

Survivor, family and professional experiences of psychosocial interventions for sexual abuse and violence: a qualitative evidence synthesis (Protocol)

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[Qualitative Protocol]

Survivor, family and professional experiences of psychosocial interventions for sexual abuse and violence: a qualitative evidence synthesis

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ABSTRACT

Objectives

This is a protocol for a Cochrane Review (qualitative). The objectives are as follows:

This review will gather and synthesise the experiences of interventions for survivors of sexual abuse and violence, their families, as well as the professionals who deliver them.

Specifically, this review seeks to:

1. identify, appraise and synthesise qualitative studies exploring the experiences of child and adult survivors of sexual abuse and violence, and their caregivers, regarding psychosocial interventions aimed at supporting survivors and preventing negative health outcomes in terms of benefits, risks/harms and barriers;
2. identify, appraise and synthesise qualitative studies exploring the experiences of professionals who deliver psychosocial interventions for sexual abuse and violence in terms of perceived benefits, risks/harms and barriers for survivors and their families/caregivers;
3. develop a conceptual understanding of how different factors influence uptake, dropout or completion, and outcomes from psychosocial interventions for sexual abuse and violence;
4. develop understanding of how features and types of interventions respond to the needs of different user/survivor groups (e.g. age groups; types of abuse exposure; migrant populations) and contexts (healthcare/therapeutic settings; low- and middle-income countries (LMICs)); and
5. explore how the findings of this review can enhance our understanding of the findings from the linked and related reviews assessing the effectiveness of interventions aimed at supporting survivors and preventing negative health outcomes.

BACKGROUND

Description of the issue

Sexual violence is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work." (Jewkes 2002). Coercion includes a wide range of behaviours including physical force, psychological intimidation, threats, and blackmail. Coercion also occurs when an individual is unable to consent; for example, because they are too young, or unable to understand the situation, or incapacitated due to drugs or alcohol, or are asleep (Jewkes 2002). Sexual violence includes a wide range of acts including rape, defined as "physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object" (Jewkes 2002), attempted rape and "other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus." (Jewkes 2002). When children are victims of sexual violence, this is typically referred to as child sexual abuse (CSA). For this reason, and given that many adult victims of sexual violence do not perceive their victimisation as 'violence', we will use 'sexual abuse and violence' throughout this qualitative evidence synthesis (QES).

Syndemic frameworks (with concurrent or sequential diseases that additively increase negative health consequences) theorise about the ways in which experiences of abuse and violence and other phenomena related to health, cultural, social and economic factors may co-occur and exacerbate each other (Brennan 2012; Singer 2003). Structural factors, like lack of housing, poverty and immigration status; and social aspects, such as gender identities, sexual identities, ethnicity, disability, history of exploitation or sex work and poor support systems; can interact with experiences of abuse to produce health inequities and reinforce the burden of disease (Willen 2017). Research evidence shows that victims of CSA are at increased risk of experiencing multiple forms of child maltreatment and abuse, and that such polyvictimisation is a key determinant in the development of negative health and behaviour outcomes (e.g. Ford 2010; Leach 2016; Turner 2016). These factors also mean that the experiences of those affected by constellations of social, political, health and economic factors are less likely to be represented in research and prevalence studies. Sexual abuse and violence is a significantly under-reported problem in all populations, but these issues mean that it is particularly under-studied and reported in vulnerable and under-represented populations and during times of conflict and war; hence, it is difficult to fully understand the extent of the problem. For example, among 2013/14 Crime Survey for England and Wales respondents, only 17% of the sexual assaults experienced since the age of 16 years were reported to the police (ONS 2015). Similarly, just 23% of the 323,450 rapes or sexual assaults against individuals aged 12 years or older disclosed in the US National Crime Victimization Survey in 2016 had been reported to the police (Morgan 2017). Following a review of research studies, London and colleagues showed that most adults (55% to 69%) who identified as survivors of CSA did not disclose this abuse to anyone during childhood, with only 5% to 13% reporting the abuse to the authorities (London 2008). In fact, many (10% to 46%) reported that the disclosure of the abuse for the research study was their first disclosure.

Estimates of prevalence vary widely depending on the definitions used, method of data collection, and populations targeted. For example, there are more population-based survey data available to estimate sexual abuse and violence perpetrated by intimate partners, compared to that perpetrated by non-partners (WHO/PAHO 2012). The lifetime prevalence of sexual violence perpetrated by an intimate partner reported by women aged 15 to 49 years in the WHO multi-country study ranged from 6% in Japan to 59% in Ethiopia (WHO 2005). In the same study, 0.3% to 12% of women reported having been forced, after the age of 15 years, to have sexual intercourse or to perform a sexual act by someone other than an intimate partner (WHO 2005). Social and legal marginalisation, exacerbated by gender-defined services, stigma, discrimination and studies with small sample sizes and varying definitions mean that the experiences of sexual abuse and violence by trans gender people (Wirtz 2018) and men are hidden and poorly understood. In relation to non-heterosexual populations, the 2010 US National Intimate Partner and Sexual Violence Survey indicated that people who identify as non-heterosexual are disproportionately victimised, with one in five bisexual women reporting rape by a partner (compared to one in 10 heterosexual women) (Waters 2013). Higher rates of sexual violence are also experienced by gay men and bisexual men compared to heterosexual men (Waters 2013). Estimates of sexual abuse and violence prevalence using reports of perpetrators are rare. A cross-sectional survey of a randomly selected sample of men in South Africa revealed that 14% had raped their current or former wife or girlfriend, while one in five reported raping a woman who was not a partner (i.e. a stranger, acquaintance or family member) (Jewkes 2011). A meta-analysis of 65 studies covering 22 countries showed that 7% of men and 19% of women had suffered sexual abuse prior to 18 years of age (Pereda 2009).

Sexual abuse and violence has devastating effects on adult and child victims, their families and communities. In the US National Epidemiologic Survey on Alcohol and Related Conditions (n = 34,653; Pietrzak 2011), sexual assault was ranked among the top three most traumatic life events. Extensive immediate and long-term consequences for adult and child victims include injuries, substance misuse, eating disorders, post-traumatic stress disorder (PTSD), anxiety, depression, self-harm and suicidality (WHO 2013). Sexual and reproductive health problems for women include unwanted pregnancy and sexually transmitted infections (WHO 2013), while physical health consequences for men include genital and rectal injuries and erectile dysfunction (Tewkesbury 2007). The mental health burden is substantial and similar across male and female victims (Guina 2019; Tewkesbury 2007; WHO 2013). PTSD, a psychiatric disorder that can follow exposure to psychological trauma, is associated with intrusive memories, nightmares, avoidance, and problems with sleep and concentration (Lerman 2019). Individuals with PTSD were four times more likely to report exposure to sexual assault than those not affected by PTSD, and 13% of women with PTSD had lifetime experience of sexual assault (Pietrzak 2011). No differences in PTSD symptoms and severity have been found between men and women who have experienced sexual trauma (Guina 2019). Other mental health consequences include alcohol use disorders, eating disorders, anxiety, depression, self-harm and suicidality (WHO 2013).

Sexual abuse and violence also has considerable social and economic costs affecting individuals' capacities to participate in family, community and economic life (e.g. to engage in work).

in addition to the health and mental health burden, there are lost productivity, police, criminal justice, social and other service costs. Each adult rape in the UK has been estimated to cost over GBP 73,000 from psychological damage to a person, the physical impacts of associated injuries and illnesses, health service use, and economic losses (Dubourg 2005). The US Centers for Disease Control and Prevention (CDC) estimated that the lifetime cost of rape in the USA was USD 122,461 per victim, which amounted to a population economic burden of almost USD 3.1 trillion (Peterson 2017). Estimates suggest that in the UK, CSA exposure leads to GBP 182 million in health spending annually (Saied-Tessier 2014), and in the USA the lifetime economic burden is approximately USD 9.3 billion (Letourneau 2018). Additional impacts include impacts on families, capacities to parent and intergenerational transmission of trauma and violence. Hence, providing accessible, evidence-based interventions for victims is essential to limit the consequences of sexual abuse and violence. Sexual abuse and violence silences and disempowers victims, and providing opportunities for individuals to talk about their trauma and experiences of the services and interventions that they have received provides an important opportunity for them to speak out and help inform the development, improvement and increased accessibility of services and interventions. Hence, it is important to understand how survivors, their families, and professionals view psychosocial interventions, in order to supplement evaluation reviews and to understand the benefits and harms of interventions, as well as their appropriateness and acceptability, from the stakeholders' perspectives.

Description of the intervention

It is well established that experiencing sexual abuse and violence can have a range of detrimental impacts for those who have experienced it directly, and beyond the individual directly affected. It impacts families and individuals supporting survivors. The nature of the support available for survivors is linked to how we understand and conceptualise the harm experienced through exposure to sexual abuse and violence. There are a wide range of interventions that support and respond to those who have experienced sexual abuse and violence.

In the early 1970s, interventions were developed for individuals who had experienced sexual abuse and violence. These early interventions arose from a crisis theory orientation (e.g. Burgess 1974). Such interventions were pivotal to informing the development of advocacy organisations (Koss 1987). However, there has been limited evidence to demonstrate how effective these interventions were, with some research studies suggesting that more intensive treatment was needed in order to address effectively the chronic symptoms experienced by some survivors (Kilpatrick 1983). Throughout the 1970s, evidence-based anxiety treatments were developed for survivors of sexual abuse and violence, including cognitive-behavioural interventions such as stress inoculation training (SIT; Veronen 1983), prolonged exposure therapy (PET; Foa 1986) and cognitive processing therapy (CPT; Resnick 1997; see Vickerman 2009 for a review of these). Situated within a trauma-response theoretical model (Goodman 1993; Herman 1992), behavioural therapies, including eye movement desensitisation reprocessing (EMDR; Rothbaum 1997; Shapiro 1995) were introduced and evaluated.

The interdependent nature of responses given by individuals and community organisations can lead to individuals each having

different types of experiences, which are dependent on their ecological circumstances. This has led to scholars of violence against women and girls emphasising the importance of adopting an ecologically-informed trauma model of rape recovery (Koss 1991; Neville 1999) that acknowledges the different systems within which social and psychological responses are given to support this population. This has been accounted for in Kelly's ecological theory (Kelly 1966; Kelly 1968; Kelly 1971). Harvey 1996 and Koss 1991 adapted Kelly's ideas to develop their own ecological model of rape recovery, which was used by Campbell and colleagues in their evaluation of how legal, medical, and mental health systems respond to the needs of survivors and what factors can impact their psychological, physical and sexual health outcomes (Campbell 1998; Campbell 1999; Campbell 2001; Campbell 2004). Similarly, the World Health Organization (WHO) (Jewkes 2002; Krug 2002) and CDC (CDC 2004) adapted this approach to address the prevention of gender-based violence. Thus, there are a wide variety of interventions that have been developed to support or respond to (or both) individuals who have experienced sexual abuse and violence. These include supportive therapies, whereby counsellors, and/or specific sexual assault/rape support workers, advocates or advisors provide this population with information, advice and support.

Psychosocial interventions are defined as "interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being" (IOM 2015). Such interventions vary considerably as they target different combinations of the aforementioned factors. For example, group education sessions (e.g. Dognin 2017) and brief video-based interventions that provide psychoeducation and model coping strategies have been developed for survivors undergoing a sexual assault nurse examination (Miller 2015). Furthermore, in the UK, Sexual Assault Referral Centres (e.g. NHS 2015 and Vandenberghe 2018) provide a range of initial response and support services. This includes the involvement of independent sexual violence advisors (ISVAs) who are non-psychologists trained to provide survivors with tailored support to address their needs, accurate and impartial information, and support before, during and after court (Home Office 2017). It is important to note that the discussion of the incident prior to court proceedings can be seen as prejudicial to a trial (CPS 2002) and so is often discouraged. In light of this, psychosocial interventions that are tailored to avoid such discussion can be a vital source of support to rape and sexual assault victims in the pretrial period.

In this QES, we will focus on the qualitative components of studies that explore the experiences of survivors, their families and professionals in relation to psychosocial interventions targeted at individuals who have experienced sexual abuse and violence. This will include a wide range of psychosocial interventions that target recovery from adult or child (or both) sexual abuse and violence. Women have been the primary focus as recipients of interventions and services for sexual abuse and violence survivors, whilst male, transgender and gender nonconforming or non-binary populations experience significant barriers in accessing such interventions. Unsurprisingly, these differences in gender regarding intervention recipients have been reflected in the intervention evaluation literature, whereby the samples used in intervention evaluation studies are usually female. In comparison, non-female populations have received little attention in evaluation

studies. There is further imbalance in relation to ethnicity, whereby evaluation samples are predominantly White/Caucasian women and girls, whilst many subgroups, including minority ethnic groups and migrant individuals, remain hidden in both practice and research. This review is pertinent to bringing together experiences of interventions across studies among individuals typically under-represented in research, who share certain social, gender, ethnic and economic characteristics, to examine the acceptability and appropriateness of interventions for subgroups of survivors.

The review will focus on any setting where a person has received an intervention or a professional has delivered an intervention aimed at supporting a survivor or family member in the aftermath of an experience of sexual abuse and violence. For all studies, interventions of any duration or frequency of treatment will be included. For the purposes of this review, we will include a wide range of psychosocial interventions (for definitions, see the list of psychological therapies on the Cochrane Common Mental Disorders (CCMD) website: cmd.cochrane.org/psychological-therapies-topics-list).

1. Integrative therapies, including SIT, PET, and CPT
2. Behaviour therapies such as EMDR and relaxation techniques
3. Formal cognitive behavioural therapy (CBT), trauma focused CBT (TF-CBT) and CBT-based techniques
4. Third wave CBT (e.g. acceptance and commitment therapy, mindfulness)
5. Humanistic therapies (e.g. supportive and non-directive therapy)
6. Other psychologically-orientated interventions (e.g. art therapy, meditation, trauma-informed body-based practices (e.g. embodied relational therapy, yoga and Tai Chi), narrative therapy)
7. Psychosocial interventions, including those delivered by mentors, support workers, advisors or advocates (such as ISVAs in the UK), support groups, and coping interventions

For all interventions, mode of intervention delivery may include face-to-face, telephone or computer-based delivery. We will include in this review studies reporting individual or group delivery of the intervention.

We will include any studies that include feedback from or perspectives of the stakeholder groups, regardless of whether the study (or broader research project) included a comparison or not.

The proposed review will synthesise qualitative evidence, including information on feasibility and acceptability, experience and outcomes of interventions to service users, their families and practitioners. From reports with survivors and practitioners, we appreciate that a good deal of the pertinent evidence about interventions, and their benefits and harms, is missed from systematic reviews of trials. We also note that user and practitioner perspectives provide important information that may explain why interventions are not as effective, widely taken up or sustained in practice, compared to the controlled conditions in which they were tested. Hence, by conducting this QES to complement our review of trials, we aim to achieve comprehensive coverage of the evidence-base for effectiveness and also understand survivors', families' and practitioners' views of psychosocial interventions, with the intention of informing and improving future practice.

How the intervention might work

As described in more detail in [Appendix 1](#) of our linked review ([Brown 2019](#)), the ways in which the interventions might work vary depending on the psychosocial intervention, the factors being targeted and the theoretical underpinnings and principles of the approach on which each intervention is founded. Some interventions are designed to be delivered within a short time period following the sexual abuse and violence (e.g. less than three months), whereas others are used for survivors in the longer term. The former attempt to provide prophylactic treatment to prevent chronic problems, while others intend to facilitate faster recovery ([Vickerman 2009](#)). CBT interventions are founded on the principles that behaviours are cognitively mediated ([Butler 2006](#)) and that cognitions (e.g. thinking patterns and beliefs) can be monitored and altered. Hence, behavioural change can be enacted via cognitive changes ([Dobson 2009](#)). Cognitive interventions for rape or sexual assault and trauma focus on two processes: (1) changing a person's cognitive appraisal of the traumatic event, or changing the process by which an individual attaches meaning to an event; and (2) changing a person's attribution of the event ([Veronen 1983](#)). Other cognitive interventions are designed to equip victims with coping skills to manage their trauma. Behavioural theorists argue that all behaviours are learned and unhealthy behaviours can be changed. Techniques such as flooding and systematic desensitisation are used to extinguish anxiety. Foa and colleagues believe, for example, that exposure to trauma allows mistaken evaluations and faulty stimulus-response associations to be corrected ([Foa 1986](#)). Victims are taught to replace a fear response with relaxation responses, which is done gradually in systematic desensitisation, and more quickly via flooding interventions. For example, in EMDR ([Shapiro 1995](#)), a survivor imagines a scene that represents the sexual abuse trauma and recites words related to it, while the therapist moves his/her fingers back and forth in front of the survivor, so that the survivor performs rhythmic, multi-saccadic eye movements (quick, simultaneous movements of both eyes between two or more phases of fixation in the same direction) by watching the therapist's fingers. This movement is argued to facilitate the processing of trauma memory through the dual attention required to focus on attending to the therapist's finger movement (external stimulus) and the trauma scene (internal stimulus). However, studies comparing EMDR with and without eye movements show that EMDR without eye movements leads to equivalent outcomes as EDMR with eye movements ([Boudewyns 1996](#); [Pitman 1996](#)). Many interventions combine behavioural and cognitive elements and hence are known as integrative therapies. For example, SIT ([Veronen 1983](#)), PET ([Foa 1986](#)) and CPT ([Resnick 1997](#)) all use combinations of relaxation training, flooding or systematic desensitisation techniques, psychoeducation and cognitive methods (see [Brown 2019](#) for a more detailed outline of these approaches). Through acceptance, being present and committed action ([Hayes 2006](#)), third wave cognitive behavioural therapies, including mindfulness and acceptance and commitment therapy, act on changing the function of the events and the survivor's relationship to them. Counselling encompasses a range of interventions ([Cryer 1980](#); [Foa 1991](#); [Resick 1988](#)), premised on a number of theoretical schools of thought (e.g. humanist and psychodynamic). Counselling may be delivered alone or in combination with other approaches. Humanistic and supportive therapies include an eclectic mix of techniques. Supportive therapy is almost always non-directive, that is, the survivor is empowered to guide the content and the therapist avoids offering direct

advice (Cohen 2005; Deblinger 2001). A diverse range of other psychologically-orientated interventions aim to help survivors cope with, express and work through trauma; for example, via expressive writing (Harte 2013), or the assistance of horses, which helps to reduce anxiety (Earles 2015). Psychosocial interventions are diverse and target a range of interpersonal, social and environmental factors in addition to, or instead of, the individual factors that are the focus of psychological therapies. Hence, the way these might work varies greatly. For example, psychoeducation aims to provide information, modelling and training. This might be to explain coping strategies and encourage the use of adaptive coping strategies over maladaptive ones (Sikkema 2018). Group programmes and the provision of advisors or mentors provide social support, which can be important given the stigma and shame associated with sexual abuse and violence that can lead to social isolation. These can increase self-esteem (Sikkema 2018), and provide emotional support and practical assistance (Home Office 2017).

Randomised controlled trials (RCTs) and meta-analyses for synthesising findings from several trials of interventions provide information on efficacy. They do not explain why some people might benefit and why others do not, or why some survivors might complete a treatment whilst others discontinue. The summary above, of how interventions might work, for example, shows that some interventions are driven by survivors, whereas others are led by professionals; some require survivors to recall the sexual abuse and violence, whereas others avoid or can be conducted without this. This is an important aspect, since there is reluctance for survivors or professionals (or both) to talk about the sexual abuse experienced prior to criminal justice trials for fear that this contaminates the survivor's testimony and undermines the court process. Even where there is a clear theoretical basis and hypothesis about the mechanism of change, RCTs cannot fully explicate the 'how' in the pathway. RCTs also assess effects based on a necessarily limited range of outcomes (and measures) and may fail to identify wider benefits and harms of the intervention. Thus, qualitative research is the ideal vehicle for answering these questions, as well as addressing questions around acceptability and for exploring the kinds of values and beliefs that might frame uptake of interventions. Data arising from qualitative studies can inform the content, delivery and provision of support for individuals who have experienced sexual abuse and violence, so that it is more effective, acceptable, accessible and of higher quality, particularly for marginalised or hard-to-reach groups. Hence, this QES will supplement our linked effectiveness review (Brown 2019), and may also extend interpretation of findings from related completed reviews (Gillies 2016; Macdonald 2012).

Why this review matters

This QES is linked to a concurrent Cochrane Review of RCTs by an overlapping team of authors (Brown 2019), which addresses the evidence gap in our knowledge on the most effective ways of intervening to improve mental health outcomes for survivors of rape and sexual assault experienced during adulthood. It is also related to a review led by Caswell (Caswell 2019), one of the co-authors of this QES, assessing the measurement of patient experience and outcomes in healthcare settings after sexual violence. Additionally, it is related to evidence reviews conducted previously on interventions for children who have experienced CSA or trauma (or both) undertaken by different

teams of authors, namely, Macdonald and colleagues' review evaluating cognitive-behavioural interventions for children who have been sexually abused (Macdonald 2012), and Gillies and colleagues' review of psychological therapies for children and adolescents exposed to trauma (Gillies 2016). While these reviews assess the evidence base for the effectiveness of interventions for survivors (adults and children) of sexual abuse and violence, or the ways in which survivors' experiences are measured, they do not assess survivors' and their families' and support networks' perspectives and experiences of these interventions, nor those of the professionals who deliver them. Hence, this QES will uncover mechanisms of intervention effectiveness, aiming to achieve a greater understanding of how and why an intervention might work or not. It will play a key role in developing a conceptual understanding of how different factors influence uptake, experiences, and dropout/completion of interventions from the perspective of survivors of sexual abuse and violence, their families and the professionals delivering the interventions. It is important to understand the experiences and views of these important stakeholder groups. We are aware from our practitioner partners, for example, that interventions and services are less frequently accessed by some groups (e.g. men; lesbian, gay, bisexual, and transgender (LGBT); ethnic minorities; and refugees) and that there are many barriers. For example, survivors have been denied access to interventions, particularly those that require talking about their experiences, for fear that this will change their memory or testimony and undermine the criminal trial process. Some interventions are not perceived positively by professionals and survivors, as they required extensive recall of the sexual abuse and violence, which is traumatic. It is therefore important to understand stakeholders' views and experiences of these interventions to gain a more complete understanding of the interventions' utility and accessibility.

Qualitative research can play a key role in developing our understanding about how interventions are experienced and work. Evidence from qualitative research and process evaluation studies can provide valuable insights into attitudes and perceptions of interventions, engagement, satisfaction, and barriers and facilitators experienced by stakeholders. It can also contribute to underlying mechanism(s) of change with regard to the particular intervention and the role of contextual factors in the delivery and impact of that intervention (Moore 2015; O'Doherty 2016). Understanding the views of intervention stakeholders who receive or deliver these interventions can help to inform decision-making and strategies regarding intervention development and enhancing their acceptability. The results from this QES, therefore, will enable us to have a greater understanding of context, benefits and harms of an intervention, and reasons for appropriateness, acceptability and implementation of interventions from the perspective of survivors, their families and professionals. Although we will not include quantitative process evaluation data, the synthesis of qualitative data may also contribute to understandings about mechanisms and pathways to change. Additionally, the results will enable us to examine how perceptions of an intervention may impact intervention engagement and effectiveness, and why intervention effects might vary across different contexts and subgroups. This may contribute to generating hypotheses about how and why certain interventions might be more effective for particular subgroups, and in which contexts, which is critical to informing subsequent subgroup analyses in future effectiveness reviews. Not all interventions available to survivors have been

evaluated using an RCT. Further, not all interventions, including those that have been tested in trials, will necessarily be perceived positively, and it is important to identify why interventions are not always widely taken up or sustained in practice compared to the controlled conditions in which they were tested. By conducting this QES to complement our systematic review of trials, we aim to achieve comprehensive coverage of the qualitative evidence base to understand the views of survivors, family members and practitioners, with the intention of informing and improving future practice. The findings may also help to inform the design of future trials, ensuring that they capture the elements of support that are important to survivors of sexual abuse and violence, their families and the professionals with whom they work.

OBJECTIVES

This review will gather and synthesise the experiences of interventions for survivors of sexual abuse and violence, their families, as well as the professionals who deliver them.

Specifically, this review seeks to:

1. identify, appraise and synthesise qualitative studies exploring the experiences of child and adult survivors of sexual abuse and violence, and their caregivers, regarding psychosocial interventions aimed at supporting survivors and preventing negative health outcomes in terms of benefits, risks/harms and barriers;
2. identify, appraise and synthesise qualitative studies exploring the experiences of professionals who deliver psychosocial interventions for sexual abuse and violence in terms of perceived benefits, risks/harms and barriers for survivors and their families/caregivers;
3. develop a conceptual understanding of how different factors influence uptake, dropout or completion, and outcomes from psychosocial interventions for sexual abuse and violence;
4. develop understanding of how features and types of interventions respond to the needs of different user/survivor groups (e.g. age groups; types of abuse exposure; migrant populations) and contexts (healthcare/therapeutic settings; low- and middle-income countries (LMICs)); and
5. explore how the findings of this review can enhance our understanding of the findings from the linked and related reviews assessing the effectiveness of interventions aimed at supporting survivors and preventing negative health outcomes.

METHODS

Criteria for selecting studies for this review

Types of studies

We will include primary empirical studies that are linked to a psychosocial intervention (as defined in the 'Types of interventions' section below) aimed at supporting survivors and preventing negative health outcomes that have:

1. qualitative study designs, such as ethnography, phenomenological studies, narrative studies, action research studies, case studies, grounded theory studies, visual studies and qualitative process evaluations;
2. both qualitative methods of data collection (e.g. focus group discussions, individual interviews, observation, diaries, arts-

based methods, document analysis, and open-ended survey questions) and qualitative data analysis (e.g. thematic analysis, framework analysis, interpretative phenomenological analysis (IPA), grounded theory or other qualitatively inspired analytical approaches); and

3. mixed-methods designs where it is possible to extract the data that were collected and analysed using qualitative methods.

It is not a precondition that the published qualitative investigation be linked to studies included in the linked Cochrane Review and related reviews nor is it a criterion that they exist alongside a published evaluation of an intervention. For example, studies may focus on personal accounts of attending or receiving a type of intervention. Since we wish to stratify our findings across intervention types, we will include studies in which more than one intervention that meets our types of intervention criteria are examined, provided we can identify clearly the specific intervention to which each finding applies.

We will exclude:

1. studies that include data using qualitative methods but do not analyse these data using qualitative analysis methods (e.g. open-ended survey questions where the response data are analysed using descriptive statistics only); and
2. editorials, commentaries and opinion papers.

We will not exclude any studies based on our assessment of methodological limitations, but will utilise this information in our sampling strategy (see 'Selection of studies' section) and to assess our confidence in the synthesised findings.

Types of participants

Eligible studies will focus on at least one of three participant groups.

1. The primary group of interest is survivors of sexual abuse and violence. We will include studies that report on the experiences and views of people of any age, gender, sexuality or ethnicity who have received a psychosocial intervention in regards to experiencing sexual abuse or violence. We will include those who were offered an intervention, even if ultimately they did not take up or complete that intervention.
2. The review will also include studies focused on non-offending caregivers, parents and other family members in the context of a child or family member who is a victim of sexual abuse and violence, and is offered or receives a psychosocial intervention. This will allow us to gather the views, experiences, decision-making and acceptance of different psychosocial interventions for the individuals for whom the interventions are designed, but also to understand the views of those involved in the person's immediate support network.
3. The review will also include studies focused on providers involved in the direct delivery of the interventions (e.g. psychologists, counsellors, psychiatrists, support workers, ISVAs, and advocates).

We will exclude studies focused on policy makers, programme administrators, managers or other stakeholders. We will exclude studies related to interventions directed at family members or significant others.

Subgroups

As our review focuses on experiences of psychosocial interventions for different types of interventions, we will explore the similarities and differences in experiences across the different types of psychosocial interventions. In addition, where possible (i.e. where this information is discussed in the studies, or the characteristics of the participants voicing or experiencing different phenomena are clearly illustrated, or both), we will explore the similarities and differences in the experiences of different survivors (e.g. children or adults, gender, ethnicity and sexuality, types of abuse), contexts (urban or rural, high-income country, low- or middle-income country), family members or caregivers (e.g. mother or father or other caregiver, gender and ethnicity), clinical outcomes (e.g. type of clinical outcome, impact of the intervention for the individual), intervention completion (e.g. completers, non-completers, dropouts) and professionals (e.g. profession, levels of experience or training, gender and ethnicity).

Settings

Any setting where a person has received, or a professional has delivered, an intervention aimed at providing psychosocial support to a survivor in the aftermath of experiencing any form of sexual abuse or sexual violence. Settings could include health care, such as general practice, sexual health and mental health services; school-based/education services; charity and voluntary sector services in the mental health or sexual and domestic violence sectors; local support communities, and home support programmes (e.g. home visits).

Types of interventions

The intervention consists of any type of psychosocial intervention that targets recovery from sexual abuse or sexual violence and that meets the definition of “interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being” (Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders (IOM 2015)), including the following.

1. Formal CBT, TF-CBT and CBT-based techniques.
2. Integrative therapies, including SIT (Veronen 1983), and later, PET (Foa 1986) and CPT (Resnick 1997).
3. Behaviour therapies such as EMDR and relaxation techniques.
4. Third wave CBT (e.g. acceptance and commitment Therapy, mindfulness).
5. Humanistic therapies (e.g. supportive and non-directive therapy).
6. Other psychologically-orientated interventions (e.g. art therapy, meditation, trauma-informed body-based practices (e.g. embodied relational therapy, yoga and Tai Chi), narrative therapy).
7. Other psychosocial interventions, including support services delivered by mentors, support workers, advisors or advocates such as ISVAs in the UK, support groups, and coping interventions.

We will include interventions of any duration or frequency of treatment so long as the intervention meets the criteria stated above.

Intervention delivery could be face-to-face, by telephone, through computer-based systems or by any combination of these delivery modes.

We will include both individual and group delivered interventions. It will need to be clear what intervention type has been experienced by the participant.

Types of phenomena of interest

The topic of interest in this synthesis is the factors (e.g. contextual and individual) involved in uptake and continuance of treatment for exposure to sexual abuse and violence across the lifespan; the experience of receiving (and providing) an intervention or treatment; and the benefits and risks/harms for survivors and their families/caregivers from both their perspectives and the perspectives of the professionals involved in providing such interventions.

We will explore the following phenomena.

1. The factors involved in the uptake and continuance of treatment for exposure to sexual abuse and violence at any age (short-term phenomena).
2. Survivors', caregivers' or families' and professionals' beliefs, attitudes, perceptions and experiences of the intervention (medium-term phenomena).
3. Survivors', caregivers' or families' and professionals' reported short, medium and long-term benefits and barriers, as well as risks/harms following exposure to interventions.

The type of evidence collected in our synthesis will include also participants' satisfaction with components of a support programme provided; for instance, in terms of level of training, and demographic and professional characteristics of the providers.

Search methods for identification of studies

The search methods for this review have been developed using guidelines published by the Cochrane Qualitative and Implementation Methods Group (CQIMG) (Harris 2018, including their earlier guidance (Booth 2011)). We will organise the search into two strands, adding a third if necessary, to allow for additional searches to capture specific themes that we uncover during the screening process and that we want to explore in more depth.

Strand 1 will identify qualitative evidence in reports related to, or embedded in, RCTs identified in the linked effectiveness review (Brown 2019) and in other relevant systematic reviews of which we are aware (Caswell 2019; Gillies 2016; Macdonald 2012). We will use the same approach for other systematic reviews that we identify during other phases of the search. Strand 2 will use a broad systematic search, including databases from a range of disciplines, and supplementary searches to increase the chance of finding eligible studies not indexed in bibliographic databases, or that do not contain the search terms in our core search strategy. In Strand 3, we will examine any eligible studies found in Strands 1 and 2, and will assess whether they fulfil our aims, objectives and criteria for this review. If necessary, we will revise our search terms and conduct additional searches.

Strand 1

We will use the search results from the linked effectiveness review (Brown 2019) to identify qualitative evidence embedded in reports of trials, and additionally, will identify qualitative studies associated with related systematic reviews, including three originally used to establish a rationale for undertaking the linked review. These related reviews examined the evidence for cognitive-behavioural interventions for children who have been sexually abused (Macdonald 2012), psychological therapies for children and adolescents exposed to trauma (Gillies 2016), and the measurement of patient experience and outcome in health care settings on receiving care after sexual violence (Caswell 2019). We will try also to contact the principal trial investigators of studies included in these reviews and the authors of the three related reviews (note, Caswell is an author of this QES) to ask about the existence of studies that meet the criteria for this qualitative review (Noyes 2019). We will include any studies identified in the search as meeting the criteria for this QES, even if they are excluded in the linked review (Noyes 2019).

Next, we will extract authors' names and keywords from the titles and abstracts of the quantitative studies in both the linked and related reviews, and use them to search for separate reports of qualitative data related to the trials (Booth 2011; Booth 2013).

We will adopt the same approach for relevant systematic reviews identified in other phases of the search.

Strand 2

Database searches

We will conduct a systematic search for this QES (independent of the linked effectiveness review (Baumeister 2019)), using the databases listed below.

1. MEDLINE Ovid (1946 onwards)
2. MEDLINE Ovid, Epub Ahead of Print (current issue)
3. MEDLINE Ovid, In-Process & Other Non-indexed Citations (current issue)
4. Embase Ovid (1974 onwards)
5. CINAHL Plus EBSCOhost (Cumulative Index to Nursing and Allied Health Literature; 1937 onwards)
6. PsycINFO Ovid (1806 onwards)
7. Epistemonikos (www.epistemonikos.org/en; current issue, limited to systematic reviews)
8. PDQ-Evidence (www.pdq-evidence.org; current issue)
9. Social Services Abstracts Proquest (1979 onwards)
10. Social Science Citation Index Clarivate Web of Science (1970 onwards)
11. PTSDpubs Proquest (1871 onwards)
12. ProQuest Dissertations & Theses A&I Proquest (1743 onwards)

We will search MEDLINE using a search strategy adapted from the linked evaluation review (Brown 2019), and in consultation with the Cochrane Information Specialist for Developmental, Psychosocial and Learning Problems. We will expand the population section to include search terms for children who have been sexually abused (the evaluation review is limited to sexual abuse in adulthood). The sensitivity of the intervention section will be augmented with general terms for treatment because qualitative studies may

not necessarily refer to specific psychosocial interventions. Where possible, we will replace the filters used to find RCTs in the linked evaluation review with published filters to find qualitative studies (McKibbin 2006; Walters 2006; Wilczynski 2007; Wong 2004), revising them as necessary to reflect, for example, new indexing terms (Appendix 1).

Supplementary searches

Reference lists

We will examine the reference lists of all included studies in this QES and in the linked or related reviews.

Related references

We will conduct a forward citation search using the Social Science Citation Index of included studies in this QES and in the linked or related reviews.

Correspondence

In addition to contacting authors of all included studies and related reviews, we will contact experts in this field to identify studies that meet our criteria, including unpublished and ongoing research.

Unpublished reports

As we believe that qualitative studies of user and practitioner perspectives may not all be included in bibliographic databases, we will also search for unpublished reports. We will search national (e.g. Women's Aid and Rape Crisis) and international websites (e.g. World Health Organization and United Nations Preventing Sexual Exploitation and Abuse) and Sexual Assault Referral Centre websites (e.g. Blue Sky Centre and Juniper Lodge) in the UK, in addition to the following sources.

1. National Institute for Health Research search portal (www.nihr.ac.uk/health-and-care-professionals/search-our-evidence.htm)
2. OpenGrey (www.opengrey.eu)
3. Grey Literature Report (www.nyam.org/library/collections-and-resources/grey-literature-report)

Strand 3

We will examine eligible studies identified during Strands 1 and 2. If we find ideas or themes that we want to explore in more depth, we will conduct specific searches using new search terms with the help of our information specialist, until we are confident that we have searched for all relevant key terms and that our electronic searches have identified as many of the qualitative studies that meet our criteria as is feasible within the time and resources available for the review.

Data collection and analysis

Selection of studies

Screening phase

Two review authors (NK and GC) will independently assess the titles and abstracts of all records identified through the literature searches against criteria for considering studies for this QES. They will code abstracts as 'retrieve' (eligible, potentially eligible or unclear) or 'do not retrieve' (not eligible). In the event of disagreements about inclusion, both review authors will assess

and discuss the full article for relevance, using the GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach (Noyes 2018). If agreement cannot be reached by discussion, they will consult a third review author (SB) as a mediator. Final decisions will be made by consensus. We will retrieve full-text articles for selected abstracts and two pairs of review authors (GC and SB, EH and LOD) will independently assess each article against the criteria for considering studies for this QES. Studies will be identified for either inclusion or exclusion. We will contact study authors, as required, to decide whether the inclusion criteria have been met. We will record reasons for excluding ineligible studies. In the event of disagreements, we will consult a third review author (KB) as a mediator. Final decisions will be made by consensus.

For titles and abstracts that are published in a language in which none of the review team and colleagues are fluent, we will carry out an initial translation through open source software (Google Translate). If this translation indicates inclusion, or if the translation is inadequate to make a decision, we will retrieve the full text of the paper. We will then ask members of Cochrane networks or other networks that are fluent in that language to assist us in assessing the eligibility of the full text of the paper for inclusion. If this cannot be done for a paper in a particular language, we will list the paper as 'studies awaiting classification', to ensure transparency in the review process. If we decide to include studies published in languages in which the review team are not fluent, we will obtain a professionally translated version of the entire paper.

We will identify and exclude duplicate records, and will collate multiple reports that relate to the same study so that each study rather than each report is the unit of interest in the review. We will record the selection process in sufficient detail to complete a four-phase (identification, screening, eligibility and included) PRISMA flow diagram for study collection (Moher 2009), and the 'Characteristics of excluded studies' Tables.

Sampling framework

Including every qualitative study we find that meets our criteria in this QES threatens its quality because it is time-consuming and will prevent us from completing an in-depth exploration of our aims and objectives. Furthermore, exhaustive sampling risks producing "superficial synthesis findings, with a large number of studies that fail to go beyond the level of description" (Benoot 2016). Therefore, we will employ Benoot's "umbrella approach" (Benoot 2016), combining several purposeful sampling techniques.

We will begin by reviewing the articles identified as meeting our QES criteria (criterion sampling, Suri 2011), conducting preparatory data extraction in order to identify the type and range of psychosocial interventions that have been examined; the sampling across our three groups of survivors, families/carers and professionals; and the characteristics (e.g. gender, age, ethnicity, sexuality) of these samples. This information will be collated and used to develop a stratified purposive sample (Suri 2011). This is to ensure that we can explore the views and experiences of our three groups across the range of psychosocial interventions while taking account, if possible, of participant characteristics and study context, in line with our QES aims and objectives. We will use a maximum variation strategy (Suri 2011), to ensure that we have considered the benefits, risks/harms and barriers for diverse populations. At this stage, we will include studies with overlapping

samples or characteristics, and complete full data extraction and an appraisal of the quality of each study.

The final selection of studies for each of our stratified criteria will be based on the availability of relevant information (e.g. participant characteristics) and the quality of studies (i.e. selecting studies rated as high quality and with more complete information). Where possible, given the availability of studies, we will include one study that examines each of the three groups (survivors, families or caregivers, and professionals) for each of the psychosocial interventions examined, and for each of our participant characteristics types (which will be determined on the basis of variation in the samples in the available range of studies).

Data extraction and management

We will perform data extraction using a form designed specifically for this review. We will extract information on: first study author; date of publication; country of study; context (urban or rural; high-income country, low- or middle-income country); type of intervention along with duration and details about the locations or settings; participant groups (survivors, families/carers, professionals); type of abuse experienced by participants; sampling strategy and ethical considerations; number of participants in each group; participants' age, gender, sexuality and ethnicity; data collection methods and justification for these; data analysis methods; key findings and the extent to which findings are supported by sufficient evidence; and details of reflexivity. We will extract relevant findings, including extracts from participants and authors, themes and sub-themes, explanations, hypotheses, theories, observations and interpretations of these data (Sandelowski 2002), reported anywhere in the primary qualitative studies. As the thematic synthesis approach shares characteristics with meta-ethnography and grounded theory (Barnett-Page 2009), we will use the same approach to identify findings regardless of the qualitative approach or analyses (e.g. thematic analysis, grounded theory) used in the study. We will use EPPI-Reviewer 4 (Thomas 2008; Thomas 2010) as a platform to manage our screening process, upload search results, select studies, extract and record data, resolve disagreements, export data into Review Manager 5 (Review Manager 2014), and generate a PRISMA diagram report.

Appraisal of methodological limitations in the included studies

We will only include studies that have a transparent audit trail of the methods used, which is a basic quality threshold. We will assess the quality of each study using an adapted version of the Critical Appraisal Skills Programme (CASP) tool (Atkins 2008; CASP 2018), which has been used in other reviews and protocols of qualitative evidence syntheses (Ames 2017; Carlsen 2016; Houghton 2017).

The adapted tool includes the following questions, which we will use to assess methodological limitations.

1. Is the qualitative research approach appropriate for the research question?
2. Is the qualitative research approach stated clearly?
3. Is the qualitative research approach justified clearly?
4. Are ethical issues considered and is formal ethical approval granted?
5. Is the sampling method described clearly?
6. Is the sampling method appropriate for the research question?

7. Is the method of data collection appropriate for the research question?
8. Does the approach to data analysis address the research question?
9. Is the approach to data analysis described clearly?
10. Are the researcher's findings supported by sufficient evidence?

Two review authors with qualitative research experience (SB and GC) will independently assess each study. Disagreements will be resolved through discussion and consultation of a third author (RC). As it is recognised that studies deemed to be of low quality may still provide new insights (Dixon-Woods 2005; Noyes 2019), we will not exclude studies on the basis of quality although as described previously, we will use the quality of the study in our purposeful stratified sampling strategy. As suggested by Hannes 2011, appraisals of the methodological limitations of the studies will form part of the assessment of confidence in the synthesis findings (discussed below) using the GRADE-CERQual assessment (Lewin 2018), which determines the level of confidence we can have in each finding in the synthesis.

Assessment of confidence in the synthesis findings

We will apply the GRADE-CERQual approach (Lewin 2018), to assess the level of confidence to place in individual review findings. Two review authors (SB and GC) will independently summarise our confidence in each finding, with disagreements resolved through discussion and consultation with a third review author (EH). GRADE-CERQual provides a transparent and structured method for assessing confidence in the findings of qualitative syntheses. The tool focuses on the following four components that assess how much confidence to place in an individual finding.

1. Methodological limitations of included studies: The extent to which there are concerns about the design or conduct of the primary studies that contributed evidence to an individual review finding.
2. Coherence of the review finding: The extent to which the review finding is well grounded in data from the contributing primary studies and provides a convincing explanation for the patterns found in these data.
3. Adequacy of the data contributing to a review finding: An overall determination of the degree of richness and quantity of data supporting a review finding.
4. Relevance of the included studies to the review question: The extent to which the body of evidence from the primary studies supporting a review finding is applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question.

We will generate a 'CERQual Evidence Profile' for each finding. This will include information on all CERQual component assessments, which we will use to make an overall judgement of confidence. All findings will be rated at high confidence initially and then graded down when there are important concerns regarding each of the CERQual components. The assessment will be discussed and agreed by SB and GC and quality assured by EH. Each finding, therefore, will be graded at one of the following four levels:

1. high confidence, where it is highly likely that the review finding is a reasonable representation of the phenomenon of interest;

2. moderate confidence, where it is likely that the review finding is a reasonable representation of the phenomenon of interest;
3. low confidence, where it is possible that the review finding is a reasonable representation of the phenomenon of interest; and
4. very low confidence, where it is not clear whether the review finding is a reasonable representation of the phenomenon of interest (Lewin 2018).

We will produce a 'Summary of qualitative findings' table to present key findings, including our overall CERQual assessment for each finding. We will follow the methodological guidance on creating an evidence profile and 'Summary of qualitative findings' table provided by the CERQual working group, and as illustrated and described in Lewin 2018. We will present detailed descriptions of our confidence assessment in an Evidence Profile(s).

Data synthesis

In the first instance, we will synthesise data using a thematic methodology, to identify the themes and alternative theories that exist throughout the studies (Thomas 2008). The process of synthesising qualitative evidence involves the comparison and analysis of findings from a variety of sources (Noyes 2019). The purpose of this method is to develop analytical themes through a descriptive synthesis and to find explanations relevant to the review questions (Ring 2011). We will use EPPI-Reviewer (Thomas 2010), specialist reviewing software, for this analysis. If this is not a good fit for this QES, then we will consider other, more appropriate synthesis methods.

The thematic synthesis, if a good fit for this QES, will include three overlapping stages. First, one review author will conduct free, line-by-line coding to identify first order constructs, that is, primary data such as quotes or other data such as images, and second order constructs, that is, themes and sub-themes generated by the authors of the studies. A second author will review a 10% sub-sample to quality assure the synthesis. We will include verbatim extracts in the report to illustrate the findings. At this stage, we will set aside our review questions in order to adopt an inductive, data-focused approach. This will avoid imposing an a priori framework onto the findings without allowing for the possibility that a different framework will represent the data better (Thomas 2008). This will generate a set of first order codes and second order constructs that will be increased and developed as each study is coded. When all studies have been coded, we will examine all of the text that have been given a code, code by code, in order to check for consistency and to identify if additional codes are needed (Thomas 2008).

For the second stage, we will compare the first and second order constructs coded in stage one against the review questions, and examine each study again in order to identify more abstract interpretations. Our starting point will be a collection of studies, using stratified purposeful followed by maximum variation sampling, as described previously. We will then take a more in-depth approach to synthesising and analysing the similarities and variances between the themes and concepts evident in the studies. We will do this by collectively examining the similarities and differences between the first and second order constructs to begin to organise them into descriptive themes. Where necessary, we will develop new second order constructs to capture the meaning of groups of extracted first and second order constructs (Thomas 2008). We will review and discuss the constructs until we have developed an appropriate order, structure or framework that best

presents the themes and allows us to synthesis them with the findings from the linked and related reviews. Until this point, the synthesis produced will stay close to the primary findings in the included studies.

The third analytical synthesis stage will move beyond the findings in the primary studies to develop new patterns, meanings and understandings. We will then integrate the findings from the linked (Brown 2019) and related reviews (Gillies 2016; Macdonald 2012), described in the section below. We will conduct a sequential synthesis using the related and linked studies (Harden 2018). Although we are conducting the linked review and QES in a similar time frame, we are completing the linked review a stage ahead of the QES. Hence, we will be able to integrate the findings of the reviews, once we have completed the analysis for the linked review and understand what that tells us about the effectiveness of interventions. These findings will allow us to generate another set of questions to further develop our third order constructs as we report new interpretations of the integrated data.

Using the synthesised qualitative findings to supplement the Cochrane Reviews on effectiveness

Our aim in conducting this QES is to identify and draw together the experiences of those delivering and receiving psychosocial interventions, allowing us to supplement our linked review (Brown 2019) and add to others (Gillies 2016; Macdonald 2012), by increasing understanding about the benefits, lack of benefit and harms of interventions. For example, we are aware from our practitioner partners that there is not necessarily a match between what is evaluated as part of RCTs and what practitioners are using in practice; interventions that show benefits in trials are not necessarily viewed as helpful by users; and conversely, negative trials may generate benefits not detected in those trials. Hence, the findings of this review, stratified by types of interventions, child or adult survivor (and other characteristics such as gender, ethnicity and sexuality), and families' and professionals' experiences will provide important information for practice on people's experiences of interventions, including their perceived benefits, risks/harms and barriers, as well as the appropriateness and acceptability of interventions for implementation. We will make a final decision on our integration method when we have completed the linked review and have a full understanding of the effects of the intervention, and when the data synthesis for this QES is completed. One possibility, if there are differences across interventions and/or participants and contexts, is that we will juxtapose findings in a matrix (Harden 2018). If there is more homogeneity in the findings, we will create a conceptual model to present this information to supplement the linked review and potentially the related reviews (Harden 2018). Using this approach, we aim to highlight interventions that have demonstrated both effectiveness, based on trial outcomes, and are also viewed positively by stakeholder groups. We will also identify areas where it might be possible to enhance user experiences, address potential harms and minimise barriers to uptake, based on the synthesised feedback across the stakeholder groups.

Sensitivity analysis

We will undertake a sensitivity analysis if low-quality studies affect the conceptual model. This will help us assess how much

of an impact these studies have on our analysis and findings, as suggested by Dixon-Woods and colleagues (Dixon-Woods 2006). Following our thematic synthesis, we will examine the contributions to the analytic themes and subsequent interventions (Thomas 2008).

Researchers' reflexivity

All authors of this QES and of the larger MESARCH (Multidisciplinary Evaluation of Sexual Assault Referral Centres for better Health) study believe in the importance of supporting and empowering all victims of sexual abuse and violence. Our QES and MESARCH teams comprise of academics from different disciplines and perspectives, practitioners, commissioners, policymakers and individuals with lived experiences of sexual abuse and violence. The MESARCH project includes a Lived Experience Group and a Study Steering Committee, and members regularly review progress and drafts of materials and reports, including this QES protocol. We hope that these teams, representing a wide range of perspectives, experiences, contexts and backgrounds, and the regular review processes by the different groups will encourage reflexivity, as well as ensuring that practitioner and lived experiences perspectives are represented. Our work to date and hence forth, will be discussed regularly among the QES and MESARCH teams to review progress, clarify procedures or methods, and identify and challenge assumptions. In our data analysis and in synthesising the findings of the QES and integrating these with the linked or related reviews, the authors conducting the analyses will use refutational analysis techniques ('disconfirming analyses'), to explore and try to understand contradictory findings between studies. These analyses will be reviewed by other members of the QES team and wider MESARCH group as per its review processes. We will document these measures in the reflexivity section of the report.

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APPENDICES
Appendix 1. MEDLINE search strategy

Lines 78-81 use search terms from the best optimization version of Wong's search strategy to detect qualitative studies in MEDLINE ([Wong 2004](#)), with the addition of the MeSH term Qualitative research/, an indexing term introduced after publication of this filter.

- 1 sex offenses/
- 2 Child Abuse, Sexual/
- 3 "Adult Survivors of Child Abuse"/
- 4 Incest/
- 5 Intimate partner violence/
- 6 human trafficking/
- 7 rape/
- 8 Spouse abuse/
- 9 (rape or raped or incest\$.tw,kf.
- 10 (sex\$ adj3 (abuse\$ or assaul\$ or attack\$ or aggress\$ or coer\$ or exploit\$ or force\$ or molest\$ or offen\$ or traffick\$ or trauma\$ or unlawful \$ or unwanted or violen\$)).tw,kf.
- 11 (intercourse adj3 (coer\$ or force\$ or unwanted)).tw,kf.
- 12 (sex\$ adj1 (victim\$ or revictim\$ or re-victim\$ or survivor\$)).tw,kf.
- 13 intimate partner violence.tw,kf.
- 14 or/1-13
- 15 Adaptation, Psychological/
- 16 exp Behavior Therapy/
- 17 Combined Modality Therapy/
- 18 community networks/
- 19 exp Complementary therapies/
- 20 exp Counseling/
- 21 Exercise/
- 22 Exercise therapy/
- 23 Health Education/
- 24 Health Knowledge, Attitudes, Practice/
- 25 Interview, Psychological/
- 26 exp mind body therapies/
- 27 Psychological adjustment/
- 28 psychosocial support systems/

- 29 exp psychotherapy/
 30 "Referral and Consultation"/
 31 Self-Help Groups/
 32 Social Support/
 33 video recording/ or videotape recording/
 34 Writing/
 35 ((abreaction or desensitization or exposure or implosive) adj3 therap\$).tw,kf.
 36 "acceptance and commitment therapy".tw,kf.
 37 (advisor\$ or advo78-91 arecate\$ or advocacy).tw,kf.
 38 ((animal\$ or art or colo?r or creative\$ or dance or dancing or drama or equine or experiential or music or narrative or play\$ or sensory or singing) adj3 (program\$ or intervention\$ or therap\$)).tw,kf.
 39 (autogenic or autosuggestion\$ or auto-suggestion\$ or breathing exercise\$ or hypnosis or hypno-therapy or hypnotherapy).tw,kf.
 40 behavio\$ activation.tw,kf.
 41 (behavio?r\$ adj3 (intervention\$ or program\$ or therap\$ or training or treatment\$)).tw,kf.
 42 ((biofeedback or feedback or imagery) adj3 (intervention\$ or therap\$ or train\$ or treatment\$)).tw,kf.
 43 ((brief or combination or compass\$ focus\$ or integrated or integrative or time-limited) adj3 (intervention\$ or therap\$ or treatment \$)).tw,kf.
 44 ((client focus\$ or non-direct\$ or nondirect\$ or solution focus\$ or trauma\$ or talking) adj3 therap\$).tw,kf.
 45 (cognitiv\$ or cognition).tw,kf.
 46 CBT.tw,kf.
 47 ((cope or coping) adj1 (intervention\$ or mechanism\$ or skill\$ or technique\$)).tw,kf.
 48 counsel?ing.tw,kf.
 49 ((couple\$ or family or group or systemic\$ or multimodal\$ or multi-modal\$) adj3 (program\$ or intervention\$ or therap\$ or treat\$)).tw,kf.
 50 dialectical behavio?r\$ therap\$.tw,kf.
 51 (exercise\$ or physical training).tw,kf.
 52 ((existential or gestalt or humanistic or interpersonal or milieu or person-centred or residential or socioenvironmental or socio-environmental) adj therap\$).tw,kf.
 53 expressive writing.tw,kf.
 54 ("Eye Movement Desensitization and Reprocessing" or EMDR).tw,kf.
 55 (meditat\$ or mental training or mindfulness\$ or mind training or brain training or yoga).tw,kf.
 56 motivational interview\$.tw,kf. (3315)
 57 (reality therap\$ or problem solving).tw,kf.
 58 (psycho\$ therap\$ or psychotherap\$).tw,kf.
 59 (psychoanalytic\$ or psycho-analytic\$ or psychodynamic\$ or psycho-dynamic\$).tw,kf.
 60 (psychodrama or psycho-drama or acting out or role play).tw,kf. (2558)
 61 (psychosocial or psycho-social or psychoeducation\$ or psycho-education\$).tw,kf.
 62 rational emotive.tw,kf.
 63 (Relax\$ adj3 (training\$ or treatment\$ or therap\$)).tw,kf.
 64 (Service\$ adj3 (refer\$ or use\$)).tw,kf.
 65 (stress inoculation training or SIT or prolonged exposure therapy or PET or cognitive processing therapy or CPT).tw,kf.
 66 ((support or advice or advis\$1) adj1 (centre\$1 or center\$1 or community or group\$ or network\$ or social or staff\$)).tw,kf.
 67 (therapeutic allianc\$ or therapeutic relationship\$ or therapeutic communit\$).tw,kf.
 68 Third wave.tw,kf.
 69 (th or rh).fs.
 70 (care or caring or heal or healing or intervention\$ or recover\$ or rehabilit\$ or support\$ or therap\$ or treat\$).ti,kf.
 71 or/15-70
 72 14 and 71
 73 (rape adj3 (centre\$ or center\$ or service\$ or support)).tw,kf.
 74 ((sex\$ assault adj3 centre\$) or (sex\$ assault adj3 center\$) or (sex\$ assault adj3 service\$) or (sex\$ assault adj3 support)).tw,kf.
 75 ((sex\$ abuse\$ adj3 centre\$) or (sex\$ abuse\$ adj3 center\$) or (sex\$ abuse\$ adj3 service\$) or (sex\$ abuse\$ adj3 support)).tw,kf.
 76 or/73-75
 77 72 or 76
 78 Interview/ or interview\$.mp.
 79 Qualitative research/ or qualitative.tw,kf.
 80 experience\$.mp.
 81 or/78-80
 82 77 and 81

HISTORY

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CONTRIBUTIONS OF AUTHORS

SB and LOD developed the concept for the review. SB, LOD, NK and GC drafted the protocol. KB, RC, GF, and EH reviewed the draft. With input from LOD, SB led the integration of the comments and feedback from the co-authors and the reviewers, and submission of the final version. SB is the guarantor for the review.

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SB declares no other conflicts of interest.

NK declares no other conflicts of interest.

GC declares no other conflicts of interest.

KB declares no other conflicts of interest.

RC declares no other conflicts of interest. In the interests of transparency, RC also declares that she works as a medical doctor and has been funded through her workplace (NHS) to carry out a PhD in a related area - disclosure of sexual violence in sexual health settings.

EH declares no other conflicts of interest.

GF declares that he is Chief Investigator or Co-Investigator on a range of NIHR and MRC (Medical Research Council) grants, including an NIHR HS&RD grant from which this review is funded.

LOD declares that she is Chief Investigator on the MESARCH project.

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