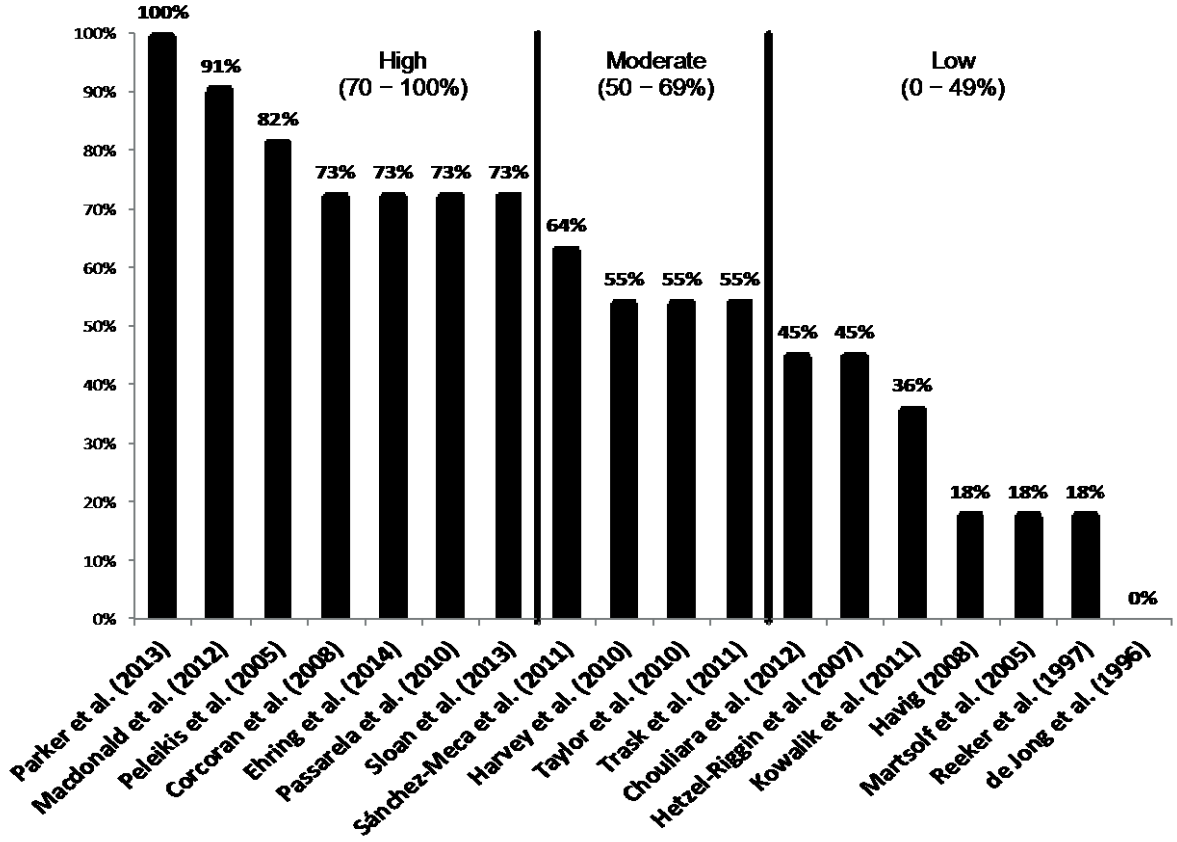
Table 2. AMSTAR quality assessment for included studies

		AMSTAR CHECKLIST CRITERIA										
Study	No. of included studies?	Was an 'a priori' design used?	Was there duplicate study selection and data extraction?	Was a comprehensive literature search performed?	Was the status of the publication (ie grey literature) used as an inclusion criteria?	Was a list of studies (included and excluded) provided?	Were the characteristics of the included studies provided?	Was the scientific quality of the included studies assessed and documented?	Was the scientific quality of the included studied used appropriately in formulating conclusions?	Were the methods used to combine the findings of studies appropriate?	Was the likelihood of publication bias assessed?	Was the conflict of interest included?
Chouliara et al. (2012)	9	YES	NO	NO	NO	NO	YES	YES	YES	YES	NO	NO
Corcoran et al. (2008)	7	YES	YES	YES	NO	NO	YES	YES	YES	YES	YES	NO
de Jong et al. (1996)	7	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
Ehring et al. (2014)	16	YES	YES	YES	NO	NO	YES	YES	YES	YES	YES	NO
Harvey et al. (2010)	39	YES	NO	YES	YES	YES	YES	NO	NO	NO	YES	NO
Havig (2008)	10	YES	NO	NO	NO	NO	YES	NO	NO	NO	NO	NO
Hetzel-Riggin et al. (2007)	28	YES	YES	YES	NO	NO	YES	NO	NO	NO	YES	NO
Kowalik et al. (2011)	8	YES	NO	NO	NO	NO	YES	NO	NO	YES	YES	NO
Macdonald et al. (2012)	11	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO	YES
Martsolf et al. (2005)	26	YES	NO	NO	NO	NO	YES	NO	NO	NO	NO	NO
Parker et al. (2013)	0	YES	NA	YES	YES	YES	NA	NA	NA	NA	NA	YES
Passarela et al. (2010)	3	YES	YES	YES	YES	NO	YES	YES	YES	YES	NO	NO
Peleikis et al. (2005)	24	YES	YES	YES	YES	NO	YES	YES	YES	YES	YES	NO

Reeker et al. (1997)	15	YES	NO	NO	NO	NO	YES	NO	NO	NO	NO	NO
Sánchez-Meca et al. (2011)	33	YES	YES	YES	YES	NO	NO	YES	YES	NO	YES	NO
Sloan et al. (2013)	4	YES	YES	YES	NO	NO	YES	YES	YES	YES	YES	NO
Taylor et al. (2010)	44	YES	NO	YES	YES	YES	YES	NO	NO	NO	YES	NO
Trask et al. (2011)	35	YES	NO	YES	YES	NO	YES	NO	NO	YES	YES	NO
Total	319											

Figure 2. AMSTAR assessment by methodological quality grouping



Characteristics of included studies

Multiple study designs, as well as mixed methodologies, were used across the included systematic reviews and meta-analyses, with most containing primary studies that employed RCT and QED designs, some using simple pre-post within-group designs (non-RCT) and some using qualitative designs. Included studies have been undertaken in various geographical locations – including the United States, Canada, Europe, Australia, Asia and New Zealand – and consist of sample groups that are both under and over the age of 18. The samples targeted were mostly child sexual abuse survivors; however, one review studied victims of PTSD and another studied non-specific child abuse. Various interventions were tested for child sexual abuse–related outcomes, with many of them being trialled against a control group. Commonly used interventions included CBT, psychotherapy, parent-involved therapy, group therapy and trauma-focused therapy. Common comparison groups included TAU, placebo or alternative treatment, and wait-list control.

Table 3. Characteristics of included studies by age (adults; children and adolescents), modality and methodological quality

Review	Included study designs	Location	Population	Age range	Interventions	Comparison	AMSTAR coding
ADULTS							
Psychotherapy/CBT – individual and group therapy included in review							
Peleikis et al. 2005 Systematic review (SR) 'A systematic review of empirical studies of psychotherapy with women who were sexually abused as children'	• Pre- and post-treatment measurement designs • Follow-up measurement designs • RCTs • Non-controlled studies • Non-randomised controlled studies	Not specified	Female survivors of child sexual abuse	Not specified	• Individual psychotherapy • Group psychotherapy • Blended therapy	• Alternative treatments • Wait-list	9 green 2 red
Ehring et al. 2014 Meta-analysis (MA) 'Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse'	RCTs	Not specified	Adult survivors of childhood abuse (sexual/physical), with a particular focus on resulting PTSD	Adults (18 years or older)	• Trauma-focused CBT • Non-trauma-focused CBT • EMDR • Alternative treatments (interpersonal, emotion-focused) • Individual and group therapies, or therapies combining individual and group delivery formats	• Wait-list or no contact control groups • TAU • Placebo	8 green 3 red
Taylor et al. 2010 MA	• 'Independent samples design' (treatments	• United States • Canada	Adult (mostly female) survivors	Adults (18 years or older)	• CBT • Insight-oriented • Eclectic	• TAU • Alternative treatment	6 green 5 red

'A meta-analysis of the effects of psychotherapy with adults sexually abused in childhood'	comparing therapy with control groups post treatment) • 'Repeated measures designs' (treatments comparing a therapy group across pre-post treatment) • Studies based on empirical measures with established psychometric properties	• Europe • Other	of child sexual abuse		• Other Intervention modes included individual, couple, group or multi-modal	• Not all included studies were based on control conditions	
Martsolf et al. 2005 SR 'Psychotherapy approaches for adult survivors of childhood sexual abuse: An integrative review of outcomes research'	• Pre-test/post-test designs • Quasi-experimental • RCTs	Not specified	Child sexual abuse survivors (may have also reported other types of abuse and neglect)	Adults (no age range specified)	Pre-test/post-test: • Cognitive restructuring individual therapy • Psycho-didactic support group • Incest survivor group • Process-oriented group • TF-CBT group • Group therapy in family systems model • Cognitive processing individual and group • Specialised therapy Quasi-experimental studies: • Integrative constructivist individual therapy • Cognitive restructuring individual therapy • Multi-modal group therapy	Quasi-experiment: • Wait-list control • Routine psychiatric care • TAU • Control group RCT: • Delayed treatment control group • Routine individual treatment • Wait-list control	2 green 9 red

					• Closed process group • Feminist empowerment group • Eclectic survivor group • Integrative body psychotherapy group • Interpersonal process group • Borderline Personality Disorder (BPD) group • Psychoeducational group • Women's Safety in Recovery Group RCT: • Individual EDMR • Interpersonal Transaction (IT) group • Process group • Eclectic group with or without symbolic confrontation exercises • Affect management group		
Adults – group therapy							
Sloan et al. 2013 MA 'Efficacy of group treatment for posttraumatic stress disorder symptoms: A meta-analysis'	RCTs	Not specified	PTSD or trauma survivors (the cause of trauma varied; however, those identified included motor vehicle accidents, combat, child	Adults (18 years or older)	Group treatment: • CBT • Dialectical Behavioral Therapy (DBT) and narrative exposure • TF-CBT • Exposure-based treatment focused on co-morbid PTSD and panic attacks	• Wait-list control • Minimal contact condition • Present-centred supportive group • Psychoeducation • TAU • Acupuncture • Anger management	8 green 3 red

			sexual abuse, interpersonal or mixed causes of trauma)		• Trauma-focused spiritually integrated treatment • Seeking safety • Culturally adapted CBT • EDMR • Interpersonal group treatment • Anger management via teleconference	• Exposure-based therapy • Support group	
de Jong et al. 1996 MA 'Short-term versus long-term group work with female survivors of childhood sexual abuse: A brief meta-analytic review'	• Pre-experimental design • Quasi-experimental/non-randomised design	• United States • Canada	Adult female survivors of child sexual abuse	Adults (18–64 years old)	Group work	• Wait-list • Short-term versus long-term group work	0 green 11 red
Adults – qualitative							
Chouliara et al. 2012 SR 'Adult survivors' of childhood sexual abuse perspectives of services: A	• Content analysis • Thematic analysis/ phenomenological approach (mixed-method) • Critical incident technique • Grounded theory • Narrative methodology	• United States • Canada • New Zealand • United Kingdom (Scotland)	Adult survivors of child sexual abuse	Adults (18 years or older)	Psychotherapy/counselling in groups or individual support	Not applicable as this is a review of qualitative studies of how child sexual abuse survivors experience psychotherapy/counselling services, and the effectiveness of these treatments	5 green 6 red

systematic review'	• Phenomenological – feminist approach • Questionnaire or structured face-to-face interviews						
Havig 2008 SR 'The health care experiences of adult survivors of child sexual abuse'	• Quantitative • Qualitative • Mixed methods	Not specified	Adult survivors of child sexual abuse	Adults (no age range specified)	• Specific intervention to reduce trauma (no further details) • Primary health care (gynaecology, physical therapy, dentistry, family practice)	Non-abused patients	2 green 9 red
CHILDREN AND ADOLESCENTS							
Psychotherapy/CBT – individual, group, parent-involved and family therapy (no comparative modality data included)							
Macdonald et al. 2012 SR 'Cognitive-behavioural interventions for children who have been sexually abused (Review)'	• Quasi-random allocation • RCTs • Cluster RCT	• United States • Australia	Child and adolescent survivors of child sexual abuse	Children and adolescents (up to 18 years old)	• Group CBT • Individual CBT • Family CBT	• Wait-list control • Control group • Conventional sexual abuse–specific group therapy • Supportive group therapy for parents • Didactic information approach for children • Supportive, unstructured therapy • Non-directive supportive therapy • 'Teaching parents CBT strategies'	10 green 1 red

Parker et al. 2013 SR 'Psychoanalytic/ psychodynamic psychotherapy for children and adolescents who have been sexually abused (Review)'	RCTs, including quasi-randomised studies	Not applicable as this was an empty review	Child and adolescent survivors of child sexual abuse	Children and adolescents (up to 18 years old)	This review did not include any studies, but the intention was to include studies of psychoanalytic or psychodynamic therapy with this population	• No treatment • Wait-list • TAU	5 green 6 yellow (n/a)
Corcoran et al. 2008 MA 'A meta-analysis of parent-involved treatment for child sexual abuse'	RCTs	Not specified	Child survivors of child sexual abuse	Children (no age specified)	• Parent–child CBT • Parent-only CBT • Child-only CBT • Individual supportive therapy	• TAU • Individual supportive therapy • Child supportive therapy • Community control • Wait-list control	8 green 3 red
Sánchez-Meca et al. 2011 MA 'The psychological treatment of sexual abuse in children and adolescents: A meta-analysis'	Pre-test/post-test design	• North America • Europe • Oceania • Asia	Child and adolescent survivors of child sexual abuse	Children and adolescents (up to 18 years old)	• CBT • TF-CBT • CBT and other treatment • Supportive therapy • Psychodynamic therapy • Humanistic treatment • Client-centred therapy • Maslow's self-regulation therapy • Play therapy	Includes studies with and without control condition. There were 44 treatment groups of children and seven control groups across included studies. No insight into what control conditions were for these seven groups	7 green 4 red

Kowalik et al. 2011 SR and MA 'Cognitive behavioural therapy for the treatment of pediatric posttraumatic stress disorder: A review and meta-analysis'	RCTs	Not specified	Child survivors of child sexual abuse with PTSD	Children and adolescents (up to 18 years old)	• CBT and metaphoric techniques • CBT for sexually abused pre-school children (CBT-SAP) • TF-CBT • Sexual abuse–specific CBT (SAS-CBT) • Child/individual CBT • Family CBT	• Supportive unstructured psychotherapy • Non-directive supportive treatment • Child-centred therapy (CCT) • Wait-list control • Control (for two studies – no further detail)	4 green 7 red
Psychotherapy/CBT – individual, group, parent-involved and family therapy (comparative modality data included)							
Passarela et al. 2010 SR 'A systematic review to study the efficacy of cognitive behavioural therapy for sexually abused children and adolescents with posttraumatic stress disorder'	RCTs	• United States • Australia	Child and adolescent survivors of child sexual abuse with PTSD	Children and adolescents (5–17 years old)	• CBT (child or family) • TF-CBT	• Wait-list control • Community care • CCT	8 green 3 red
Harvey et al. 2010 MA	• 'Independent samples design' (treatments comparing therapy	• United States • United Kingdom • Canada	Child and adolescent survivors of child sexual abuse	Children and adolescents (up to 18 years old)	• Group therapy • Individual therapy • CBT • Combination • Child and carer	• TAU • Supportive counselling • EMDR • Abuse-specific • Minimal attention	6 green 5 red

'A meta-analysis of the effects of psychotherapy with sexually abused children and adolescents'	with control groups post treatment) • 'Repeated measures designs' (treatments comparing a therapy group across pre-post treatment) • Studies based on empirical measures with established psychometric properties	• Other			• Play therapy • Group art therapy	• Wait-list	
Trask et al. 2011 MA 'Treatment effects for common outcomes of child sexual abuse: A current meta-analysis'	• Single group pre-post test design • Quasi-experimental • RCTs	Not specified	Child and adolescent survivors of child sexual abuse who were or are in treatment for PTSD and have internalising or externalising problems	Children and adolescents (up to 18 years)	• Individual CBT • Group CBT • Combined CBT	• No treatment • Wait-list • Minimal contact • Attention placebo • TAU	6 green 5 red
Hetzel-Riggin et al. 2007 MA 'A meta-analytic investigation of therapy modality outcomes for sexually abused children and	Pre-test/post-test design	Not specified	Child and adolescent survivors of child sexual abuse	Children and adolescents (under 12 years old – although nine studies did not specify an age range)	• Individual • Group • CBT • Abuse-specific • Supportive • Family • Play • EMDR	• No treatment • No control group	5 green 6 red

adolescents: An exploratory study'							
Children and adolescents – group							
Reeker et al. 1997 MA 'A meta-analytic investigation of group treatment outcomes for sexually abused children'	Pre-test/post-test design	Not specified	Child and adolescent survivors of child sexual abuse	Children and adolescents (up to 18 years old)	Group therapy: • Integrated (which includes combinations of psychoeducation, abuse experience, exploration of feelings, art therapy, play therapy, role-play, problem solving, puppet work, writing exercises and behaviour management) • CBT • Drama therapy • Play therapy	Not specified	2 green 9 red

Outcomes of included studies

The articles reviewed varied greatly in the number of included primary studies, ranging from 3–44 (with one article returning no studies that fit the inclusion or exclusion criteria). Similarly, the mean sample sizes ranged from 14.8–179, with total sample sizes for entire reviews reaching up to 360 participants. This variance provided a breadth of information about intervention efficacy on multiple outcomes. Primary outcomes that were dominant across studies included measurements of PTSD symptoms, internalising, externalising, behavioural problems, self-perception, depression, anxiety, sexualised behaviour and global functionality. Many studies tested intervention efficacy through pre-post treatment testing of these outcomes, as well as comparative treatments for the same outcomes. Results were interpreted through the calculation of effect sizes, cited in columns five and seven of Table 4 below. Some studies included post-test treatment results, with follow-ups ranging from one month to 72 months (see Table 4). Broadly speaking, most of the programs and services tested showed improvement in at least one outcome area. Larger effects were seen with less-controlled studies (that is, those that did not use a control condition). There was also some evidence that modality and approach impacted outcomes; however, the extent to which these affected outcomes differed depending on whether the service was being delivered to an adult or a child.

Table 4. Outcomes of included studies by age (adults; children and adolescents), modality and methodological quality

Review	No. of incl. studies	No. of studies included	Primary outcome investigated	Effect sizes primary outcome [standardised mean difference/odds ratio] (Confidence intervals) – significant results in bold	Secondary outcomes investigated (if any)	Effect sizes secondary outcomes or subgroupings (Confidence intervals) – significant results in bold	What is the length of follow-ups for outcomes? (Confidence intervals) significant results in bold	AMSTAR coding
ADULTS								
Psychotherapy/CBT – individual and group therapy included in review								
Peleikis et al. 2005 SR 'A systematic review of empirical studies of psychotherapy with women who were sexually abused as children'	24	Mean sample size: n=45.29 Smallest: n=12 Largest: n=102	Determine outcomes of psychotherapy with women who had been victims of child sexual abuse Primary outcome measures: • Depression • Anxiety • Global Severity Index (GSI) • Self-esteem • Trauma symptoms	Mean effect size for controlled studies **SMD = 0.63 (0.54–0.72)** Depression **SMD = 0.69 (0.53–0.84)** Anxiety **SMD = 0.51 (0.28–0.74)** GSI **SMD = 0.72 (0.47–0.98)** Trauma **SMD = 0.44 (0.25–0.64)** Self-esteem **SMD = 0.75 (0.55–0.94)**	No information provided	No information provided	Follow-up effect sizes recorded (per study) in relation to post-treatment: <u>Study 1 (6 months post) – Interpersonal:</u> Depression: SMD = 0.07 Anxiety: SMD = -0.18 GSI: SMD = -0.35 <u>Process:</u> Depression: SMD = 0.02 Anxiety: SMD = 0.12 GSI: SMD = 0.11 <u>Study 2 (12 months post)</u> GSI: SMD = 0.4 <u>Study 3 (3 months post)</u> Depression: SMD = 0.09 Self-esteem: SMD = 0.04 Trauma: SMD = 0.06 <u>Study 4 (9 months post)</u> GSI: SMD = 0.09 Trauma: SMD = 0.14 <u>Study 5 (6 months post)</u> Depression: SMD = 0.08 Trauma: SMD = 0.00	High 9 green 2 red

							Study 6 (6 months post) Depression: SMD = 0.05 Study 7 (6 months post) Depression: SMD = 0.12 Self-esteem: SMD = 0.02 Trauma: SMD = 0.28 Study 8 (7 months post) – Safety Depression: SMD = 0.14 Anxiety: SMD = 0.28 GSI: SMD = 0.07 TAU Depression: SMD = 0.09 Anxiety: SMD = 0.14 GSI: SMD = 0.14 Study 9 (60 months post) GSI: SMD = 0.21	
Ehring et al. 2014 MA 'Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse'	16	Mean sample size: n=76.56 Smallest: n=45 Largest: n=253	Efficacy of psychological interventions for PTSD in adult survivors of childhood abuse Aggregated and associated symptoms: • Depression • Anxiety • Dissociation	Aggregated effect sizes Aggregated uncontrolled effect size (pre-treatment vs. post-treatment): **SMD = 1.24 (0.21–0.56)** Aggregated controlled effect sizes (post-treatment, comparison to wait-list control): **SMD = 0.72 (0.33–1.11)** Aggregated controlled effect sizes (post-treatment, comparison to TAU/placebo control conditions): SMD = 0.50 (-0.11–1.12)	Trauma-focused (TF) interventions vs. non-trauma-focused (non-TF) interventions Individual sessions vs. group treatments	TF interventions vs. non-TF interventions – controlled effect sizes (post) Active treatments vs. any control condition TF: **SMD = 0.92 (0.49–1.36)** Non-TF: SMD = 0.23 (-0.15–0.62)	(Uncontrolled effect sizes) Pre vs. follow-up (< 6 months) TF-CBT: **SMD = 1.86 (1.58–2.15**) Non-TF-CBT: **SMD = 1.11 (0.54–1.67)** EMDR: **SMD = 1.82 (1.17–2.47)** Other: **SMD = 1.24 (0.77–1.71)** Control conditions Wait-list/no contact: SMD = 0.57 (-0.27–1.41) TAU/placebo: **SMD = 0.77 (0.25–1.29)**	8 green 3 red

				<u>Controlled effect sizes (post)</u> – <u>depression</u> Active treatments vs. wait-list/no contact control conditions: **SMD = 1.08 (0.70–1.45)** Active treatments vs. TAU/placebo control conditions: **SMD = 1.29 (0.61–1.98)** <u>Controlled effect sizes (post) – anxiety</u> Active treatment vs. wait-list/no contact control conditions: **SMD = 1.08 (0.63–1.54)** Active treatments vs. TAU/placebo control conditions: **SMD = 0.66 (0.14–1.17)** <u>Controlled effect sizes (post) – dissociation</u> Active treatment vs. wait-list/no contact control conditions: **SMD = 1.05 (0.62–1.48)** Active treatment vs. TAU/placebo control conditions: **SMD = 0.67 (0.10–1.24)** <u>Pre vs. post: all active treatments</u> TF-CBT: **SMD = 1.34 (1.10–1.58**) Non-TF-CBT: **SMD = 0.82 (0.51–1.13)** EMDR: **SMD = 1.53 (1.20–1.86)** Other:		Active treatments vs. wait-list/no contact control TF: **SMD = 0.84 (0.45–1.23)** Non-TF: SMD = 0.61 (-0.05–1.27) Active treatment vs. TAU/placebo TF: **SMD = 1.05 (0.18–1.92)** Non-TF: SMD = -0.12 (-0.37–0.12) <u>Individual sessions vs. group treatments – controlled effect sizes (post)</u> Active treatments vs. any control condition *Individual or combined: **SMD = 0.86 (0.43–1.30)** *Group:	<u>Pre vs. follow-up 2 (≥ 6 months)</u> TF-CBT: **SMD = 1.70 (1.44–1.97)** Non-TF-CBT: **SMD = 1.11 (0.73–1.48)** EMDR: **SMD = 2.00 (1.24–2.75)** Other: **SMD = 1.49 (1.05–1.93)** <u>Control conditions</u> Wait-list/no contact: SMD = 0.11 (-0.21–0.42) TAU/placebo: **SMD = 0.66 (0.27–1.05)**	

				SMD = 1.46 (0.14–1.78) <u>Control conditions</u> Wait-list/no contact: **SMD = 0.38 (0.21–0.56)** TAU/placebo: **SMD = 0.53 (0.23–0.84)**		SMD = 0.20 (-0.19–0.59) Active treatments vs. wait-list/no contact control *Individual or combined: **SMD = 0.97 (0.67–1.27)** *Group: SMD = 0.46 (-0.16–1.08) Active treatments vs. TAU/placebo *Individual or combined: SMD = 0.80 (-0.02–1.62) *Group: SMD = 0.14 (-0.51–0.23)		
Taylor et al. 2010 MA 'A meta-analysis of the effects of psychotherapy with adults sexually abused in childhood'	44	Mean sample size: n=43.44 Smallest: n=3 Largest: n=198	Measuring treatment outcomes for different types of psychotherape-utic approaches for adults sexually abused as children	[Independent samples studies = IS; repeated measures studies = RM] PTSD/trauma symptoms: **SMD = 0.77 (0.50–1.04) (IS)** **SMD = 0.72** (**0.55–0.89 (RM)** Internalising symptoms **SMD = 0.72 (0.44–1.01) (IS)** **SMD = 0.68** (**0.55–0.81) (RM)**	No information provided	No information provided	Follow-up data collected: <u>Follow-up at 1–3 months:</u> PTSD/trauma symptoms: **SMD = 0.77 (0.38–1.18) (IS)** **SMD = 1.18** (**0.73–1.62) (RM)** Internalising symptoms **SMD = 0.85 (0.51–1.20) (IS)** **SMD = 1.04** (**0.83–1.25) (RM)** Externalising symptoms:	6 green 5 red

			Outcomes measured: • PTSD/trauma symptoms • Internalising symptoms • Externalising symptoms • Self-esteem • Global functioning or symptoms	Externalising symptoms: **SMD = 0.53 (0.11–0.95) (IS)** **SMD = 0.41 (0.23–0.59) (RM)** Interpersonal functioning: SMD = 0.05 (-0.20–0.30) (IS) **SMD = 0.61 (0.35–0.87) (RM)** Self-concept/self-esteem: **SMD = 0.56 (0.12–1.00) (IS)** **SMD = 0.58 (0.38–0.78) (RM)** Global functioning or symptoms: **SMD = 0.57 (0.23–0.91) (IS)** **SMD = 0.60 (0.38–0.82) (RM)**			**SMD = 0.54 (0.21–0.88) (IS)** **SMD = 0.35 (0.09–0.61) (RM)** Interpersonal functioning: **SMD = 0.50 (0.01–0.98) (IS)** **SMD = 0.83 (0.22–1.43) (RM)** Self-concept/self-esteem: **SMD = 1.88 (0.45–3.31) (RM)** Global functioning or symptoms: **SMD = 0.33 (0.03–0.64) (IS)** **SMD = 0.89 (0.48–1.31) (RM)** <u>Follow-up at 4–6 months</u> PTSD/trauma symptoms: **SMD = 0.98 (0.50–1.47) (IS)** **SMD = 0.82 (0.51–1.14) (RM)** Internalising symptoms **SMD = 0.80 (0.33–1.28) (IS)** **SMD = 0.76 (0.55–0.97) (RM)** Externalising symptoms: SMD = 0.40 (-0.07–0.86) (IS) Interpersonal functioning: SMD = 0.27 (-0.07–0.60) (RM) Self-concept/self-esteem: **SMD = 0.57 (0.25–0.88) (RM)** Global functioning or symptoms: SMD = 0.22 (-0.24–0.68) (IS) **SMD = 0.78 (0.57–0.87) (RM)** <u>Follow-up at 6 months or more</u> PTSD/trauma symptoms: **SMD = 1.04 (0.48–1.59) (IS)** **SMD = 1.09 (0.58–1.59) (RM)**	

							Internalising symptoms **SMD = 1.08 (0.50–1.65) (IS)** **SMD = 0.94 (0.62–1.26) (RM)** Externalising symptoms: SMD = 0.24 (-0.38–0.86) (RM) Interpersonal functioning: **SMD = 0.96 (0.29–1.62) (IS)** **SMD = 0.52 (0.08–0.95) (RM)** Self-concept/self-esteem: **SMD = 0.55 (0.12–0.98) (RM)** Global functioning or symptoms: **SMD = 2.14 (1.35–2.93) (IS)** **SMD = 0.74 (0.47–1.00) (RM)**	
Martsolf et al. 2005 SR 'Psychotherapy approaches for adult survivors of childhood sexual abuse: An integrative review of outcomes research'	10	Mean sample size: n=35.5 Smallest: n=7 Largest: n=95	Efficacy of abuse-focused psychotherapy techniques for survivors of child sexual abuse	Short-term group studies (n=6) SMD = 0.79 (no confidence interval data) Long-term group study (n=1) SMD = 0.66 (no CI data) Pre-post treatment changes to Beck Depression Inventory: SMD = 0.92 (no CI data) Pre-post treatment changes on Symptom Checklist (psychological problems) 90-R SMD = 0.80 (no CI data)	No information provided	No information provided	No information provided	2 green 9 red
Adults – group therapy								
Sloan et al. 2013 MA	16	Mean sample size: n=105.31	Efficacy of group treatment for PTSD symptoms	Group treatment pre-post: reduction in PTSD symptom severity **SMD = 0.71 (0.51–0.91)**	Calculating within-group and between-	Within-group effect size **SMD = 0.71 (0.51–0.91)**	No information provided	8 green 3 red

Adult outcomes

The effectiveness of CBT

The majority of high-quality original studies, and therefore existing syntheses, have involved the evaluation of CBT. The outlined systematic search for articles returned five systematic reviews (*Peleikis 2005, Ehring 2014, Taylor 2010, Martsolf 2005, Sloan 2013*) that examined the efficacy of interventions that use a CBT approach to treat adult survivors of sexual abuse. Reviews were rank-ordered within this question based on two elements of quality: (1) the primary study design used in the review and (2) the AMSTAR assessment. Four reviews (*Peleikis 2005, Ehring 2014, Taylor 2010, Martsolf 2005*) examined the efficacy of psychotherapy or psychological treatments for adults who had been sexually abused in childhood, with all studies containing CBT treatment within multi-modal interventions. One study (*Sloan 2013*) reviewed the efficacy of group treatment for PTSD symptoms[3], with CBT included as a therapeutic approach. Additionally, *Ehring 2014, Martsolf 2005* and *Sloan 2013* all used trauma-focused CBT (TF-CBT) and non-trauma-focused CBT (non-TF-CBT) within the evaluation of CBT efficacy.

All studies demonstrated general psychotherapeutic treatment efficacy of CBT in the treatment of child sexual abuse or PTSD-related outcomes, including mixed-modal treatments. Medium-sized post-treatment gains were demonstrated in *Peleikis 2005* (SMD = 0.63), *Ehring 2014* (SMD = 0.72) and *Sloan 2013* (SMD = 0.71), which are all considered to be high-quality studies. Improvements in child sexual abuse and PTSD symptoms were also demonstrated in *Taylor 2010* and *Martsolf 2005* (medium- and lower-quality studies, respectively).

Ehring 2014 found that psychological interventions that include both TF-CBT and non-TF-CBT were effective in reducing adult PTSD symptoms (particularly for PTSD symptom severity, depression, anxiety and dissociation), although it did not report on CBT versus non-CBT results. The study did, however, demonstrate that TF-CBT had significantly higher effect sizes than non-TF-CBT (active treatment versus control conditions: TF-CBT SMD = 0.92; non-TF-CBT SMD = 0.23). Both TF-CBT and non-TF-CBT maintained treatment gains more than six months after treatment ([pre-post] TF-CBT SMD = 1.70; non-TF-CBT SMD = 1.11).

Taylor 2010 found that psychotherapeutic approaches to treatment (CBT included) were effective in addressing the psychological effects of child sexual abuse. CBT produced very large effects for internalising symptoms (SMD = 1.84), well in excess of other therapy types (insight-oriented SMD = 0.44; eclectic SMD = 0.9). It also produced large effects for self-esteem (SMD = 1.17). *Taylor 2010* found post-treatment improvements in controlled groups persisted universally at the 1–3 month follow-up. It also noted improvements in some treatment outcomes at a later follow-up (6 months or more), including PTSD/trauma symptoms (SMD = 1.04), internalising symptoms (SMD = 1.08), interpersonal functioning (SMD = 0.96) and global functioning (SMD = 2.14), with a slight decrease in self-esteem and a larger decrease for externalising behaviour.

[3] It should be noted that this study combined single incident and complex traumas rather than looking at them separately.

Martsolf 2005 found that no particular therapeutic approach was demonstrably superior; however, it noted that abuse-focused psychotherapy was generally beneficial in reducing psychiatric distress, depression and trauma symptoms. *Martsolf 2005* did not report on the efficacy of TF-CBT versus non-TF-CBT and is a low-quality review, so findings should be viewed with caution since they differ from the higher-quality reviews.

Peleikis 2005 and *Sloan 2013* did not comment on the comparative efficacy of theoretical approaches. *Chouliara 2012,* a moderate-quality qualitative synthesis, did not review the efficacy of CBT, but reported on study-participant perceptions of the therapeutic approaches they received. Participants in both the eclectic and EDMR group found benefit in the treatment they received: the eclectic group reported learning new coping strategies but did not feel 'healed' from their trauma, whereas the EMDR group felt a deeper and more profound shift towards trauma resolution.

The effectiveness of group-based approaches

The outlined systematic search for articles returned eight reviews (*Peleikis 2005, Ehring 2014, Taylor 2010, Martsolf 2005, Sloan 2013, de Jong 1996, Chouliara 2012, Havig 2008*) focused on the care of adults who had been victims of sexual abuse as a child or adolescent. Each of these reviews touched on the efficacy of individual or group-based delivery methods in some way. Reviews were rank-ordered within this question based on two elements of quality: (1) the primary study design used in the review and (2) the AMSTAR assessment. The systematic reviews that covered group versus individual care contained studies that tested the singular efficacy of individual therapy, group therapy, and blended or multi-modal therapy. Four reviews used a mixture of group and individual interventions (*Peleikis 2005, Ehring 2014, Taylor 2010, Martsolf 2005*); two specifically reviewed the efficacy of group therapy (*Sloan 2013, de Jong 1996*); and two used a qualitative approach to explore service experiences (including some related to group and individual care) of adult survivors of child sexual abuse (*Chouliara 2012, Havig 2008*). All six quantitative articles demonstrated the efficacy of individual psychotherapeutic treatment for adult survivors of child sexual abuse, particularly in relation to common child sexual abuse or PTSD symptomatology. The four articles that included mixed therapy modes primarily reviewed the efficacy of psychotherapy or psychological treatments.

Three of these articles presented integrative results of individual, group and mixed-modal therapy to demonstrate efficacy (*Peleikis 2014, Taylor 2010, Martsolf 2005*), while *Ehring 2014* also investigated the comparative efficacy of individual versus group therapy as a secondary outcome. *Ehring 2014* (considered a high-quality study) found that the largest effect sizes were identified in treatment outcomes from 'individual/combined therapy' (including group therapy), with consistently higher effect sizes than group therapy only (SMD for active treatment versus any control condition = 0.86 for individual/combination; SMD for group versus control condition = 0.20). However, it is important to note that group therapy was still found to be moderately effective in comparison to no treatment (pre-post uncontrolled effect size = 0.78). Controlled effect sizes in *Ehring 2014* demonstrated consistent gains in outcome measures of depression, anxiety and dissociation as a result of psychological treatments. Post-treatment improvement in symptomatology was also found in *Peleikis 2014* (high quality) and *Taylor 2010* (medium quality). *Taylor 2010* also found gains in the categories of trauma or PTSD, self-esteem, global symptoms, internalising and

externalising symptoms, and interpersonal functioning. Where follow-up data post treatment completion was present, gains tended to be maintained.

Sloan 2013 and *de Jong 1996* specifically reviewed studies that used group-based therapy, with *Sloan 2013* also capturing comparative data from individual treatment as active control condition. *Sloan 2013* (considered high quality) found no significant findings to demonstrate greater efficacy of group therapy relative to active treatment comparisons. However, similarly to *Ehring 2014,* it did find that group therapy still demonstrated moderate efficacy for pre-post reduction in PTSD symptoms (SMD = 0.71). *De Jong 1996* compared short-term group therapy to long-term approaches, finding no empirical evidence to suggest differential efficacy, though again suggesting general effectiveness (SMD = 0.79 for a majority of short-term studies) and particular improvements in adult female affect management and self-esteem.

These latter findings from *de Jong 1996* should be cautiously viewed, since the review has some methodological issues and is ranked last on the AMSTAR assessment of quality. In addition, while *Sloan 2013* demonstrated statistically significant reductions in PTSD symptoms when measuring pre-post treatment, as well as in controlled comparisons, the study included mixed-trauma samples (such as motor vehicle accidents and combat), but examined child sexual abuse–related trauma separately. Overall effects decreased for child sexual abuse (and combat) trauma samples, with the trauma type moderating the between-treatment effects on PTSD (SMD = 0.13 for the child sexual abuse sample versus 0.40 for mixed/other trauma samples). In other words, treatment gains were made for both groups, but gains were higher for those who were not seeking treatment for child sexual abuse. This indicates that the trauma of child sexual abuse may differ from other forms of trauma in ways that affect outcomes.

Sloan 2013 found that group treatment for PTSD did not have any unique benefits beyond the general benefits of group therapy. *Taylor 2010* suggested that such unique benefits potentially exist, such as participants' perceived benefit of the group and the benefit of increased social contact, but noted that they are not captured or reported on. Some of these conjectures were, perhaps, articulated in *Chouliara 2012*, a review that examined child sexual abuse survivors' perspectives on services (although the services they received were not necessarily for sexual abuse). Survivors identified different benefits from different therapeutic approaches, with each potentially contributing to different outcomes or stages in the recovery process. This speaks to participant circumstances as a potential moderator in both individual and group interventions, but this has not been measured in any of the included quantitative reviews.

Differences in treatment outcomes for men and women

The outlined systematic search for reviews returned one systematic review that primarily examined gender-specific sample groups in order to evaluate psychotherapeutic efficacy without moderating for differences in gender. *Peleikis 2005* evaluated psychotherapeutic outcomes for adult women who had been sexually abused as children. It did not review comparative data for women and men. No reviews examined study samples made up only of adult men, and no studies primarily reviewed comparative treatment outcomes for men and women. A number of studies did, however, mention gender as a moderator for

treatment outcomes, including one quantitative study (*Sloan 2013*) and two qualitative studies (*Havig 2008, Chouliara 2012*).

Peleikis 2005 (considered a high-quality study) found moderate psychotherapeutic treatment efficacy for adult female survivors of child sexual abuse (overall SMD = 0.63). These outcomes are measured by an improvement in the typical symptoms of child sexual abuse, including depression (SMD = 0.69), anxiety (SMD = 0.51), Global Severity Index (SMD = 0.72), trauma (SMD = 0.44) and self-esteem (SMD = 0.75). Post-treatment effect size results were mixed on follow-up (ranging from 3–72 months), including for depression (SMD = -0.09–0.14), anxiety (SMD = -0.18–0.28), Global Severity Index (SMD = -0.35–0.11), self-esteem (SMD = 0.02–0.04) and trauma (SMD = 0.00–0.28). (No study recorded follow-up data nor was data recorded for all treatment outcomes at follow-up).

Another high-quality study (*Sloan 2013*) reported that gender moderated within-group treatment effects for PTSD symptom severity (though this included mixed-trauma samples that were separately examined for those who had experienced child sexual abuse). The results showed a trend towards larger effects sizes for female-only samples (SMD = 0.89) as compared to mixed gender samples (SMD = 0.77) and male-only samples (SMD = 0.32). *Sloan 2013* concluded that gender is an important moderator of group treatment for PTSD; however, it noted that these findings should be interpreted with caution as the majority of included studies examined female trauma survivors.

Havig 2008, a qualitative review, cited one study (Teram et al., 2006) that focused only on the experiences of male survivors of child sexual abuse. This study described how important it is for healthcare treatment providers to understand existing culturally constructed gender roles, as well as the need for different victimisation dynamics to be recognised for males as opposed to females, in order to better provide for the unique needs of male survivors. *Havig 2008* also noted that the choice of provider gender (and age) could positively enhance the experience of survivors when receiving health care.

Child and adolescent outcomes

The effectiveness of CBT

The outlined systematic search returned nine reviews (*Macdonald 2012, Corcoran 2008, Sánchez-Meca 2011, Kowalik 2011, Passarela 2010, Harvey 2010, Trask 2011, Hetzel-Riggin 2007, Reeker 1997*) that examined the efficacy of interventions that use a CBT approach for child and adolescent victims of child sexual abuse. The study qualities were rank-ordered within this question based on two elements of quality: (1) the study design included in primary studies within reviews and (2) the AMSTAR assessment. The nine systematic reviews contained multi-modal treatments, including individual, group and family CBT therapies, as well as other psychological treatments, including combinations of play and art therapy, abuse-specific therapy, supportive therapy, EMDR, and child and carer therapy. A number of studies (*Sánchez-Meca 2011, Kowalik 2011, Passarela 2010*) reviewed TF-CBT to establish treatment efficacy comparative to other non-trauma-focused interventions, but these studies did not compare TF-CBT with a more standard form of CBT. To establish comparative efficacy, the controlled studies (*Macdonald 2012, Corcoran 2008, Kowalik 2011, Passarela 2010, Harvey 2010, Trask 2011*) and partially controlled studies (*Sánchez-*

Meca 2011) used the following comparison groups: alternative treatment, wait-list control and no treatment.

The highest-quality review (*Macdonald 2012*) directly compared CBT treatment efficacy to control groups, finding large gains in child depression in the intermediate term (3–6 months post treatment; SMD = -1.84), as well as child PTSD and child anxiety, where effect size gains were maintained 'long-term' (at least one year post treatment; SMD = -0.38 and -0.28 respectively). *Macdonald 2012* also reported effect size gains in parental skills and knowledge through involving parents in CBT treatment, including short-term measures of parent's belief of the child's account (SMD = 0.30). It also reported very large effect sizes for short-term measures of parenting skills (SMD = 3.86) and very large effect sizes for 'parent's emotional response in adjusting to abuse disclosure' (SMD = -6.95 in the short term; -4.50 in the long term).[4]

Passarela 2010 and *Kowalik 2011* (high- and lower-quality studies, respectively) also reviewed CBT treatment efficacy in comparison to control groups. In *Passarela 2010*, the main CBT techniques used were coping, psychoeducation, gradual exposure, body safety skills and role-play. CBT was found to be effective in treating PTSD symptoms – more effective than child-centred therapy, wait-list and community care. *Passarela 2010* also reported that providing information to parents and children (such as epidemiological data on child sexual abuse, or information on the consequences of trauma and the role parents can play in helping their children deal with trauma) contributed to a reduction in trauma-related distress. *Kowalik 2011* found small positive CBT treatment effect sizes (total problems SMD = -0.33), particularly in addressing internalising symptoms such as depression and anxiety (SMD = -0.31), and externalising symptoms such as aggression and rule-breaking (SMD = -0.19); however, limited follow-up data is recorded.

Corcoran 2008, Sánchez-Meca 2011, *Harvey 2010, Trask 2011, Hetzel-Riggin 2007 and Reeker 1997* all tested mixed-modal treatment efficacy against PTSD or child sexual abuse–related outcome measures. These studies consistently demonstrated CBT efficacy in treatment. *Corcoran 2008* primarily tested the efficacy of parent-involved therapy; however, the therapeutic approach used across the studies involved CBT, which was associated with positive gains in child sexual abuse–related symptomatology.

Sánchez-Meca 2011 found small to medium-sized treatment group effect sizes for a range of measures (global outcome SMD = 0.63; sexualised behaviours SMD = 0.45; anxiety SMD = 0.53; depression SMD = 0.41; self-esteem SMD = 0.61; and behavioural problems SMD = 0.66).These effect sizes all increased at the follow-up collection of data (median = 21 months), except for behavioural problems, which slightly decreased (SMD = 0.61). *Harvey 2010* found CBT to be a stronger positive moderator of PTSD or trauma outcomes (SMD=1.37) than insight-oriented (SMD=0.35) and eclectic approaches (SMD=0.40). *Trask 2011* found that CBT interventions were more beneficial than comparison treatment approaches, particularly in addressing child sexual abuse–related symptoms (overall SMD = 0.54). Similarly, *Hetzel-Riggin 2007* found CBT most effective in reducing psychological distress (SMD = 1.41).

[4] Please note: these larger effect sizes are based on a very small sample of studies that measured these outcomes.

Harvey 2010, one of the more comprehensive studies in terms of controlling for a range of competing explanatory factors, found that CBT may not be as effective for children with significant and disruptive behavioural problems, such as significant externalising problems and persistent sexualised behaviour. Similarly, *Trask 2011* noted the importance of age as a factor in considering the efficacy of cognitive-based treatments such as CBT, cautioning that older children may be more responsive to CBT because of their better-developed cognitive capacity. Unfortunately, the reviews included were unable to shed much more light on treatment efficacy by age of the child.

In summary, CBT, and particularly TF-CBT, appears to be the strongest type of treatment across multiple outcomes. However, there may be benefits to providing a mix of approaches, most likely including both CBT and a trauma focus. More information is needed to determine the age at which CBT begins to offer a substantial benefit.

The effectiveness of group-based approaches

The outlined systematic search returned 10 reviews (*Macdonald 2012, Parker 2013, Corcoran 2008, Sánchez-Meca 2011, Kowalik 2011, Passarela 2010, Harvey 2010, Trask 2011, Hetzel-Riggin 2007, Reeker 1997*) that focused on the care of children and adolescents who had been victims of sexual abuse. Reviews were rank-ordered within this question based on two elements of quality: (1) the primary study design used in the review and (2) the AMSTAR assessment. The systematic reviews that covered group versus individual care contained studies that tested the singular efficacy of individual therapy, group therapy, and blended or multi-modal therapy (including family or parent-involved therapy, which will be discussed separately). Although high in quality, *Parker 2013* was an 'empty review' (that is, no studies were found that met the review's rigorous inclusion criteria, indicating that there is a dearth of evidence for this type of treatment). Eight reviews used a mixture of group, individual, and family or parent-involved therapy, with four providing no comparative data on group versus individual delivery (*Macdonald 2012, Corcoran 2008, Sánchez-Meca 2011, Kowalik 2011*) and another four comparing treatment efficacy between group and individual therapies as a secondary outcome (*Passarela 2010, Harvey 2010, Trask 2011, Hetzel-Riggin 2007*). One article (*Reeker 1997*) specifically reviewed the efficacy of group therapy for this population group.

All 10 quantitative studies demonstrated overall efficacy for tested interventions. That is, regardless of the group or individual modality, a positive treatment effect was observed across a number of outcomes. The primary studies in the reviews commonly used CBT; psychosocial, psychological and psychotherapeutic treatments; and treatment elements such as play therapy, supportive counselling and family-involved therapy. For instance, *Harvey 2010* (a comprehensive, moderate-quality AMSTAR review) found generally large effect size gains in all outcomes against a control group (PTSD SMD = 0.77; internalising SMD = 0.8; externalising SMD = 1.39; self-concept SMD = 1.15; social skills SMD = 1.07; global outcome SMD = 0.99), with overall effect sizes decreasing at the 1–3 month follow-up, then increasing at both 4–6 months and more than 6 months post treatment. Similarly, *Trask 2011* showed pre-post effect gains for overall effect (SMD = 0.54), as well as for externalising (SMD = 0.47) and internalising (SMD = 0.50) behaviours.

Passarela 2010, a high-quality review examining differences between individual and group therapy, found no evidence of large differences between the two modalities when

considering other factors. The two moderate-quality reviews that directly compared the effect of individual and group modalities (*Trask 2011, Harvey 2010*) had similar findings for most outcomes, but also found that individual therapy was generally more effective than group care in improving trauma-related symptoms. *Harvey 2010* found that family-based (SMD = 2.11) and individual (SMD = 1.31) approaches had greater effectiveness than group therapy (SMD = 0.89). *Reeker 1997* had similar findings, but is ranked lower in terms of quality.

In contrast, *Hetzel-Riggin 2007* found that different treatment modalities were effective in targeting specific outcomes. It concluded that group therapy (along with abuse-specific and CBT approaches) was most effective for low self-concept, while supportive therapy (along with abuse-specific therapy and CBT) delivered in either group or individual settings was most effective for behavioural problems. However, *Hetzel-Riggin 2007* did not rank as well as *Trask 2011* and *Harvey 2010* on the AMSTAR scale; therefore, this more detailed finding needs to be interpreted with caution.

Differences in treatment outcomes for girls and boys

The outlined systematic search for articles returned no reviews that primarily reviewed differences in treatment outcomes for boys versus girls, and no studies reviewed gendered therapy or gender-specific group samples. Some reviews did, however, mention gender as a moderator for treatment outcomes, and recommended more gender-specific studies be undertaken in future research. Six reviews discussed the impact of gender in child and adolescent sexual abuse interventions: *Passarela 2010, Trask 2011, Sánchez-Meca 2011, Hetzel-Riggin 2007, Harvey 2010* and *Reeker 1997.* Reviews were rank-ordered within this question based on two elements of quality: (1) the primary study design used in the review and (2) the AMSTAR assessment. Several reviews cited poor or inaccurate recording of gender in study samples as a limitation of treatment efficacy tests.

Reeker 1997 (considered a lower-quality study) reviewed the efficacy of group therapy for child and adolescent survivors of child sexual abuse. It suggested that the gender composition of the group potentially affected the efficacy of treatment outcomes. However, no significant differences were found in overall study effect sizes based on sample gender composition (which may be due to the small number of studies included in the review, limiting the power to detect differences if they existed). Non-significant mean effect sizes were larger for girls than boys (girls SMD = 0.96; boys SMD = 0.30; mixed SMD = 0.63). This was also the case for *Hetzel-Riggin 2007*, with larger non-significant effect sizes found in samples composed of girls only (girls only SMD = 0.96; boys only SMD = 0.30). *Sánchez-Meca 2011* found similar non-significant results in the same direction (girls only SMD = 0.79; boys only SMD = 0.57). *Trask 2011* (considered a moderate-quality study) likewise found that there were no significant moderating effects for gender, but noted that the direction of the effect favoured larger effect sizes for studies with a larger raw proportion of boys in the sample. *Harvey 2010*, one of the few studies using meta-regression to ascertain the individual contribution of gender, found that gender was not a clear moderating factor in treatment outcomes (that is, boys did not consistently do better than girls and vice versa). Since all of these tests within reviews were conducted on small subsamples of studies with a potential lack of power, tests of significance may have been compromised.

The effectiveness of parent-mediated and family-mediated outcomes

The outlined systematic search returned seven reviews (*Macdonald* 2012*, Corcoran 2008, Kowalik 2011, Passarela 2010, Harvey 2010, Trask 2011, Hetzel-Riggin 2007*) that included parent or family-involved therapy in their treatment samples. Reviews were rank-ordered within this question based on two elements of quality: (1) the primary study design used in the review and (2) the AMSTAR assessment. One study (*Corcoran 2008*) specifically reviewed parent-involved treatment for child sexual abuse (in comparison to control groups). The other seven studies reviewed the efficacy of various psychological treatments for the symptomatology of this population group (*Macdonald 2012, Kowalik 2011, Passarela 2010, Harvey 2010, Trask 2011, Hetzel-Riggin 2007*), with parent or family-involved treatment included in the mixed-modal treatment outcomes (often alongside child-only treatment).

Corcoran 2008 is a high-quality review that specifically examined the effects of parent-involved treatment (versus control groups of TAU, individual supportive therapy, community control and wait-list control) in four major child sexual abuse symptom areas. The effect sizes found post treatment for parent-involved treatment versus control groups were small but positive (that is, favouring parent-involved treatment), including for internalising (SMD = 0.4) and externalising (SMD = 0.32) behaviours, sexualised behaviour (SMD = 0.31) and PTSD (SMD = 0.37). These gains decreased at the first recording of follow-up for studies collecting such data, ranging from 12 weeks to one year post treatment. *Corcoran 2008* concluded that parent-involved treatment for child sexual abuse victims demonstrates small effects on child adjustment over various types of comparison conditions, with the largest effects found in improvements in internalising behaviour and PTSD-related outcomes; however, these outcomes diminished upon follow-up. (*Corcoran 2008* cited the small number of studies with follow-up data as a reason for interpreting this finding with caution).

Harvey 2010, a medium-quality comprehensive review, examined within-group effects. It found that family involvement in therapy (that is, non-offending caregivers) was associated with positive outcomes, particularly for trauma-related symptoms. Incorporating family involvement in treatment resulted in better PTSD and trauma outcomes than those in which family was not involved, producing a large effect size (SMD = 2.11) in comparison with individual (SMD = 1.31), group (SMD = 0.89) and mixed treatments (SMD = 0.49). Positive effect sizes were also reported for ‘some use of family’ (SMD = 1.44) compared with ‘no use of family’ (SMD = 0.67). Family-involved therapy produced comparatively larger effect sizes (SMD = 0.60) for improvements in externalising behaviour problems than individual and group treatments, though mixed-modality treatments produced the largest effect sizes (SMD = 1.06). Family-involved therapy (SMD = 0.40) was reported to be less effective than ‘no use of family’ (SMD = 0.72) for outcomes related to sexualised behaviour problems. Similarly, family-involved therapy was less effective in improving social skills and competencies than no use of family in treatment (SMD = 0.22 versus 0.67).

Macdonald 2012, Kowalik 2011, Passarela 2010, Trask 2011 and *Hetzel-Riggin 2007* also used parent-involved or family-involved interventions. However, their lack of comparative data between parent- or family-involved therapy and child-only therapy is a large limitation. *Trask 2011* (considered a medium-quality study) reported that, contrary to *Harvey 2010,* the inclusion of a caregiver in the moderator analyses had no effect in single-group pre-

test/post-test analyses. Rather, it was associated with lower treatment efficacy in between-group analyses. However, this may be due to the type of control groups used – the majority of child-only treatments were measured against no-treatment comparison groups, whereas the majority of parent-involved treatments were measured against attention placebo control groups. The comparison of child-only CBT and family CBT (which involves including parents or caregivers in treatment with the child) in *Passarela 2010* – a high-quality study – did not reveal any significant differences in efficacy.

In summary, there is some evidence to suggest that family involvement improves outcomes, but the effect may be small for most outcomes. There may be large effects for improving PTSD-related outcomes that are independent of approach and other delivery issues, but the evidence for this benefit is tentative.

Implementation and delivery of programs and services (fidelity/duration/dosage)

Implementation – the process of integrating evidence systematically into human service practice – has received growing attention as a central factor in achieving high-quality service delivery and subsequent outcomes (Joyce and Showers, 2002; Durlak and DuPre, 2008; Lipsey, 2010; Powell et al., 2014). The quality of implementation can be assessed on the basis of at least eight implementation outcomes: the acceptability of an intervention; its uptake; its appropriateness within a given practice context; its costs; its feasibility; the degree to which it is implemented with fidelity; its degree of spread and penetration; and its sustainability (Proctor et al., 2011). Fidelity – the degree to which a program has been implemented as intended by its developers – is one of the most commonly used measures of implementation quality and would normally be the primary measure of implementation for a review of evidence. This is based on the assumption that consumers cannot benefit from services they do not receive (Browne, Puente-Duran, Shlonsky, Thabane and Verticchio, 2014; Mildon and Shlonsky, 2014). In the context of this review of reviews, implementation can only be described at a fairly high level. This is because each included systematic review or meta-analysis is already a synthesis of evidence from a large number of individual studies that vary widely in terms of how they are delivered, who delivers them and for how long. Unless the individual studies consistently report fidelity and the review author synthesises this information, it will not be present in the included reviews.

Indeed, this is the case for all studies in this review. Fidelity is only mentioned in *Kowalik 2011* and *Martsolf 2005*, which both indicate, in their discussion sections (not results), that fidelity and other more detailed information about what people received and how they received it could have substantially affected their findings. In the absence of such information, this section of the evidence review will focus on reviews that contain information about dosage, duration and format that is not covered by other sections (such as group versus individual; parent-mediated versus individual). Information about dosage and format, similar to the rest of the review, comes from reviews that employ two types of studies: between-group comparisons (controlled studies) and within-group comparisons (mean change for single groups pre-post). While the former provide information about a specifically defined set of interventions, the latter attempt to identify the unique contribution of each factor towards specific outcomes.

As with other results sections, reviews were rank-ordered within this question based on two elements of quality: 1) the primary study design used in the review and 2) the AMSTAR assessment. While various interventions are listed, detailed intervention data is, at times, lacking across included studies. Many articles listed the intervention used without providing any further description or definition. Commonly used interventions included variations of both TF-CBT and non-TF-CBT, including coping, psychoeducation, exposure, body safety skills, role-play, cognitive reframing, positive imagery, relaxation, parent management training and EDMR. Intervention dosage and format also varied, and included short- and long-term sessions in both individual and group settings. A number of articles stipulated that treatment was manualised, as well as being semi-structured or unstructured. Four articles noted attrition rates.

Adult survivors

For adults receiving a specific, known treatment described in an included review (*Peleikis 2005; Ehring 2014, Taylor 2010*), the number of sessions ranged from a low of eight to a high of 25 (*Ehring 2014*), while the overall duration of treatment ranged from less than 10 weeks to more than 20 weeks (*Taylor 2010*). *Taylor 2010* reported that sessions lasted anywhere from 50 to 120 minutes, with most being conducted weekly; however, about one-third of primary studies reported that interventions were conducted 2–3 times per week. Outcomes related to the frequency and duration of treatment were assessed in detail only by *Taylor 2010*, a moderate-quality study, with the information largely obtained from using single group, pre-post mean change scores (within-group comparisons) as part of a meta-regression (meta-analysis version of multivariate regression). *Taylor 2010* found that PTSD symptoms were best addressed when (a) there were more than 10 sessions, (b) the overall duration of treatment lasted from 10–20 weeks, (c) sessions were conducted twice per week and (d) sessions each lasted 50–60 minutes. Similarly, improvements in global functioning were seen when the overall treatment duration was 10–20 weeks and the number of sessions was greater than 10. *Taylor 2010* did not find clear and consistent differences across outcomes with respect to the type of provider (that is, psychologists, social workers and counsellors, psychiatrists and medical practitioners).

There were, however, differences in the way the various programs were delivered. Three studies (*Peleikis 2005*, *Ehring 2014*, *Taylor 2010*) reported on the use of treatment manuals (an indicator of fidelity), finding that a fairly large proportion of interventions tested used a manualised or at least a semi-structured approach. Only one study (*Taylor 2010*) measured the effect of using manuals on outcomes, finding that instructional therapy tended to be associated with larger treatment effects across outcomes as compared with self-directed and, to some extent, dialogue-based approaches.

Child and adolescent victims

For child and adolescent victims receiving a specific, known treatment described in an included review (*Macdonald 2012*, *Corcoran 2008*, *Passarela 2010*, *Harvey 2010*), the number of sessions ranged from a low of six (*Macdonald 2012*) to a high of 24 (*Harvey 2010*), while the duration of treatment, where reported, tended to last more than 20 weeks (*Harvey 2010*). *Harvey 2010* contained the greatest amount of detail about treatment delivery and associated characteristics. It reported that individual sessions were evenly split in terms of session length (n=3 lasting less than 60 minutes; n=4 lasting more than 60 minutes), and all sessions were conducted weekly.

Outcomes related to the frequency and duration of treatment were assessed in detail only by *Harvey 2010*, a moderate-quality study, with the information largely obtained from using single group, pre-post mean change scores (within-group comparisons) as part of a meta-regression (meta-analysis version of multivariate regression). *Harvey 2010* found that PTSD symptoms were best addressed when (a) there were more than 10 sessions, (b) the overall duration of treatment lasted more than 10 weeks and (c) the sessions lasted less than 60 minutes. Similarly, improvements in internalising and externalising symptoms were seen with sessions that lasted less than one hour, though these outcomes were most improved when participants received therapy for more than 20 weeks. Findings about the optimal length of treatment were mixed across outcomes, indicating that longer sessions may be needed to deal with other issues that weren't measured (such as severity of sexual abuse and other existing issues). Some interesting and tentative findings emerged from the moderator analysis about the use of manuals and the context in which services were delivered, and these differed from the findings for adults.

Manualised approaches tended to better improve outcomes for PTSD symptoms; semi-structured approaches worked best for sexualised behaviour and social skills; and unstructured or semi-structured approaches tended to better improve externalising symptoms. Internalising behaviour problems, global functioning and possibly PTSD symptomology and externalising problems tended to be improved through the use of homework. Interestingly, *Harvey 2010* did not find that the therapist experience or level of involvement translated into better outcomes for children and adolescents (that is, other things mattered a great deal more).

Discussion

This review of reviews used a comprehensive search strategy to locate current best international evidence about the provision of support services for adult survivors and child/adolescent victims of child sexual abuse. We included only systematic reviews and meta-analyses that specifically addressed child sexual abuse and its aftermath, and only those reviews that met a fairly rigorous standard with respect to transparency and replicability of methods. The focus of the review was not limited to individuals who experienced child sexual abuse in institutional contexts. This was due to concerns that insufficient rigorous research has been undertaken on this particular subgroup. As anticipated, this concern was borne out in the evidence review. Beyond brief mentions in the primary studies that comprised the reviews we located (such as some participants in the studies residing or having resided in out-of-home care), this information was not present in the included reviews. While the proportion of children and adults abused in institutional care in these reviews remains speculative, some of the participants in the primary studies doubtlessly experienced abuse in one or more of the institutional settings that fall under the purview of the Royal Commission.

A large amount of solid evidence exists about the treatment of child sexual abuse, and much of this has been synthesised by the included studies in this evidence review. That is, there is strong, rigorous evidence about the effects of specific treatments, delivered in specific ways. While strong evidence exists, a great deal remains unknown, and findings must be both interpreted and acted upon with caution. In summary, this is what the evidence says about the treatment of child sexual abuse from these reviews.

For adult survivors of child sexual abuse:

- CBT approaches have the best evidence of treatment effectiveness for those experiencing trauma-related symptoms and internalising symptoms (such as depression and anxiety), with large and substantial clinical gains clearly evidenced in these areas.
- Individual and mixed modalities appear to perform better than group-based modalities. Group-based modalities also have a positive effect, but treatment gains tend to be smaller.
- Treatment gains tend to be maintained over the short and medium term, though there can be some diminution over time.

For child and adolescent victims of child sexual abuse:

- TF-CBT has the best evidence of treatment effectiveness, with large and substantial reductions in trauma-related symptoms and internalising symptoms (such as depression and anxiety).
- Individual or family-based modalities probably work best.
- Parent-mediated approaches (that is, working with the parent to improve child/adolescent outcomes) appear to offer an additional, small benefit as compared with approaches that do not incorporate the parent in treatment.

- Treatment gains tend to be maintained over the short and medium term, though there can be some diminution over time.

Other important, but less evidenced, findings for adult survivors include the following:

- There are other theoretical approaches that may be effective, such as EMDR and supportive counselling, but these have less evidence to recommend them, and CBT tends to repeatedly outperform most other interventions across a range of commonly tested outcomes, including depression, anxiety, PTSD symptoms, and internalising and externalising problems.
- A trauma-focused approach appears to increase the effect of treatment, though the extent to which this is the case is difficult to gauge when considering other factors such as approach, modality and individual participant characteristics.
- The best results have been observed when there are 10–20 sessions over the course of 10–20 weeks, with each session lasting 50–60 minutes each.

Other important, but less evidenced, findings for child and adolescent victims include the following:

- CBT may not be as effective for children with significant and disruptive behavioural problems, such as significant externalising problems and persistent sexualised behaviour. The strongest findings relate to reductions in PTSD and internalising symptoms.
- Findings about the optimal length of treatment were mixed across outcomes, indicating that other issues that were not measured (such as severity of sexual abuse, living situation, and parental support or skills) may have been at play.
- The therapist experience or level of involvement did not translate into more improved outcomes for children and adolescents. That is, other things mattered far more (such as theoretical orientation).
- No rigorous evidence of effectiveness was found for psychoanalytic and psychodynamic psychotherapeutic approaches. While elements of psychodynamic approaches may be found in various interventions, no controlled (that is, compared to a no-treatment or TAU group) studies of the approach were located as of May 2013 in a high quality systematic review (Parker and Turner, 2013) and no subsequent systematic reviews were identified that tested their effectiveness.

There are also a number of important considerations about which little evidence exists:

- There is very little strong evidence about existing differences in treatment effects by age or gender, nor is there any strong evidence about which treatments appear to work best by age or gender. The same can be said about any other socio-demographic characteristic (such as race or ethnicity, socio-economic status and sexual orientation). Age is a particular concern, given cognitive approaches generally require participants to have a certain level of developmental attainment (though TF-CBT adjusts delivery, and has an age range of 3–18).
- There is very little evidence about the association between offender type, severity and chronicity of abuse, and treatment effectiveness. While this data is routinely collected, it is generally not included in the treatment literature as part of highly controlled primary

studies. Yet these factors may play a substantial role in determining treatment effectiveness, ultimately informing key decisions about the type, timing and quantity of recommended services.

- As mentioned, there is very little high-quality experimental evidence that specifically examines the treatment of children and adolescents in out-of-home care. This is a concern given the finding that parent-mediated approaches may be more effective than other approaches, and the possibly more limited effectiveness of CBT for problem sexual behaviour.

Limitations

These findings are important, but they have limitations.

First, they are based on the existence of systematic reviews and meta-analyses. While it is likely that most rigorously tested programs and services found their way into one of the included reviews, this is not a certainty. There may be a body of rigorous research that has not been properly synthesised.

Second, some of the reviews, and their searches, are a number of years old, and they have not been updated. There could be an influential number of primary studies that are not part of the included reviews; however, a review of primary studies was not viable within the time frame for this project.

Third, systematic reviews and meta-analyses rely on the existence of primary studies, such that the more varied primary studies, the better the analysis. In this case, the data (primary studies) is sufficient to draw an important but small set of conclusions about the types of treatment and delivery methods that have been found to be effective. However, the limited number of studies completed to date makes it impossible to draw firmly evidenced conclusions about the comparative efficacy of competing interventions; the characteristics of clients best suited for specific interventions and modes of delivery; and the effects of severity, frequency and chronicity of abuse.

Moreover, the type of theoretical orientation that overwhelmingly dominates the effectiveness literature, CBT, builds on a rich experimental tradition in behaviourism (that is, testing what is done to what effect). Other approaches might be viable, but they have simply not been rigorously tested.

Fourth, the conclusions drawn from this review of reviews are narrative in nature rather than quantitative. The methods for quantitatively synthesising reviews are in their infancy, and such an approach was beyond the scope of this review. While we have made every effort to maintain transparency and objectivity, the narrative process is inevitably biased.

These findings must be carefully considered, both in terms of what we know and do not know about this body of evidence. Findings can be misconstrued as too certain or dismissed as irrelevant because certain questions remain unanswered. In light of the evidence, a few major points that draw on our understanding of child sexual abuse and the treatment of its consequences can be made.

- Internal versus external validity of findings: The best causal evidence from primary studies is necessarily drawn from randomised controlled and quasi-experimental studies. These studies have high internal validity, meaning that we can be fairly certain that the observed effect of treatment is true *for the population included in the studies*. However, less is known about external validity – the extent to which these findings apply to the larger population of victim/survivors. This is particularly important when differences between people included in the studies differ from people in the larger population *and* these differences have the potential to influence the outcomes being measured. For example, in order to maintain the integrity of the experimental design, participants are often screened for existing co-morbid (co-occurring) conditions that might require different types of treatment, such as borderline personality disorder, psychotic illness, severe depression and suicide risk (Australian Centre for Posttraumatic Mental Health, 2007: p. 62). This does not mean that the findings do not apply to individuals with co-morbid conditions; it simply means that we are not as certain about the extent to which these findings apply to them. This same thinking applies to any differences in people who were systematically or inadvertently excluded from the primary studies. Differences among people and their experience are endless. The primary studies on which this and other reviews are based report average treatment effects for a population. While synthesis provides greater certainty of the average, an individual seeking treatment may experience different results. The important point is that people seeking treatment should be provided with information about what is known about this average, allowing them to make an informed decision about their course of treatment.
- Comparative effectiveness research: Most of the primary studies on which this and other reviews are based only test a single approach (such as CBT or narrative therapy) versus a wait-list control or TAU. Few studies test the effectiveness of competing interventions. There is a broader trend among researchers and funders to conduct more comparative effectiveness research, but this will take time. Some advances in the use of meta-analytic techniques (such as network meta-analysis) and other statistical approaches have been made, but these typically require relatively large number of studies and/or large sample sizes. Some of the studies included in this review (Harvey and Taylor, 2010; Taylor and Harvey, 2010) use reasonably good meta-analytic techniques to examine a number of differences in treatment and population characteristics, but the undertaking is complex and includes designs that have lower internal validity. In short, this review does not adequately compare different treatment approaches for victim/survivors with different characteristics. This is an area that is ripe for ongoing primary research.
- Duration of follow-up: The outcomes measured in the primary studies that make up this review of reviews tend to be short term due to the use of wait-list controls (that is, treatment is delayed for a short period). More research on longer-term outcomes, including the use of 'booster' sessions for shorter-term approaches such as CBT, is needed.
- Outcomes measured: The outcomes measured in the primary studies that make up this review of reviews can be classified into symptom reduction and longer-term recovery (or general wellbeing in light of what has happened). Symptom reduction is more easily defined and measured, while recovery is more subjective. Combined

with the shorter-term nature of most of the existing studies, this means that symptom reduction is more often rigorously evaluated than overall recovery. Both are clearly important outcomes, but less is known about recovery. That said, it would be hard to argue that recovery and symptom reduction are not related. That is, an individual will likely have a greater sense of recovery if symptoms are at least partially abated. Victim/survivors seeking treatment should be made aware of treatments that can potentially decrease symptoms, and future research should focus on approaches that maximise both symptom reduction and recovery in the long term.

- Gender differences: A larger number of female victim/survivors were included in the primary studies in this review of reviews. Given the known, often cross-cultural differences in gender with respect to social norms and values, and how this can play out with victim/survivors of child sexual abuse (for example, males may be less likely to disclose child sexual abuse than females and may also have different help-seeking behaviour), gender adapted treatment may be warranted. This too is an emerging and important area of treatment research.

Implications

Findings from this review indicate that cognitive behavioural approaches should be made widely available to adult survivors, and child and adolescent victims who are experiencing problems stemming from their abuse experience. For adults, these treatments should predominantly be delivered individually. For children and adolescents, parents and/or caregivers should probably be involved, unless there is a good reason not to include them. For both adults, and children and adolescents, a trauma-informed approach appears to bring measurable benefit.

While providers of other types or formats of services may, correctly or otherwise, claim that their services are effective, evidence that supports such claims was not identified in this review. There may be one or more studies showing no effect or even a harmful effect. However, without a high-quality systematic review of evidence, results from individual studies cannot be relied upon. The scientific pathway to developing or adapting different approaches is to develop a strong logic for their use, and to test them using high-quality research methods. When a sufficient number of these tests have been conducted, a systematic review can test whether there is reason to suggest they are effective. Again, there may be very effective services and programs that have not been sufficiently tested, but these cannot be credibly recommended.

Along with the need to use existing evidence is the need to generate more evidence. While CBT has the strongest evidence of effectiveness in terms of service type, there is a large number of important questions that remain unanswered. First, within the CBT approach, far more work needs to be done with respect to generating an understanding of how age, gender, cultural background, life circumstances and other key demographic characteristics interact with the delivery and ultimate effectiveness of treatment. In addition, abuse-specific characteristics, particularly chronicity, need to be better understood, and, if influential in terms of outcomes, responded to within the CBT intervention. Second, innovation in theoretical approach should be welcomed, and even funded, but consumers

of services should be informed about the evidence and allowed to make a personal choice. The choice of service should not be dictated by what is available at an agency or what a provider prefers to deliver. Third, comparative effectiveness research that tests different approaches within CBT and compares CBT to other theoretical approaches is needed. Fourth, the nation's educational institutions, including certificate programs, should require proficiency in behavioural and cognitive behavioural approaches as a core competency. Beyond the treatment of child sexual abuse, these approaches are repeatedly found to have positive treatment effects in evidence reviews. Finally, the studies included in this evidence review rarely detailed important information about the implementation of interventions in the various settings in which they were deployed. Evidence from numerous studies, as indicated in the implementation section of this review, indicates that proper implementation is paramount. One thing is certain: if people do not receive the treatment, they cannot benefit from it.

Client choice is important in another way. The objective of EIP is to infuse evidence into treatment decisions, both on the part of practitioners and the client. That is, client involvement in the process of evidence use is an indispensable part of EIP (Gambrill, 1980, 1999; Gambrill, 2012; Shlonsky, Noonan, Littell and Montgomery, 2011). In its optimal form, treatment decisions are made in a consultative process that links current best evidence, client state and circumstances, and client preferences and values (Gambrill, 1999; Sackett, Straus, Richardson, Rosenberg and Haynes, 2000). For instance, even when there is evidence to suggest that CBT has the strongest evidence of effectiveness, the client may not like the approach, or may have already tried it and it did not work for them. An evidence-informed decision, in such circumstances, might actually involve the selection of a different approach. Involving a client in their own treatment choices is likely to improve their willingness to participate and, ultimately, their outcomes.

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Appendices

Appendix A: full search strategy

Total prior to duplicate removal: 1848 items

(Embase: 402; PsycINFO: 323; SocINDEX: 273; MEDLINE: 242; Criminal Justice Abstracts: 82; Family & Society Studies Worldwide: 79; CINAHL: 69; Sociological Abstracts: 63; PILOTS: 60; ASSIA: 59; Social Services Abstracts: 44; NCJRS: 36; ERIC: 33; IBSS: 14; Cochrane Database of Systematic Reviews/Cochrane Central Register of Controlled Trials: 6; Families & Society Collection: 2; Campbell Collaboration Library: 61)

Total after duplicate removal: 883 items + 61 Campbell Collaboration Library – 944 items

Summary of unique items by type:

- Journal articles: 795
    - English: 764
    - Non-English: 31
- Other items (such as book chapters, theses and reports): 88

Summary of unique items by year of publication:

- 2010–2016: 520
- 2000–2009: 292
- 1990–1999: 65
- Before 1990: 6

Database/host	***Strategy***	***Result***
Applied Social Sciences Index and Abstracts (ASSIA)/ProQuest Date searched: 11 April 2016 ASSIA: Applied Social Sciences Index and Abstracts is a tool covering health, social services, psychology, sociology, economics, politics, race relations and education. Its featured strength is its coverage of both psychology and sociology. Updated monthly.	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND (rape* OR molest* OR (sex* NEAR/2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND (metaanal* OR meta-anal* OR “meta anal*” OR metasynth* OR meta-synth* OR “meta-synth*” OR ((systematic OR realist) NEAR/2 (synthesis OR review*)) OR “synthesis of studies” OR “review of reviews”) in abstract	**59**
Campbell Collaboration Date searched: 11 April 2016	(“sexual abuse” OR rape OR molestation OR “sexually abused” OR “sexual coercion” OR “sexual maltreatment” OR “sexual assault”) in all text	**61**

<table>
<tr><td></td><td>AND
(child OR children OR infant OR adolescent OR teen OR teenage OR peer OR peers) in all text
AND
(metaanalysis OR “meta analysis” OR “systematic review” OR “systematic synthesis” OR “realist review” OR “realist synthesis” OR “synthesis of studies” OR “review of reviews” OR metasynthesis) in all text</td><td></td></tr>
<tr><td>CINAHL/EBSCO

Date searched: 11 April 2016

CINAHL Database provides indexing of nursing and allied health literature, including nursing journals, and a range of publication types, from textbooks to legal cases and clinical trials. Updated weekly.</td><td>((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text
AND
(rape* OR molest* OR (sex* N2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text
AND
(metaanal* OR meta-anal* OR “meta anal*” OR metasynth* OR meta-synth* OR “meta-synth*” OR ((systematic OR realist) N2 (synthesis OR review*)) OR “synthesis of studies” OR “review of reviews”) in abstract</td><td>69</td></tr>
<tr><td>Cochrane/Ovid
(EBM Reviews – Cochrane Central Register of Controlled Trials, February 2016; EBM Reviews – Cochrane Database of Systematic Reviews, 2005 to 7 April 2016)

Date searched: 11 April 2016

One item (Wilen, 2012 – protocol only) was not duplicated in the other databases.</td><td><table>
<tr><th>#</th><th>Searches</th><th>Results</th></tr>
<tr><td>1</td><td>child sexual abuse/</td><td>173</td></tr>
<tr><td>2</td><td>(child abuse/ and (sexual abuse/ or sex offenses/ or rape/)) or pedophilia/</td><td>17</td></tr>
<tr><td>3</td><td>sexual abuse/ or sexual crime/ or rape/ or acquaintance rape/ or sexual assault/ or sexual violence/</td><td>185</td></tr>
<tr><td>4</td><td>3 and (child/ or infant/ or adolescent/)</td><td>92</td></tr>
<tr><td>5</td><td>1 or 2 or 4</td><td>259</td></tr>
<tr><td>6</td><td>(baby or infant or infants or toddler or child* or adolescent or teen* or youth or peer or peers).ti,ab,hw.</td><td>166,841</td></tr>
<tr><td>7</td><td>(rape* or molest* or (sex* adj2 (abus* or coerc* or maltreat* or assault*))).ti,ab,hw.</td><td>851</td></tr>
<tr><td>8</td><td>6 and 7</td><td>499</td></tr>
<tr><td>9</td><td>(metaanal* or meta-anal* or “meta anal*” or ((systematic or realist) adj2 (synthesis or review*)) or “synthesis of studies” or “review of reviews” or metasynth* or meta-synth* or “meta synth*”).ti,ab,hw.</td><td>7,095</td></tr>
<tr><td>10</td><td>8 and 9</td><td>6</td></tr>
</table></td><td>6</td></tr>
</table>

Criminal Justice Abstracts/EBSCO Date searched: 11 April 2016 Criminal Justice Abstracts provides international coverage of the criminal justice field and criminology studies from 1968.	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND (rape* OR molest* OR (sex* N2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND (metaanal* OR meta-anal* OR "meta anal*" OR metasynth* OR meta-synth* OR "meta-synth*" OR ((systematic OR realist) N2 (synthesis OR review*)) OR "synthesis of studies" OR "review of reviews") in abstract	**82**
Embase/Ovid (Embase Classic+Embase, 1947 to 2016 Week 15) Date searched: 11 April 2016 Subject term child sexual abuse added 2003. Sexual abuse added 1978 Newest items: March 2016; oldest items: 1992 A scan of 50 items seemed to indicate that most items were on topic and that the use of subject headings matched what was expected. An English language limit only reduced the set to 386, so was not applied.	**# Searches — Results** 1 child sexual abuse/ — 7,409 2 sexual crime/ or sexual abuse/ or rape/ or acquaintance rape/ or sexual assault/ or sexual violence/ — 26,737 3 limit 2 to (infant or child or preschool child <1 to 6 years> or school child <7 to 12 years> or adolescent <13 to 17 years>) — 7,841 4 1 or 3 — 14,504 5 (baby or infant or infants or toddler or child* or adolescent or teen* or youth or peer or peers).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] — 3,481,339 6 (rape* or molest* or (sex* adj2 (abus* or coerc* or maltreat* or assault*))).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword] — 41,457 7 5 and 6 — 21,583 8 4 or 7 — 22,721 9 limit 8 to (meta analysis or "systematic review") — 259 10 (metaanal* or meta-anal* or "meta anal*" or ((systematic or realist) adj2 (synthesis or review*)) or "synthesis of studies" or "review of reviews" or metasynth* or meta-synth* or "meta synth*").mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, — 256,243	**402**

	drug manufacturer, device trade name, keyword] 11 8 and 10 402 12 9 or 11 402	
ERIC/ProQuest Date searched: 11 April 2016 ERIC is a well-known index to educational-related literature. Established in 1966, ERIC is supported by the U.S. Department of Education's Office of Educational Research and Improvement. Updated monthly.	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND (rape* OR molest* OR (sex* NEAR/2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND (metaanal* OR meta-anal* OR "meta anal*" OR metasynth* OR meta-synth* OR "meta-synth*" OR ((systematic OR realist) NEAR/2 (synthesis OR review*)) OR "synthesis of studies" OR "review of reviews") in abstract	**33**
Families & Society Collection/Informit Date searched: 11 April 2016 The search needed to be split up in this fashion in order for the Informit search engine to behave correctly. When too many terms were combined, an incorrect result set was provided.	**# Searches Results** 1 child sexual abuse OR sexually abused children OR sexually abused teenagers OR sexual abuse victims OR adult child sexual abuse victims 256 2 baby OR infant OR infants OR toddler OR child* OR adolescent OR teen* OR youth OR peer OR peers 5,588 3 rape* OR molest* OR sex* %2 abus* OR sex* %2 coerc* OR sex* %2 maltreat* OR sex* %2 assault* 443 4 2 and 3 423 5 metaanal* OR meta-anal* OR "meta anal*" 5 6 systematic %2 review* 9 7 realist %2 review* 0 8 realist %2 synthesis 0 9 "review of reviews" 0 10 "synthesis of studies" 0 11 metasynth* OR meta-synth* OR "meta synth*" 0 12 6 and 1 0 13 6 and 4 0 14 5 and 1 2 15 5 and 4 2 16 14 or 15 2	**2**
Family & Society Studies Worldwide/EBSCO Date searched: 11 April 2016	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND (rape* OR molest* OR (sex* N2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND	**79**

This bibliographic database provides coverage of research, policy and practice literature in social work, social science and family practice from 1970.	(metaanal* OR meta-anal* OR "meta anal*" OR metasynth* OR meta-synth* OR "meta-synth*" OR ((systematic OR realist) N2 (synthesis OR review*)) OR "synthesis of studies" OR "review of reviews") in abstract	
International Bibliography of the Social Sciences (IBSS)/ProQuest Date searched: 11 April 2016 The International Bibliography of the Social Sciences (IBSS) is an online resource for social science and interdisciplinary research dating back to 1951. It has broad coverage of international material. Updated biweekly (every two weeks).	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND (rape* OR molest* OR (sex* NEAR/2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND (metaanal* OR meta-anal* OR "meta anal*" OR metasynth* OR meta-synth* OR "meta-synth*" OR ((systematic OR realist) NEAR/2 (synthesis OR review*)) OR "synthesis of studies" OR "review of reviews") in abstract	**14**
MEDLINE/Ovid (Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R), 1946 to Present) Date searched: 11 April 2016 (Limiting search to English language only reduced the result set to 234, so all items were left in.) Most recent item: April 2016; oldest item: August 1992 A scan of items 187–242 did not identify any other appropriate subject terms used.	**# Searches — Results** 1 Child Abuse, Sexual/ — 8,844 2 Sex Offenses/ — 6,769 3 Rape/ — 5,678 4 2 or 3 — 11,774 5 limit 4 to "all child (0 to 18 years)" — 5,000 6 1 or 5 — 12,845 7 (baby or infant or infants or toddler or child* or adolescent or teen* or youth or peer or peers).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] — 3,423,037 8 (rape* or molest* or (sex* adj2 (abus* or coerc* or maltreat* or assault*))).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] — 28,344 9 7 and 8 — 16,826 10 6 or 9 — 18,052 11 meta analysis.pt. — 63,888	**242**

	12 (metaanal* or meta-anal* or "meta anal*" or ((systematic or realist) adj2 (synthesis or review*)) or "synthesis of studies" or "review of reviews" or metasynth* or meta-synth* or "meta synth*").mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier] 164,399 13 11 or 12 164,399 14 10 and 13 242	
National Criminal Justice Reference Service Abstracts/ProQuest Date searched: 11 April 2016 The NCJRS (National Criminal Justice Reference Service Abstracts) Database is published by the Office of Justice Programs, U.S. Department of Justice's National Criminal Justice Reference Service, an information clearinghouse on research, policy and practice related to criminal and juvenile justice, and drug control. Unique elements of the collection include agency-produced documents and final grant reports of Office of Justice Programs–sponsored research.	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND (rape* OR molest* OR (sex* NEAR/2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND (metaanal* OR meta-anal* OR "meta anal*" OR metasynth* OR meta-synth* OR "meta-synth*" OR ((systematic OR realist) NEAR/2 (synthesis OR review*)) OR "synthesis of studies" OR "review of reviews") in abstract	**36**
PsycINFO/Ovid (PsycINFO 1806 to April Week 1 2016) Date searched: 11 April 2016 No specific subject term exists for child sexual abuse. A scan of items with the phrase in the title indicated that most items are given dual subject headings of child abuse and sexual abuse; however, in some cases only child abuse is given. Child abuse is more general than child sexual abuse, so the combination of terms was used, as well as the general keyword strategy.	**# Searches Results** 1 (child abuse/ and (sexual abuse/ or sex offenses/ or rape/)) or pedophilia/ 11,829 2 sexual abuse/ or sex offenses/ or rape/ 28,397 3 limit 2 to (100 childhood or 200 adolescence) 8,066 4 1 or 3 15,570 5 (baby or infant or infants or toddler or child* or adolescent or teen* or youth or peer or peers).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] 818,306	**323**

Most recent item: March 2016; oldest item: 1984 A scan of some of the items in the result set indicates that in most relevant cases both subject headings for sexual abuse and child abuse have been used. There are some irrelevant items in the result set due to inclusion of the table of contents field for books in the indexes searched. This is not a highly significant set of records, so no steps have been taken to correct for this.	6 (rape* or molest* or (sex* adj2 (abus* or coerc* or maltreat* or assault*))).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] 36,226 7 5 and 6 22,639 8 4 or 7 25,075 9 limit 8 to ("0830 systematic review" or 1,200 meta analysis) 209 10 (metaanal* or meta-anal* or "meta anal*" or ((systematic or realist) adj2 (synthesis or review*)) or "synthesis of studies" or "review of reviews" or metasynth* or meta-synth* or "meta synth*").mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures] 37,291 11 8 and 10 296 12 9 or 11 323	
Published International Literature On Traumatic Stress (PILOTS)/ProQuest Date searched: 11 April 2016 The PILOTS bibliographic database, covering the published international literature on traumatic stress, is produced at the headquarters of the National Center for Post-Traumatic Stress Disorder in White River Junction, Vermont. The U.S. Department of Veterans Affairs sponsors the PILOTS database. Updated monthly.	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND (rape* OR molest* OR (sex* NEAR/2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND (metaanal* OR meta-anal* OR "meta anal*" OR metasynth* OR meta-synth* OR "meta-synth*" OR ((systematic OR realist) NEAR/2 (synthesis OR review*)) OR "synthesis of studies" OR "review of reviews") in abstract	**60**
SocINDEX/EBSCO Date searched: 11 April 2016 SocINDEX offers comprehensive coverage of sociology and its sub-disciplines. It contains abstracts for core coverage journals dating back, in some cases, to 1895.	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND (rape* OR molest* OR (sex* N2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND (metaanal* OR meta-anal* OR "meta anal*" OR metasynth* OR meta-synth* OR "meta-synth*" OR ((systematic OR realist) N2 (synthesis OR review*)) OR "synthesis of studies" OR "review of reviews") in abstract	**273**
Social Services Abstracts/ProQuest Date searched: 11 April 2016	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND	**44**

Social Services Abstracts provides bibliographic coverage of current research in social work, human services and related areas, including social welfare, social policy and community development. The database includes abstracts of journal articles and dissertations, as well as citations to book reviews.	(rape* OR molest* OR (sex* NEAR/2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND (metaanal* OR meta-anal* OR "meta anal*" OR metasynth* OR meta-synth* OR "meta-synth*" OR ((systematic OR realist) NEAR/2 (synthesis OR review*)) OR "synthesis of studies" OR "review of reviews") in abstract	
Sociological Abstracts/ProQuest Date searched: 11 April 2016 Sociological Abstracts indexes the international literature of sociology and related disciplines in the social and behavioural sciences. It includes the companion file Social Services Abstracts, which provides bibliographic coverage of current research focused on social work, human services and related areas.	((baby OR infant OR toddler OR child* OR adolescent OR teen* OR youth OR peer) in all text AND (rape* OR molest* OR (sex* NEAR/2 (abus* OR coerc* OR maltreat* OR assault*)))) in all text AND (metaanal* OR meta-anal* OR "meta anal*" OR metasynth* OR meta-synth* OR "meta-synth*" OR ((systematic OR realist) NEAR/2 (synthesis OR review*)) OR "synthesis of studies" OR "review of reviews") in abstract	**63**

Database descriptions from https://www.ebsco.com/products, http://www.proquest.com/, and UlrichsWeb Global Serials Directory. Accessed 12 April 2016.

Appendix B: Protocol for data extraction

Data extraction 1 – key features of reviews – please extract:

1. First author name
2. Publication year
3. Systematic review (SR) or meta-analysis (MA) or both (SR + MA)
4. Included study designs
5. Location in which included studies were conducted (by country)
6. Population
    a. Survivors of child sexual abuse and/or other, if other describe
    b. Age range
    c. Other characteristics?
7. Interventions tested in included studies – name the general category of treatment covered by review (such as group therapy) and all named interventions tested in included studies
8. Comparison conditions – name all comparison conditions the tested interventions get compared with, such as wait-list, no treatment, alternative treatment (if the latter, list the treatments if mentioned)

Data extraction 2 – outcomes – please extract:

9. First author name
10. Publication year
11. Sample sizes of included studies
12. Primary outcome investigated
    a. Effect sizes for primary outcomes
13. Secondary outcomes investigated (if any)
    a. Effect sizes for secondary outcomes

Data extraction 3 – implementation data – please extract:

14. First author name
15. Publication year
16. Intervention characteristics:
    a. Name the intervention(s) that was tested and its key characteristics, as described in the SR or MA;
    b. Dosage of tested intervention (How long? How much? How often?) and format (individual, group, other; delivered where – clinic? Home? Who delivers – therapist? Parent-mediated?)
    c. Implementability: information about fidelity requirements, use of manual, minimum requirement for session attendance, training
    d. Implementation outcomes: measured fidelity among practitioners, program drop-out rates, session attendance rates, client satisfaction rates

Appendix C: Bibliography of eligible and ineligible studies

Included studies

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