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

A briefing for providers and practitioners

Introduction

Psychosocial interventions target biological, behavioural, cognitive, emotional, interpersonal, social, and environmental factors to improve health functioning and wellbeing. Two recent Cochrane Reviews assessed the effects of psychosocial interventions on mental health and wellbeing for survivors of sexual violence and abuse. The first review combined the findings of published trials from around the world that have 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]. This briefing, summarising the findings of the two Cochrane Reviews, has been designed to help optimise the care provided by sexual assault and abuse services and other services where survivors seek support for their mental health and wellbeing.

What we did

Review of trials: We searched for studies comparing the effects of psychosocial interventions for individuals who had been subjected to rape, sexual assault, or sexual abuse from the age of 18 years, with a control group (a group of participants who did not receive the intervention but instead were given their usual care, were placed on a waiting-list for treatment, or received very minimal assistance, such as a leaflet). In another comparison, we also included studies that compared relevant interventions to other interventions. We looked for differences between groups on post-traumatic stress disorder (PTSD) and depression symptoms after receiving the intervention; drop-out from interventions (non-completion); and any unwanted effects related to the intervention or research.

Qualitative Review: We looked for qualitative and mixed-methods studies that explored the experiences of survivors and professionals who took part in interventions that supported survivors of sexual violence and abuse, and the family members who supported participants in those interventions.

About the included research

Review of trials: We included 36 studies which were randomised controlled trials, published up to January 2021. Participants were invited from a range of settings: community; universities; places where people seek help for their mental health, sexual trauma or for problems that occur alongside the experience of sexual violence and abuse; and via media requests. 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: We identified 97 studies published up to August 2021. Using purposive sampling, we selected 37 of these to analyse using thematic synthesis techniques. In 27 of these, the participants were survivors, in three they were intervention facilitators, and the remaining seven studies were a mix of survivors, facilitators and/or survivors' family members. Seventeen studies were conducted in the USA, five in Canada and five in the UK. Two studies were done in Chile, two in South Africa, and 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 the participants were African, Black or African-American and 10% were from other minority ethnic or cultural backgrounds. The average age was 36 years, and nearly all had clinically important symptoms of PTSD at entry into the studies.

Qualitative review: 292 survivors, 19 survivors' family members or partners and 60 intervention facilitators. Where reported, most of the survivors were women, 26 were men and 3 were gender diverse; around 85% of the facilitators 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 the evaluated interventions were Cognitive Behavioural Therapies including Cognitive Processing Therapy and Prolonged Exposure Therapy. About 20% were Behavioural interventions such as Eye Movement Desensitisation Reprocessing (EMDR) and new approaches such as Reconsolidation of Traumatic Memories. Low intensity psychosocial interventions (e.g., psychoeducation, videos, or community interventions where the emphasis on sexual violence and abuse was secondary to other social or health concerns) made up around a third, consisting of approaches that tended to require less specialist training for staff and were relatively accessible. Three-quarters of the interventions were delivered on an individual one-to-one basis, 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; a range of psychotherapies; and a range of yoga, Reiki, dance, and art therapies.

Are interventions effective?

Psychosocial interventions compared to control groups
When we combined the findings of all the studies where any psychosocial intervention was compared with a control group, we found survivors of sexual violence and abuse during adulthood experienced a large reduction in PTSD symptoms and depressive symptoms at post-treatment (i.e., the days and week after the psychosocial intervention concluded) relative to control groups. There were also reductions in

anxiety and distress. It is unclear if these benefits were sustained over time due to lack of long-term follow-ups. However, delaying access to treatment in order to follow-up a control group raises ethical concerns. Thus, gaining long-term outcome data without an active comparison group may be impractical. Interventions did not seem to worsen symptoms or lead to unwanted effects. Sub-group analyses suggested large effects for behavioural interventions and CBT, but no evidence of improvement in PTSD and depression for low intensity interventions.

Trauma-focused 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. Here, 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 with 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). There was also no difference in the adverse events experiences by survivors. Three months later, whilst both groups experienced further improvements, these were more pronounced in the trauma-focused intervention group, with a slight reduction in PTSD, and a moderate reduction in depressive symptoms. This relative improvement needs to be balanced against the finding that participants who received trauma-focused interventions were less likely to complete the interventions.

The Qualitative Review supported these findings; participants reported that the 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. Participants identified the potential risks and harms associated with completing interventions but felt that it was important to face and process trauma. Learning how to set and maintain boundaries within the intervention was identified by survivors as a key mechanism that enabled movement towards recovery.

Features of effective intervention provision

Participants across studies in the Qualitative Review did not discuss content and mechanisms of interventions (e.g., aspects related to EMDR, or the type of therapy, or activities); rather, a wide range of contextual factors associated with the interventions had salience for them.

The context in which interventions were delivered impacted how individuals accessed and experienced them. This included **organisational features**, such as staff turnover, which could influence engagement with interventions; the **setting or location** of intervention delivery; and the **characteristics associated with who delivered interventions**.

Open, accepting and non-judgemental therapists/facilitators were crucial in enabling recovery. Participants highlighted that it was important that **all staff they encountered** in accessing interventions (e.g., reception and administrative staff) enacted these characteristics. In contrast, the absence of these characteristics acted as a barrier.

A positive therapeutic relationship was one that was trusting, non-judgmental and where the person felt safe and empowered. This involved times where it was appropriate for the facilitator to encourage/push survivors, but was distinctly different to facilitators 'leading' the intervention. Where positive therapeutic relationships did not develop, or survivors did not feel safe, they struggled to derive benefit from interventions. Survivors felt a sense of loss if their facilitator left.

Interventions that were **flexible and could be tailored to the individual needs of participants** impacted their perceived suitability and effectiveness. Some elements of interventions were specific to the intervention type (e.g., faith-based interventions), or related to an experience of an intervention that held particular relevance to sub-groups of survivors (e.g., minority populations); these issues could impact how individuals experienced accessing (or delivering) interventions.

Relationships with peers were identified as an enabler or barrier to recovery. 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 group membership and dynamics so that all feel welcome and safe; this was particularly stressed by participants from minority populations.

Support from partners, family, and a peer network outside of the intervention facilitated change; by contrast, the lack of family support was described as a barrier to healing. Survivors within couples therapy felt that the presence of a supportive partner helped them and their partner to understand their experiences and the impacts this had. Survivors who were socially isolated often struggled when the intervention came to an end, and with sustaining benefits and accessing further help.

Survivors' **levels of readiness and preparedness to both start and end interventions** could have positive (if they were ready) or negative (if they were not) impacts. Hence, listening to survivors and providing appropriate interventions, at the right time for them, can make a significant difference to their health and wellbeing. **Empowering survivors** and allowing them **the opportunity to take control over intervention decisions** was important for survivors and their families. Such an approach requires giving survivors and their families clear information and choice.

Enabling survivors to take an **active role** in how their care needs are met is a further factor 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 our findings demonstrated was a particularly important aspect of care and support. Co-production helps survivors to engage with services, ensures that services address survivors' needs and enables therapeutic alliance to develop.

Implications for practice

A range of psychosocial interventions has been shown to improve the mental health and wellbeing of survivors of sexual violence and abuse. These included traditional approaches with a trauma focus recommended by NICE guidance (e.g., CBT and EMDR), as well as several non-trauma-focused approaches and novel treatments such as Reconsolidation of Traumatic Memories, trauma-sensitive or trauma-informed yoga, Lifespan Integration and cognitive training. It is noteworthy that survivors, their supporters, and therapists did not tend to discuss content and mechanisms related to the type of intervention (e.g., CBT, EMDR, counselling); rather, the salient factors were context, timing, relationships with therapists and intervention peers, and other features that allowed survivors to feel safe, supported and empowered. We generated questions from our findings to help programme leaders, developers, managers, staff and other stakeholders assess the provision of interventions for survivors of sexual violence and abuse.

1. Is the intervention survivor-centred?

2. Are all staff in the facility/organisation aware that they might interact with survivors of sexual violence and abuse and equipped to interact with them in a trauma-informed way?

3. Are measures in place to minimise staff turn-over, support the availability of the same therapist(s) throughout the intervention, and to manage changes in providers when necessary?

4. Does the location, setting, format, organisational structure, delivery of the intervention and, where applicable, group dynamics (i.e., for survivors attending group interventions), promote safety for all survivors?

5. Can the intervention, its format and delivery style be tailored to meet the needs of all survivors and their changing levels of trauma? And are intervention providers supported and given confidence in making such changes?

6. Are measures in place to help prepare survivors for both the start and end of the intervention?

7. Are intervention practitioners open, accepting, and non-judgemental in their practice?

8. Does the intervention help survivors establish boundaries and be assertive?

9. Is the level of support from survivors' friends, family and wider social networks considered in the design and delivery of the intervention?


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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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