MESARCH

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What does the evidence say about the effectiveness of interventions for people exposed to sexual violence and abuse?

A briefing for commissioners

Introduction

Two recent Cochrane Reviews assessed the effects of psychosocial interventions on mental health and well-being for survivors of sexual violence and abuse. The first review combined published trials from around the world that examined the effects of interventions designed to support adults in the aftermath of rape, sexual assault, or abuse.[1] The second review, designed to complement the first, combined qualitative studies of adult and child survivors of sexual violence and abuse to develop a picture of service users' (and family members') experiences of interventions, as well as the perspectives of the professionals who delivered them.[2] Evidence based practice is vital for effectively meeting the lifelong care needs of survivors. Based on the evidence from the international literature, this briefing has been designed to inform future policy and commissioning decisions in relation to sexual assault and abuse services and has relevance in any setting where survivors of abuse may access support for their health and wellbeing.

About the included research

Review of trials: 36 research trials, published up to January 2021, compared the effects of psychosocial interventions offered to survivors aged 18 years and above, with an inactive control group (e.g., usual or standard care, treatment waiting lists, or very minimal assistance, such as a leaflet). In a second comparison, we undertook a head-to-head comparison of trauma-focused interventions (e.g., Prolonged Exposure) versus non-trauma-focused interventions (e.g., Cognitive Restructuring). The main outcomes across the comparisons were post-traumatic stress disorder (PTSD)/symptoms, depression, treatment acceptability (based on drop-out from interventions) and adverse events. Participants were invited from a range of settings: community; universities; mental health clinics; specialist sexual assault services; and primary care, sexual health, and emergency settings. Most studies were done in the USA (26); there were two from South Africa, two from the Democratic Republic of the Congo and single studies from Australia, Canada, the Netherlands, Spain, Sweden, and the UK.

Qualitative Review: 97 qualitative and mixed-methods studies, published up to August 2021, explored the experiences of survivors who took up interventions in response to exposure to sexual violence and abuse, their supporters as well as professionals working in the delivery of interventions. Using purposive sampling, we selected 37 studies to analyse using thematic synthesis methodology. In 27 of these, the participants were survivors, in three they were intervention facilitators and the remaining seven included a mix of, or all three, groups. Seventeen studies were done in the USA, five in Canada, and five in the UK. Two were carried out in Chile and two in South Africa with single studies in Australia, Iceland, Ireland, Nicaragua, Norway, and the Philippines.

About the participants

Review of trials: A total of 3,965 women and 27 men were included. Half of participants were African, Black or African-American and 10% were from minority ethnic or cultural backgrounds. The average age was 36 years and 94% of participants had clinically relevant PTSD symptoms at entry.

Qualitative Review: 292 survivors were included in the studies we analysed with just 26 men and 1% identifying as gender diverse. There were 19 survivors' family members or partners and 60 intervention facilitators (two-thirds were women). Across the studies where age was reported, survivors' ages ranged from 5 to 69. Most studies did not report ethnicity.

About the interventions

Review of trials: Half of the interventions in the experimental groups were Cognitive Behavioural Therapies (CBT) including Cognitive Processing Therapy and Prolonged Exposure Therapy. Behavioural interventions such as Eye Movement Desensitisation Reprocessing (EMDR) and new approaches such as Reconsolidation of Traumatic Memories were evaluated in just under 20% of the experimental groups. The remaining third was psychosocial interventions which tended to be less manualised and did not require the same level of training for staff but were more accessible (e.g., psychoeducation, a video preparing victims for forensic care, or community interventions where the emphasis on sexual violence and abuse was secondary to other social or health concerns). Traditional individual 1:1 delivery was the format in 75% of interventions in the experimental group, with a clear shift to alternative modalities such as telemedicine and computer based interventions in the more recently published studies.

Qualitative Review: There was a wide range of interventions included in the studies we analysed, with only one type, trauma-informed CBT, examined in more than one study. The other interventions included EMDR, compassion-focused therapy, faith-based interventions, several psychotherapies, and a range of yoga, Reiki, dance, and art therapies.

Are interventions effective?

Psychosocial interventions compared to inactive control groups

When we combined studies where a psychosocial intervention was compared with an inactive control group, we found that survivors of sexual violence and abuse during adulthood experienced a large reduction in their PTSD symptoms and depressive symptoms in the post-treatment phase (i.e., in the days and weeks after

experiencing a psychosocial intervention) relative to control groups. There may also be large effects from psychosocial interventions for post-treatment anxiety and global mental health. Interventions did not seem to worsen symptoms or lead to unwanted effects. Findings from the Qualitative Review supported these findings, with participants indicating that interventions had positive impacts on their physical health, mood, understanding of trauma, interpersonal relationships and enabled them to re-engage with a wide range of valued domains in their lives. Across the included studies, there was only very minimal follow-up beyond the post-treatment phase due to reasons such as participants initially on waiting lists being offered the active interventions. Sub-group analyses suggested large effects for PTSD and depression from behavioural interventions and CBT, but no evidence of effects from low intensity psychosocial interventions on those particular outcomes.

Trauma-focused interventions compared to non-trauma-focused interventions

Some interventions, such as EMDR and trauma-focused CBT, involve confronting feared memories of the sexual trauma (or to cues that are associated with fear at the time of the trauma), and we refer to these collectively as trauma-focused interventions. Other interventions do not involve this trauma-focus and hence we refer to them as non-trauma-focused interventions. They included Holographic Reprocessing, Stress Inoculation Therapy, supportive counselling, Present-Centred Therapy, and emerging interventions such as trauma-sensitive yoga. When we combined the results of studies that compared trauma-focused to non-trauma focused interventions, we found that there was little or no difference in PTSD symptoms and depressive symptoms at post-treatment (*both* groups experienced important improvements). Further, we detected no difference in the adverse events experienced by survivors. At three months, trauma-focused interventions may result in a small important effect, with a slight reduction in PTSD, and a moderate effect for depressive symptoms. This relative improvement needs to be balanced against the finding that participants who receive trauma-focused interventions may have increased risk of not completing the treatment.

Features of effective intervention provision

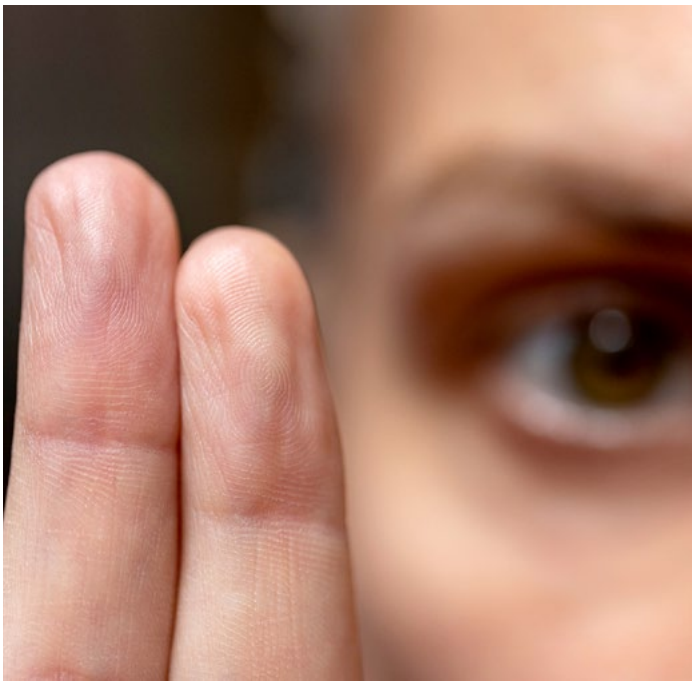
Enabling survivors to take an active role in how their care needs are met is an important step in recovery. Co-producing services in partnership with survivors provides an opportunity to address power imbalances between professionals delivering services and survivors accessing them, which as our findings demonstrate, is a particularly important aspect of psychosocial interventions for sexual violence and abuse. Addressing this power imbalance through co-production of services helps survivors to engage more effectively with services, ensures that services address survivors' needs and promotes therapeutic alliance.

Each survivor's level of readiness and preparedness to both start and end interventions could have positive (if they were ready) or negative (if they were not) impacts. Readiness is vital, shaping engagement and may be as important as intervention content. Survivors said that not being prepared for ending an intervention undermined potential benefits. Empowering survivors and allowing them the opportunity to exercise control over intervention decisions was important for survivors and their families. Such an approach requires giving survivors and their families clear information, a range of intervention options, and supportive provision both prior to, and after, the interventions.

Interventions that were flexible and tailored to the individual needs of participants improved perceptions about suitability and effectiveness. This concerned intervention types (e.g., selecting faith-based interventions), or elements of an intervention that held particular relevance to sub-groups of survivors (e.g., minority groups); these issues could impact how individuals experienced receiving interventions. Relationships with peers were identified as an enabler or barrier to realising benefits from interventions. Survivors described a trusting relationship with peers participating in the intervention as central to the healing process. Feelings of safety were a prerequisite for trust. It is therefore important to consider membership so that all feel welcome and safe; this was particularly stressed by participants from a range of minority populations.

The context in which interventions were delivered had an impact on how individuals accessed and experienced them. This included organisational features, such as staff turnover, the setting or location in which interventions were delivered, and the characteristics associated with who delivered interventions. The wider context within which survivors and interventions are situated (e.g., relationships, families, services, and communities) are important considerations in the design and delivery of psychosocial interventions for sexual violence and abuse. For example, support from partners, family, and a peer network outside of the intervention was identified as facilitating change and, conversely, the lack of support was described as a barrier to healing, particularly once the intervention had ended.

Survivors experiencing ongoing violence or abuse are often excluded from interventions and some practitioners were concerned that this led them to turn people away who may otherwise have benefitted from the intervention. Some facilitators noted that survivors who had experienced re-victimisation, multiple traumas and/or reported complex trauma found achieving stabilisation within the intervention challenging. This was particularly the case for children and young people. Professionals felt that it would be beneficial to have more flexibility to work with the carer or family to address any wider problems and stabilise home environments, and therefore the individual, prior to, or alongside intervention. When interventions are not appropriate, alternative support or provision should also be considered.



Implications for practice

Our reviews of existing research underscore the importance of enabling disclosure and access to psychosocial interventions in the aftermath of sexual violence and abuse: a range of psychosocial interventions has been shown to improve the mental health and wellbeing of survivors of sexual violence and abuse in the short-term. These include traditional trauma-focused approaches such as those recommended by NICE guidance (e.g., CBT and EMDR) which showed the strongest effects for mental health; non-trauma-focused approaches; and several emerging areas such as Reconsolidation of Traumatic Memories, trauma-sensitive or trauma-informed yoga, Lifespan Integration and cognitive training (e.g., neurofeedback). The newer interventions offer scope for flexibility with or without a trauma focus. They involve features such as shorter duration, computer-based or minimal interpersonal contact with a therapist, and somatic practice/movement as the main modality. However, all newer interventions warrant further research to establish effectiveness.

We found no evidence of harm in the short-term as a result of receiving interventions. However, the evidence base lacks long-term follow-up with those who participated in the interventions, including hearing from survivors who had dropped out of programmes early. Our Qualitative Review did find areas where there was *potential* for harm, for example, in not enabling survivors to have control over when they completed interventions, not feeling comfortable and safe in group interventions (due to the group composition), and pressures to continue with an intervention where the person was not able to form a positive, trusting relationship with the therapist or facilitator.

Flexibility in terms of intervention provision is therefore important, as well as providing some choice with regard to access to interventions (e.g., traditional trauma approaches, psychotherapies, alternatives to 'talking' therapies such as trauma-sensitive yoga and faith-based interventions). Interventions need to have the time to be clinically effective. Quality and safety must also be prioritised over prescribing a number of sessions. Drop-out from an intervention is often perceived as negative; however, our findings indicate that survivors should be involved in whether the intervention approach fits their psychological and social needs at that time and alternatives should be explored.

Our conclusions and recommendations are limited by the content and quality of the studies included in the two Cochrane Reviews.[1,2] The evidence can inform stakeholders on choice and monitoring of interventions for sexual violence and abuse, and tools to increase the responsiveness of agencies to the needs of survivors. We generated questions from our findings to help policy-makers and commissioners assess the provision of interventions for survivors.

1. Are different types and formats of interventions available to survivors which recognise varying needs (e.g., survivors of single traumas versus those with multiple traumas across the lifetime)?

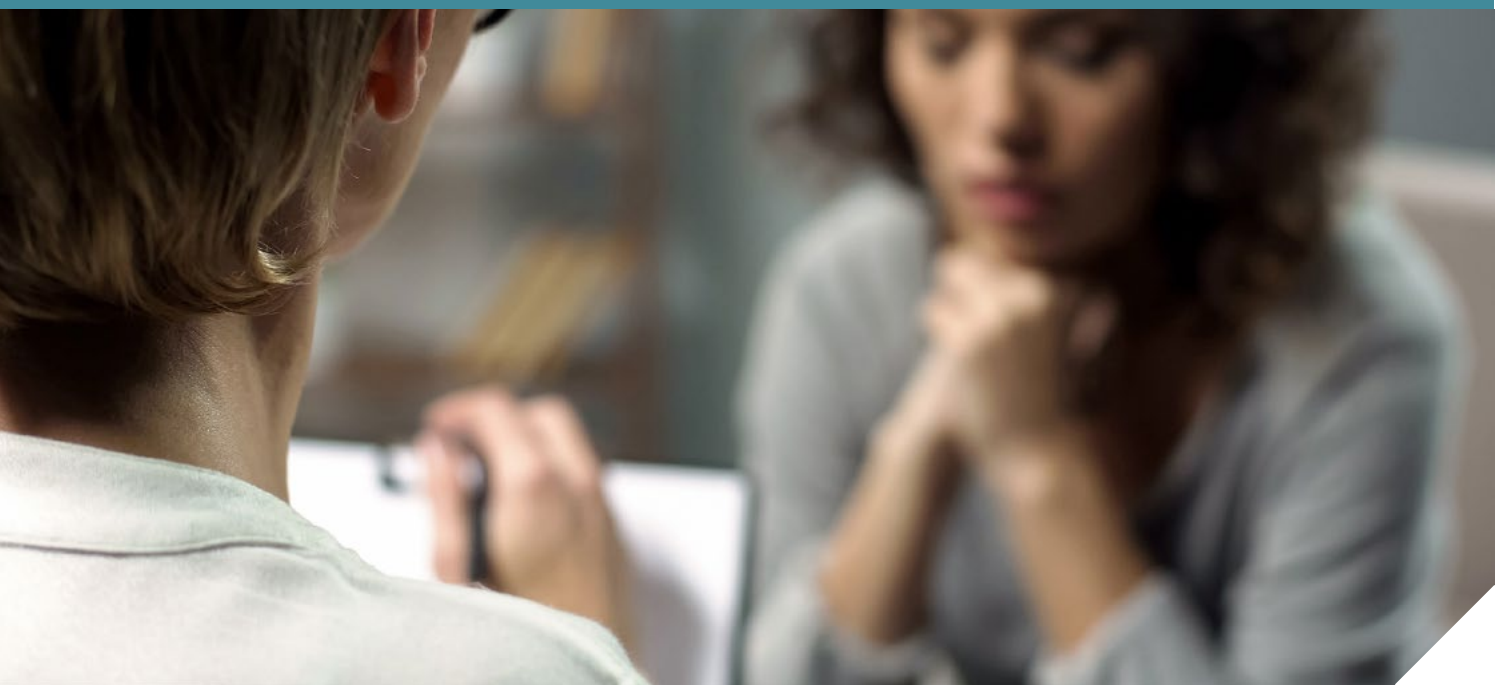
2. In collaboration with practitioners, are survivors able to take an active role in deciding which interventions are suitable for them and when they are ready to start an intervention?

3. Are survivors supported to access an alternative if an intervention or its timing is not right for them?

4. Is alternative support provided for survivors who might not be suitable for interventions due to ongoing abuse and/or levels or types of trauma?

5. Is feedback about interventions sought from those who decline them or start them and 'drop-out', as well as from those who complete them and do services share and implement learning from this?

6. Is the right support with the right capacity to meet the demand within a given geographical area being commissioned?

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The Cochrane Reviews were undertaken as part of the NIHR-funded MESARCH project (2018-2023). This is one of three briefings for different stakeholder groups, including survivors, and has been designed in consultation with the MESARCH Lived Experiences Group. Find out more about the MESARCH project at http://mesarch.coventry.ac.uk, where links to the other briefings can also be found.

[1] O'Doherty L, Whelan M, Carter GJ, Tarzia L, Brown K, Hegarty K, Feder G, Khasteganan N, Brown SJ. (In Press). Psychosocial interventions for survivors of rape and sexual assault experienced during adulthood. Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD013456

[2] Brown SJ, Carter GJ, Halliwell G, Brown K, Caswell R, Howarth E, Feder G, O'Doherty L. Survivor, family and professional experiences of psychosocial interventions for sexual abuse and violence: a qualitative evidence synthesis. Cochrane Database of Systematic Reviews 2022, Issue 10. Art. No.: CD013648. DOI: 10.1002/14651858.CD013648.pub2.

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