



A meta-review of interventions to support children and their families in the aftermath of child sexual abuse

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1. Background

Estimates of the prevalence of child sexual abuse in the UK range from 3% to 36% for females and from 3% to 29% for males, depending on the definition used, methods of sampling and data collection adopted (Cawson, Wattman, Brooker & Kelly, 2000). For the year ending March 2008, 2300 children in England were the subject of a Child Protection Plan (CPP) under the category of sexual abuse (DCSF, 2007). In Wales 160 children are on the child protection register for being subject to a CPP in the year ending 2008, with a further 50 children on the Welsh child protection register in the category of sexual abuse together with neglect and/or physical abuse (Local Government Data Unit Wales, 2008). Children become the subject of a CCP if following a child protection conference (meeting of relevant professionals e.g., GP, social worker, police) they are "considered to be at risk of continuing harm" (DfES, 2006).

The impact of child sexual abuse can manifest itself in a variety of behavioural and psychological problems both for those who suffer the trauma directly and those who are affected by it. These problems can affect children and young people in the short term, but also in later adult life (Putnam, 2003). Most frequently child sexual abuse has been associated with sexualised behaviour (e.g., McClellan et al, 1996) and symptoms of Post Traumatic Stress Disorder (PTSD) e.g., Deblinger, Lippman & Steer, 1996; Paolucci, Genius & Violato, 2001. Links have also been made with poor psychological functioning (e.g. Fergusson, Horwood & Lynskey, 1996; Read, 1997), depression and low self-esteem (Mullen et al, 1996) eating disorders (Wonderlich et al, 1997) suicide (Paolucci, Genius & Violato, 2001) and substance misuse (Arellano, 1996). Interventions reported in the literature seem to have most commonly targeted fear, anxiety, low mood and sexually inappropriate behaviour (MacDonald, Higgins & Ramchandani, 2006; Kendall-Tackett, Williams & Finkelhor, 1993).

Kendall-Tackett, Williams and Finkelhor (1993) suggest that there is a lack of evidence to support one obvious syndrome displayed by children who have been sexually abused and that children display a variety of symptoms with no single symptom being displayed by a majority.

Interestingly, some highlight the significant numbers of children who survive child sexual abuse without appearing to experience short term psychological consequences (Dominguez, Nelka & Perry, 2006; Taylor, 2002). It is possible that these children are less affected than others, but also that in some survivor's consequences of abuse may only become apparent later; especially given that child sexual abuse has been linked to an increased risk of a variety of psychological problems in adulthood (Jumper, 1995).

It is also true of course that children differ and do not form one homogeneous group; for example in terms of culture, ethnicity or stage of development. These factors may play a part in determining the recovery of children following experience of trauma, including that of child sexual abuse. Rutter (1999) suggests that multiple risk and protective or resilience factors are significant in children's recovery from trauma with considerable variation in baseline

vulnerability to psychosocial stress related to various genetic and environmental factors.

A variety of interventions exist to promote recovery from trauma following child sexual abuse. These interventions differ in their theoretical bases as well as their structure and content. The purpose of this meta-review is to provide a review of reviews of published data from such interventions to provide messages of best practice to practitioners and service managers in the field.

2. This meta-review

Overview

A meta-review can be defined as an overview of reviews. This meta-review will comprise an overview of the results of research reviews that evaluate and summarise the effectiveness, or the impact on outcomes of interventions offered to children and families affected by sexual abuse. The process used is described more fully in the methods section, but the intention is to gather existing evidence together from reviews that have summarised the results from individual studies.

Background

This meta-review forms one part of an evaluation being conducted by Canterbury Christ Church University in partnership with a UK network of Action for Children projects which focus on child sexual abuse, as described below. The evaluation is part of a central Action for Children initiative called Safe and Secure which aims to *"improve the availability of and access to therapeutic support services to children who have been sexually abused and to significantly impact on their potential for success, against the Every Child Matters Outcomes"*.

The evaluation itself is comprised of four components:

- This systematic meta-review of reviews of recent published literature
- A general overview evaluation of projects' structure and operations
- A child outcomes-focused evaluation (pre-test post-test design)
- A qualitative evaluation utilising a child-focused activity book designed to elicit children and young people's views about the services received.

For the purposes of this meta-review, therapeutic interventions are defined as those that intervene with children and young people or their families and carers, to reduce the longer term symptomatic impact of the experience of trauma resulting from sexual abuse.

Aims

The aim of this systematic meta-review is to provide an overview of reviews of primary interventions that promote recovery from trauma following child sexual abuse. Moreover, this meta-review will place the operational evaluation in context of the recent literature on effectiveness of relevant interventions. It is

further hoped that the meta-review will assist in the development of current practice in line with recent best evidence.

Format

The format of this review will follow a standard structure whereby the headings follow on from each other in the sequence in which the review was conducted. Within this format, the results section includes findings for included reviews being presented without interpretation. As such, the results section presents the data as included in the review whilst the discussion section provides a summary of the findings with some additional explanatory material, some interpretation and some discussion. There is also a section at the end of the report which identifies the main messages of the review in bullet points.

In most cases where standardised effect sizes are reported, the size of the effect represents the overall impact of an intervention on a group of participants. This is expressed as the magnitude of the effect in relation to proportions of total participants rather than the simply the magnitude of the effect. Similarly, where a comparison between two or more groups is presented the reported effect size represents a statistical comparison between the two groups.

3. Methods

3.i Inclusion and Exclusion Criteria

In a systematically conducted review, the criteria against which studies are screened for eligibility for inclusion are set up in advance and these criteria determine whether studies reach the threshold for inclusion. This serves to ensure that eligibility decisions are made transparently. The inclusion and exclusion criteria are presented below:

Inclusion Criteria

Type of study/report

Only systematically conducted literature reviews of therapeutic interventions for child sexual abuse published from 2005 to 2008 in the English language, that include a transparent methodology and explicit and consistent review methods and processes were included in the meta-review. The narrow time frame was imposed due to limitations of resources and time. When considering the narrow time frame for the search it should also be borne in mind that the reviews included studies dating back as far as 1981, so the review reflects a larger evidence base than reflected in the search for included reviews.

The main elements of transparency for which included reviews were assessed were the clarity of the processes and methods used, including the search strategy, or how the authors went about finding the included studies and their own inclusion criteria.

Participants

Children and young people who have disclosed sexual abuse (as defined by the included reviews). For the purposes of this meta-review the age of included children was according to definitions used in the included reviews themselves and within the jurisdictions in which the reviews took place.

Settings

The meta-review included reviews of studies conducted in any of the following settings and provided by any of the following list of service provider types.

- Community settings defined as non inpatient or residential environments
- Services provided by any provider, including:
 - Statutory
 - Voluntary
 - Health
 - Social care
 - Education.

Interventions

The intention of the review was to include any intervention focused on children or young people who have reported sexual abuse or interventions focused on the families/carers of children and young people who have reported sexual abuse where the intervention is intended to promote the child's recovery¹.

Outcomes

Only reviews that address outcomes listed below were included in this meta-review. These were the outcomes of interest as agreed with Action for Children staff for the whole evaluation project, including this meta-review, prior to beginning the work.

These outcomes were arrived at following considerable discussion with project staff. They focus on priorities identified by the agency as: measuring the development of stability in children's lives following the trauma of abuse; being focused on practice expertise as to which elements promote the child's recovery; being related to service delivery as applicable to their various stakeholders.

Some of the identified outcomes were not included directly; for example 'the child's feelings about their abuse' as such outcomes are difficult to measure consistently. One of the criteria for included outcomes was that they be measurable.

- ***Service delivery***
 - Referrals to other agencies
- ***Safety***
 - Is child having contact with alleged abuser?

¹ In actual fact, all of the included reviews in this meta-review included studies which focused on children and young people themselves, rather than their families or carers specifically.

Is work with non-abusing carer/parent to be undertaken?
Parents/carer engagement with the therapeutic process

- **Behaviour**
Sexualised behaviour
Violent/aggressive behaviour
Self harm behaviour
- **Education**
Attendance levels at appropriate educational provision/employment
- **Mental/emotional health**
Depression/anxiety (standardised measure)
Social functioning/relationships (standardised measure)
Sleep patterns
Bedwetting
Nightmares
- **Other**
Medication
Security of residential placements, measured as changes of placement or breakdown in placement stability.

Exclusion Criteria

The following criteria reflect study and intervention characteristics not included in the scope of this meta-review, and as such form the basis on which studies were excluded:

- Primary studies – not reviews of literature
- Reviews that explicitly include children who are not safe from abuse
- Interventions conducted in the developing world
- Reviews not published in the English language
- Inpatient settings
- Reviews focused on outcomes not on the priority list
- Reviews that include studies that are focused only on children and young people exhibiting sexualised behaviour or sexually inappropriate behaviour.²

² Whilst it is true to say that many young people exhibiting sexually harmful behaviour have also experienced sexual abuse, and also the case, including within the projects being evaluated in other elements of this evaluation project, that some services do provide a service to intervene in relation to such behaviour; it was decided to exclude such young people and such interventions from this review to avoid undue complexity in the review process. It was the view of the project team that in order to be covered sufficiently, this aspect should be considered in a separate review, which this project did not have the scope or the resources to undertake at this time.

3.ii Searching

A search strategy was conducted by the Canterbury Christ Church University Health and Social Care Faculty Librarian in consultation with the project team. The aim was to find reviews that focus on interventions and outcomes for children and young people who have disclosed sexual abuse. Searches were conducted of ASSIA, The Campbell Library, CINAHL, DARE, Medline, PsychInfo and the Cochrane Library for reviews published between 2005 and 2008. The databases searched represent the relevant databases available at Canterbury Christ Church University.

The full search strategy is attached at Appendix 1. This search was systematically conducted but is not fully comprehensive since non-locally available sources were not searched. This may have the implication that relevant reviews were missed. That being said, the databases listed above are the most important, most widely indexed databases in the field. It may therefore be unlikely that anything significant is missing, although without a fully comprehensive search it is impossible to be certain.

In addition, websites of the following organisations/initiatives were searched for any literature which might be relevant: Stop It Now, The Australian Childhood Foundation, Action for Children, NSPCC, Barnardos, National Children's Bureau, Childline, Department for Children Schools & Families, Rape Crisis, The Lucy Faithfull Foundation, National Organisation for the Treatment of Abusers, British Association for the Study and Prevention of Child Abuse and Neglect and The Save the Children Fund.

First stage screening was done by one reviewer (JH) and checked by another (EC). The second stage of screening was undertaken by two of the following four reviewers (AK, CP, CY, JH) in consultation with the lead reviewer (EC). Screening was undertaken according to the inclusion and exclusion criteria listed above.

3.iii Data Extraction

A data extraction form was devised as a tool to extract the following information from the included reviews:

- Report details
- Type of review
- Where conducted
- Number and type of studies included in review
- Specific details of review inclusion criteria
- Specific exclusions from the review
- Findings of individual reviews

A copy of the data extraction form used can be found in Appendix 2. This form allowed for standardised data extraction by all reviewers. In order to develop consistency of use of the form and to resolve any misunderstandings in its use,

the data extraction form was piloted by all reviewers on one of the included reviews.

Data was extracted from each included review by two reviewers working independently. A final version to be included in the review was then agreed between the reviewers. This consensus method is similar to that employed in EPPI Centre reviews (EPPI-Centre, 2007).

3.iv Quality appraisal of included reviews

Due to the constraints of time and resources, it was only possible to undertake limited quality assessment of included reviews. This limited quality assessment included assessment of the following domains:

- Transparency of reporting of methods
- Comprehensiveness of search
- Single/double screening and/or extraction
- Quality appraisal of studies included in review
- Relevance to Action for Children review

This appraisal is much more limited than that incorporated in standardised and validated appraisal tools such as 'a measurement tool for the assessment of multiple systematic reviews' (AMSTAR) (Shea et al, 2007) although that tool and others do include some of the domains included in this instance, particularly items 2-5 above. AMSTAR was designed to appraise the quality of fully systematic reviews, such as those produced within the Cochrane Collaboration, of which the only one focused on child sexual abuse interventions is included here (Macdonald, 2006). It was our intention to include more reviews than that one alone, but in including less systematically conducted reviews, to attempt to appraise a more basic level of systematicity in the approaches of the reviews. Furthermore, the time and resource constraints that beset this project limited the approach we were able to take.

The tool for quality appraisal was incorporated in the data extraction form and was thus piloted as part of this form.

4. Results

A total of 1258 titles were found by the initial searches of which 1122 studies were excluded according to the predefined criteria at the first stage of screening. A further 136 full text articles were retrieved of which 125 were found to be unsuitable. Following complete screening, a total of five review reports (taking into account the overlap between databases) were included in the meta-review (Avinger & Jones, 2007; Cohen, Mannarino, Murray & Igelman, 2006; Hetzel-Riggin, Brausch & Montgomery, 2007; MacDonald, Higgins & Ramchandani, 2006; Skowron & Reinemann, 2005).

Table 1 gives details of the numbers of titles found from each database

Table 1. Search results by database

Database	Total citations retrieved by search	Total citations excluded at initial screening	Total citations excluded at second screening	Total citations included in meta-review	Number of included reviews unique to this source
ASSIA	562	513	46	3	3
Campbell	26	25	0	1	1
CINAHL	140	132	7	1	0
Cochrane Library	2	1	0	1	0
DARE	4	2	0	2	1
Medline	69	68	1	0	0
PsychInfo	105	81	20	4	0
SCIE Online	348	348	0	0	0
TOTAL	1256	1170	74	12	5

Table 2 below shows the number of studies excluded from each database according to the reason for exclusion.

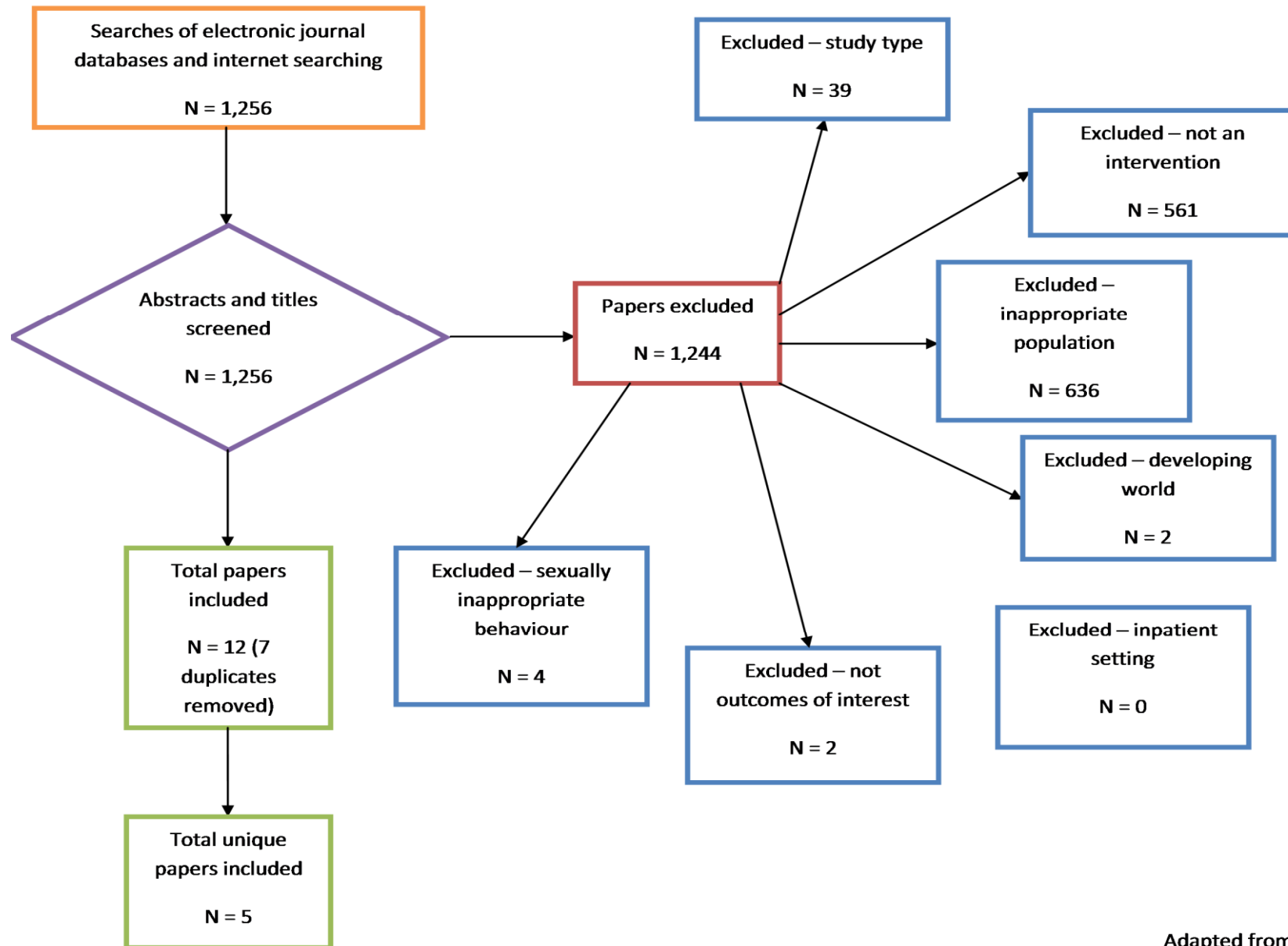
Table 2. Exclusions by reason for exclusion.

Database	S	I	P	L	In	O	B
ASSIA	18	136	403	1	0	1	0
Campbell	0	0	25	0	0	0	0
CINAHL	3	14	122	0	0	0	0
Cochrane Library	0	1	0	0	0	0	0
DARE	0	0	2	0	0	0	0
Medline	3	62	4	0	0	0	0
PsychInfo	15	20	66	0	0	0	0
SCIE Online	0	328	14	1	0	1	4
Total	39	561	636	2	0	2	4

S = not a primary study, I = not an intervention study appropriate to this review, P = inappropriate population, L = interventions in the developing world, In = inpatient settings, O = not focused on the outcomes of interest, B = focus on sexualised/sexually inappropriate behaviour.

Figure 1 shows the flow of literature through the screening process detailing the number of studies excluded at each stage of screening.

Figure 1. The flow of literature through the screening process.



Adapted from EPPI- Centre (2004).

5. Description of included reviews

A very brief description of each of the five included reviews can be found below. For more extensive detail of each review see Table 3.

1. Avinger and Jones (2007) reviewed the impact of various types of group interventions on recovery from sexual abuse in adolescent girls. They included a total of 10 studies reporting the effects of such interventions.

2. Cohen et al (2006) reviewed 20 randomized controlled trials of psycho-social interventions, seven of which were specifically aimed at children who had been sexually abused.

3. Hetzel-Riggin et al (2007) conducted a statistical meta-analysis of 28 studies reporting pre- and post-test results for any type of intervention for children and young people who have been sexually abused.

4. MacDonald et al (2006) conducted a systematic (Cochrane) review of cognitive behavioural interventions for child sexual abuse.

5. Skowron and Reinemann (2005) conducted a statistical meta-analysis of psychological interventions for child maltreatment, including seven studies specifically related to child sexual abuse.

Table 3. Description of Included Reviews

Review identifier	<i>Avinger & Jones, 2007</i>	<i>Cohen et al 2006</i>	<i>Hetzel-Riggin et al, 2007</i>	<i>Macdonald, et al, 2006</i>	<i>Skowron and Reinemann, 2005</i>
Included study types	A review of 10 pre/post test studies evaluating group intervention treatments for CSA. Seven of the 10 included studies had no control groups.	A review of 20 RCTs evaluating psycho-social interventions for children exposed to violence & maltreatment, 7 of which specifically assessed intervention for CSA.	A review of 28 pre/post test studies evaluating treatment for CSA. Includes only sample sizes > 10; enough to compute effect sizes & published in peer reviewed journal.	A review of 10 RCTs of the treatment of CBT for CSA.	A review of 21 studies examining treatment for child/parent referred for child maltreatment, 7 of which specifically assessed intervention for CSA. Compares treatment against control groups in the same population.
Included participants	Adolescent girls (11-18 years) who have experienced sexual abuse.	Children & adolescents (3-17 years) exposed to violence & maltreatment, including CSA.	Children & adolescents (3-18 years) who have experienced sexual abuse.	Children & adolescents up to age 18 years who have experienced CSA.	Children & adolescents (3-17 years) who have experienced sexual abuse. Three out of the 7 included only girls & one focused on deaf adolescents.
Included Treatment Interventions	All 10 interventions involved group therapy, but treatments varied: TF-CBT (2*), psychodrama (2*), 'multi-dimensional model' (2*), Rogerian/humanistic (1*), Eriksonian (1*), dynamic group model (1*), & unspecified model incorporating an element of sex education (1*). Number of sessions varied between 6-24. Session length varied 1-5 hours. Group sizes also varied as did settings including outpatient treatment, inpatient & residential, school setting (6 out of 10 outpatients).	Out of the 7 RCTs which assessed intervention for CSA, 6 evaluated the effectiveness of TF-CBT & 1 evaluated the effectiveness of psychodynamic treatment. Number of sessions varied between 20- 11 (12 sessions on average).	Various interventions included: individual (17*), group (15*), CBT (15*), abuse specific (15*), supportive (11*), family therapy (9*) no treatment (9), play therapy (4*), 'other' (Eye Movement Desensitisation and Reprocessing (1*) - categories not mutually exclusive.	All 10 RCTs assessed the effectiveness of CBT (group & individual) against treatment as usual (with/without placebo) & control. Number of sessions varied between 6-20 (6-10 for group therapy, 8-20 individual therapy).	Varying therapeutic approaches: cognitive, behavioural, psychodynamic, humanistic, developmental/ecological, combination. This compares treatment modality rather than intervention type. Treatment modalities include individual, group, family, milieu & multi-component.

Included Treatment Outcomes	Outcome 'categories' included: internalising & externalising behaviours, trauma symptoms, anxiety, depression, self-esteem, behaviour problems, knowledge of sexual anatomy & physiology.	Outcome 'categories' included: internalising, externalising, PTSD symptoms, sexualised, behaviour problems, depression, social competence, dissociation, safety skills, shame, fear, negative abuse related cognitions.	Outcome 'categories' included behaviour problems, psychological distress, social functioning, self concept, other problems (level of academic functioning & risk assessment abilities).	Outcome 'categories' included; depression, PTSD, anxiety, sexualised behaviour externalised behaviour, future offending behaviour, parental skills & knowledge.	Outcome 'categories' included: child cognitive process (intellectual ability, cognitive processing) child personality (self-report on self esteem, depression, anxiety), parent self-report (parenting attitudes & behaviours), parent/teacher rating of child (internalising/externalising disorders, classroom disruption & social skills), objective behavioural observations of child & family. They were not set as inclusion criteria.
Level of Quality	Low – small sample sizes, some studies had no control groups and review not transparent. Inclusion criteria specified.	Low – no aggregated results, difficult to report results precisely and review not transparent. Inclusion criteria specified.	Medium – Meta analysis, but small sample sizes make power v.low and findings difficult to interpret. Only exploratory; many interventions examined, but no specific theory tested.	High – A systematic review (Cochrane Collaboration); fully transparent.	Medium - Meta analysis, but many obscure individual study effects due to wide range of treatments & populations included
Included Treatment Findings	PTSD: 3/3 (x2 TF-CBT x1 multi-dimensional model) reported a significant benefit Anxiety: 3/5 (1x psychodrama, 1x CBT, x1 multi-dimensional model) found reduced symptoms, one (1x Rogerian/humanistic) found reduced, equivalent to individual treatment & one (1x psychodrama) found no improvements; though probably	Six studies reported that TF-CBT was related to an improvement in all outcomes compared to other therapeutic interventions (non-directive supportive therapy, child-centred therapy, family therapy, community treatment or no treatment) children who received TF-CBT showed greater	Regardless of the intervention, treatment was significantly better at improving outcomes than no treatment. Psychological distress: greatest improvements related to CBT, play therapy, supportive therapy, abuse specific therapy & family therapy Behaviour problems: greatest improvements related to CBT, supportive therapy & abuse-	PTSD: data from six studies found statistically significant decrease of 0.43 standard deviations. 2/ 6 reported sustained decrease of 0.50 standard deviations after at least one year Anxiety: data from five studies showed a small overall average decrease of 0.2 standard deviations on various scales. A further two	Meta-analysis: 71% participants who received therapy reported greater improvements than participants who received no treatment. Treatment increased the improvement rate for participants by 28% Larger effect sizes for CSA compared with general child maltreatment: $d+ = 0.69$ (SE .09) $N=7$ compared to $d+ = 0.40$ (SE .12) $N=12$ with $p > .05$ but significant in group variance – need to identify critical

	<p>due to small sample size Depression: 2/5 (2x psychodrama) found significant improvement, but three did not (1x Rogerian/humanistic, 2x TF-CBT) Self-esteem: 6/6 (1x psychodrama, 1x Rogerian/humanistic, 1x dynamic group model, 1x multi-dimensional model, 1xTF-CBT, 1x unspecified model incorporating an element of sex education) Behaviour problems: 1/2 (1xTF-CBT) found sig improvement on self-report but not parent report, whereas the other (1x dynamic group) did not find any changes in externalised behaviour Knowledge of sexual anatomy & physiology: 1/1 (1x unspecified model incorporating an element of sex education) found significant improvements post test.</p>	<p>improvements in all outcomes. One study found that individualised psychoanalytic therapy was related to greater PTSD improvements than psycho educational therapy.</p>	<p>specific therapy. Although 'no treatment' groups also showed improvements in behavioural problems Social functioning: greatest improvements related to children who received play therapy Self concept: greatest improvements related to CBT, group therapy & abuse specific therapy Other problems (level of academic functioning & risk assessment abilities): improved most by children who received CBT, play therapy, abuse specific therapy, supportive therapy, group therapy.</p>	<p>studies showed benefit of 0.28 standard deviations after at least one year although this was not statistically significant Depression: data from five studies showed an average small decrease of 1.8 points on the Child Depression Inventory, in three studies, the benefit sustained after one year of follow-up Sexualised behaviour: data from five studies showed an average small non-statistically significant benefit variation between included studies & therefore clinical significance unclear Externalised behaviour: data from seven studies show a decrease of 1.14, however these results are inconsistent Future offending behaviour: not assessed in any of included studies Parental skills & knowledge: two studies found increased 'belief of their children & support for them'. One found decrease in self-blame, child blame, perpetrator blame & negative impact. Two found</p>	<p>moderators e.g. length of treatment, severity of abuse, co morbidity, theoretical orientation & participant characteristics. Effects didn't vary according to individual/group/family etc also parent/child, mandated/voluntary - all led to positive treatment gains.</p>
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				decrease on the parent emotional reaction questionnaire. Three found increase in the parenting practices questionnaire.	
Comments	List of results not synthesis; actual data not presented in review. Small sample sizes in individual studies & no synthesis to increase power. Review draws conclusions about the effectiveness of different treatment types & approaches but compromised validity as small groups & broad comparisons. Authors emphasise that range of treatment approaches makes it difficult to draw conclusions about group model & outcome & that settings impact on outcomes.	No aggregated results so difficult to report precisely CSA findings from the results presented. Lead authors have developed & evaluated TF-CBT & aim of review was to assess various treatments across various types of child violence & maltreatment. Review conclusions promote TF-CBT.	Meta analysis with subgroup analyses & assessments of heterogeneity, but wide variety of treatment types included.	High quality Cochrane review. Clarity of findings demonstrates benefit of clear transparent, systematic approach & more narrow eligibility criteria for inclusion.	Meta-analysis used but many obscure individual study effects due to wide range of treatments & populations included. However, tests for heterogeneity were conducted on various dimensions.

*Numbers in brackets refer to the number of treatment interventions assessed in a review

Table of abbreviations

CSA - Children who have experienced sexual abuse **CBT** - Cognitive behavioural therapy **TF-CBT** - Trauma-focused cognitive behavioural therapy **RCTs** - randomised control trials
PTSD - Post traumatic stress disorder **SE** - Standard error **N** - Number of participants **p** - probability level **d+** - weighted unbiased effect size

6. Quality appraisal of included reviews

Of the five reviews included in this meta-review: one was assessed as being of high quality according to the terms of this meta-review, being a Cochrane review conducted to Cochrane standards (Macdonald et al, 2006). Two were assessed as being of moderate quality: both including description of the search strategy, the inclusion criteria and the methods used for synthesis but not including quality appraisal of included studies (Hetzl-Riggin et al, 2007; Skowron & Reinemann, 2005). A further two studies were assessed as being of low quality (Avinger & Jones, 2007; Cohen et al, 2006). In both these instances these reviews appear to have been conducted using systematic methods reporting clear inclusion criteria, but the quality could not be assessed as the methods were not fully and transparently reported. In addition, Cohen et al (2006) had an interest in the results of the review as some of the review authors were authors of two included primary studies (Judith Cohen and Anthony Mannarino) and had developed one of the therapies that was a focus of the review (TF-CBT).

7. Overlap of studies included in the reviews

The level of overlap between the content of the included reviews was assessed. This assessment was conducted to determine the number of unique individual studies included in this meta-review and the extent of overlap between them. Seventeen studies (highlighted in yellow) were included in more than one review and the total number of unique inclusions was 62. A full reference list of these 62 inclusions can be found in Appendix 3. The results of this assessment are presented in Table 4 (below).

Table 4. Overlap between content of included reviews

Paper	A&J	C	H-R	M	S&R	Total inclusions in meta-review
Bagley & LaChance (2000)					x	1
Baker (1987)	x					1
Berliner & Saunders (1996)			x	x		2
Brunk, Hengeller & Whelan (1987)		x				1
Burch & Mohr (1980)					x	1
Burke (1988)				x		1
Carbonell & Partelena-Barehmi (1999)	x					1
Celano et al (1996)			x	x	x	3
Cohen & Mannarino (1992)	x					1
Cohen & Mannarino (1996a)		x	x	x	x	4
Cohen & Mannarino (1997)		x		x	x	3
Cohen & Mannarino (1998)		x	x	x		3
Cohen, Deblinger, Mannarino & Steer (2004)		x		x		2
Cohen, Mannarino & Knudsen (2005)		x				1
Cohen, Mannarino & Staron (In press)		x				1

Culp et al (1987)					x	1
Culp et al (1991)					x	1
Deblinger, Cohen, Mannarino & Steer (In press)		x				1
Deblinger, Lippmann & Steer (1996)		x	x	x	x	4
Deblinger, McLerr & Henry (1990)			x			1
Deblinger, Stauffer & Steer (2001)		x	x	x		3
Deblinger, Steer & Lippmann (1999)				x	x	2
DeLuca et al (1995)			x			1
Dominguez (2001)				x		1
Elmer (1986)					x	1
Fantuzzo et al (1996)		x			x	2
Friedrich et al (1992)			x			1
Gaudin et al (1990)					x	1
Graham-Bermann (2000)		x				1
Jabaghaderi et al (2004)			x			1
Jenson et al (1996)			x			1
Jouriles et al (1998)		x				1
King et al (2000)		x	x	x		3
Kitchur & Bell (1989)		x				1
Kolko (1996a)		x			x	2
Kolko (1996b)		x			x	2
Krakov et al (2001)			x			1
Kruczek & Vitanza (1999)			x			1
Lanktree & Briere (1995)			x			1
Layne et al (2001)		x				1
Lieberman, Ippen & Van Horn, 2006)		x				1
Lindon & Nourse (1994)		x				1
MacKay, Gold & Gold (1987)		x				1
McGain & McKinzey (1995)			x			1
Meezan & O'Keefe (1998)			x			1
Moore et al (1998)					x	1
Nolan et al (2002)			x			1
Oates et al (1994)			x			1
Reeker & Ensing (1998)			x			1
Rust & Troupe (1991)			x			1
Sankey et al (1985)					x	1
Scott et al (2003)			x			1
Sinclair et al (1995)		x	x			2
Stein et al (2003)		x				1
Sullivan et al (1992)			x		x	2
Szykula & Fleischman (1985)					x	
Trowell et al (2002)		x	x			2
Verleur et al (1986)		x	x		x	3
Whiteman et al (1987)					x	1
Wolfe et al (1981)					x	1
Wolfe et al (1988)					x	1
Wolfe, Wekerle & Scott (1997)		x				1

In conducting reviews of reviews, some overlap between the results of included reviews is not unusual. There are a number of ways of approaching this issue. On the one hand, it would be expected that reviews with overlapping objectives would be likely to contain a similar range of studies if they searched in a similar way. So it could be seen as of concern that there are in fact only 17 out of 62 studies were included in more than one review. Of course, as described in Table 3 above, the reviews included in this meta-review were conducted for different purposes, had different questions and inclusion criteria, different ranges of included data and included different study designs. So the low level of overlap is in some ways not a surprise.

It was beyond the scope of this review to assess all of the included studies listed below so it is not possible to know what the implications are of the low level of overlap, except for identifying the differences between the scope of the included reviews as described above.

8. Aggregated findings

Findings should be read in light of the fact that the included reviews varied in their methodological quality, which affects robustness of findings and that only one review included here was deemed to be of high quality (Macdonald et al, 2006).

8.i Action for Children Outcomes

Of the outcomes of interest to the evaluation, as agreed with practitioners, the following were not addressed in any of the included reviews: referrals to other agencies, self harm, decreased medication, more secure placements, attending school and bedwetting. Of those that were included, they were not always expressed in the same way as they are expressed in the Action for Children evaluation. As such, we have listed below each heading the Action for Children outcomes that are included within it.

8.i.i Service delivery

Reduced referrals to other agencies

This outcome was not assessed in any of the reviews included in this meta-review.

8.i.ii Safety

None of the outcomes of interest under this heading (contact with alleged abuser; therapeutic intervention with parent; engagement of parent with therapeutic process) were explicitly addressed by any of the included reviews.

Cohen et al (2006) did report one study which found that children receiving TF-CBT experienced significantly greater improvements in safety skills compared to children in a supportive therapy group ($p = < .05$).

8.i.iii Behaviour

Results under this section include those pertaining to sexualised behaviour; violent/aggressive behaviour and self harm as well as other behavioural outcomes as included in the five reviews included in this meta-review.

Aspects of child behaviour were measured by all of the included reviews although both the reviews and the studies included in them also measured varying aspects of behaviour in differing ways. Therefore, the results aggregated here from the various studies included in the five reviews must be seen as significantly diluted down from the results obtained in the various original included studies. Where it is not clear what aspects or types of behaviour are included in any particular review, the outcome name is presented in quotation marks, denoting that the authors of this meta-review are unclear as to what is meant.

For example, Skowron and Reinemann (2005) in their review of psychological interventions for child sexual abuse listed as of interest to their review various child behaviour outcomes including aggression, inappropriate sexual behaviours and classroom behaviour. They also aggregated together different types of psychological behaviours in their review into 'constructs' as mentioned earlier. In their final analysis Skowron and Reinemann (2005) aggregated child behaviour outcomes into two such 'constructs' representing the synthesised findings from the various included measures in effect sizes. For the 'child behaviour construct' (parent rating), the synthesised result obtained an effect size of 0.42, and for observed child behaviour, the effect size was 0.3, indicating a moderate effect. However, the conclusions from this-though positive-should be treated with caution, as both intervention types and outcome types were aggregated in this review. Nonetheless, these results do indicate a positive outcome on child behaviour from psychological intervention but do not assist with separating out the effects of any particular intervention specifically.

Macdonald et al (2006) included measures of 'externalising behaviour', and 'sexual behaviour'. This review of CBT interventions found that the impact of CBT on externalising behaviours was variable between the included studies and averaged in meta-analysis as a small, statistically non significant benefit. It is not clear whether this benefit is clinically significant. For sexualised behaviour Macdonald et al (2006) found conflicting evidence from five of the included studies with two showing an increase in sexualised behaviour following the intervention and three showing a decrease, with one of these results being statistically significant.

Hetzel-Riggin et al (2007) also included measures of 'behaviour' in their review. The aspects of behaviour included in the category 'behaviour' in this review are not explicitly described by the review authors. They do note significant heterogeneity in the results, perhaps unsurprising considering the potential variation in behaviour problem types that may have been included under this broad category. That being said, the review found that a range of therapy types listed as CBT, supportive therapy, individual therapy, group therapy, abuse-specific therapy, and also '*no treatment*' had a positive effect on 'behaviour'.

Play and family therapies were found to have moderate effects on this outcome. The fact that 'no treatment' comparison groups were found also to improve on this outcome may perhaps mean that some improvement in some aspects of behaviour in some children may occur naturally over time. However, in this case the reviewers note that groups coded as receiving 'no treatment' may have been receiving an alternative treatment or be on a waiting list as their coding did not distinguish between these. It is therefore difficult to draw any meaningful conclusions about this observation.

Hetzel-Riggin et al (2007) conducted analyses looking at factors moderating the results and found both number of sessions and number of months in therapy to be significant moderators of the mean weighted effect size. It is perhaps not a surprising result that the intensity or duration of treatment may have an impact on outcomes; although it is also true to say that where a treatment is ineffective the duration would be unlikely to make a difference to the outcome.

Cohen et al (2006) included measures of sexualised behaviour problems and externalising behaviour in their review. However, aggregated results are not presented in the review so could not be included here.

Avinger and Jones (2007) reviewed the impact of group therapy on the recovery of sexually abused adolescent girls. Two included studies measured behavioural outcomes: one finding a positive result and one no evidence of effect. However, the findings were moderated by small sample sizes and methodological concerns so should be treated with great caution.

8.i.iv Education

School attendance

This outcome was not assessed in any of the reviews included in this meta-review.

8.i.v Mental/emotional health

Depression/anxiety

Macdonald et al (2006) assessed the outcome of child depression and found that data from five studies showed an average small decrease of 1.8 points on the Child Depression Inventory in three of which studies the benefit demonstrated was sustained after one year of follow-up.

Macdonald et al (2006) also assessed the outcome of anxiety and found that data from five studies showed a small overall average decrease of 0.2 standard deviations on various scales. This was not significant; although two of these studies maintained the benefit, sustaining a decrease of 0.28 standard deviations after at least one year. It should be noted that, as above, with standardised outcomes such as these; extremely helpful in meta-analysing data that come from different scales, clinical applicability would ideally need to be assessed by transforming the statistics onto one of the clinical scales (Deeks, Higgins & Altman, 2008).

Cohen et al (2006) found that TF-CBT obtained a significantly greater improvement in four included studies for depression and anxiety than the usual treatment. It should be noted that there is considerable overlap of studies included between Cohen et al (2006) and Macdonald et al (2006).

Hetzel-Riggin et al (2007) measured psychological distress (not defined in the review) and found the largest effect sizes in this group of outcomes across a range of therapies including CBT, play therapy, supportive therapy, abuse-specific therapy, individual and family therapy. They found moderate effects for this outcome also for some other types of therapy that didn't fit these categories.

Hetzel-Riggin et al (2007) found that for the outcome of self-concept (not defined in the review); CBT, group therapy and "abuse specific therapies" obtained the largest effects. They found that family, supportive and individual therapies showed moderate effects, and play therapy a small effect.

Overall, from the findings of this group of reviews, it appears that for non-clinical populations, most forms of intervention demonstrate an impact for young people on this outcome.

Avinger and Jones (2007) included clinical (inpatient and/or residential) samples in their review, as well as studies including only community based participants. This of course may have an impact on findings for depression as compared to solely non-clinical groups. This review found that group therapy seems effective, psycho-drama may alleviate depression (two studies), and trauma focused CBT, humanistic and Rogerian therapies showed no significant decrease in depression. This finding is discussed further below.

Social relationships/functioning

Aspects of social relationships and social functioning were measured by two studies included in this meta-review. Hetzel-Riggin et al (2007) (moderate quality review), reported findings for social functioning which suggest that play therapy has the largest effect on this outcome, with cognitive behavioural interventions, family, abuse specific, supportive, individual and group therapy obtaining moderate effects.

Cohen et al (2006) (low quality review) reported that TF-CBT was superior to non-directive therapy with regard to the outcome of social competence. However, it is important to note that this outcome was only measured by one included study in this review and not under any other treatment type. Findings are therefore less robust for this outcome than for some others and should be treated with more caution.

Post traumatic stress disorder (PTSD) symptoms

It was agreed in the Action for Children evaluation to measure the impact of the interventions on sleep patterns and nightmares and bedwetting. None of the included reviews explicitly included these outcomes. We have included PTSD as

an outcome in this review as some of the Action for Children outcomes, in particular nightmares and sleep disturbances, overlap with PTSD symptoms (Ohayon & Shapiro, 2000; Zayfert & DeViva, 2004).

Macdonald et al (2006) reported the findings of six studies which included post-traumatic stress as an outcome and found a statistically significant decrease in this outcome of 0.43 standard deviations. Two out of these six studies reported a sustained decrease of 0.50 standard deviations after at least one year.

Cohen et al (2006) found that children receiving TB-CBT for the effects of child sexual abuse experienced greater improvements in PTSD symptoms as well as shame symptoms compared to those receiving Child-Centred Therapy. These authors also report positive effects of psychoanalytic therapy on PTSD symptoms although they only cite one study with this finding.

Avinger and Jones (2007) report that TB-CBT and multi-dimensional group therapy may be effective in treating PTSD symptoms but with little strength of evidence, given the lack of a control group in any of the CBT studies and the finding that the effects of multidimensional groups therapy were no more significant than individual therapy.

8.i.vi Other

Medication

Children and young people's use of medication was agreed as an outcome of interest to the evaluation. This has been observed by the projects to be an important outcome for service users, particularly in view of the types of medication that can be prescribed. In particular, Ritalin and Risperidone were mentioned as frequently used. The impact of interventions on this outcome was not assessed in any of the reviews included in this meta-review.

Security of residential placements

It was agreed in the Action for Children evaluation to measure the impact of the interventions on the number of residential placements as it is the experience of the projects that this service user group may experience frequent placement breakdowns. This outcome was not assessed in any of the reviews included in this meta-review.

8.ii General points relating to the results

8.ii.i Additional observations regarding results

This meta-review has focussed on the outcomes that were agreed to be of interest for the Action for Children evaluation. The included reviews do assess a number of other outcomes. However, these have not been incorporated here as they do not reflect Action for Children's priorities for the project overall. Other outcomes assessed include parenting outcomes e.g., measures of parental depression. In addition, it should be noted that findings from Avinger and Jones (2007) are reported separately as this review did not distinguish between inpatient and outpatient samples and so cannot be seen as entirely comparable with the other studies.

The sections above present the findings from the included reviews under the headings of the individual outcomes listed. Any points made by the included reviews that do not neatly fit in the outcomes section but that have a bearing on interventions are described here.

Hetzel-Riggin et al (2007) note that in their review it was found that regardless of the type, therapy with longer duration led to better outcomes. More specifically, the number of therapy sessions and the number of months in therapy was a significant moderator of outcomes. Hetzel-Riggin et al (2007) also found that interventions with children or young people who had been victims of intra-familial abuse were less effective than in cases of extra-familial abuse. In general, however, they note that the choice of treatment should depend on individual service user needs rather than other factors.

Macdonald et al (2006) found that CBT can be a useful intervention for children who have been sexually abused, particularly in relation to the outcomes of Post-traumatic Stress Disorder, anxiety and sexualised behaviour. TB-CBT was found to be an effective form of CBT.

Avinger and Jones (2007) found that overall the studies suggest the benefit of tailoring individual groups for particular symptoms rather than including all young people in the same groups.

The low quality of two of the reviews should be borne in mind when considering the validity of the findings obtained by Avinger and Jones (2007) and Cohen et al (2006).

8.ii.ii Presentation of results

One final point to make about the presentation of results overall is that where results are meta-analysed, i.e. statistically aggregated within individual studies, and where results are presented from a number of studies that measure an outcome (e.g. depression) using different scales, the findings cannot be presented as units of any one scale. As a consequence of this, the findings are often presented (as in the studies included here) either as effect sizes or units of standard deviation. These terms in general are taken to mean the same thing, i.e. a standardised measure of effect used to denote how strong the evidence is for a particular outcome. Such measures do not however readily translate into clinically meaningful terms. As a rule of thumb, effect sizes of 0-0.3 are usually seen as a small effect, those of 0.4-0.6, as a moderate effect, and those of 0.7-1.0 as a large effect.

Where results are aggregated from studies that measure an outcome (e.g. depression) on the same scale, the results are usually presented as units of that scale, so the difficulties in interpretation do not apply in the same way.

In one particular example Skowron and Reinemann (2005) synthesised constructs derived from the outcomes reported, rather than individual outcomes. Outcomes were coded according to their type and the target of the assessment measure.

This resulted in seven outcome constructs e.g., child personality self report, parent ratings of child. Skowron and Reinemann (2005) found that the average effect overall was better for the intervention than for the wait list control groups. Other moderators of treatment effect suggested in this review were length of treatment, severity of abuse and/or co-morbidities.

9. Strengths and limitations of the meta-review

There are a number of strengths of this meta-review which make it a timely and useful resource for both practitioners and researchers in the field of child sexual abuse. Firstly, the meta-review adopts a systematic and transparent methodological approach to searching, screening and reviewing the included reviews. The meta-review includes some quality appraisal of the included reviews and recognised quality assurance techniques, e.g. double screening of reviews at all stages from title to data extraction.

Secondly, the meta-review aggregates the results of the five included reviews using a structured narrative synthesis focused on important clinical and social outcomes, rather than specific intervention types; which makes it potentially more user-friendly.

Thirdly, the meta-review highlights 62 primary studies in this area, which may be of wider use to practitioners, researchers and other research users in the field. A list of these 62 studies can be found at Appendix 3.

Finally, this meta-review identifies relevant existing evidence on this topic, bringing the results of several reviews together in one place, making it a useful resource and preventing duplication of effort.

This meta-review is limited by a number of factors, many of which were driven by time and resource constraints which prevented a more comprehensive review being undertaken. Firstly the search was restricted to the databases available at Canterbury Christ Church University and dates were limited in order to reduce the size of the task due to time and resource constraints. The authors hope that this also promotes a product that is relevant to current practice. This may in practice have narrowed the literature included in the review. Also, no non English language databases were searched and no unpublished literature included, with the likely outcome that language and other publication biases may be reflected in this meta-review.

Methodologically there are a number of additional limitations. The meta-review has been systematically conducted but utilising limited quality appraisal and synthesis thus reducing the systematicity of the product. For example, no statistical meta-analysis to combine the results of individual included reviews has been conducted. To do so in any valid way, aggregating the already aggregated results of the individual studies, would have required access to statistical expertise and forms of statistical modelling not possible within the available resources. Furthermore, the included reviews represent diverse pieces of work such that it may have proved inappropriate to perform statistical meta-analysis. This may indeed have been the decision made following consultation with appropriate statistical experts. However, the lack of statistical meta-analysis limits

the ability of this review to make robust comparisons between the included reviews, particularly in view of the varying quality of the reviews.

A further methodological issue arises from the overlap in included studies between the included reviews. It is difficult to fully assess the impact that this has had on the review findings. However, the inclusion of some of the same studies in a number of the included reviews at the very least magnifies the effect of the results of these studies on the overall findings, potentially introducing a further element of bias.

The review also only included published literature as no unpublished literature was found in the search undertaken, and therefore only covers interventions that have been evaluated and published. It therefore does not reflect the full range of interventions which may be available in practice.

Furthermore, this work was conducted as a meta-review rather than a systematic review of primary studies. Of course, the further aggregation of already aggregated data can have the impact of reducing the sensitivity of the findings and the ability to tease out nuances of recommendations from the data.

10. Discussion

As is evident from the results section above, not all of the outcomes of interest to Action for Children were measured in included reviews. It is of note that there was consensus in the consultation phase among a group of Action for Children therapists experienced in this area as to the central importance of these outcomes in the lives of children and young people who have been sexually abused. It is therefore possibly a curious artefact of the research/practice divide that included studies do not measure all of these outcomes. Of course, there are perennial difficulties in relation to the measurement of some types of outcome within this area of research. As noted elsewhere in this report, any aggregation of the results of published research is dependent on the body of work that has been evaluated and published. It would appear that this meta-review may reflect the degree to which published research does not always reliably represent the range of interventions and expertise within communities of practice.

Overall findings from the review in relation to problem behaviours were that a range of different treatment types showed varying levels of small benefit, although one robust study found conflicting evidence in relation to sexualised behaviour. The finding in another study that 'no treatment' groups were found to improve in relation to aspects of child behaviour could imply that some aspects of behaviour in some children may naturally improve over time, although of course clinical practice can never rely on this alone.

The summarised findings for depression and anxiety showed some robust benefits of interventions for the outcome of depression, with weaker evidence in relation to anxiety, with TF-CBT appearing to demonstrate significantly greater improvement than other intervention types. Another study found that a range of different therapies showed benefit for psychological distress. It should be noted that the review which included both clinical and non-clinical groups (Avinger & Jones, 2007) showed no significant decrease in depression with TF-CBT. This may

imply that it is more difficult to demonstrate improvement within clinical groups, or that depressive symptoms may be harder to change when at a clinical level.

It should be noted that this particular review (Avinger & Jones, 2007) included some earlier studies than those included in the other reviews which may partially account for the difference in the findings. This might have a number of implications. Firstly, it may have included different studies to the other later reviews which could account for differences in findings. Secondly, the population and/or interventions included in older studies might be systematically different due to changes in practice over time.

Findings in relation to the outcomes of social relationships and functioning are considerably less robust than for other outcomes and should therefore be treated with some caution. However, this is not an outcome that was measured by all included reviews so the strength of evidence is inevitably weaker.

In relation to PTSD symptoms there appear to be some benefits for young people who receive CBT and TF-CBT as compared to those who receive Child-Centred therapy. However, whilst a number of studies compared Child-Centred therapy with various forms of non-directed therapy, only one study involving 229 children directly compared CBT and Child-Centred therapy.

The view that multi-dimensional therapy is useful in the treatment of a number of symptoms is highlighted by more than one review, which suggests that therapy should be flexible and the modality in which it is delivered determined by the child's needs. Thus, the range of available therapies should reflect the variety of symptoms experienced by children who have been sexually abused. In relation to this, it would have been interesting to examine Skowron and Reinemann's (2005) planned analysis of the covariance of effect sizes with other treatment characteristics (therapist experience, attrition rates, and use of treatment manuals) and client characteristics (ethnicity, age, gender). However, there were insufficient studies reporting these characteristics for the review authors to make this assessment, and therefore this may represent a gap in the current evidence base in this area.

Overall it seems that in the majority of reviews included in this meta-review treatment is viewed as better than no treatment but that effect sizes vary greatly between treatments and with no treatment for a variety of both symptoms and outcomes. Authors of one review suggest that the variability in results may be partly due to the resilience of some children in response to trauma, particularly sexual abuse.

A further consideration in the effectiveness of different types of therapeutic intervention is the long held belief across different types of therapy that the quality of the therapeutic relationship, i.e. the relationship between the receiver and the giver of therapy, has a crucial role to play in determining successful outcomes. Recently, some systematic review work has been undertaken that considers this very issue within therapy for children and adolescents (Karver et al, 2006; Shirk & Karver, 2003). Interestingly, these reviews have found that across

different types of therapy including behavioural therapy, cognitive behavioural and psychodynamic therapies, aspects of the quality of the therapeutic relationship (many different variables included) do appear to have a moderate but consistent level of observed relationship with outcomes obtained (op.cit).

Given that this phenomenon has been observed in different studies of differing types of therapeutic approach, it is important to view the quality of the therapeutic relationship as a key issue in researching and evaluating practice as well as in the actual delivery of therapy. It may be that this element should be a key focus in staff development and training. It may also account for some findings in this meta-review that seem not to differentiate between the effectiveness of different therapeutic approaches.

11. Conclusions

Overall, a number of different therapies and treatment modalities have been shown to have positive effects on the various sequelae of child sexual abuse. Whilst the majority of reviews included in this meta-review were supportive of the use of CBT, given its reported association with greater improvements in symptoms than other types of therapy and control groups, it is possible that this is the most frequently and easily tested therapy in empirical studies and may also be subject to a publication bias. Despite this, the authors of the most methodologically robust review included here, highlight the weak nature of the current evidence base in relation to CBT and suggest that future studies should be more carefully conducted and better reported.

Furthermore, as suggested in a number of reviews, the impact of moderator variables, such as treatment and client characteristics e.g. number of sessions, experience and training of therapist, age and gender of child, that may have an impact on outcomes should certainly be investigated in future research.

Further implications for research arising out of this review suggest that robust child-centred outcomes-focused evaluations should be undertaken and published in order for the field of literature to better represent the range of treatment interventions available to children and their families. In addition, there needs to be better coordination between research and practice to ensure that the outcomes measured in research better reflect priorities in practice.

In terms of the demonstrated implications for practice, bearing in mind the methodological limitations described above, the results of this meta-review appear to demonstrate for some outcomes that intervention is better than no intervention in the aftermath of child sexual abuse. However, practitioners and service delivery agencies should work more closely with the research community in order to more effectively articulate both these benefits and the nuances of differences between different intervention types.

12. Summary of main messages from this meta-review

- The evidence base includes reviews of varying quality and the results should be considered in the light of this, with lower quality evidence being treated with more caution than higher quality evidence
- The meta-review does not overall find a clear benefit of one intervention type over another
- Evidence from the highest quality review found that evidence for the effectiveness of CBT is less robust than had been assumed
- Findings may not generalise to clinical groups e.g. those with depression
- The importance of the therapeutic relationship should not be understated.
- Included reviews make the point that a tailor-made focussed approach is preferable for each child or young person referred rather than a 'one size fits all' approach
- The impact of moderator variables on outcomes such as aspects of individual interventions or participant details should be investigated further in future systematic reviews of intervention studies
- Evaluations should include dimensions of service delivery which may moderate outcomes
- Evaluation and research needs better co-ordination with practice priorities, lending support to the idea that such research should include input from those working in the field
- Service evaluations should be conducted robustly and published to improve the evidence base
- Outcome measurement is patchy and seems to be less robust for social outcomes than mental health outcomes in this study.
- Researchers do not appear to be measuring outcomes which have been prioritised by users and practitioners
- SMDs should be translated into effect sizes that can be more readily interpreted
- The experience of this meta-review was that meta-review has limitations due to the repeated aggregation of data reducing the detail obtained in the original studies included in the reviews

13. References

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Appendix 1

Full search strategy

ASSIA:
Child abuse or Rape or Sexual Abuse
And
Treatment* or Service*
And
Child* or Adolesc*
Limited to 2005-2008

The Campbell Library:
Child abuse or sexual abuse
Limited to 2005-2008

CINAHL:
Child Abuse or Sexual Abuse
Limited to 2005-2008
Limited to resource type Review or Systematic Review

DARE:
Child abuse or sexual abuse
Limited 2005-2008
Medline:
Child abuse or sexual abuse
Limited to 2005-2008

PsychInfo:
Child Abuse or Sexual Abuse
Limited to 2005-2008
Limited to resource type Review or Systematic Review or Meta Analysis

SCIE Online:
Sexual Abuse
And
Treatment or Services
Limited to 2005-2008

The Cochrane Library:
Child Sexual Abuse
Limited to 2005-2008

Review methods (main search terms and where searched, what quality appraisal conducted, synthesis strategies etc)

Inclusion criteria:

- Participants

- Intervention

- Setting

- Outcome

(s) _____

- Study Type

Exclusion criteria

Total number of studies finally included in review _____

Total number of child sexual abuse studies finally included in the review

Outcomes and Results

Summary of main findings (include text and figures e.g. main effect size)

Limitations:

- Small number/range of databases searched
- Excessively narrow inclusion/exclusion criteria
- Non-representative research team
- Uneven evidence base
(e.g part of target population not represented in included papers)
- Lack of transparency in reporting
- Lack of transparency in methods
- Lack of transparency in quality appraisal

Other limitations

Other relevant information/comments

Appendix 3

Unique studies included in included reviews

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