers then searched for eligible studies according to predetermined keywords and recorded it using PRISMA. Studies are selected based on abstracts and full content. Furthermore, researchers conducted quality assessment on selected studies with *Quality Assessment Tools for Quantitative Studies* (QATQS) by Thomas, Ciliska dan Dobbins (2003). Selected studies, which are moderate and strong quality studies, would be included in systematic review and meta analysis. Meta analysis will be done by using Jamovi to determine

the size of Cohen's d and publication bias.

Data Collecting Strategy

Search for eligible studies were done in several electronic databases accessible to Universitas Airlangga, such as ProQuest, Science Direct, SAGE, Scopus, Springer, and PubMed. Search were also done in several repositories of Indonesian university, ProQuest Theses and Dissertations and EBSCO Open Dissertations. Results of search were managed with Mendeley and screened for duplicates.

Here are the criteria of inclusion:

1. Participants in the study are sexually abused child who exhibit problem sexual behavior
2. Problem sexual behavior may be primary or secondary intervention goals.
3. Outpatient treatment
4. Age of participants are 14 years old and younger
5. Using TF-CBT as method of intervention
6. Using RCT (randomized controlled trial)
7. There are means, deviation standard and pretest of problem sexual behavior
8. There is no time limit determined for eligible articles
9. Published in Indonesian or English.

Keywors used in searching are *"trauma focused cognitive behavior"* OR *"TF CBT"* AND *"child sexual behavior"* OR *"problem sexual behavior"* AND *"child sexual abuse"* AND *"victims", "CBT" OR "cognitive behavioral therapy"* AND "*trauma"* AND *"child sexual behavior"* OR *"problem sexual behavior" "* AND *"child sexual abuse"* AND *"victims" , TF CBT for sexual behavior in child victim of sexual abuse, CBT for trauma and sexual behavior in child victim of sexual abuse.* Keywords are subjectible to modification based on certain condition. Below is the PRISMA diagram for systematic review (Figure 1).

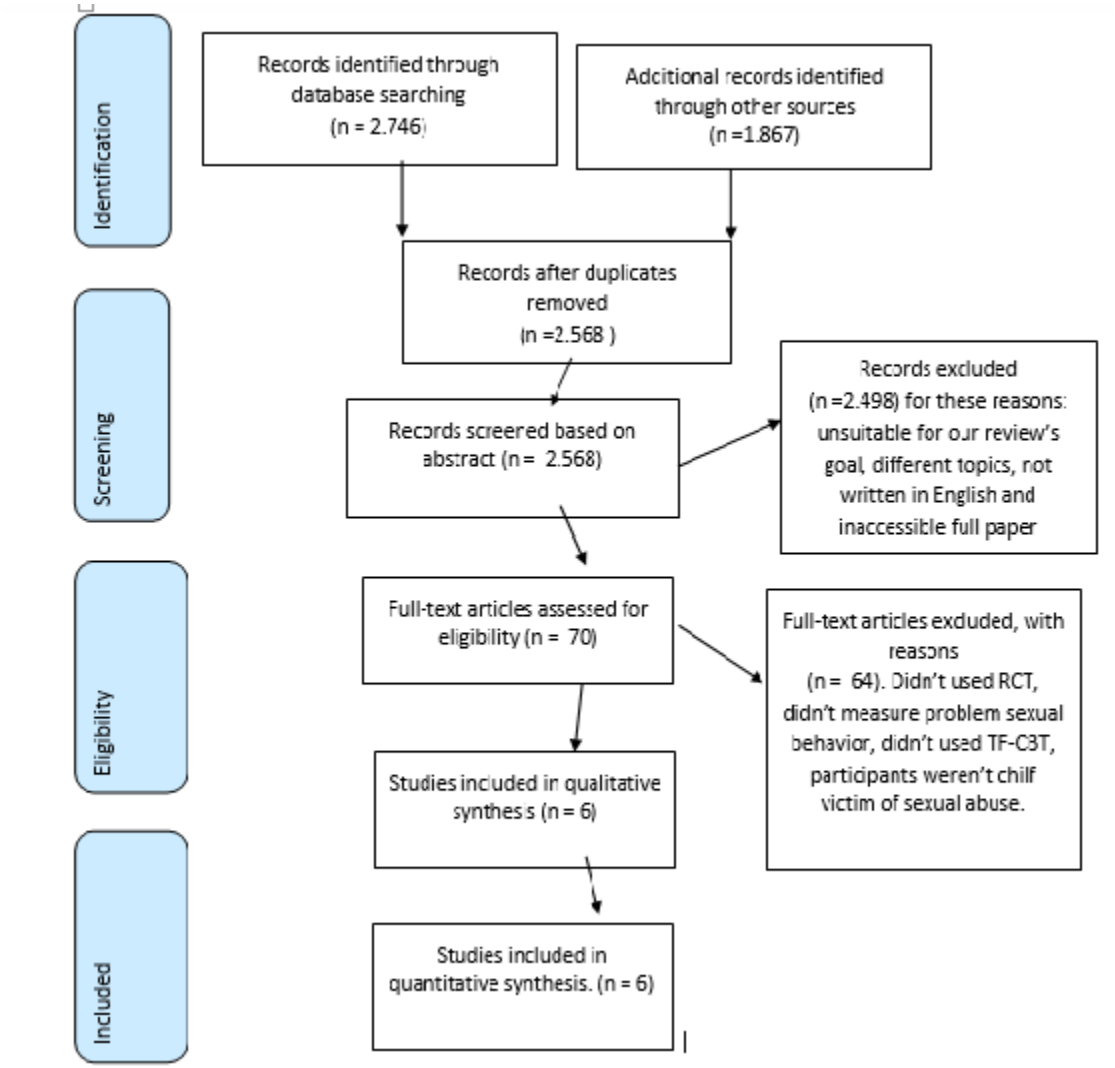

Figure 1. PRISMA Diagram

Data Analysis

Determining effect size will be done by analyzing post-test score and standard of deviation. Analysis will be done by Jamovi using random effect model. Random effect model is based on assumptions that the results of studies will be heterogenous (Deeks, Higgins & Altman, 2019). All effect sizes were interpreted using the suggestions submitted by Cohen (1988) for describing magnitudes as small (ES < .20), medium (ES < .50), and large (ES < .80). Risk for publication bias was assessed with funnel plot and Fail Safe N value. The homogeneity of effect size distributions were examined by inspecting values for Cochrane's Q and the inconsistency index.

Results

There are 6 studies included in this review. Based on quality assessment, there are 5 moderate studies and 1 strong study. Overall, there were 422 participants that completed post-test and interventions out of 632 participants. The range of age of participants are 2-15 years old and all of them resided in USA. All of these studies used CSBI (Child Sexual Behavior Inventory) to measure problem sexual behavior. All of these studies also implemented alternative treatment comparison, notably client centered and supportive therapy. Table below explained the included studies and details of the studies.

Table 1
Studies Included in Systematic Review

Study	Methods	Participants	Interventions	Outcomes	Limitations
A treatment outcome study for sexually abused preschool children: Initial findings (Cohen & Mannarino, 1996)	RCT, randomization done with Efron's Coin Toss	86 children aged 2-7 years old, 67 completed post-test and intervention. 58% female, 42% male	TF-CBT and NST (Non-directive Supportive Therapy)	CSBI TF-CBT N= 39, pre: 25.16 (18.84) Post: 11.47 (8.18) NST N= 28, pre: 25.37 (19.36) Post: 17.85 (13.38)	Possibility of bias in parent-reported scales. Clinically significant lower score on PRESS scale, hence there wasn't significant decline.
A treatment study for sexually abused preschool children: Outcome during one year follow-up (Cohen & Mannarino, 1997)	RCT. This study was a 1 year follow up after Cohen & Mannarino (1996)	86 children, 67 finished intervention and post-test. 43 children aged 4-11 years old participated in *follow up* 1 year after intervention., 56% female, 44% male	TF-CBT and NST (Non-directive Supportive Therapy)	CSBI TF-CBT N= 39, pre: 25.16 (18.84) Post: 11.47 (8.18) 6 bulan: 10.43 (7.77) 12 bulan: 8.75 (6.16) NST N= 28, pre: 25.37 (19.36) Post: 17.85 (13.38) 6 bulan: 16.78 (13.23) 12 bulan: 16.79 (18.17)	Some of the earlier participants didn't participate in this study.

Interventions for sexually abused children: initial treatment outcome findings (Cohen & Mannarino, 1998)	RCT, randomization done with Efron's Coin Toss	82 children aged 7-15 years old, 78 participated in intervention , 49 completed intervention 69% female and 31% male	TF-CBT and NST (Non-directive Supportive Therapy)	CSBI TF-CBT, N=30 Pre: 12.33 (10.18) Post: 8.31 (8.70) NST, N=19 Pre: 11.95 (9.43) Post: 10.42 (9.20)	High drop out rate, especially on NST group which caused decreased statistical power to detect differences between 2 group. Several children were removed from study due to problem sexual behavior that harmful to others. There were no CSBI given to this removed children. There were no evaluation questionnaire for participants.
Comparative efficacies of supportive and cognitive behavioral therapies for young children who have been sexually abused and their non-offending mothers (Deblinger, dkk, 2001)	RCT, randomization done with software	67 children aged 2-8 years old, 63 participated in intervention, 54 completed intervention and 44 completed post-test and *follow up* 3 months later. 61% female and 39% male	TF-CBT and Supportive Therapy	CSBI TF-CBT, N=23 Pre: 9.67 (5.67) Post: 5.48 (4.00) 3 months: 7.52 (6.62) d: 0.74 ST, N=21 Pre: 6.39 (5.23) Post: 3.74 (4.93) 3 months: 3.91 (5.39) d: 0.47	The children didn't show significant behavioral problem before intervention. *Similar ceiling/floor effects contributed to lack of statistical differences between group on parent's intervention.* Three months *follow was not long enough to measure simptom differences between participants.* There wasn't any joint session between children and parents on supportive therapy. There wasn't any

					waiting list or control groups
A multi-site, randomized controlled trial for children with abuse-related ptsd symptoms (Cohen, dkk, 2004)	RCT	229 children aged 8-14 years old. 203 completed intervention. 180 completed post-test. 160 female, 43 male.	114 children on TF-CBT group. 115 children on CCT (*Client Centered Therapy*) group	CSBI: TF-CBT N = 88, pre: 10.38 (9.02); post: 6.26 (6.02); Client centered N = 91, pre: 11.42 (10.99); post: 8.2 (10.45) d: 0.22	Lack of representation from Hispanic and Asian. There wasn't any no treatment group as control group. It was unclear which TF-CBT component is most prominent for reducing PTSD symptoms.
Treating sexually abused children: 1 year follow-up of a randomized controlled trial (Cohen, dkk, 2005)	RCT. Randomization done by random number based on software	82 children, 49 completed intervention. 39 completed post-test. 56 female dan 26 male.	41 children on TF-CBT group, 41 children on NST group	CSBI: TF-CBT, N= 41 Pre: 11.44 (10.7), post: 8.59 (9.52) d: 0.3 (12 months later) NST. N=41 Pre: 11.10 (8.91), post: 10.37 (8.77)	High rate of *drop out* especially on NST group, because they were involved in harmful problem sexual behavior. Lack of sensitivity in PTSD scale because it didn't measure sexual abuse related symptoms.

These six studies was included in meta analysis, using random effect model with Der Simonian-Laird as estimators in Jamovi. Based on forest plot, six studies who compared TF-CBT with humanistic or supportive therapy yielded a pooled effect size of -0.25 (CI 95% = -0.5, -0.01). Nevertheless, conclusion that TF-CBT is more effective than other intervention can not be concluded. Visually, there are 4 studies that cross the line of no effect. Therefore, if those studies are repeated, the results will be inconsistent. There may be possibilities that TF-CBT will be more effective, but at different times other intervention may be proven more effective.

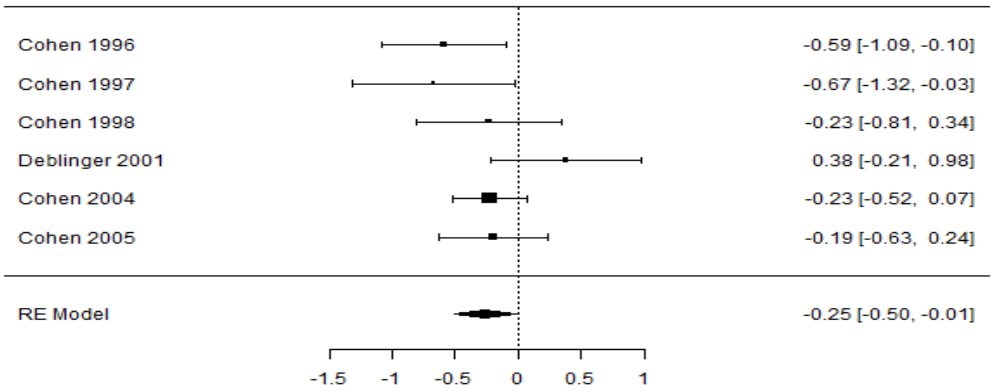

Figure 2. Forest Plot

Result of heterogenity test concluded that there were no significant factors contributing to the variability of the studies ($p > 0.05$). Below is the result of heterogeneity test.

Table 2
Heterogeneity Test

Tau	Tau^2	I^2	H^2	R^2	df	Q	p
0.184	0.0338 (SE= 0.0593)	36.68%	1.579	-0.5	5.000	7.896	0.162

Publication bias assessment shows that there is significant publication bias based on Fail-Safe N ($p > 0.05$). There is probability that if there are 9.000 unpublished studies with insignificant result, pooled effect size will be decreased to 0 (no effect). Funnel plot shows uneven and assymetrical spread, which shows there is publication bias in this review. There is possibility that other studies were not included in this review.

Table 3.
Publication Bias

Test name	Value	p
Fail-Safe N	9.000	0.005
Kendalls Tau	-0.067	1.000
Egger's Regression	-0.043	0.966
Trim and Fill Number of Studies	0.000	-

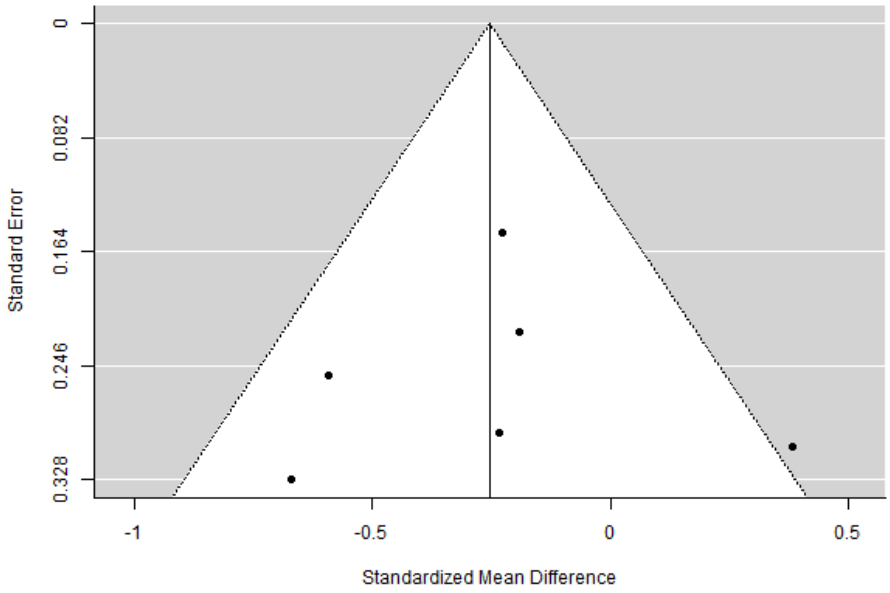

Figure 3. Funnel Plot

Discussion

Based on meta analysis, it can't be said that TF-CBT is more effective for reducing problem sexual behavior than other interventions. There are possibilities that if some studies are repeated, the results will be inconclusive. Discussion below will analyze why TF-CBT is not more effective than other interventions.

First is the age of participants. Participants aged 7-14 years old are more active and able to manage informations, which results in their better capability to cope with problems (Cohen &

Mannarino, 1998; Deblinger, et al., 2001). In terms of cognitive development, they are more ready to receive TF-CBT compared to pre-school aged children. Therefore, it is important to consider simpler behavioral strategies for pre-school aged children. Second is other mental disorder. In the six studies included, participants also experienced other mental disorder besides problem sexual behavior, such as depression, anxiety, PTSD, and behavior problems. The presence of other comorbid may affect the effectivity of intervention (Lambert & Vermeersch, 2002). Other than that, the participants were children who had not been able to give consent on their own. It also affected their own willingess to participate in the intervention, hence decreasing the effectivity (Lambert & Vermeersch, 2002).

Third is cognitive capability of participants. In the six studies included, cognitive capability of participants were not controlled based on the absence of cognitive related measurement. It is widely considered that executive functioning is important to client's capability to comprehend CBT. Executive functioning is a set of cognitive abilities such as ability to focus, analyze and generalize (Mohlman & Gorman, 2005). Therapists should have modified CBT based on the cognitive abilities of the participants. (Neenan, 2012). Fourth is traumatization or stress during intervention. Chasson, Vincent dan Harris (2008, in Sprang, et al., 2013) stated that trauma related stressor can enhance distress on the participants. Participants may be prone to leave intervention earlier than they should be. Avoidance behavior, including avoiding trauma related stressors and intrusive thoughts are predictors of drop outs (Chasson, et al., 2008 in Sprang, dkk., 2013).

Fifth is intensity of trauma on participants. TF-CBT, as the name suggested, focused on traumatic events and how to cope with different psychological disorders caused by trauma. It is important for researchers to conduct assessment and decide whether problem sexual behavior is related to trauma or not (Allen, 2018). If problem sexual behavior occured without trauma, other intervention may be more suitable to reduce problem sexual behavior (Allen, 2018). Sixth is the implementation of intervention. In Deblinger et al (2001), the implementation of TF-CBT and support therapy did not differ much compared to other studies. Both interventions used didactic methods whereas support therapy in other interventions did not use didactic but client centered methods. Other than that, ceiling effect where parents tended to be biased and reported their

children low in problems also occured in Deblinger et al (2001). In Cohen and Mannarino (1998), several participants from support therapy dropped out and caused the statistical power to detect differences between group decreased. High drop outs rate also happened on both groups in Cohen et al (2005) and caused the same problem. In Cohen et al (2004), the mean of post-test only differed 1,31 points between both groups. It caused low effect size for TF-CBT in this study.

Seventh is publication bias in this review. Not all studies related were included in this study because of limited access to databases. Therefore, pooled effect size can not be concluded because of this bias. Nevertheless, TF-CBT is still potentially effective to reduce problem sexual behavior on child victim of sexual abuse. TF-CBT is more directive and focuses on behavioral changes compared to supportive therapy. Because of its dire consequences, problem sexual behavior needs to be urgently treated with behavioral modification such as reinfocement and contigencies (Cohen & Mannarino, 1996). Meanwhile support therapy is not directive and clien-centered so psychoeducation is more limited compared to TF-CBT (Cohen & Mannarino, 1996). It will be an obstacle for children who needs instruction and behavioral example to achieve behavioral changes (Cohen & Mannarino, 1997).

TF-CBT also contains trauma narrative where children and parents are asked to retell their story, thoughts and emotions of traumatic events. It is deemed effetive to resolve conflicts related to traumatic events (Cohen & Mannarino, 1996). Openness and awareness to traumatic evens is a part of normalization and acceptance toward traumatic events. The use of TF-CBT needs to consider the age of participant. The content and method of TF-CBT needs to be adapted to their cognitive capabilities. Gradual exposure and trauma narrative may not be suitable to all ages because of different developmental stages and cognitive processing ability (Deblinger, et al., 2001). Standardized modules are also needed to ensure standard and uniformity of TF-CBT, so it can be used in the same way by different researchers in different places.

Conclusion

Effectivity of TF-CBT to reduce problem sexual behavior needs to be studied more in future studies. This review shows that TF-CBT may not be the most effective methods to reduce problem sexual behavior. There are no significant moderating variable which contributes to variability of the result of the studies. There is publication bias in this review where not all related studies were included due to limited access to databases.

There are several factors that contribute to the lack of effectivity of TF-CBT. Such as age and cognitive capacity of participants, other mental problems, traumatization, and antecedenta of problem sexual behavior. The implementation of TF-CBT is also lacking in standardization. Some factors related to the implementation of studies such as high dropouts rate and floor effect also contribute to the lack of effectivity of TF-CBT.

However, TF-CBT has potential to be an effective intervention due to its directive nature and focus on behavioral changes. TF-CBT also uses trauma narrative and gradual exposure to resolve trauma related problem sexual behavior. TF-CBT can be used by professionals to reduce problem sexual behavior with some adaptation regarding age and cognitive capability of clients. Recommendations for future reviews are increasing the database for searching studies to avoid publication bias and reviewing other intervention methods for reducing problem sexual behavior.

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