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COMPREHENSIVE REVIEW

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Psychological intervention with adult victims of sexual abuse: A comprehensive review

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Abstract

Child sexual abuse (CSA) is a phenomenon that is ubiquitous to all cultures and social classes. It has short- and long-term consequences, with specific treatment models that have been developed and adapted from psychological intervention models. A wide variety of studies have sought to evaluate the results of treatments with adult CSA survivors. This study presents an overview of research on the treatment of adult victims of CSA, by reviewing the existing literature on the types of treatment and the most studied psychotherapeutic avenues, and reports the findings related to the efficacy of these treatments. It is possible to conclude that psychological intervention exhibits benefits in the reduction of symptoms resulting from the experience of CSA and demonstrates the need to conduct further research on the effectiveness of intervention.

KEYWORDS
adult, child sexual abuse, efficacy, treatment, victim

1 | INTRODUCTION

Child sexual abuse (CSA) is recognized as a global public health problem (Arboleda et al., 2011; George & Bance, 2019) and is an experience that is universal to all cultures and social classes (Cantón-Cortés & Cortés, 2015; López et al., 2012). This phenomenon can have devastating consequences not only for victims but also for their families and society in general (Institute of Medicine and National Research Council, 2013).

According to the World Health Organization (WHO; 2013, p. 10), sexual abuse is defined as 'the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society' and that 'children can be sexually abused by both adults and other children who are, by virtue of their age or stage of development, in a position of responsibility, trust or power over the victim'. The child's involvement in sexual activity can manifest itself in several ways, including the attempt or concretization of sexual intercourse, exhibitionism, exposure or use of the child for sexual activity or even for purposes of prostitution or pornography (Xie et al., 2016). However, it is important to note that the concept of sexual abuse has undergone changes over the years, because it has not always been regarded as an abusive and illegal phenomenon (Kinnear, 2007), inevitably influencing the understanding of its extent, public policies for protection and performance, research and intervention. Indeed, criminalization and changes in beliefs and social representations have a massive influence on prevention and seeking help in the CSA cases.

A meta-analysis, which sought to determine the prevalence of CSA, analysed 65 studies, from 22 countries, and found a percentage of 19.7% among women and 7.9% among men (Pereda et al., 2009). Barth et al. (2013) estimated that the experience of childhood sexual abuse affects up to 17% of boys and 31% of girls, worldwide. Mateus (2012) conducted a study that sought to determine the prevalence of CSA in Portugal. The study included 200 individuals, between 18 and 30 years of age, of whom 132 were women. Mateus (2012) estimated a CSA prevalence of 14.5%, specifically 15.9% for women and 11.7% for men. Considering the prevalent and common character

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of CSA, as well as the significant physical and psychological consequences, both short term (Cantón-Cortés & Cortés, 2015; Kendall-Tackett et al., 1993) and long term (Cantón-Cortés & Cortés, 2015; Hailes et al., 2019; Papalia et al., 2016), a cross-cutting concern has emerged, which has led to a greater interest in research on this phenomenon. There are several epidemiological studies that seek to understand the real dimension of this problem; however, the methodological limitations indicated in the research are recurrent, making it difficult to build a clear notion of the true extent of the phenomenon (Barth et al., 2013; Pereda et al., 2009; Stoltenborgh et al., 2011).

Key Practitioner Message

- There are no syndrome resulting from the experience of child sexual abuse, but survivors have a significant risk associated with the development of medical, psychological, social, behavioural and sexual psychopathology.
- Most child sexual abuse victims at some point in their lives have symptoms ranging from moderate to severe.
- When the aggressor is intrafamilial and/or penetration is present, the consequences are more severe and chronic.
- Psychological interventions are generally effective in reducing symptoms caused by child sexual abuse although some therapies are better than others.

2 | CONSEQUENCES OF SEXUAL ABUSE

The consequences of CSA go beyond the end of the experience of abuse and generally entail repercussions with a highly damaging and lasting impact (Hansard et al., 2020). The experience of CSA is associated with various forms of physical illness (Institute of Medicine and National Research Council, 2013) and is also a significant risk factor linked to the development of psychopathology (López et al., 2012) that can manifest itself after abuse, and remain throughout development impacting all phases of the victim's life, or emerge in adulthood.

There is no syndrome resulting from the experience of CSA nor a set of nosological framework. Therefore, there is no evidence of a cause–effect relationship between the experience of CSA and the presence of a specific pathology in adulthood (López et al., 2012). Nonetheless, it is recognized that survivors have a significant risk associated with the development of medical, psychological, social, behavioural and sexual psychopathology. Given this relationship, Maniglio (2009) proposes that the experience of CSA be understood as a general risk factor for health, with mental health problems not being specific.

Victims of sexual abuse experience various consequences and are dependent of the interaction between several factors, namely, the child's age when the first abuse occurred, as well as the developmental stage of the child; the duration of the abuse; the relationship with the offender; whether force was used to guarantee the child's participation and the degree of said participation; the degree of shame and/or guilt felt by the child, in addition to the reaction of others, namely, parents, relatives and professionals (health, education and social) to the revelation of the experience of sexual abuse or its discovery (Kinnear, 2007). Furthermore, psychological consequences tend to be more severe and chronic in cases where abuse is perpetrated by family members and/or when sexual abuse includes penetration (Sarasua et al., 2013).

The psychological consequences associated with the experience of CSA can be categorized into five major dimensions, the emotional, relational, functional, sexual and adaptation dimensions, among which can be found depressive, anxiety, post-traumatic, sexual, eating, substance abuse and personality disorders (Batchelder et al., 2018; Berg et al., 2017; Carter et al., 2006; Grover et al., 2007; Ullman, 2016). Among these, the difficulties experienced in the sexual domain and internalizing psychopathology seem to be more prevalent among victims of CSA, in particular depression (with and without suicidal ideation) and post-traumatic stress disorder (PTSD) (López et al., 2012).

The study of the consequences associated with experiences of CSA has guided clinical practice and the development of research, which seeks to support the effectiveness of both prevention and treatment programmes, aimed not only toward children and adolescents but also toward adults who were victims of sexual abuse in childhood (Del Campo & Fávero, 2020; Gamble et al., 2011). Psychotherapy presents itself as a fundamental and indispensable treatment approach for victims of CSA, aiming to minimize malaise and psychological distress, elaboration of the procedural experience and greater well-being at personal, family social and/or professional and academic level (Caffaro, 2016; Price et al., 2004; Thomas, 2005).

Therefore, this study analyses studies on the treatment of adult victims of CSA, by reviewing the existing literature on the types of treatment and the most studied psychotherapeutic avenues, and reports the findings related to the efficacy of these treatments.

3 | METHOD

3.1 | Search strategy

A comprehensive literature search was conducted to identify journal articles focused on the treatment of adult victims of CSA. To identify studies for this review, first searches of the following databases were conducted: EBSCO, PubMed and Web of Science. Search terms included in the abstract: adult victims of sexual abuse, intervention, treatment, psychotherapies, programmes, effectiveness, efficacy and evaluation. Second, other reviews of issues from relevant peer-reviewed journals (i.e., *Aggression and Violent Behavior*, *Child Abuse and Neglect*, *Journal of Adolescent Health*, *Journal of Child Sexual Abuse*, *Journal of Interpersonal Violence*, *Psychological Reports and Psychology of Violence* and *Sexual Abuse: Journal of Research and Treatment*) were made.

TABLE 1 Summary of studies characteristics

Study	Approach	Sample size (N)	Methodology	Results	Limitations
Becker (2015)	Eclectic–integration of artistic expression with narrative therapy	5	Pilot study	Results demonstrated the potential and feasibility of integrating artistic expression tasks among adult survivors of CSA, to substantially reduce symptoms of PTSD and depression. When comparing the results between the pretreatment and post-treatment, there was a reduction of symptoms for all clinical scales up to 1 month after treatment, except for the anger/irritability dimension.	Small sample size and absence of a control group.
Bohus et al. (2013)	Dialectical behaviour therapy	74	Randomized controlled clinical trial	Results suggested a reduction in PTSD symptoms and revealed significantly greater improvement in the DBT-PTSD group compared with a TAU-WL control, with large effect sizes between groups. There was a 30-point reduction on the CAPS in 39% of patients in the treatment group, compared with only 3% of patients in the control group. In addition, improvements were seen in global social functioning and depression. However, DBT-PTSD treatment was not superior to TAU-WL on other symptomatic measures such as the psychopathological symptoms, dissociative symptoms and borderline symptoms. No significant differences were found between patients with and without a diagnosis of BPD, because they obtained quite similar effect sizes.	Absence of an adequate control group (waiting list), small sample size and composed only of women and absence of an assessment of the effect of variables such as group cohesion and residential treatment.
Calvert et al. (2015)	Cognitive analytic therapy	157	Cohort study	There were improvements in terms of the primary measure, and overall psychological distress, from the initial assessment up to the beginning of the group CAT, though it is not appropriate to associate these changes because of treatment. Results also indicate a statistically significant decrease in overall distress, from the evaluation to the end of treatment, in the participants who completed the CAT. During the waiting time, there was stability in interpersonal functioning, anxiety and well-being, which improved during group treatment. Depression scores continued to improve during the GCAT, whereas participants' self-esteem scores deteriorated during group treatment.	Absence of a control group, sample composed only of women lack of data on follow-up and absence of an assessment of the effects of interventions by other team members and effects of the intragroup.

TABLE 1 (Continued)

Study	Approach	Sample size (N)	Methodology	Results	Limitations
Chard (2005)	Cognitive processing therapy	71	Randomized controlled clinical trial	Statistical effects were found on depressive symptoms, dissociative symptoms and PTSD between pretreatment and post-treatment. It is noteworthy that the symptoms of PTSD showed a significant reduction throughout the treatment, even until the follow-up, with the gains of CPT for this measure being maintained. However, although CPT has been shown to be effective in reducing dissociative symptoms, this variable has less effect. Perhaps this result may be due to the high levels of dissociation presented by the participants in the pretreatment, or on the other hand, it is due to the possibility that this measure may be more resistant to change, which is why it is necessary that future studies assess the effects of CPT about dissociative symptoms.	Small sample size and impossibility of generalization to non-Caucasian people and the generalization of the effects of CPT compared with other therapies for adult victims of CSA.
Clarke and Llewelyn (1994)	Cognitive analytic therapy	7	Exploratory study	Results suggest an improvement in global functioning, depressive symptoms, self-esteem and a reduction in beliefs related to self-injurious behaviours. However, CAT proved to be resistant to altering dysfunctional interpersonal constructs (centrality of abuse in their relationships) that have been in place since childhood, for example, associating the relationship that today as adults have with men in general to the way they interpreted his relationship as a child with the aggressor. Although CAT has been shown to be effective in producing symptomatic relief during treatment, there have been some relapses during follow-up.	Small sample size and absence of a control group.
Clarke and Pearson (2000)	Cognitive analytic therapy	4	Exploratory study	Changes in identification and a reduction in depressive symptoms, cognitive distortions and a general improvement in general symptoms after treatment were observed. Before receiving CAT, most participants demonstrated that they identified less with their self-child and more with the aggressor, whereas after treatment, changes in identification and a reduction in depressive symptoms and cognitive distortions were observed.	Small sample size and absence of a control group.

(Continues)

TABLE 1 (Continued)

Study	Approach	Sample size (N)	Methodology	Results	Limitations
Edmond et al. (1999)	EMDR	59	Randomized experimental study	Reductions in specific anxiety associated with CSA, specific post-traumatic trauma symptoms, depressive symptoms and associated negative beliefs were observed after EMDR treatment. Additionally, an increase in positive self-referential beliefs was observed in participants who received EMDR when comparing the pretreatment and post-treatment scores. Although EMDR has been shown to be effective, there have been no significant differences between EMDR and routine individual treatment after treatment. Results showed that the participants who received EMDR scored significantly better during the follow-up, demonstrating a maintenance of the gains obtained in comparison with the participants who received a routine treatment. However, the authors warn against a cautious interpretation of the results of the follow-up because some of the participants in both treatment conditions continued to receive some treatment after the post-treatment. In addition, the similar results between the different conditions in the post-treatment can be explained by the incorporation of EMDR assumptions in the condition of routine individual treatment.	Small sample size and composed only of women and the receipt of some treatment after the post-treatment, which may have influenced the results of the follow-up.
Elkjaer et al. (2014)	Analytic therapy and systemic therapy	106	Randomized controlled clinical trial	Results showed statistically significant improvements for both treatments, demonstrating the superiority of the SGT after treatment, which decreased, however, during follow-up. However, both GAT and SGT did not differ significantly in terms of improvement in general symptoms, psychosocial functioning, quality of life and the occurrence of flashbacks, 1 year after the end of treatment, in adult women who suffered from CSA.	Difference in the number of hours between the two treatment groups, sample composed only of women, the power analysis used to assess the follow-up was not performed and the PTSD and depression measurements were not included in the follow-up assessment.

TABLE 1 (Continued)

Study	Approach	Sample size (N)	Methodology	Results	Limitations
Gamble et al. (2011)	Interpersonal psychotherapy	69	Randomized controlled clinical trial	Improvements were noted in general social functioning, particularly among direct family members, as well as in social leisure activities, among patients in the IP group, when compared with UT. However, there were no statistically significant improvements for intimate relationships, parenting and nuclear family. Nonetheless, overall, improvements were found in patients from both treatment groups, especially in the social domain. Thus, regardless of the treatment administered, it was concluded that both IP and UT demonstrate improvements in social functioning, in the domains of work, leisure and extended family relationships.	Small sample size and composed only of women, impossibility of generalization to males and the possibility that the statistical analysis did not detect additional differences because the participants filled out only the subscales that they found relevant.
Krupnick et al. (2008)	Interpersonal psychotherapy	48	Pilot study	Statistically significant effects of IP for PTSD were found on depressive and post-traumatic symptoms and interpersonal functioning, concretely on the domains: interpersonal sensitivity, need for social approval, lack of socialization and interpersonal ambivalence, although there are no effects on aggression. There were also statistically calculated effects on depressive symptoms but essentially on post-traumatic symptoms. Results also suggest that group IP remains basically advantageous in the management of PTSD symptoms and in promoting improvements in interpersonal functioning.	Small sample size and composed only of women and lack of an adequate control group (waiting list).
Lau and Kristensen (2007)	Analytic therapy and systemic therapy	151	Randomized controlled clinical trial	Results showed statistically significant reductions in general symptoms, quality of life and psychosocial functioning for both treatment groups, although more significant for SGT.	Small composed only of women, differences in the conditions of the treatment groups, lack of evaluation of the follow-up data and high level of attrition.
Laughlin and Rusca (2020)	Narrative therapy			Theoretical study	

(Continues)

TABLE 1 (Continued)

Study	Approach	Sample size (N)	Methodology	Results	Limitations
McDonagh et al. (2005)	Cognitive behavioural therapy	74	Randomized clinical trial	CBT proved to be more effective compared with the waiting list, although client-centred therapy has also shown significant reductions in anxiety and post-traumatic symptoms, as well as a change in the cognitive schemas associated with the traumatic experience. However, there was no effect of both therapies on quality of life, depressive, dissociative symptoms and hostility compared with the waiting list. Despite the results, it is important to consider that the main focus of treatment was on the symptoms of PTSD, a measure that obtained better results with CBT compared with the waiting list.	Small sample size and composed only of women.
McLean et al. (2017)	Compassion-focused therapy			Theoretical study	
Pulverman et al. (2017)	Intervention focused on expressive writing	138	Qualitative study, method of extracting meaning	Results showed changes in the use of certain themes of sexual self-schemas, in women with a history of CSA, after expressive writing treatment. There was a decrease in the use of abuse, family and development, virginity and attraction schemas and an increase in the use of the existentialism schema, associated with the construction of meaning and reflection between pre and post-treatment. There was also an initial increase in schemas with the relationship theme, which subsequently decreased. There were no changes in the use of the sexual activity theme after treatment. Therefore, results showed a reduction in the use of the abuse schema after treatment, which may have resulted from the processing of memories and emotions inherent in the history of sexual abuse.	Small sample size and composed only of women, nonrandom sample (participants seeking treatment were selected) and attrition during follow-up that made it impossible to assess the potential between changes in the prominence of the topic and changes in treatment results.
Rosner et al. (2019)	Cognitive processing therapy	88	Randomized clinical trial	Results showed that the participants who received the CPT reported improvement in the symptoms of PTSD, when compared with the participants on the waiting list. In addition, participants demonstrated improvements in all secondary outcomes, such as depression, severity of borderline symptoms, behavioural problems and dissociation. Consistent with the results obtained in other studies, authors concluded that patients with PTSD, associated with a history of CSA, who received treatment with CPT, showed significant improvements when compared with patients on the waiting list, who received no treatment.	Small sample size, exclusion of participants with serious problems and short follow-up time that does not allow the evaluation of long-term effects.

TABLE 1 (Continued)

Study	Approach	Sample size (N)	Methodology	Results	Limitations
Sarasua et al. (2013)	Cognitive behavioural therapy	131	Unicentric study	Statistically significant differences were found after CBT treatment in all measures. After treatment, participants demonstrated significant improvements in PTSD symptoms, depression, anxiety, self-esteem and feelings of inadequacy. Results showed that the participants improved significantly in all measures, from the beginning of the treatment to the follow-up. Significant reductions in symptoms of PTSD, depression and anxiety were observed. Before the treatment, there was a high frequency of emotional stress (66.9%), followed by PTSD (44.6%) and avoidance of sexual behaviours (44.7%), among the women in the sample. The study obtained a high rate of rejection (7.6%) and dropout (28.1%), which the authors believed was due to the difficulty of the treatment itself, which puts the victims in direct contact with their cognitions and negative emotions associated with the perpetrator, a member of their own family. It is important to take these results into consideration, because brief treatment was provided to victims who exhibited severe clinical conditions, resulting from the experience of sexual abuse over more than 15 years ago.	Absence of a control group, sample composed only of women and exclusion of people with severe mental disorders.
Steil et al. (2011)	Dialectical behaviour therapy	29	Pilot study	Results showed that the participants improved significantly in all measures, from the beginning of the treatment to the follow-up. Significant reductions in symptoms of PTSD, depression and anxiety were observed. The differences found between pretreatment and post-treatment for PTSD and depression symptoms suggest a statistically significant effect of treatment. Considering that no patient abandoned treatment, it is possible to say it was well accepted. In addition, the treatment also appears to be safe because there was no exacerbation of symptoms in any of the patients. However, although the results suggest that DBT may prove to be a promising treatment for severe PTSD in adult victims of CSA, it was not possible to determine the relationship between the components of DBT and the effects of treatment.	Small sample size and composed only of women, absence of a control group, absence of diagnostic status and measures indicative of severe PTSD associated with CSA in the post-treatment and impossibility of generalization to non-Caucasian people.

(Continues)

TABLE 1 (Continued)

Study	Approach	Sample size (N)	Methodology	Results	Limitations
Steil et al. (2018)	Dialectical behaviour therapy	21	Pilot study	Results suggest that outpatient DBT for PTSD is a safe treatment with good acceptance, with dropout rates consistent with general treatments for PTSD. After DBT treatment, significant reductions in PTSD symptoms were observed, as well as in depressive and borderline symptoms. It should be noted that all patients who met the criteria for borderline personality disorder, in the pretreatment, did not meet the sufficient criteria for diagnosis 4 weeks after treatment.	Small sample size and composed only of women and absence of a control group.
Talbot et al. (2011)	Interpersonal psychotherapy	70	Randomized clinical trial	Significant reductions in depressive symptoms, post-traumatic symptoms and shame associated with the experience of CSA were observed for participants who received interpersonal psychotherapy compared with participants who received usual treatment. However, despite the improvements in symptomatology, it is not possible to identify which factors of therapy will have enhanced a positive outcome. In addition, the authors point out that some of the participants in both groups would be taking an antidepressant medication, a variable that may have influenced the course of treatment and, consequently, its results.	Small sample size and composed only of women, inability to assess factors that may have contributed to the change (specific components of therapy and antidepressants) and the evaluator's prior knowledge of treatment assignment, which may have produced bias.

Abbreviations: BPD, borderline personality disorder; CAPS, Clinician-Administered PTSD Scale; CAT, cognitive analytic therapy; CBT, cognitive behavioural therapy; CPT, cognitive processing therapy; CSA, child sexual abuse; DBT, dialectical behaviour therapy; DBT-PTSD, dialectical behaviour therapy–post-traumatic stress disorder; EMDR, eye movement desensitization and reprocessing; GCAT, group cognitive analytic therapy; IP, interpersonal psychotherapy; PTSD, post-traumatic stress disorder; SGT, systemic group therapy; TAU-WL, treatment-as-usual wait list; UT, usual treatment.

3.2 | Study selection criteria

The inclusion criteria were *type of publication*: academic peer-reviewed journals; studies were eligible for inclusion if they examined the effectiveness of intervention strategies for adult victims of sexual abuse and literature reviews of such articles were included as well. The exclusion criteria were studies on other types of child abuse (e.g., physical, emotional and neglect) and sexual violence in adults.

3.3 | Results of the search and coding of data

The main characteristics of the studies were coded according to the following criteria: study (authors and year), approach, sample size, methodology, results and limitations.

4 | RESULTS

A summary of the characteristics of revised studies is presented in Table 1.

Numerous studies have sought to evaluate the results of treatments among this population, with the most referred psychotherapeutic approaches, in recent years, being interpersonal psychotherapy (IP), cognitive behavioural therapy (CBT), cognitive processing therapy (CPT), dialectical behaviour therapy (DBT), cognitive analytic therapy (CAT), analytic therapy, systemic therapy, compassion-focused therapy (CFT) and narrative therapy. Some of the interventions are characterized by their eclecticism, that is, by the use of a diversity of strategies that include different therapeutic approaches, as is the case of the study by Becker (2015) that integrates artistic expression with a set of other strategies.

4.1 | Interpersonal psychotherapy

IP was developed by Klerman et al. (1984), with the purpose of briefly treating major depression, for which it has been shown to be effective (Cuijpers et al., 2011), and is also used to treat other clinical conditions (Martins & Monteiro, 2016). It is characterized by being a short-term intervention, focused on the present and on the patient's interpersonal relationships (Klerman et al., 1984). Frequently, interpersonal difficulties are associated with clinical depression, which emerges in the context of social and interpersonal events that compromise good interpersonal functioning and intensify depressive symptoms (Klerman et al., 1984). IP presupposes that solving these interpersonal problems leads to an improvement in symptoms and is, thus, considered a focused treatment. In addition to the impairment in interpersonal and social functioning, experienced by victims of CSA, the potential and compatibility of IP in these populations is also considered (Klerman et al., 1984).

Gamble et al. (2011) compared the effectiveness of IP with the usual treatments (UTs) for depression, in women victims of CSA, which included the support, cognitive behavioural, dialectical behavioural, client-centred and integrative/eclectic approaches. In this study, there were improvements in terms of overall social functioning, particularly among direct family members, as well as in social leisure activities, among patients in the IP group, when compared with UT.

Focused on the dimension of depressive and post-traumatic symptoms, Talbot et al. (2011) carried out a randomized clinical trial that compared the effects of IP with the effects of UT (CBT, DBT eclectic therapy and client-centred therapy) in adult women victims of sexual abuse. The authors showed greater reductions in depressive symptoms, post-traumatic symptoms and shame associated with the experience of CSA for participants who received IP compared with participants who received UT.

Krupnick et al. (2008) evaluated the effectiveness of group IP among low-income women victims of aggression and abuse. The programme consisted of 16 sessions that aimed to provide psychoeducation on PTSD, promote the identification and sharing of difficulties experienced in the interpersonal domain associated with it and anticipate triggers of potential future situations that could reactivate the symptoms. Unlike CBTs, IP focused on regulating emotions such as shame and anger, which are often associated with an inappropriate and maladaptive expression that causes difficulties in interpersonal relationships (Krupnick et al., 2008). The results of the study suggest that IP for PTSD demonstrated positive effects on interpersonal functioning, specifically on four domains (1) interpersonal sensitivity, (2) need for social approval, (3) lack of socialization and (4) interpersonal ambivalence, although there are no significant effects on the aggression.

4.2 | Cognitive behavioural therapy

Several studies evidence the effectiveness of CBT for the treatment of PTSD (Bisson et al., 2013; Forman-Hoffman et al., 2018), and there are also many studies that use CBT approaches for PTSD, which include cognitive therapy, CPT, exposure/prolonged exposure therapy, virtual reality exposure therapy, mindfulness-based cognitive therapy, eye movement desensitization and reprocessing (EMDR) and narrative exposure therapy (Mavranezouli et al., 2020).

With regard to traumatic experiences, CBTs essentially focus on conditioned fear and on how the traumatic experience promotes the development of dysfunctional cognitive schemes that are activated in circumstances where an unreal danger is perceived as a consequence of a state hyperexcitation and hypervigilance, conditioned by the traumatic experience (Heim & Nemeroff, 2009; Resick & Schnicke, 1992).

A cognitive behavioural programme, of 12 individual sessions, with a total duration of 1 year, for the treatment of adult women victims of CSA, was implemented by Sarasua et al. (2013). The study included 131 women, between the ages of 25 and 30, who sought treatment 15 years after repeated abuse perpetrated by family members. The intervention sought, at first, to establish empathy and provide emotional support for the victims and, subsequently, to focus on the psychopathological consequences of the CSA experience.

The latter included emotional catharsis, psychoeducation, cognitive restructuring and skills training (cognitive distraction techniques, progressive muscle relaxation and self-exposure techniques).

There was a decrease in PTSD symptoms (90.7%), avoidance of sexual contact (81.2%), emotional distress (64.5%) and maintenance of gains (74.42%), up to at least 1 year, when compared with pretreatment. Nonetheless, it is also important to consider the limitations inherent to the study, particularly the absence of a control group and the exclusion of serious disorders such as bipolar disorder and borderline personality disorder (BPD).

A randomized clinical trial by McDonagh et al. (2005) evaluated the effectiveness of CBT compared with client-centred therapy and a group on the waiting list among adult women with PTSD associated with the experience of CSA. The treatments were operationalized in order to be similar, having been carried out 14 individual sessions with the same number of hours for both treatments. CBT privileged psychoeducation, imagery exposure and gradual live exposure according to the subjective units of discomfort of each participant and the cognitive restructuring. This last component is indispensable for CBTs because it allows to guide patients in self-monitoring and in the identification of automatic thoughts and emotions associated, in this case, with the abuse experienced, at the same time that they attribute the type of cognitive distortion and learn to test the its veracity, replacing it with another more functional and adaptive (McDonagh et al., 2005). CBT proved to be more effective compared with the waiting list. In addition to CBT, client-centred therapy has also shown significant reductions in anxiety and post-traumatic symptoms, as well as a change in the cognitive schemas associated with the traumatic experience.

4.3 | Cognitive processing therapy

CPT has also been one of the most studied treatments for PTSD in adults, because cognitive interventions have highlighted its potential for significant symptom reduction, as demonstrated in the literature (Asmundson et al., 2019; Holliday et al., 2018; Lenz et al., 2017).

According to Rosner et al. (2019), CPT proposes an understanding of how the traumatic situation affects thoughts, feelings and behaviours, as well as how some of these beliefs may have potentiated and perpetuated the symptoms. Resorting to psychoeducation, exposure and acquisition of skills, the aim is to reduce symptoms and cause changes in the way the patient thinks about him or herself, about events and about others, changing the cognitive structures that maintain and prevent recovery (Lenz et al., 2017; Resick et al., 2017).

Resick et al. (2017) explain that some victims of trauma experienced in childhood and adolescence develop maladaptive cognition, in response to the traumatic situation, due to the immaturity of executive functions. Moreover, the authors add and highlight the potential of CPT for these populations, in promoting affect regulation, cognitive flexibility and the restructuring of beliefs, originated in an early period of cognitive development. However, it is important to take into account that CPT is not adapted to the specific needs of victims with a history of abuse (Resick et al., 2017) but is promising in the reduction of PTSD symptoms (Rosner et al., 2019).

The study by Rosner et al. (2019) evaluated the effectiveness of CPT in a sample of adolescents and young adults (aged 14–21 years) seeking treatment at three university outpatient clinics in Germany compared with the waiting list among 88 adolescents with PTSD associated with CSA. Assessed based on clinical interviews and self-report instruments, participants who attended CPT reported improvements in PTSD symptoms, when compared with participants on the waiting list.

Chard (2005) compared the effectiveness of CPT among adult victims of CSA with a control group on the waiting list that was given minimal attention. CPT was adapted to respond to post-traumatic symptoms associated with CSA, and the following dimensions were included in the treatment (1) information processing, (2) linking, (3) cognition and (4) the role of development in the current state (Chard, 2005). The treatment took place over 17 weeks and combined the individual and group format in order to attend to individualized aspects, centred on traumatic cognitions and memories and, later, integration in a group context fostering social interactions and promoting a space for sharing feelings and experiences with others. The results of the intervention demonstrated statistically significant effects on depressive symptoms, dissociative symptoms and PTSD between pretreatment and post-treatment. However, it is important to consider the limitations of this study, namely, the small sample size, the design of the control group that does not allow the generalization of the effectiveness of CPT in relation to other treatments and the inclusion of a small number of minorities, making it impossible the generalization of results to non-Caucasian populations (Chard, 2005).

4.4 | Dialectical behaviour therapy

Developed by Linehan (1993), DBT is based on a biosocial perspective of personality, focused on emotional regulation difficulties (Steil et al., 2011), and originally designed for the treatment of patients with BPD. According to Linehan (1993, p. 42), the premise of DBT is that 'a dysfunction in the emotional regulation system results from biological irregularities combined with certain dysfunctional environments, as well as from their interaction and transaction over time'. In view of the recognition of this dysfunction at an emotional level, the objective of DBT is to modulate excess emotion and reduce behaviours that promote maladaptive moods, as well as to promote the confidence and validation of one's own emotions, thoughts and behaviours (Linehan, 1993).

Steil et al. (2011) implemented an uncontrolled pilot study to assess the acceptance, safety and efficacy of DBT for PTSD, in 29 women victims of CSA. The intervention aimed to reduce the fear of primary emotions related to the traumatic situation and to question secondary emotions associated with it, thus seeking to promote the elaboration of the traumatic event (Steil et al., 2011). The authors demonstrated that, overall, patients demonstrated statistically

significant improvements on all measures, from the beginning of treatment to follow-up, evidenced by reduced scores on the Post-Traumatic Diagnostic Scale (PDS), the Beck Depression Inventory (BDI) and the State–Trait Anxiety Inventory (STAI), which assess the severity of post-traumatic stress, depression and anxiety, respectively. In addition, the results are limited by the absence of a control group and the lack of determination of post-treatment diagnostic status, and by the lack of a measure of PTSD symptoms that could relate to the CSA experience.

In the same vein, Bohus et al. (2013) implemented a DBT protocol for PTSD, based on the dimensions described in the study by Steil et al. (2011). The study sought to analyse the effectiveness of a 12-week residential programme, for 74 women with PTSD associated with CSA, and with or without a diagnosis of BPD. The authors suggest that DBT-PTSD proves to be a safe treatment, because dysfunctional or suicide ideation behaviours did not increase during, nor after, treatment. However, Bohus et al. (2013) warn that results related to treatment safety may be due to the specific treatment approach, as well as residential conditions.

Later, Steil et al. (2018) conducted a pilot study with the aim of also evaluating the feasibility, acceptance, and safety of outpatient DBT treatment for PTSD, in 21 women victims of CSA. DBT treatment for PTSD, similar to the structure of the original DBT, prioritizes risky and self-destructive behaviours, such as attempting suicide seeking to solve problems, and emotional difficulties that negatively impact quality of life and well-being (Steil et al., 2018). The intervention was structured in five essential phases: (1) conducting the anamnesis interview, treatment contract and psychoeducation; (2) setting treatment goals, introducing mindfulness, discussion about exposure and about the maintenance of PTSD symptoms; (3) introduction and learning of behavioural, cognitive and emotional strategies related to trauma; (4) application of exposure tasks and (5) radical acceptance of the traumatic event and psychosocial problems, with a reinforcement session 6 weeks after the end of treatment. Steil et al. (2018) found a significant reduction in PTSD symptoms, as well as in depressive and borderline symptoms.

4.5 | The artistic expression technique

Artistic expression has also been an approach integrated in PTSD treatment by several researchers, often used for a wide variety of traumas, including sexual abuse (Becker, 2015; Murray et al., 2017; Pifalo, 2006). Becker (2015) evaluated the applicability of an adapted group intervention that included artistic tasks with narrative therapy, grounding and psychoeducational techniques, as well as cognitive restructuring and exposure techniques, in five adult victims of CSA with symptoms of PTSD. The artistic tasks were included with the aim of reflecting on personal experiences and promoting group discussions about the performed task. The integration of artistic expressions, grounding and narrative therapy demonstrated a statistically significant reduction in depressive and post-traumatic symptoms during treatment, with a maintenance of gains in follow-up. However, it should be considered that the sample that completed the treatment is very limited ($n = 5$), and the study does not include a control group (Becker, 2015).

4.6 | Cognitive analytic therapy

CAT, in group form, is an intervention that has shown promising results with these populations. CAT is a brief, customer-centred and collaborative approach that focuses on the person, rather than on symptoms, behaviours, beliefs or conflicts, and includes a narrative reconstruction of patients' current and past difficulties, providing greater self-reflection and integration (Pollock, 2001; Ryle et al., 2014). It emerges as a fusion of psychodynamic therapy and cognitive psychology that seeks to 'recognize and challenge the restrictions and distortions imposed by persistent and dysfunctional intra- and interpersonal patterns' (Ryle et al., 2014, p. 9). Thus, CAT does not dispense with the use of cognitive and behavioural techniques such as reprocessing nightmares, cognitive restructuring and assertiveness training that promote the deconstruction of dysfunctional behavioural and interpersonal patterns, as well as psychodynamic techniques such as reflection and interpretation of transference and countertransference (Clarke & Pearson, 2000).

Clarke and Llewelyn (1994) implemented an exploratory study on the personal constructs in women victims of CSA who received CAT for 16 weeks and showed an improvement in global functioning, depressive symptoms, self-esteem and a reduction in beliefs related to self-injurious behaviours. It is worth mentioning that the study has a low methodological quality because it is composed of a very small sample and does not include any control group (Clarke & Llewelyn, 1994).

Later, Clarke and Pearson (2000) replicated the previous study with men who were victims of CSA, in order to assess the effect of therapy on personal constructs, general symptoms, depression, self-esteem and dysfunctional beliefs associated with CSA. Before receiving CAT, most participants demonstrated that they identify less with their self-child and more with the aggressor, whereas after treatment, changes in identification and a reduction in depressive symptoms and cognitive distortions were observed. However, methodological weaknesses such as the small sample size and the absence of a control group should be considered.

Calvert et al. (2015) evaluated the results of group CAT, in a sample of 108 women who survived CSA. The authors found that, overall, the results suggest that group CAT can be an effective approach for participants who completed treatment. It should be noted that 69% of patients attended the full treatment, 12% did not attend any sessions and 19% dropped out while treatment. These values, in addition to revealing good acceptability of the treatment, demonstrate a dropout rate lower than other group therapies implemented in these populations.

Consistent with previous research (Clarke & Pearson, 2000) results suggest that CAT group is associated with moderate to substantial improvements in secondary outcome measures, except for

self-esteem. However, the results should be interpreted with caution, because there was no control group and there was also no record of community mental health interventions that participants could have also been receiving. As such, there is no certainty that the observed improvements are due solely and exclusively to the group CAT.

4.7 | Group analytic therapy

Group analytic therapy (GAT) sought to reduce anxiety, promote safe relationships and sharing among members of the group in women victims of sexual abuse who were in treatment for 3 years at a psychotherapy centre in Denmark (Elkjaer et al., 2014). According to Alexander et al. (1989), group therapy provides greater support than the individual approach, because it allows participants to share experiences that promote a feeling of identification and, consequently, symptom relief (Elkjaer et al., 2014). The effectiveness of group therapy was evidenced by Alexander et al. (1989), with the long-term improvement of negative consequences associated with the experience of sexual abuse. However, the effects of long-term treatments are still unknown, and there is still a lack of knowledge about which group therapy is most effective (Elkjaer et al., 2014).

Lau and Kristensen (2007) implemented a randomized controlled clinical trial to compare the effects of GAT and systemic group therapy (SGT) on adult CSA victims. The results demonstrated statistically significant reductions in general symptoms, quality of life and psychosocial functioning for both treatment groups, although more significant for SGT.

A prospective, controlled and randomized study, published in 2014 by Elkjaer et al., aimed to assess the course of general symptomatology, psychosocial functioning and interpersonal problems, in CSA victims. The study compared the long-term effectiveness of group analytic and systemic psychotherapies in a sample of 106 women and found no significant differences. In the study by Elkjaer et al. (2014), analytic therapy, based on the theory of group analysis by Foulkes (1986), focused on the intrapsychic and interpersonal difficulties of patients' past and current relationships. Often, there is a difficulty among victims of CSA to identify feelings, whether present or past, and, for this reason, GAT, as a goal, promotes, in a safe and validating environment, a connection with feelings, in order to be able to symbolize the experience of abuse (Elkjaer et al., 2014). According to Lau and Kristensen (2007), it is assumed that improvements would naturally be caused by the relationships, identification and communication established with the group members.

4.8 | Systemic group therapy

SGT is an approach that understands problems within the contexts in which people function and is guided toward resources and solutions (Elkjaer et al., 2014; Pinquart et al., 2016). In this study, it was implemented through the establishment of individual goals, which included psychoeducation and focus on flashbacks, guilt and the validation of perceptions and feelings. SGT's main objective was to reformulate the participants' life stories, promoting more adequate perceptions of themselves and situations and, consequently, the implementation of new behaviours (Elkjaer et al., 2014).

Elkjaer et al. (2014) found statistically significant improvements for both treatments, demonstrating a superiority of SGT after treatment, which decreased, however, during follow-up. Nonetheless, both GAT and SGT did not differ significantly in terms of improvement of overall symptoms, psychosocial functioning, quality of life and occurrence of flashbacks, 1 year after the end of treatment, in women suffering from CSA.

4.9 | Intervention focused on expressive writing

Based on a study by Stanton et al. (2015)—which determined the existence of seven unique themes of sexual self-schemas: family and development, virginity, abuse, relationship, sexual activity, attraction and existentialism—a group of researchers (Pulverman et al., 2017) sought to assess changes in the sexual self-schemas of 138 women with a history of CSA, after an intervention focused on expressive writing. According to Stanton et al. (2015), these self-schemas differ depending on age, relationship status and history of sexual abuse. Thus, Pulverman et al. (2017) hypothesized that the closer the victims were to recovery, the more the sexual schema of these women resembled that of women who are victims of CSA. In the assessment sessions, each woman individually performed an expressive writing task lasting 30 min. They were asked to express, in a detailed way, their emotions and thoughts about sex, related to past, present or future sexual experiences, as well as about their perception of themselves as a sexual being.

The results of the study by Pulverman et al. (2017) showed changes in the use of certain themes of sexual self-schemas, in women with a history of CSA, after expressive writing treatment. The expressive writing treatment, which assists in the processing of past traumatic events (Pennebaker & Chung, 2011), led to a lower frequency, at the end of the treatment, in the use of the theme of abuse, to the detriment of other themes of sexual self-schemas. Pulverman et al. (2017) suggest that expressive writing treatment produces significant changes in sexual schemas after intervention, in women who are victims of CSA. However, given the convenience sample, as well as the small number of participants, the results should be interpreted with caution.

It is also important to discuss other interventions that, despite not seeing their proven effectiveness in these populations, are studied by researchers as promising treatment options. In addition to the studies cited above, there are others that seek to explore the potential of other treatment options, in which theoretical assumptions are seen as capable of offering an advantageous treatment to victims of CSA and may allow future studies to support their validity and effectiveness.

4.10 | Compassion-focused therapy

Within these, as an individual treatment option, CFT is highlighted, developed by Paul Gilbert (2013), which is an integrative therapy that

encompasses an evolutionary, cognitive, social, developmental and Buddhist approach (Gilbert, 2005; Gilbert, 2010), characterized by a transdiagnostic perspective. Its focus is intervention among people with chronic and complex mental health problems, who experience high levels of shame, guilt and self-criticism. Considering that the experience of shame, guilt and avoidance, as well as reduced levels of self-compassion, are common consequences among survivors of sexual abuse, the potential of CFT, in the ability to respond to these specificities, is evident (Miron et al., 2016).

According to Gilbert (2009), CFT seeks to assist people in building an understanding of how threats are processed and their consequent response, promoting relief from suffering, through the acquisition of a set of compassion-based skills. Therefore, it proves to be a potentially advantageous intervention for these populations, because it proposes to intervene in the dimensions associated with them. The process of developing compassion skills, also known as compassionate mind training, can be practiced not only with other people but also with only the subject him or herself, assuming that motivational, emotional, behavioural and cognitive skills guide the self, in a search for satisfaction of their needs and those of others, which include help, altruism and a response to care, thus promoting well-being and assistance in the recovery process (Gilbert, 2010).

Although there are no studies that prove its effectiveness with adult victims of CSA, compassion is a promising treatment option (Gilbert, 2010), with increasing evidence in other clinical conditions that share similar symptoms, namely, depression and anxiety (Hofmann et al., 2011; Judge et al., 2012). Considering the potential of CFT in the depathologizing of the CSA experience, reduction of self-criticism and in the acquisition of coping strategies, future studies should evaluate the effectiveness of the intervention among this population (McLean et al., 2017).

4.11 | Narrative therapy

Narrative therapy for couples was studied by Laughlin and Rusca (2020), as an approach that promotes resilience among victims of CSA. According to Laughlin and Rusca (2020), 'couples in which one or more partners are survivors of CSA usually report problems of social/relational adjustment, emotional expressiveness, revictimization, low satisfaction and stability in relationships, and sexual dysfunction' (p. 15). Bidirectional vicarious resilience can be promoted through sharing and witnessing narratives of resilience among peers, while promoting a positive connection. Often, the experience of CSA is related to interpersonal suffering and difficulties (Lassri et al., 2018; Nielsen et al., 2018); however, these relationships can also be support for recovery (Laughlin & Rusca, 2020), through the promotion of resilience (Ungar, 2013).

Given the depathologizing and client-centred nature of narrative therapy, the authors suggest its suitability to deal with the systemic consequences of the traumatic experience and in promoting vicarious resilience, in couples where at least one member reports a history of CSA. By focusing on the subjugated narratives, it attempts to make sense of the experience and reconstruction of identity and of more satisfactory and adequate alternative narratives (White, 2007). Mapping and defining ceremonies are narrative interventions that promote the development of resilience among couples. These interventions, based on the sharing of subjugated narratives through an externalizing language (White, 2007), promote the reconstruction of identity based on acceptance, strength and agency, instead of shame, avoidance and interpersonal difficulty (Laughlin & Rusca, 2020).

There is, therefore, an externalizing approach to the problem seen as something separate from the patient's identity, which defines the problem and maps its influence on various areas of life (White, 2005; White, 2007). This approach allows one to interrupt the dominant narrative and identify the moments of exception, when the problem had little or no influence on one's life, expanding these unique results. Thus, the focus on unique results, and their potential, allows the construction and consolidation of an alternative narrative, which is more positive and empowering for the individual (Carr, 1998; White, 2007). This new identity, differentiated from the previous totalitarian narrative, is presented to the significant others, through defining ceremonies, aiming toward the recognition and validation of the new narrative by the audience (White, 2007). In addition to the potential of narrative therapy in promoting resilience among couples, in which at least one member is a survivor of CSA, future research should seek to evaluate its effectiveness.

4.12 | Eye movement desensitization and reprocessing

EMDR, developed by Francine Shapiro, is a model of psychotherapy initially developed for the treatment of PTSD, which is based on the premise that psychological disorders result from a set of past experiences that cause high suffering, due to inadequate information processing. This intervention centralizes the role of initial memories as the basis of psychological difficulties, with the aim of treatment being to change the impact of these memories, in order to promote symptomatic relief and remission of symptoms. It is recommended that there is a failure in the processing of these memories, which are associated with a set of emotions, sensations and disturbing thoughts and that cause significant suffering whenever these traumatic memories are activated (Shapiro, 2017).

A double attention stimulus, such as eye movement or the focus of attention on auditory and tactile stimuli, are mechanisms by which integral information processing can be activated, as they induce physiological responses that activate information processing. It is through these that connections are recreated between memories of past events and dysfunctional responses that are redirected and where new responses are integrated, more adaptive that reduce psychological suffering (Shapiro, 2001; Shapiro, 2017).

Edmond et al. (1999) evaluated the effectiveness of EMDR for a six-session treatment and 3-month follow-up, compared with a routine treatment and a control group, in reducing post-traumatic, anxious and depressive symptoms presented by adult women victims

of CSA. In this study, post-traumatic, anxious, depressive symptoms and dysfunctional beliefs associated with CSA were evaluated among 59 women participating in the study in the pretreatment and post-treatment moments and during the follow-up. The results demonstrate that all measures evaluated demonstrated clinically significant improvements for participants who received EMDR compared with the remaining conditions. However, we must consider that this study lacks a significant sample, because the sample is composed of 59 participants, representing a very limited number to allow more robust generalizations and conclusions (Edmond et al., 1999).

5 | DISCUSSION

CSA is a form of early-life trauma that can lead to psychiatric impairment across a number of domains (Bücker et al., 2012; Chen et al., 2010; Maniglio, 2009). It is a worldwide concern due to its alarming rate of increase despite of various precautions and laws for the protection of children. Adverse childhood experiences leave an extensive and profound influence on the physical and mental health of a person in later life (Moreira et al., 2020). Violence in childhood, particularly sexual abuse, is devastating because of its long-term detrimental consequences that thwarts the child's impending growth as an adolescent and healthy adult (Voith et al., 2017). CSA has a significant and pervasive impact on individuals, producing a variety of mental, emotional, relational, physical and trauma symptoms. Despite the devastating and compromising effect, the empirical studies regarding therapy with survivors, once a disclosure of CSA has been made, is limited. Most therapeutic interventions for CSA focus primarily on reliving or retelling, in great detail, the sexual abuse experience, as well as reducing the symptoms associated with the experience.

The analyses of the several studies on the treatment of adult victims of CSA is revealing that CSA can result in negative outcomes in psychosocial dimensions, leading to anxiety, depression, post-traumatic stress, behavioural problems and social difficulties. To eliminate these negative consequences of CSA, intervention options for its victims include treatment in individual, familial and group modalities; all have been developed mainly with the aim of addressing the trauma-based symptoms (Habigzang et al., 2013; Macdonald et al., 2006).

Research and clinical investigation are uncovering many of the long-term negative sequelae of sexual abuse. Individuals who have been sexually abused in childhood may have difficulties with self-image and sexual self-esteem, manifest higher levels of anger, revolt, guilt, shame, depression, PTSD and problems with sexuality issues. They may find themselves in a life-long struggle to heal the trauma of the sexual abuse and subsequent feelings of vulnerability (Monahan & Lurie, 2003).

We found 12 models of potential interventions among adult victims of CSA, in which those who proposed to offer treatment demonstrated that they were able to reduce some of the symptoms presented by the survivors. The symptoms presented by the victims are very variable; however, the outcomes associated with this experience are consistent with that presented in the literature such as depressive symptoms (Chen et al., 2014; Fergusson et al., 2013; Li et al., 2020), anxiety (Fergusson et al., 2013; Maniglio, 2013), PTSD (Hartley et al., 2016; Robinaugh & McNally, 2011), interpersonal difficulties (Gamble et al., 2011; Krupnick et al., 2008), suicidal behaviours and self-harm (Daray et al., 2016; Obikane et al., 2018), mental health and physical problems and lower quality of life (Kamiya et al., 2016) and sexual behaviour problems (Hailes et al., 2019; Ports et al., 2016).

It should be noted that studies with CFT and narrative therapy are theoretical studies and explore their potential in the treatment of adult victims of CSA. Although one of the studies (Becker, 2015) includes narrative therapy in the treatment, it must be considered that the study adopts an eclectic approach where other strategies are included. Considering that the objectives of these therapies are aligned with the common characteristics presented by the victims, we can recognize the potential of these treatments in this population. However, further studies are needed to assess the effects of these interventions on CSA survivors.

It was possible to realize that interventions are generally effective in reducing symptoms that are proposed to be reduced, although some therapies have better results for more measures, such as CBT, DBT, CAT and EMDR. However, it is not possible to conclude that one therapy is more effective than the other in treating victims of CSA. Nonetheless, we also noticed that the reduction of post-traumatic, depressive and anxious symptoms is more evident, regardless of the intervention received. Results suggest an improvement in global functioning, self-esteem, quality of life and psychosocial functioning, as well as a reduction in negative beliefs about themselves. Interventions may increase self-efficacy, resilience and awareness of healthy coping skills, resulting in positive changes in everyday functioning. Such changes are inherently helpful to the survival process and can offer survivors valuable tools with which to approach future experiences.

Despite the wide variety of existing programmes and the multitude of evaluation measures used in the studies, the results of almost all the studies suggest the effectiveness of this type of intervention. It must be stressed that psychotherapy is a powerful tool and should be used only by those experienced in working with survivors of sexual abuse. The therapist must be sensitive to how strong or fragile each client is, to know if they can handle the tension this tool uses. Also, understanding the clinical decision-making strategies of therapists treating adult CSA survivors will provide an important path for therapists and survivors to follow toward healing.

5.1 | Implications for CSA interventions

Among the various treatment modalities for CSA victims, CBT has received the greatest amount of support, because of its efficacy. Research has shown that CBT was the most promising type of CSA intervention, reporting substantial improvement and the maintenance of positive effects in diverse aspects of psychosocial functioning in the effects of CSA. Significant improvements in psychological reaction

(e.g., anxiety, fear, depression, distress and PTSD symptoms), knowledge of abuse or personal safety, intrusive negative thoughts, externalizing problems, sexually inappropriate behaviours, self-protection skills and parenting practice toward CSA victims or their parents were found in the majority of studies involving the CBT approach (Bisson et al., 2013; Forman-Hoffman et al., 2018; Mavranezouli et al., 2020; McDonagh et al., 2005; Sarasua et al., 2013; Simon et al., 2019).

Following CBT, the next most frequent treatment modality was that of interventions focused on group therapy. The respective studies reported positive outcomes for the psychosocial sequelae of CSA, such as psychopathological symptoms (e.g., anxiety, depression and PTSD), problems related to self-image and empowerment, behavioural problems, coping ability, global functioning and relationship with mothers (McDonagh et al., 2005; Sarasua et al., 2013). In addition, interpersonal psychotherapy, analytic therapy, systemic therapy, narrative therapy and EMDR show treatment effects on the psychosocial consequences of CSA as well.

Intervention formats included individual, group and combined formats, with the group format being the most frequent (Becker, 2015; Calvert et al., 2015; Elkjaer et al., 2014; Krupnick et al., 2008; Lau & Kristensen, 2007). Group treatment is a frequently chosen method of intervention for CSA victims because the feedback, support and being understood from a peer group facing very similar problems can provide a safer environment to explore and resolve the negative feelings resulting from CSA (Calvert et al., 2015; Elkjaer et al., 2014; Lau & Kristensen, 2007). In fact, there is no one intervention format that works more than another. For example, a meta-analysis of studies on treatment outcomes in children suggested that individual therapy is more effective than group therapy (Weisz et al., 1995); comparing the relative efficacy of focused individual and group therapy, the individual format led to a greater improvement in the manifestations of PTSD (Trowell et al., 2002); and Nolan et al. (2002) concluded that both treatments were effective, with no marked difference between the degree of effectiveness and the respective modalities. The question of how each intervention format affects certain factors related to the treatment of CSA should be clarified in future studies.

It is important to take into consideration the characteristics of sexual abuse, the diverse strategies of CSA interventions and a number of methodological and ethical issues with the aim of strengthening the therapeutic effects of psychosocial interventions. This said, there is a shortage of studies from a variety of sociocultural contexts and cross-cultural studies, even though CSA is a substantial health-related and social problem worldwide.

The methodological limitations pointed out by all studies are real barriers to understanding the results and, consequently, to making generalized conclusions. These limitations are related either to the absence of control groups or to the absence of long-term assessment and concrete measures that relate the symptoms to the experience of CSA. In addition, a major limitation pointed out by most studies is the small sample sizes, perhaps resulting from the hideous and complex nature of the phenomenon, which naturally prevents a precise generalization of the results.

The experience of CSA is a phenomenon with serious repercussions on the victim's health, which can occur at any time in the life cycle. Knowing the devastating consequences that this traumatic event can produce, it is imperative to conduct additional research that offers a treatment capable of minimizing the impact of the experience, promoting symptom relief and improving well-being and quality of life. To this end, randomized clinical trials are needed to assess the effectiveness of psychotherapeutic interventions, through the inclusion of a control group. Despite the vast literature, the studies are not of a randomized and controlled experimental character. Instead, most studies are concerned with evaluating preintervention and postintervention data without a control group, which does not allow testing the effectiveness of the treatment or predicting relationships between variables.

Screening measures and treatment considerations for adult survivors of CSA should be accompanied by investment in selective primary prevention. Although supporting adult survivors of CSA is important, it is also vital to improve support for youth who are currently experiencing abuse. It is important to reinforce the need to address CSA through comprehensive education and resource programmes in primary and secondary schools. Understanding the clinical decision-making strategies of therapists treating adult CSA survivors will provide an important path for therapists and survivors to follow toward healing.

CONFLICT OF INTEREST

The authors do not have financial, personal or professional conflicts of interests.

ETHICS STATEMENT

After the local ethics committee approved the study, it was conducted according to APA ethical standards.

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