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

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[Qualitative Review]

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

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ABSTRACT

Background

It is well-established that experiencing sexual abuse and violence can have a range of detrimental impacts; a wide variety of interventions exist to support survivors in the aftermath. Understanding the experiences and perspectives of survivors receiving such interventions, along with those of their family members, and the professionals who deliver them is important for informing decision making as to what to offer survivors, for developing new interventions, and enhancing their acceptability.

Objectives

This review sought 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 a conceptual understanding of how features and types of interventions responded 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));

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.

Search methods

In August 2021 we searched MEDLINE, Embase, PsycINFO and nine other databases. We also searched for unpublished reports and qualitative reports of quantitative studies in a linked systematic review, together with reference checking, citation searches and contacting authors and other researchers to identify relevant studies.

Selection criteria

We included qualitative and mixed-methods studies (with an identifiable qualitative component) that were linked to a psychosocial intervention aimed at supporting survivors of sexual abuse and violence. Eligible studies focused on at least one of three participant groups: survivors of any age, gender, sexuality, ethnicity or [dis]ability who had received a psychosocial intervention; their carers, family members or partners; and professionals delivering such interventions. We placed no restrictions in respect of settings, locations, intervention delivery formats or durations.

Data collection and analysis

Six review authors independently assessed the titles, abstracts and full texts identified. We extracted data using a form designed for this synthesis, then used this information and an appraisal of data richness and quality in order to stratify the studies using a maximum variation approach. We assessed the methodological limitations using the Critical Skills Appraisal Programme (CASP) tool. We coded directly onto the sampled papers using NVivo and synthesised data using a thematic synthesis methodology and used the GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach to assess our confidence in each finding. We used a narrative synthesis and matrix model to integrate our qualitative evidence synthesis (QES) findings with those of intervention review findings.

Main results

We identified 97 eligible studies and sampled 37 of them for our analysis. Most sampled studies were from high-income countries, with four from middle-income and two from low-income countries. In 27 sampled studies, the participants were survivors, in three they were intervention facilitators. Two included all three of our stakeholder groups, and five included two of our groups. The studies explored a wide range of psychosocial interventions, with only one type of intervention explored in more than one study.

The review indicates that features associated with the context in which interventions were delivered had an impact on how individuals accessed and experienced interventions. This included organisational features, such as staff turnover, that could influence survivors' engagement with interventions; the setting or location in which interventions were delivered; and the characteristics associated with who delivered the interventions.

Studies that assess the effectiveness of interventions typically assess their impact on mental health; however, as well as finding benefits to mental health, our QES found that study participants felt interventions also had positive impacts on their physical health, mood, understanding of trauma, interpersonal relationships and enabled them to re-engage with a wide range of areas in their lives.

Participants explained that features of interventions and their contexts that best enabled them to benefit from interventions were also often things that could be a barrier to benefiting from interventions. For example, the relationship with the therapist, when open and warm was a benefit, but if such a relationship could not be achieved, it was a barrier. 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. Study participants identified the potential risks and harms associated with completing interventions but felt that it was important to face and process trauma.

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 subgroups of survivors (e.g. minority groups); these issues could impact how individuals experienced delivering or receiving interventions.

Authors' conclusions

We had high or moderate confidence in all but one of our review findings. Further research in low- and middle-income settings, with male survivors of sexual abuse and violence and those from minority groups could strengthen the evidence for low and moderate confidence findings. We found that few interventions had published quantitative and qualitative evaluations. Since this QES has highlighted important aspects that could enable interventions to be more suitable for survivors, using a range of methodologies would provide valuable information that could enhance intervention uptake, completion and effectiveness. This study has shown that although survivors often found interventions difficult, they also appreciated that they needed to work through trauma, which they said resulted in a wide range of benefits. Therefore, listening to survivors and providing appropriate interventions, at the right time for them, can make a significant difference to their health and well-being.

PLAIN LANGUAGE SUMMARY

Survivor, family and professional experiences of interventions for sexual abuse and violence

What is the aim of this review?

The aim of this review was to explore the experiences of survivors of sexual abuse and violence who received interventions to support them and improve their health and well-being, as well as experiences of their family members and the professionals who delivered such interventions. To do this, we analysed 37 studies that described views and experiences of an intervention.

Key messages

- Survivors, their family members and professionals highlighted that the organisational settings (e.g. their locations and the approach of all staff in the organisation) within which interventions were delivered were very important for their experience of the interventions and the benefits they drew from them.

- Participants talked about positive outcomes from therapies and interventions, such as improved physical and mental health, mood, interpersonal relationships, understanding of trauma, and their abilities to re-engage in a wide range of areas of their lives.

- Participants explained that features of interventions and their settings that best enabled them to benefit from interventions were often features that could be a barrier. For example, the relationship with the therapist when open and warm was a benefit, but if such a relationship could not be achieved, it was a barrier.

- Aspects of interventions relevant to subgroups of survivors (e.g. for faith-based interventions) and the extent to which they made all survivors (e.g. survivors who were men, had a disability or were from other minority communities) feel a sense of inclusion were also important to enable each survivor to gain the most benefit from them.

What was studied in this review?

We looked for studies that explored the experiences of survivors and professionals who took part in interventions that supported survivors of sexual abuse and violence, or family members who supported survivors who completed these interventions.

We included studies that:

- treated survivors who were sexually abused when they were children or adults, or both;

- involved participants of any age, gender, sexuality, ethnicity, or [dis]ability.

We included studies from any country and setting.

What are the main findings of this review?

We analysed 37 of the 97 studies that were relevant to our review. Most of the 37 studies were from high-income countries and included survivors. There was a wide range of interventions that supported and responded to those who had experienced sexual abuse and violence included in these studies, with only one type of intervention examined in more than one study.

Our review highlighted that people did not discuss the features of the different types of interventions (e.g. aspects related to mindfulness therapy, or rape counselling) but rather, referred to a wide range of features associated with the interventions they considered important. For example,

- they emphasised that a good relationship with the therapist was vital,

- that other members of the group (where interventions were delivered in groups) could make them feel more or less included.

They also stressed that features of the wider setting of the intervention, such as the location and friendliness of a receptionist and other staff, had an important impact on them being able to benefit from interventions.

The review showed that survivors benefitted from the interventions in a wide range of ways, most of which have not been examined in more quantitative research studies that look at how effective these interventions are. Such studies tend to examine mental health, but our review found that survivors thought interventions had also benefitted their:

- physical health,

- mood,

- relationships with others,

- confidence

- and ability to set boundaries and be assertive.

How up to date is this review?

This review includes studies published up to May 2021.

SUMMARY OF FINDINGS

Summary of findings 1. Summary of findings for the main qualitative comparison

Finding	Studies contributing to the review finding	GRADE- CERQual assessment of confidence in the evidence	Explanation of GRADE-CERQual assessment
Contextual features			
Finding 1: contextual features can affect survivors' access to and experiences of interventions Features associated with the context in which an intervention was set impacted its accessibility and how survivors experienced it. The setting affected the extent to which survivors felt safe and non-clinical settings helped survivors feel more comfortable. When the location was too difficult to access, survivors were discouraged from returning. Family members bringing children to an intervention valued settings that were easy to locate or near their home. Staff who were friendly and welcoming made individuals feel at ease and survivors quickly got a sense of whether the facilitator was the 'right fit' for them.	Beiza 2015 Carpenter 2016 DiCesare 2015 Farr 2021 Heberling 2006 Hoffman 2016 Horton 2021 Jones-Smith 2018 Kahan 2020 Kerlin 2013 Margain 2020 Mills 2002 Røberg 2018 Parker 2007 Polk 2021 Silverberg 2019 Stevens 2019 Walker 2020	High confidence	Due to no or very minor concerns regarding methodological limitations; and minor concerns regarding coherence, adequacy, and relevance. Minor concerns related to the finding not reflecting nuances between different types of interventions and not being evident across different participant groups. In addition, the finding was identified in studies conducted in high-income countries and one middle-income country.
Finding 2: organisational features can impact on survivors' engagement with interventions Features associated with the organisation in which the intervention was situated could impact survivors' engagement with the intervention. High staff turnover or frequent rotations of staff made it challenging for survivors to develop their relationship with the intervention facilitator. Survivors felt a sense of loss when their facilitator left, and children and young people struggled to re-establish trusting bonds within the intervention if facilitators changed or were inconsistent.	Beiza 2015 Carpenter 2016 Capella 2018 Farr 2021 Kahan 2020 Margain 2020 Parker 2007 Røberg 2018 Stevens 2019 Visser 2015	Moderate confidence	Due to moderate concerns regarding adequacy; minor concerns regarding relevance; and no or very minor concerns regarding methodological limitations and coherence. Minor concerns related to the studies being conducted in high-income countries and two studies in middle-income countries. Moderate concerns were due to the data being not highly rich and studies focused on one participant group (survivors) who had participated in group based interventions; the data had poor representa-

	Walker 2020		tion regarding age and ethnicity of participants.
Finding 3: the format and delivery of interventions played an important role in their acceptability to survivors The intervention format (e.g. individual or group therapy) and how it was delivered (e.g. mode of delivery and the types of activities included) were critical in helping survivors feel safe; this was especially important for group interventions. Intervention routines established a safety net for survivors and informal discussion amongst group members facilitated a safe group space. Survivors who had physical disabilities found it challenging to participate in activities that were based on physical exercise and young people valued meeting their facilitator at a range of community-based venues where they felt safe and comfortable.	Asselstine 1997 Beiza 2015 Bluntzer 2016 Braxton 2017 Carey 1996 Carpenter 2016 Edwards 2015 Farr 2021 Fields 2019 Forde 2021 Heberling 2006 Hoffman 2016 Horton 2021 Kahan 2020 Kane 2003 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Parker 2007 Polk 2021 Røberg 2018 Schwarz 2020 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Taylor 2018 Visser 2015 Walker 2020	High confidence	Due to no or very minor concerns regarding adequacy; and minor concerns regarding methodological limitations, coherence, and relevance. Minor concerns related to five studies that were not transparent about ethics, sampling and/or data analysis. In addition, the finding was often descriptive with no in-depth exploration of the acceptability issues and all but two studies were conducted in high-income countries.
Effectiveness			

Finding 4: interventions improved survivors' understanding of trauma Interventions enabled survivors with opportunities to process their trauma and develop their understanding about what they had experienced. Interventions helped survivors challenge negative beliefs about their role in the abuse, such that they no longer felt that they were to blame and developed an acceptance for what happened. Survivors who engaged in group interventions were reassured in knowing that they were not the only one who had experienced abuse. An improved understanding of trauma led survivors to respect themselves and want to help others who had experienced something similar to them.	Asselstine 1997 Beiza 2015 Bluntzer 2016 Braxton 2017 Carey 1996 Carpenter 2016 DiCesare 2015 Edwards 2015 Fields 2019 Heberling 2006 Hoffman 2016 Horton 2021 Jones-Smith 2018 Kahan 2020 Kallivayalil 2013 Kane 2003 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Parker 2007 Polk 2021 Røberg 2018 San Diego 2011 Schwarz 2020 Shaw 2015 Silverberg 2019 Stevens 2019 Taylor 2018 Visser 2015 Walker 2020 Walker-Williams 2017	High confidence	Due to no or very minor concerns regarding relevance; and minor concerns regarding methodological limitations, coherence, and adequacy. Minor concerns related to six studies that were not transparent about ethics, sampling and/or data analysis. In addition, the finding did not reflect nuances between different types of interventions and participant voices could have been more fully represented across age, gender and ethnicity.

Finding 5: interventions enabled survivors to re-engage in a wide range of areas of their lives Survivors felt empowered through the intervention and had developed skills, such as learning how to assert boundaries, which enabled positive changes to occur in their lives. Survivors were able to re-engage in different aspects of their lives beyond the specific context of the intervention such as in education, work, hobbies, and new interests.	Asselstine 1997 Braxton 2017 Bluntzer 2016 Carey 1996 Edwards 2015 Fields 2019 Heberling 2006 Hoffman 2016 Horton 2021 Kahan 2020 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Shaw 2015 Silverberg 2019	Moderate confidence	Due to no or very minor concerns regarding methodological limitations and coherence; minor concerns regarding relevance; and moderate concerns regarding adequacy. Minor concerns related to the majority of studies being conducted in the USA and Canada, with one study conducted in a low-income country in central America. Moderate concerns centred on the views of young people and professionals being poorly represented.
Finding 6: interventions helped improve survivors' interpersonal relationships Survivors shared how the intervention had helped them to end or resolve unhealthy intimate and social relationships, as they learned what healthy relationships looked like. Particularly, group-based interventions helped survivors develop their communication skills, build trust, develop gratitude, and grow in confidence. Some survivors reported that the intervention had helped them to improve relationships with family members, start new friendships outside the intervention, and develop existing or new sexual relationships.	Asselstine 1997 Bluntzer 2016 Braxton 2017 Carey 1996 Capella 2018 Edwards 2015 Farr 2021 Fields 2019 Heberling 2006 Hoffman 2016 Horton 2021 Jones-Smith 2018 Kahan 2020 Kane 2003 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019	High confidence	Due to no or very minor concerns regarding adequacy and relevance; and minor concerns regarding methodological limitations and coherence. Minor concerns related to five studies that were not transparent about ethics, sampling and/or data analysis. In addition, the finding was not explored in terms of how reductions in anxiety or depression helped improve relationships.

	Mills 2002 Parker 2007 Polk 2021 Røberg 2018 Schwarz 2020 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Taylor 2018 Visser 2015		
Finding 7: interventions helped improve survivors' mental health Survivors reported improvements in their mental health because of what they had learned through the intervention content and through their experience of participating in the intervention. The improvements included reductions in depression, anxiety, symptoms of post-traumatic stress disorder, fear, anger and increases in self-esteem, confidence and having a positive view of themselves and the world.	Asselstine 1997 Beiza 2015 Bluntzer 2016 Braxton 2017 Capella 2018 Carey 1996 Carpenter 2016 Farr 2021 Fields 2019 Forde 2021 Hoffman 2016 Jones-Smith 2018 Kahan 2020 Kallivayalil 2013 Kane 2003 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Parker 2007 Polk 2021 Røberg 2018 San Diego 2011	High confidence	Due to no or very minor concerns regarding coherence and adequacy; and minor concerns regarding methodological limitations. Minor concerns related to six studies that were not transparent about ethics, sampling and/or data analysis.

	Schwarz 2020 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Visser 2015		
Finding 8: interventions helped improve survivors' mood As a result of what they had learned and experienced through the intervention, survivors reported feeling that a weight had been lifted off their shoulders. They felt more freedom in expressing positive thoughts, and the improvement in mood had positive impacts on other areas of their lives.	Asselstine 1997 Beiza 2015 Bluntzer 2016 Braxton 2017 Capella 2018 Carey 1996 Carpenter 2016 Farr 2021 Fields 2019 Forde 2021 Heberling 2006 Horton 2021 Kane 2003 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Parker 2007 Røberg 2018 Schwarz 2020 Shaw 2015 Sigurdardottir 2016 Silverberg 2019	High confidence	Due to minor concerns regarding methodological limitations, coherence, adequacy, and relevance. Minor concerns related to five studies that were not transparent about ethics, sampling and/or data analysis. In addition, the finding was interpretive, as we understood or interpreted a range of things to encompass mood. The views of professionals could have been represented more and based on a wider range of intervention types and all but two studies were conducted in high-income countries.
Finding 9: interventions helped improve survivors' physical health Survivors reported a range of improvements related to their physical health, including improvements in muscle strength, movement, sleep, stamina, and an increased acceptance and appreciation of their physical bodies. They described a reduction in the use of pain medication, acid reflux, digestive and	Asselstine 1997 Bluntzer 2016 Braxton 2017 Capella 2018 Carey 1996	High confidence	Due to no or very minor concerns regarding methodological limitations, coherence, adequacy and relevance.

uterine problems, nightmares, constipation, substance misuse and eating disorders. Such physical health improvements were described across a range of intervention types showing how physical benefits were not limited to interventions that had a specific physical focus.	Carpenter 2016 Edwards 2015 Fields 2019 Hoffman 2016 Jones-Smith 2018 Kahan 2020 Magnuson 2003 Mills 2002 Mead 2019 Parker 2007 Schwarz 2020 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Taylor 2018		
Characteristics that enabled or hindered change			
Finding 10: interventions that were survivor-centred and flexible were considered beneficial Survivors valued a sense of choice and control within the intervention, which they considered essential when sharing sexual abuse and violence narratives. Having the ability to determine pace, co-produce content and treatment modality was identified as central to healing. Young people particularly valued this in the context of making their own decisions about which tasks or activities they wanted to engage with, and they felt supported if they knew the practitioner would stop, take a break, or support them whenever they were distressed.	Bluntzer 2016 Edwards 2015 Carpenter 2016 DiCesare 2015 Heberling 2006 Kahan 2020 Mills 2002 Shaw 2015 Walker-Williams 2017	Moderate confidence	Due to no or very minor concerns regarding methodological limitations and coherence; minor concerns regarding relevance; and moderate concerns regarding adequacy. Minor concerns related to studies being conducted in the high-income countries of Australia, the UK or USA, with the exception of one study based in a low-income country (the Philippines). Moderate concerns related to a limited representation of participants.
Finding 11: readiness to enter therapy/support was central to survivors feeling able to engage with interventions Survivors' feelings of being ready to participate in an intervention were critical to their motivation and engagement with it. When survivors did not feel ready to take on the intervention, they expressed ambivalence and inhibitions about the healing. For some survivors, not being ready was linked to feelings of guilt and shame related to their experience of sexual abuse and violence, and this hindered their confidence to engage with the intervention. Survivors who were not ready, often found the early phases of the intervention challenging and showed 'avoid-	Asselstine 1997 Beiza 2015 Braxton 2017 Carpenter 2016 DiCesare 2015 Edwards 2015 Farr 2021 Forde 2021 McLean 2021	Moderate confidence	Due to no or very minor concerns regarding methodological limitations and coherence; minor concerns regarding relevance; and moderate concerns regarding adequacy. Minor concerns related to all but one study being based in a high-income country. Moderate concerns were due to a limited representation of participants, mainly female survivors.

ance' or 'frustration' in talking about or taking steps towards processing the trauma.	Parker 2007 San Diego 2011 Shaw 2015 Silverberg 2019		
Finding 12: preparedness to start and end interventions impacted on survivors' abilities to derive benefit from them Assessment and/or introductory sessions associated with the intervention combined with regular communication helped survivors feel prepared to start the intervention. Survivors reported that inadequate preparation raised anxieties around the suitability of the intervention, confidentiality, fear of being pressured to talk about the sexual abuse and violence, and the composition of the intervention group. Preparation to end the intervention was considered just as important; many survivors reported that the intervention's end was 'sudden' or 'abrupt', which led to concerns about being able to sustain change, or feeling that recovery was 'incomplete'.	Beiza 2015 Carpenter 2016 DiCesare 2015 Edwards 2015 Farr 2021 Heberling 2006 Kane 2003 Mills 2002 Mead 2019 Parker 2007 Polk 2021 Røberg 2018 Shaw 2015 Silverberg 2019 Taylor 2018 Walker-Williams 2017	High confidence	Due to no or very minor concerns regarding coherence and relevance; and minor concerns regarding methodological limitations and adequacy. Minor concerns as four studies were not transparent about ethics and/or sampling. In addition, studies provided rich data regarding ending interventions and moderately rich data regarding starting interventions.
Finding 13: establishing an open, accepting, and non-judgemental therapeutic relationship with a facilitator is key to healing The relationship between survivor and facilitator across intervention types was critical to enabling recovery. Survivors reported that a positive therapeutic relationship was one that was trusting, non-judgemental, and where they felt safe and empowered. This did involve times where it was appropriate for the facilitator to encourage/push survivors but was distinctly different to the facilitator 'leading' the intervention. Maintaining equality and respecting boundaries between the survivor, family members included in the intervention, and the facilitator was critical to the success of the intervention.	Asselstine 1997 Beiza 2015 Braxton 2017 Capella 2018 Carpenter 2016 DiCesare 2015 Edwards 2015 Farr 2021 Fields 2019 Forde 2021 Heberling 2006 Hoffman 2016 Jones-Smith 2018 Magnuson 2003	High confidence	Due to no or very minor concerns regarding methodological limitation, coherence, adequacy, and relevance.

	McLean 2021 Parker 2007 Røberg 2018 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Visser 2015 Walker 2020		
Finding 14: interventions that help survivors to establish boundaries and be assertive enabled positive change to occur Learning how to set and maintain boundaries within the intervention was identified by survivors as a key mechanism that enabled their recovery. Being able to say 'no' and assert personal boundaries helped survivors recognise their empowerment, self-worth, and connection to others. Interventions that enabled survivors to be assertive helped them to build confidence in their own decision making, to establish boundaries and be more assertive in different areas of their lives outside of the intervention context.	Asselstine 1997 Hoffman 2016 Heberling 2006 Kahan 2020 Magnuson 2003 Mead 2019 Parker 2007 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Walker 2020	High confidence	Due to no or very minor concerns regarding methodological limitations and coherence; and minor concerns regarding adequacy and relevance. Minor concerns related to the limited representation of participants, e.g. 7 of 11 studies included female survivors and no studies represented the experiences of children and young people; all but one study was conducted in a high-income country.
Finding 15: participants identified risks and harms associated with participating in interventions Some survivors reported that they experienced anxiety from interventions activating traumatic memories. Whilst this was challenging, survivors felt that this was necessary to enable recovery. Some survivors felt that therapies involving movement or touch could involve risks whereby the facilitator was too comfortable in initiating certain activities. In relation to interventions for children, some parents felt excluded because of the relationship formed between their child and the facilitator. Survivors reported that they struggled to find similar sources of support once the intervention ended, which could be harmful because the benefits were perceived as being confined to the boundaries of the intervention.	Asselstine 1997 Beiza 2015 Braxton 2017 Capella 2018 Carey 1996 Carpenter 2016 Fields 2019 Forde 2021 Hoffman 2016 Jones-Smith 2018 Kahan 2020 Kane 2003 Kerlin 2013 Magnuson 2003	High confidence	Due to no or very minor concerns regarding methodological limitations, coherence and adequacy.

	Margain 2020 Mead 2019 Mills 2002 Polk 2021 Røberg 2018 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019		
Finding 16: survivors recognised that even though it was difficult, they needed to face and process the trauma within interventions Survivors identified the importance of seeing the intervention as a process that has different stages. They described the most emotionally challenging aspect as the need to face and process trauma within interventions, which created a sense of power and resilience that enabled them to remain engaged with the therapeutic process and 'acquire skills' for overcoming trauma. Survivors who derived benefit from interventions highlighted that there is a need to be simultaneously strong and vulnerable.	Beiza 2015 Capella 2018 DiCesare 2015 Fields 2019 Forde 2021 Heberling 2006 Horton 2021 Jones-Smith 2018 Margain 2020 Mills 2002 Røberg 2018 Sigurdardottir 2016 Silverberg 2019 Taylor 2018 Visser 2015	High confidence	Due to no or very minor concerns regarding methodological limitations, coherence, and relevance; and minor concerns regarding adequacy. Minor concerns related to the finding not being evident across every study.
Finding 17: survivors' abilities to engage with interventions were dependent on the level of trauma symptomology High levels of trauma symptomology, particularly flashbacks and disassociation, prevented some survivors from engaging with the intervention, which was more likely to occur as survivors moved towards opening the trauma narrative or began processing work. Avoidance and resistance prevented the processing of the trauma narrative and some survivors expressed frustration and anger with focusing on things that happened in the past. If survivors were not ready to move past the stabilising stage, then they were less likely to engage with the intervention.	Asselstine 1997 DiCesare 2015 Edwards 2015 Jones-Smith 2018 Hoffman 2016 Kahan 2020 Mead 2019 San Diego 2011	Moderate confidence	Due to no or very minor regarding methodological limitations and coherence; and moderate concerns regarding adequacy and relevance. Minor concerns related to all but one study being conducted in high-income countries. Moderate concerns related to the finding not being evident across every study and the experience of family members not being included in any of the studies.

Finding 18: the influence of family, friends, and wider social networks can be an enabler or barrier to healing Support from partners, family, and a peer network outside of the intervention facilitated change. Within couple's therapy, survivors felt a supportive partner helped them to understand their experiences and the impacts this had. Children and young people said having fun and playing with friends generated a sense of well-being. By contrast, the lack of family support was a barrier to healing and socially isolated survivors often struggled when the intervention came to an end. Children who were dependent on parents/carers to access interventions faced difficulty if engagement from parents/carers was inconsistent or resistant.	Beiza 2015 Bluntzer 2016 Capella 2018 Carpenter 2016 DiCesare 2015 Farr 2021 Heberling 2006 Kerlin 2013 McLean 2021 Polk 2021	Moderate confidence	Due to no or very minor concerns regarding methodological limitations; minor concerns regarding coherence and relevance; and moderate concerns regarding adequacy. Moderate concerns related to the finding not being evident across every study and the experience of family members not being included in any of the studies. In addition, all but two studies were conducted in a high-income country and the finding was evident in a limited range of intervention contexts, with all but one study conducted in community-based services.
Subgroup and specialism			
Finding 19: the extent to which professionals could tailor interventions to meet the individual needs of participants impacted intervention suitability and effectiveness Survivors said that it was important for professionals to see them 'holistically' and tailor the intervention to suit their needs. Professionals highlighted that cognitive limitations and developmental issues prevented some children from engaging with and deriving benefit from interventions. They stressed the importance of interventions that encouraged flexibility, facilitating the shaping of the cognitive capacity of survivors, which was particularly important for children and young people.	Carpenter 2016 Edwards 2015 Farr 2021 Heberling 2006 Horton 2021 Jones-Smith 2018 Kahan 2020 McLean 2021 Polk 2021 Sigurdardottir 2016 Walker-Williams 2017	Moderate confidence	Due to no or very minor concerns regarding methodological limitations and coherence; minor concerns regarding relevance; and moderate concerns regarding adequacy. Minor concerns as the finding did not reflect nuances across participant groups, particularly friends and family members who were less present across studies and the limited range of contexts in which the studies were conducted - one study was conducted in a community-based setting and no information was provided about the context of the intervention in the remaining 10 studies. Moderate concerns related to the limited representation across participant groups - all but three studies were focused on the experiences of female participants.
Finding 20: relationships with peers can be an enabler or barrier to recovery A trusting relationship with peers participating in the intervention was central to the healing process, which was especially important to survivors from ethnic and minority groups. Sharing similar experiences created a sense of solidarity, with differences in distance travelled within the recovery journey being important features that shaped effective group composition. When survivors did not feel safe in their relationship with peers, this created a barrier to them engaging in the intervention. Inconsistent attendance from peers could destabilise feelings of	Bluntzer 2016 Hoffman 2016 Kahan 2020 Kane 2003 Kerlin 2013 Margain 2020 McLean 2021 Mills 2002	Moderate confidence	Due to minor concerns regarding methodological limitations, coherence, adequacy, and relevance. Minor concerns related to limited range of contexts in which the studies were conducted - all but one study was conducted in a community-based setting. Moderate concerns as this finding is only relevant to group-based interventions.

safety, and survivors struggled to establish relationships within the group if trauma experiences were dissimilar.	Parker 2007 Røberg 2018 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Visser 2015 Walker-Williams 2017		
Finding 21: survivors' faiths can impact recovery when receiving faith-based interventions For faith-based interventions, resolving spiritual struggles and finding faith were critical aspects of recovery. Faith-based teachings and practices that were learned during the intervention were key to developing survivors' faith and resolving damaging beliefs about themselves. This was often facilitated in group interventions when individuals could demonstrate their faith to others, such as praying for others in the group, or survivors who could be peer mentors demonstrating that recovery was possible.	Kahan 2020 Kerlin 2013 Magnuson 2003 Margain 2020	Moderate confidence	Due to no or very minor concerns regarding methodological limitations; minor concerns about coherence and adequacy; and moderate concerns about relevance. Minor concerns related to the finding being largely interpretative and one that does not reflect nuances within spirituality or across different faiths. In addition, there was limited representation across participant groups, as all studies related to the experiences of female survivors. There were moderate concerns as all studies were conducted in the USA and there were a limited range of contexts in which the interventions were conducted.
Finding 22: ongoing abuse can hinder engagement with interventions Survivors who were experiencing ongoing abuse at the start or during the intervention were often excluded from participation, which was particularly the case for children and young people. Some practitioners were concerned that this led them to turn children away who may otherwise have benefitted from the intervention. Professionals felt that it would be beneficial to have more flexibility to work with the carer or family to address any wider problems as this would allow them to stabilise the home environment and then be able to work with the child.	Carpenter 2016 Heberling 2006 Jones-Smith 2018	Low confidence	Due to no or very minor concerns regarding methodological limitations and coherence; minor concerns regarding relevance; and serious concerns regarding adequacy. Minor concerns related to all studies being conducted in high-income settings, two in the USA and one in the UK. There were serious concerns related to limited representation across participant groups, as two of the three studies related to the experiences of children and young people.

CERQual: Confidence in the Evidence from Reviews of Qualitative research

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 transgender people (Wirtz 2020) 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 1 in 10 heterosexual women) (Walters 2013). Higher rates of sexual violence are also experienced by gay men and bisexual men compared to heterosexual men (Walters 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). It should be noted that the effects of the COVID-19 pandemic led to global increases in reports of domestic violence. Sexual abuse and violence was likely to be occurring alongside domestic violence (ONS 2021). During the pandemic, sexual violence services observed increases in vulnerability and the severity of abuse experienced by victims as well as a combination of both increases (Almeida 2020), and reductions in service use by survivors (Muldoon 2021).

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 so 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 effectively address 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 (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 focused on the qualitative components of studies that explored the experiences of survivors, their families and professionals in relation to psychosocial interventions targeted at individuals who had experienced sexual abuse and violence. This included a wide range of psychosocial interventions that targeted 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 non-conforming

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 involve 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.

This review focused on any setting where a person had received an intervention or a professional had delivered an intervention aimed at supporting a survivor or family member in the aftermath of an experience of sexual abuse and violence. Interventions of any duration or frequency of treatment were included. We included a wide range of psychosocial interventions, using the list of psychological therapies on the Cochrane Common Mental Disorders (CCMD) website: cmd.cochrane.org/psychological-therapies-topics-list.

1. Behaviour therapies, such as eye movement desensitisation reprocessing (EMDR) and relaxation techniques
2. Formal cognitive behavioural therapy (CBT), trauma-focused CBT and CBT-based techniques
3. Third wave CBT (e.g. acceptance and commitment therapy, mindfulness)
4. Integrative therapies
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 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 included face-to-face, telephone or computer-based delivery. We included studies reporting individual or group delivery of the intervention.

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

The review synthesised 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 appreciated that a good deal of the pertinent evidence about interventions, and their benefits and harms, is missed from systematic reviews of trials. Hence, by conducting this QES to complement our review of trials (Brown 2019), we aimed 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 3 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. For example, Stress Inoculation Therapy (Veronen 1983), Prolonged Exposure Therapy (Foa 1986), and Cognitive Processing Therapy (Resnick 1997), all use combinations of relaxation training, flooding or systematic desensitisation techniques, psychoeducation and cognitive methods. 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. EMDR (Shapiro 1995) gets its name from the desensitising phase of the intervention where 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, this aspect is just one of eight phases of the intervention and it is possible to complete EMDR without eye movements. Studies comparing EMDR with and without eye movements show that EMDR without eye movements leads to equivalent outcomes as EMDR with eye movements (Boudewyns 1996; Pitman 1996). Through acceptance, being present and committed action (Hayes 2006), third wave CBTs, 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 the 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 supplements 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 addressed 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 assessed 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 did 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 uncovered likely 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. Some interventions are not perceived positively by professionals and survivors, as they require 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 towards and perceptions of interventions, engagement, satisfaction, and barriers and facilitators experienced by stakeholders. It can also contribute to understanding 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 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 did 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 a 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 aimed 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 gathered and synthesised evidence about the experiences of interventions for survivors of sexual abuse and violence, their families, as well as the professionals who delivered them.

Specifically, this review sought 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 a conceptual understanding of how features and types of interventions responded 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 Brown 2019 and related Gillies 2016 and Macdonald 2012 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 included primary empirical studies that were linked to a psychosocial intervention (as defined in the 'Types of interventions' section below) aimed at supporting survivors and preventing negative health outcomes that had:

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 was possible to extract the data that were collected and analysed using qualitative methods.

It was not a precondition that the published qualitative investigation was linked to studies included in the linked Brown 2019 review or related reviews (Caswell 2019; Gillies 2016; Macdonald 2012), nor was it a criterion that they existed alongside a published evaluation of an intervention. For example, some studies focused on personal accounts of attending or receiving a type of intervention.

We excluded:

1. studies that included data using qualitative methods but that did 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 did not exclude any studies based on our assessment of methodological limitations, but utilised 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 focused on at least one of three participant groups.

1. The primary group of interest was survivors of sexual abuse and violence. We included studies that reported on the experiences and views of people of any age, gender, sexuality, ethnicity or [dis]ability who had received a psychosocial intervention in regards to experiencing sexual abuse or violence. We intended to include those who were offered an intervention, even if ultimately they did not take up or complete that intervention. However, none of the studies we identified included survivors who were offered the intervention but did not take it up.
2. The review also included studies focused on non-offending caregivers, parents and other family members in the context of a child or family member who was a victim of sexual abuse and violence who had been offered or received a psychosocial intervention. This allowed us to gather the views, experiences, decision making and acceptance of different psychosocial interventions for the individuals for whom the interventions were designed from the perspective of those involved in the person's immediate support network.
3. The review also included studies focused on providers involved in the direct delivery of the interventions (e.g. psychologists, counsellors, psychiatrists, support workers, ISVAs, and advocates).

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

Subgroups

As our review focused on the experiences of psychosocial interventions for different types of interventions, we explored the similarities and differences in experiences across the different types of psychosocial interventions. In addition, we explored the similarities and differences in the experiences of different survivors (e.g. children or adults, gender, ethnicity and sexuality), contexts (high-income country, low- or middle-income country LMIC)), 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). However, since the information, or participants, were not always included in the studies identified, we could not examine experiences by impact of the intervention for the individual, or levels of experience, training, gender and ethnicity of the professionals.

Settings

Any setting where a person had received, or a professional had 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 included health care, sexual health and mental health services; charity and voluntary sector services in the mental health or sexual and domestic violence sectors; and local support communities. While we intended to include school-based/education services and home support programmes (e.g. home visits), we found no studies that had examined such interventions.

Types of interventions

The interventions were any type of psychosocial intervention that targeted recovery from sexual abuse or sexual violence that met the definition of "interpersonal or informational activities, techniques, or strategies that target biological, behavioural, 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. Behaviour therapies such as EMDR and relaxation techniques
2. Formal CBT, trauma-focused CBT and CBT-based techniques
3. Third wave CBT (e.g. acceptance and commitment therapy, mindfulness)
4. Integrative therapies
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 included interventions of any duration or frequency of treatment.

While we did not exclude interventions delivered by telephone, computer-based systems or a combination of approaches, nearly all of the studies that met our criteria involved face-to-face delivery. One study employed virtual methods to deliver the intervention due to the COVID-19 pandemic.

We included both individual and group delivered interventions.

Types of phenomena of interest

The topics of interest in this synthesis were 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 explored 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 also included 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 were developed using guidelines published by the Cochrane Qualitative and Implementation Methods Group (CQIMG) (Harris 2018, including their earlier guidance (Booth 2011)). We organised the search into two strands.

Strand 1 identified qualitative evidence in reports related to, or embedded in, RCTs identified in the linked Brown 2019 effectiveness review and in other relevant systematic reviews of which we were aware (Caswell 2019; Gillies 2016; Macdonald 2012). We used the same approach for other systematic reviews that we identified during other phases of the search. Strand 2 used 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 did not contain the search terms in our core search strategy.

Strand 1

We re-screened the search results from the linked Brown 2019 effectiveness review to identify studies that met our criteria. We included any studies identified in the search as meeting the criteria for this QES, even if they are excluded in the linked review (Noyes 2021). In addition, we searched for qualitative studies associated with related systematic reviews, including three originally used to establish a rationale for undertaking

the linked Brown 2019 review. These related reviews examined the evidence for cognitive-behavioural interventions for children who had 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 healthcare settings on receiving care after sexual violence (Caswell 2019). We contacted the principal trial investigators of studies included in these reviews (Brown 2019; Caswell 2019; Gillies 2016; Macdonald 2012), and the authors of the three related reviews (Caswell 2019; Gillies 2016; Macdonald 2012 note, Caswell is an author of this QES), to ask about the existence of studies that meet the criteria for this qualitative review (Noyes 2021).

We extracted authors' names and keywords from the titles and abstracts of the quantitative studies in both the linked Brown 2019 and related reviews (Caswell 2019; Gillies 2016; Macdonald 2012), and used them to search for separate reports of qualitative data related to the trials (Booth 2011; Booth 2013).

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

Strand 2

Database searches

In August 2021, we conducted a systematic search for this QES (independent of the linked Brown 2019 effectiveness review), using the databases listed below.

1. MEDLINE Ovid (1946 to July Week 5 2021)
2. MEDLINE Epub Ahead of Print Ovid (6 August 2021)
3. MEDLINE Ovid, In-Process & Other Non-indexed Citations (6 August 2021)
4. Embase Ovid (1974 to 6 August 2021)
5. CINAHL Plus EBSCOhost (Cumulative Index to Nursing and Allied Health Literature; 1937 to 10 August 2021)
6. APA PsycINFO Ovid (1806 to August Week 1 2021)
7. Epistemonikos (www.epistemonikos.org/en). Searched 10 August 2021
8. PDQ-Evidence (www.pdq-evidence.org). Searched 10 August 2021
9. Social Services Abstracts Proquest (1979 to 10 August 2021)
10. Social Science Citation Index Web of Science, Clarivate (1970 to 10 August 2021)
11. PTSDpubs Proquest (1871 to 10 August 2021)
12. ProQuest Dissertations & Theses A&I Proquest (1743 to 10 August 2021)

We searched MEDLINE using a search strategy adapted from the linked Brown 2019 evaluation review, in consultation with the Cochrane Information Specialist for Developmental, Psychosocial and Learning Problems (DPLP). We expanded the population section to include search terms for children who had been sexually abused (the evaluation review was limited to sexual abuse in adulthood). The sensitivity of the intervention section was augmented with general terms for treatment because qualitative studies did not necessarily refer to specific psychosocial interventions. Where possible, we replaced the filters used to find RCTs in the linked Brown 2019 evaluation review with published filters to find qualitative studies (McKibbon 2006; Walters 2006; Wilczynski 2007; Wong 2004), revising them as necessary to reflect new indexing terms. The exact strategies for each database are reported in Appendix 1.

Supplementary searches

Reference lists

We examined the reference lists of all included studies in this QES and in the linked Brown 2019 or related reviews (Caswell 2019; Gillies 2016; Macdonald 2012).

Citation search

We conducted a forward citation search of included studies in this QES and in the linked Brown 2019 or related reviews (Caswell 2019; Gillies 2016; Macdonald 2012), using the Social Science Citation Index.

Correspondence

In addition to contacting authors of all included studies and related reviews (Caswell 2019; Gillies 2016; Macdonald 2012), we contacted experts in this field to identify studies that met our criteria, including unpublished and ongoing research.

Unpublished reports

As we believed that qualitative studies of user and practitioner perspectives may not all be included in bibliographic databases, we also searched for unpublished reports. We searched the following websites for relevant reports on 25 November 2020 using the keywords shown in Appendix 1. Due to the unproductive nature of these searches, no further searches were made.

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)
4. World Health Organisation (WHO; www.who.int)
5. UN Preventing sexual exploitation and abuse (www.un.org/preventing-sexual-exploitation-and-abuse)
6. Rape Crisis UK national website (rapecrisis.org.uk)
7. Women's Aid UK national website (www.womensaid.org.uk)
8. Centre of Expertise on Child Sexual Abuse (www.csacentre.org.uk)
9. Horizon Sexual Assault Referral Centre (SARC; horizonsarc.org.uk)
10. The Bridge (www.thebridgecanhelp.org.uk)
11. Blue Sky (blueskycentre.org.uk)
12. Harbour Centre (www.theharbourcentre.co.uk)
13. Hertfordshire SARC (www.hertssarc.org)
14. Teesside SARC (www.sarcteesside.co.uk/about)
15. Treetops (www.solent.nhs.uk/sarc)
16. Oakwood Place (www.oakwoodplace.org.uk)
17. Saturn Centre (www.saturncentre.org)
18. First Light - Swindon & Wiltshire SARC (www.firstlight.org.uk/swindonwiltshiresarc)
19. Hope House (www.hopehouse.nhs.uk/sarc)
20. Serenity (www.nhft.nhs.uk/serenity)
21. The Elms (www.theelmssarc.org)

22.Reach (www.reachsarc.org.uk)
23.The Glade (www.theglade.org.uk)

Data collection and analysis

Selection of studies

Screening phase

Using Covidence, pairs of two review authors (SB, GC, GH, KB, LOD, RC) independently assessed the titles and abstracts of all records identified through the literature searches against criteria for considering studies for this QES. They coded abstracts as 'retrieve' (eligible, potentially eligible or unclear) or 'do not retrieve' (not eligible). In the event of disagreements about inclusion, the full articles were retrieved and reviewed for relevance, using the GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach (Noyes 2018). We retrieved full-text articles for selected abstracts and two review authors (GC, GH) independently assessed each article against the criteria for considering studies for this QES. Using Covidence, studies were identified for either inclusion or exclusion. We contacted study authors, as required, to decide whether the inclusion criteria had been met. We recorded reasons for excluding ineligible studies. Where there were disagreements, a third review author (SB) acted as a mediator. Final decisions were made by consensus.

Using Covidence and our own assessments, we identified and excluded duplicate records, and collated multiple reports that related to the same study so that each study rather than each report was the unit of interest in the review. We exported information about the included and excluded studies into RevMan Web (RevMan Web 2022).

Language translation

For titles and abstracts that were published in a language in which none of the review team or their colleagues were fluent, we carried out an initial translation through open source software (Google Translate). If this translation indicated inclusion, we retrieved the full text of the paper. We used Google Translate in three instances, and in all cases, the studies did not meet our criteria.

Sampling framework

Including every qualitative study we found that met our criteria in this QES would threaten its quality because it is time-consuming and would 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 employed Benoot's "umbrella approach" (Benoot 2016), combining several purposeful sampling techniques.

We began by reviewing the articles identified as meeting our QES criteria (criterion sampling, Suri 2011). Two review authors (GC and GH) collated information into an evidence map (see Table 1; Table 2) that was later used to stratify a purposive sample (Suri 2011), and this was reviewed by SB. Information collated into the evidence map included: first study author; date of publication; country of study; context (urban or rural; high-income country, low- to 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; and data analysis methods. The extent to which findings were supported by sufficient evidence and details of reflexivity were also considered and are presented in Table 3; Table 4; Table 5. This approach ensured that we could 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 used a maximum variation strategy (Suri 2011), to ensure that we considered the benefits, risks/harms, and barriers for diverse populations. At this stage, we included studies with overlapping samples or characteristics, and completed an appraisal (on a scale of 1 to 5) of data richness and quality of studies (EPOC 2017; see Table 3). The final selection of studies for each of our stratified criteria was 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). Due to the overlapping timeframe in which the QES and linked Brown 2019 review were being conducted, the selection of studies for the QES was conducted blind and independent to the study selection for the linked Brown 2019 review.

Data extraction and management

Two review authors (GC and GH) coded each of the papers, including extracts from participants and authors, themes and subthemes, explanations, hypotheses, theories, observations and interpretations of these data (Sandelowski 2002), reported anywhere in the primary qualitative studies. We used NVivo (Version 12, Release 1.3; QSR International 2020), as we coded directly onto the papers to conduct the analyses.

Appraisal of methodological limitations in the included studies

We only included studies that had a transparent audit trail of the methods used, which was a basic quality threshold. We assessed the quality of each study using the Critical Appraisal Skills Programme (CASP) tool (Atkins 2008; CASP 2019), which has been used in other reviews and QES' (Ames 2017; Carlsen 2016; Houghton 2020a).

The tool included the following questions, which we used 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 researchers' findings supported by sufficient evidence?

Two review authors with qualitative research experience (GC and GH) independently assessed each study. Disagreements were resolved through discussion and consultation with a third review author (SB). As it was recognised that studies deemed to be of low quality may still provide new insights (Dixon-Woods 2005; Noyes 2021), we did not exclude studies on the basis of quality, although as described previously, we used the quality of the study in our purposeful stratified sampling strategy. As suggested by Hannes 2011, appraisals of the methodological limitations of the studies formed part of the assessment of confidence in the synthesis findings (discussed below) using the GRADE-CERQual assessment (Lewin 2018), which determined the level of confidence we can have in each finding in the synthesis.

Assessment of confidence in the synthesis findings

We applied the GRADE-CERQual approach (Lewin 2018) to assess the level of confidence to place in individual review findings. Two review authors (GC and GH) independently summarised our confidence in each finding, with disagreements resolved through discussion and consultation with a third review author (SB). 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 generated a 'CERQual Evidence Profile' for each finding. This included information on all CERQual component assessments, which we used to make an overall judgement of confidence. All findings were rated at high confidence initially and then graded down when there were important concerns regarding each of the CERQual components. The assessments were discussed and agreed by GC, GH and SB. Each finding was 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 followed 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.

Data management, analysis and synthesis

In the first instance, we synthesised data using a thematic synthesis methodology, to identify the themes that existed throughout the studies (Thomas 2008). The process of synthesising qualitative evidence involves the comparison and analysis of findings from a variety of sources (Noyes 2021). The purpose of this method was to develop analytical themes through a descriptive synthesis and to find explanations relevant to the review questions (Ring 2011). We used NVivo (Version 12, Release 1.3; QSR International 2020) for this analysis.

The thematic synthesis included three overlapping stages. First, two review authors (GC and GH) conducted free, line-by-line coding to identify first order constructs (i.e. primary data such as quotes), and second order constructs (i.e. themes and subthemes generated by the authors of the studies). At this stage, we adopted an inductive, data-focused approach to avoid imposing an a priori framework onto the findings (Thomas 2008). This generated a set of first order codes and second order constructs that were increased and developed as each study was coded. When all studies had been coded, both review authors reviewed each others coding in discussion with a third review author (SB) to ensure consistency and quality. We then examined all of the text that had been given a code, code by code, in order to check for consistency and to identify if additional codes were needed (Thomas 2008).

For the second stage, we compared the first and second order constructs coded in stage one against the review questions, and examined each study again in order to identify more abstract interpretations. We then took a more in-depth approach to synthesising and analysing the similarities and variances between the themes and concepts evident in the studies. We did this by examining the similarities and differences between the first and second order constructs and began to organise them into descriptive themes. We then reviewed and discussed the constructs until we developed an appropriate framework that best presented the themes and allowed us to synthesise them with the findings from the linked Brown 2019 and related reviews (Caswell 2019; Gillies 2016; Macdonald 2012). Until this point, the synthesis remained close to the primary findings in the included studies. We included verbatim extracts in the report to illustrate the findings.

The third analytical synthesis stage moved beyond the findings in the primary studies to develop new patterns, meanings and understandings. We then integrated the findings from the linked Brown 2019 and related reviews (Gillies 2016; Macdonald 2012). We conducted a sequential synthesis using the related and linked studies (Harden 2018). Although we were conducting the linked Brown 2019 review and QES in a similar time frame, we were completing the linked review a stage ahead of the QES. Hence, we were able to integrate the findings of the reviews, once we had completed the analysis for the linked Brown 2019 review, and understood what that told us about the effectiveness of interventions.

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

Our aim in conducting this QES was to identify and draw together the experiences of those delivering and receiving psychosocial interventions, allowing us to supplement our linked Brown 2019 review and add to others (Gillies 2016; Macdonald 2012), by increasing understanding about the benefits, lack of benefit, and harms of interventions. For example, we were 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 were not necessarily viewed as helpful by users; and conversely, negative trials may generate benefits not detected in those trials. We conducted this QES at the same time as our linked Brown 2019 review, with the QES conducted slightly later than the linked review, allowing us to synthesis the findings of this QES with the linked Brown 2019 review. Our linked Brown 2019 review considered interventions for survivors of sexual violence and abuse suffered during adulthood and so we also synthesised the QES findings with related reviews that examined interventions for children who had been sexually abused (Gillies 2016; Macdonald 2012). Integrating findings from intervention and qualitative reviews is an emerging methodological area, and there are no agreed methods for how to conduct this type of analysis. We used two approaches: a narrative discussion; and matrix model.

First, we brought together the findings of this QES with the linked Brown 2019 review and related studies (Caswell 2019; Gillies 2016; Macdonald 2012), in a narrative discussion that was achieved by a meeting of the QES and linked Brown 2019 study author teams and the Lived Experience Group of the wider Multidisciplinary Evaluation of Sexual Assault Referral Centres for better Health (MESARCH) study. We identified many areas of overlap across the studies, which are presented narratively in the Results section.

Second, we used a matrix model similar to Candy 2011, Ames 2017 and Bohren 2019 to explore whether the interventions examined in the linked and related studies included the features identified in this QES as being important. To create the matrix, we first reviewed the QES findings to identify features that participants in the examined studies identified as important features of interventions that enabled them to derive most benefit from them. These were organised into nine questions (see Authors' conclusions) and two review authors (GC and GH) created a table listing the questions and the studies included in the linked Brown 2019 and related Gillies 2016 and Macdonald 2012 reviews. Since the focus of two of the reviews was on interventions for survivors of sexual abuse and violence (Brown 2019; Macdonald 2012), all the studies included in these reviews were listed in the matrix. One review had a broader focus (Gillies 2016), examining interventions for children who had experienced trauma resulting from a range of adverse events, so we only listed studies in the matrix where half or more of the sample in each study had been victims of child sexual abuse, in line with our criteria for selecting studies for this QES and our linked Brown 2019 review. For each of the listed studies, two review authors (GC and GH) adopted a similar approach as Bohren 2019, and determined the answer for each of the nine questions, answering 'yes', 'no', 'not reported' or 'not applicable', to reflect whether each feature was described or reported for the interventions examined by the studies.

Sensitivity analysis

While we planned to undertake a sensitivity analysis if low-quality studies affected the conceptual model, this was not needed as the findings were not influenced by low-quality studies.

RESULTS

Results of the search

The results of the searches are summarised in Figure 1. Our electronic and supplementary searches retrieved a total of 63,532 records, from which we removed 22,837 duplicates. We screened titles and abstracts of the remaining 40,695 records and excluded 40,189 which were irrelevant. We reviewed full-text reports of the remaining 506 records, of which we excluded 396 with reasons. From the remaining records, 105 reports appeared to meet our inclusion criteria, and from these we identified 97 included studies (from 104 reports), and one ongoing study (from one report; NCT03966963). It should be noted that five studies are awaiting classification. As described in the Methods (sampling framework), we purposively sampled 37 studies (40 papers) for inclusion in the thematic synthesis analysis (Figure 1).

Figure 1. PRISMA flow diagram

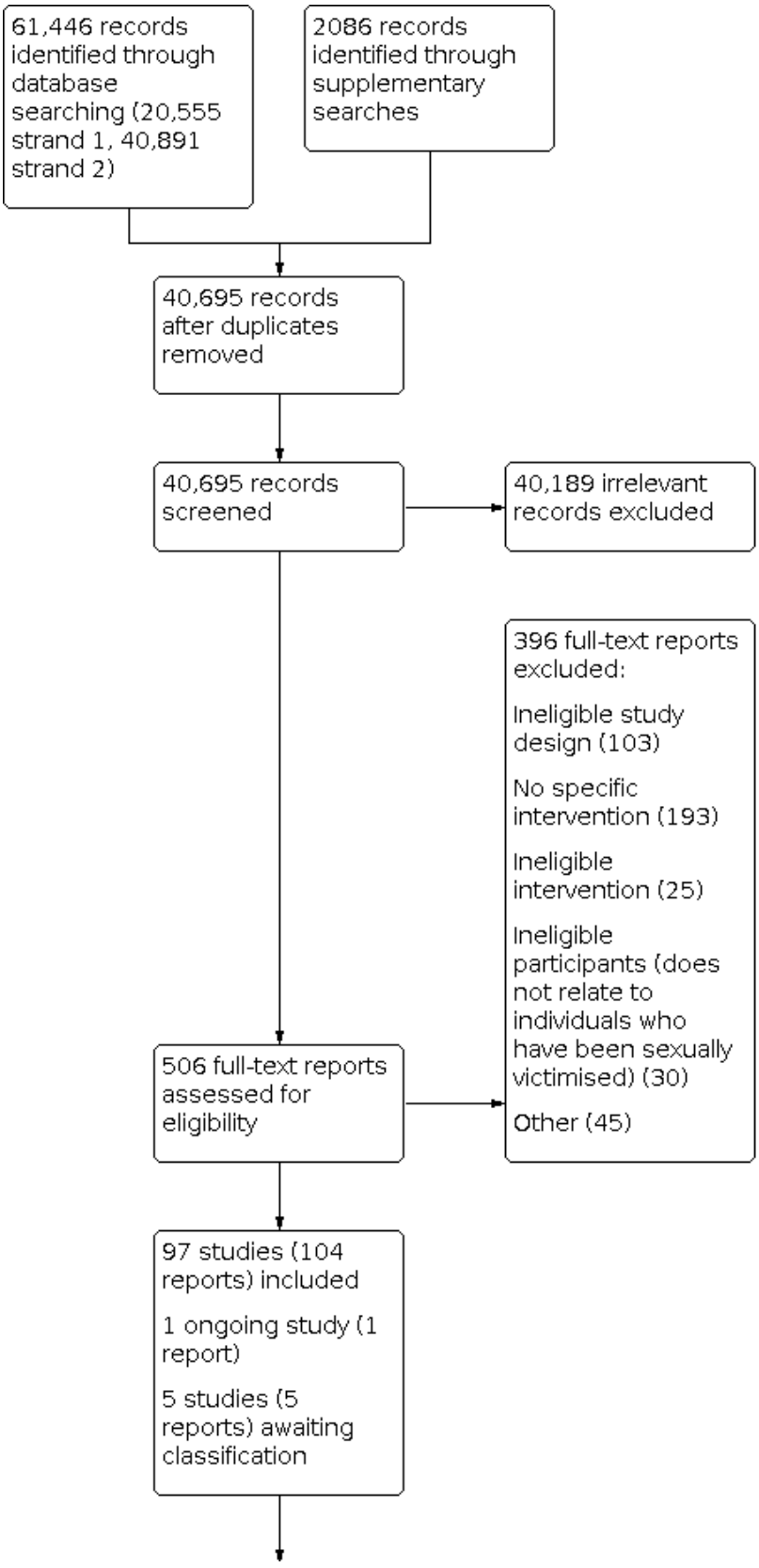
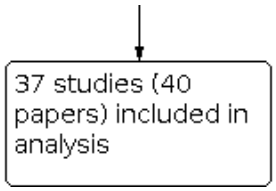


Figure 1. (Continued)



Description of the included studies

In this section, we describe the 37 studies (40 papers) that we sampled for analysis. For a description of each included and sampled study, see studies rated 4 and 5 (the study author/year of these studies has also been indicated) in Table 1; Table 2. For an overview of the studies that we included but did not sample for analysis, see studies rated 1 to 3 in Table 1; Table 2. It should be noted that Table 1 provides details about the study context and intervention characteristics and Table 2 provides information about participant characteristics, study methodology and overall rating of the quality of analysis. Details of all included studies can be found in the Characteristics of included studies tables.

Participants

In 27 of the studies (73%), the participants were survivors, while in three studies (8%) the participants were facilitators. Two studies (5%) included survivors, survivors' family or partners and intervention facilitators. Four studies (10%) included survivors and intervention facilitators and one study (3%) included survivors and survivors' family or partners. In total, 292 survivors were included in the studies analysed, 19 survivors' family members or partners and 60 intervention facilitators. It should be noted that throughout the review we report gender, age, ethnicity and sexuality as it was reported in the studies. Sex or gender were recorded for all the survivors and survivors' family members or partners, but in one study, Heberling 2006, the details for both types of participants were combined, with 5 female and 3 male participants (4 of which were survivors and 4 partners). In the remaining 33 studies, there were 231 female survivors, 22 cisgender female survivors, 26 male survivors, 1 bigender, and 2 transgender survivors and 13 female and 2 male family members or partners. In three studies, the sex or gender of the professionals was not recorded. In the seven studies where this was recorded, there were 40 female and 6 male facilitators. Where reported, age was generally reported as a range and is shown in the Characteristics of included studies tables and Table 2. Ethnicity was not reported in the majority (22; 59%) of studies. Sexuality was only reported in two studies. Details of ethnicity and sexuality can be found in the Characteristics of included studies tables and Table 2.

Interventions

A wide range of interventions was examined in the studies analysed, with only trauma-informed CBT being examined in more than one study. The interventions are listed below, broadly grouped into similar types of in interventions.

1. Eye Movement Desensitisation Reprocessing (EMDR)
2. Trauma-focused CBT (2 studies); trauma-informed CBT and play therapy; trauma-informed CBT with a sexual health component; cognitive processing therapy (CPT)
3. Psychotherapy, integrative humanistic psychotherapy; specialised psychotherapy; trauma informed outpatient psychotherapy; trauma recovery group – psychotherapy based
4. Compassion focused therapy (CFT); conjoint therapy based on emotion focused therapy and social learning; expressive therapy; intensive multi-modal holistic therapy; mindfulness-based therapy; Time2Talk (counselling for young people)
5. Christian-based support group; spiritually integrated residential treatment
6. 'Letting the future in' (interventions designed to help children recover from child sexual abuse); rape counselling; sexual assault referral centre (SARC) and integrated independent sexual violence advisor (ISVA); women recovery from abuse programme (WRAP)
7. Yoga complementing traditional psychotherapy; one-to-one Reiki and group/individual psychotherapy
8. Group forest yoga; kemetic yoga; trauma-informed yoga; trauma-sensitive yoga peer support group; touch inclusive therapy
9. Dance therapy
10. Expressive art therapy group
11. Verbal body-focused
12. Education/support group; peer education and connection through empowerment programme; psychoeducational group
13. Strengths-based group intervention

The duration or number of sessions included in the interventions were not reported in eight studies. Otherwise, it ranged from 1 occasion to 6 weeks, 14 weeks, 6 to 12 months, 12 to 38 months, and 1 to 5 years.

Where the number of sessions was reported, these ranged from a single 2-hour session, a minimum of 6 sessions, 8 weekly group sessions and 1 individual therapy session per survivor per week, 14 to 26 sessions, and 23 to 63 sessions.

Settings

The majority of studies (n = 31; 84%) were from high-income countries: Australia (n = 1), Canada (n = 5), Iceland (n = 1), Ireland (n = 1), Norway (n = 1), UK (n = 5) and USA (n = 17). Four studies (11%) were from two middle-income countries: Chile (n = 2) and South Africa (n = 2). The remaining two studies (5%) were from low-income countries: Nicaragua (n = 1) and the Philippines (n = 1).

The information describing the settings of interventions was often sparse and was not reported in six studies. Twelve studies were conducted in community settings.

Participants were also recruited from a range of healthcare settings: community mental health agency (n = 1), healthcare setting (n = 1), inpatient setting (n = 1), outpatient setting/clinic (n = 2)

and a trauma outpatient clinic (n = 1). Four studies recruited participants from interventions specifically for sexual violence and abuse survivors, including rape crisis centres (n = 2), a rape counselling programme (n = 1) and sexual assault referral centre (n = 1).

Three studies examined interventions delivered in a range of treatments centres (e.g. those that specialised in the treatment of abuse, or responding to children's needs typically arising from a range of adverse events). One setting was a social service agency, another, a private non-profit agency and another, a charity organisation. One study recruited participants from a military veteran centre, another, from a college campus and one intervention was delivered in a church setting.

Methodological limitations of the studies

The assessments for each sampled study are shown in Table 4; Table 5. We assessed the majority of the 37 sampled studies as having no or minor methodological limitations, with 31 studies having no concerns. One study, Kane 2003, had limitations in a number of areas. It was not possible to tell in four studies whether ethical issues had been considered or formal ethical approval granted (Kallivayalil 2013; Kane 2003; Mills 2002; San Diego 2011). Two studies did not describe the sampling method clearly and hence it was not possible to tell if it was appropriate (Farr 2021; Kane 2003). One study, Taylor 2018, did not justify the use of qualitative methodology and another, Kane 2003, did not clearly describe the approach to analysis.

Confidence in the review findings

Of the 22 review findings, we had high confidence in 12 findings, moderate confidence in 9, and low confidence in 1, assessed using the CGRADE-CERQual approach (see Summary of findings 1). We had no or only minor concerns across all our findings in respect of methodological limitations and coherence. Most of our moderate (8 findings) or serious (1 finding) concerns related to adequacy, as the data were less rich than in relation to other findings and/or represented a limited range of participants (e.g. did not include all our participant groups, or did not represent male or minority groups of survivors). We had moderate concerns about relevancy in respect of three findings as they were drawn from studies mostly conducted in the USA and across a limited range of intervention contexts. Our explanations of the GRADE-CERQual assessment for each review finding are shown in the full evidence profiles in Appendix 2.

Review findings

From our analysis, we identified 22 findings, which we organised into four broad themes.

1. **Contextual features** are features associated with the context in which interventions were delivered, and impacted how individuals accessed and experienced the intervention. These features included the organisational context in which the intervention was situated that could impact on survivors' engagement with interventions, such as staff turnover; the setting or location in which the intervention was delivered; and the characteristics associated with who delivered the intervention.
2. **Effectiveness** was defined through the range of benefits associated with participating in an intervention.
3. **Characteristics that enabled or hindered change** related to the causal underpinnings of why the intervention was or was not effective. These were interlinked with things that could have an impact on an individual's engagement with an intervention.
4. **Subgroup and specialism** are elements of interventions that were specific to the intervention type, or aspects related to an experience of an intervention that held particular relevance to subgroups of survivors; these issues could impact how individuals experienced delivering or receiving the intervention.

Contextual features

Finding 1: contextual features can affect survivors' access to and experiences of interventions

Features associated with the context in which an intervention was set impacted the accessibility of the intervention, and how survivors experienced it. The setting or environment in which the intervention was located affected the extent to which survivors felt safe and protected from further harm. For example, the extent to which there was privacy and confidentiality, and how physically safe survivors felt when attending the intervention were important. It was noted that when the location of the intervention was too difficult for survivors to access, this discouraged survivors from returning (Walker 2020). Family members bringing children to an intervention valued having interventions that were easy to locate or near their home (Carpenter 2016). The wider setting or service in which the intervention took place also impacted how survivors experienced the intervention. For example, if they received the intervention within a wider service that provided other forms of support, then this was also linked to their experience of the intervention (Stevens 2019). The extent to which the setting felt non-clinical helped survivors feel more comfortable; for example, by having cups of tea and eating toast, which are not associated typically with a medical or forensic environment, *"It was nice surroundings, there was a fish tank there and for some reason, I don't know why that seems to make a difference, but for me, it just relaxes me"; "You're sat in a comfortable area, not waiting on hard seats waiting to be called out"* (Walker 2020). Reception staff who were friendly, welcoming and made individuals feel at ease were also valued by survivors and family members, *"At the reception they were brilliant...nothing was too much trouble, there was always a word for the children. You didn't feel you were being fobbed off"* (Carpenter 2016).

Features associated with who delivered the intervention were also critical to how individuals experienced the intervention. Survivors quickly got a sense of whether the facilitator was the 'right fit' for them whereby they gained an initial impression of feeling a *"nice connection"* and comfort with the facilitator (Hoffman 2016). Survivors also valued having a facilitator who ensured that their needs were met, even if this meant that the facilitator took a more passive role (Jones-Smith 2018). Particularly in a couple's intervention, survivors and family members were willing to try multiple facilitators until they found the 'right one' with whom they 'clicked' (Heberling 2006).

Finding 2: organisational features can impact on survivors' engagement with interventions

Features associated with the organisation in which the intervention was situated could affect the extent to which survivors were able to engage with the intervention. High staff turnover or frequent rotations of staff made it challenging for survivors to develop their

relationship with the intervention facilitator. Survivors felt a sense of loss when their facilitator left, and sometimes preferred their original facilitator compared to their new one. In some cases, survivors had to wait for the new facilitator to start their role, which meant there was a period when they were not participating in any intervention. Children and young people struggled to re-establish trusting bonds within the intervention if facilitators changed or were inconsistent (Carpenter 2016). Consistency of facilitator created "*much needed*" stability for both children and parents (Farr 2021).

Finding 3: the format and delivery of interventions played an important role in their acceptability to survivors

The intervention format (e.g. if this was individual or group therapy) and how the intervention was delivered (e.g. mode of delivery and the types of activities included) were critical in helping survivors feel safe, and this was especially important for those attending group interventions. Survivors highlighted that feelings of safety grew organically, *"I think that [it] even starts with something as simple as a check-in because you're all committing and you're all making yourself present and it was very respectful"* (Shaw 2015). The group nature of interventions was perceived as providing a safe space of unity with other people who had experienced similar things *"you can get things in group therapy that you don't get in individual therapy. Just having other people say that they've experienced a lot of the same things that I have. You get that sense of not being the only one anymore"* (Shaw 2015). Furthermore, intervention routine established a safety net for survivors; structure, rhythm and repetition of an intervention helped to provide a secure frame of reference (Røberg 2018). Informal discussion amongst group members was also identified as facilitating a safe group space as relationships developed in the group (Braxton 2017; Shaw 2015). Survivors who had physical disabilities found it challenging to participate in intervention activities that were based on physical exercise. Although they found it challenging, they recognised that the exercises could still be beneficial to them (Sigurdardottir 2016). Young people valued the accessibility of the intervention whereby they could meet their facilitator at a range of community-based venues, where they felt safe and comfortable, "*Some young people felt more comfortable in an informal setting, such as a café, and professionals from other services suggested that this significantly improved the accessibility of counseling for this client group*" (Farr 2021). It was reported that the impact of the COVID-19 pandemic was such that the intervention was delivered to children virtually rather than in person. The implications of the pandemic affected how individuals experienced the intervention, *"She reported that the pandemic "limits me to video therapy, which—I love video therapy, but sometimes the kids are like, 'I don't want you to read a book to me today. I want to be able to see you in person'"* (Polk 2021).

Effectiveness

Finding 4: interventions improved survivors' understanding of trauma

The intervention enabled survivors the opportunity to process their trauma and develop their understanding about what they had experienced. The intervention helped them break negative beliefs about their role in the abuse, and enabled them to develop vocabulary to describe their experience (Kallivayalil 2013). Survivors reported that they no longer felt that they were to blame for what happened, felt less guilty and developed an acceptance for what happened, *"I feel less guilty than before. I learned there that lots of things that happened in the past; it wasn't my fault. And I as a child didn't have the power to stop anything or change anything, so it wasn't my fault"* (Parker 2007), *"I've blamed myself for so long - I've now realised that it wasn't my fault. There was nothing I could do to stop it"* (Kane 2003).

Survivors who engaged in group interventions felt reassurance knowing that they were not the only one who had experienced abuse and they were not alone or to blame (Carey 1996; Margain 2020; Silverberg 2019). An improved understanding of trauma led survivors to respect themselves, and many reported that they wanted to help others who had experienced something similar as this was part of healing, *"oh my god, I'm going through the same thing…it's about what I can do for the next person and how can I help them out, and… be an influence by the next generation in our children and our children's children"* (Braxton 2017).

Finding 5: interventions enabled survivors to re-engage in a wide range of areas of their lives

Survivors felt a sense of empowerment because of the intervention and had developed skills, such as learning how to assert boundaries, which enabled positive changes to occur in their lives. These involved survivors being able to re-engage in different aspects of their lives beyond the context of the intervention such as in education, work, hobbies, new interests, or even walking in the street.

"…she found she had 'altered a lot of things' in her life that she did not anticipate being able to change. Her new sensitivity to smell gave her messages about taking care of herself and limiting harmful lifestyle choices" (Asselstine 1997); "*Participants reported that strengths of the CPT [cognitive processing therapy] experience included feeling stronger, braver, wiser, and more courageous. They reported feeling safer, more trusting, and less ashamed…I have changed. I am more outgoing, back to doing things I loved, and I've added new interests. I am more social, more trusting, and stronger. I go out with friends"* (Mead 2019).

Finding 6: interventions helped improve survivors' interpersonal relationships

Survivors shared how the intervention had helped them to end or resolve unhealthy intimate and social relationships (Magnuson 2003). This was facilitated through the intervention as survivors learned what a healthy relationship looked like. Particularly, group-based interventions helped survivors develop their communication skills, build trust, develop gratitude, grow in confidence, and help model healthy relationships, *"it felt more like it was modeling a kind of a healthy family unit. Let [SIC] sit down, and we are all going have [SIC] a family discussion. It didn't feel like people played family roles, but it was like a healthy family"* (Shaw 2015; *clarification added*). Survivors reported that these things encouraged them to develop honesty with family members about their experience of trauma (Kerlin 2013), and in some cases this improved relationships with carers/parents (Farr 2021; Polk 2021). Survivors who participated in a group intervention reported that they developed friendships with others in the group outside of the intervention setting, "*It has given me friends that I can trust. I can say what I want to say and know that I can say it without getting their feelings hurt*" (Carey 1996). Survivors in a couple's intervention shared that *"partners garnered increased trust by better understanding the survivor's perspective and validating their feelings"* (Heberling 2006). For some survivors,

the changes that took place had a positive effect on their whole family, *"Now, even my children reap the benefits. My older son said to me not long ago: 'Why haven't you always been like this, Mom? You're much better now'. I asked him to explain what he meant and he said: 'You're not always sad anymore as you used to be. You do more with us'. This says it all, I think"* (Sigurdardottir 2016). Some survivors shared how the intervention had helped them to develop existing or new sexual relationships after the intervention ended, *"I'm really recognizing…there is a difference between physical and sexual touch, which is really good"; "she was now able to tell her partner when she was 'uncomfortable'"* (Asselstine 1997).

Finding 7: interventions helped improve survivors' mental health

Survivors reported improvements in their mental health because of what they had learned through the intervention content and through their experience of participating in the intervention. This included survivor-reported reductions in depression, anxiety, PTSD, fear, anger and increases in self-esteem, confidence and having a positive view of themselves and the world.

"My mental health has been better now than it has been for the last few years, if not decades! I've been twice to a mental hospital and have been on numerous medications as well as having gone twice for electroconvulsive therapy. Today I am almost free from the anxiety and social anxiety disorder and I stopped taking all my medication this spring" (Sigurdardottir 2016).

"The world is more colourful and worthwhile now. I am not isolating or having suicidal thoughts anymore. Now I feel human and I love life" (Mead 2019).

Finding 8: interventions helped improve survivors' mood

As a result of what they had learned and experienced through the intervention, survivors reported that they felt a weight had been lifted off their shoulders. They felt freer to express positive thoughts, which had impacts on other areas of their life too, *"I'm happier, I get up in the morning in a better mood, now I'm more interested in school, I do my homework, I do lots of things, now I'm going to a dance workshop"* (Capella 2018).

Finding 9: interventions helped improve survivors' physical health

As a result of participating in the intervention, survivors reported a range of improvements related to their physical health. Physical improvements were reported by survivors across a range of intervention types such as yoga, dance therapy, Reiki, EMDR and psychotherapy; thus, the physical benefits were not only limited to interventions that had a specific physical focus. These included improvements in muscle strength, movement, sleep, stamina, and an increased acceptance and appreciation of their physical bodies. Survivors reported a reduction in use of pain medication, acid reflux, digestive and uterine problems, nightmares, constipation, substance misuse and eating disorders.

"I still get pain, but not as much as before. I recover much more quickly and the acid reflux is nearly gone. I sleep from dawn till dusk whereas I used to wake up 3–4 times every single night. Now, I just sleep. I can sleep 10 hours straight, which is something I don't ever remember being able to do" (Sigurdardottir 2016).

Characteristics that enabled or hindered change

Finding 10: interventions that were survivor-centred and flexible were considered beneficial

Survivors reported that they valued a sense of choice and control within the intervention. Having the ability to determine pace, co-produce content and treatment modality was identified as central to healing (Kahan 2020). This was valued particularly by young people in the context of making their own decisions about which tasks or activities they wanted to engage with (Carpenter 2016). This was considered essential when survivors shared sexual abuse and violence narratives within the intervention. Survivors appreciated the choice of not having to talk about the sexual abuse and violence if they did not want to (Shaw 2015), and the ability to set a 'slow' pace if necessary (Mills 2002). Children and young people felt supported if they knew the practitioner would stop, take a break, or support them whenever they were distressed (Carpenter 2016). Facilitators and survivors shared the view that treatment should be targeted and "*structured based on the needs of each individual client*" (Edwards 2015; Heberling 2006). "*Don't be extremely rigid in your outline of therapy. Always be open. Everybody's an individual*" (Heberling 2006). Children and young people were more likely to complete the intervention and the processing of their trauma narrative if the treatment model allowed the therapist to listen to the child's needs and switch between activities and content (Carpenter 2016).

Finding 11: readiness to enter therapy/support was central to survivors feeling able to engage with interventions

Survivors' feelings of readiness were critical to motivation and engagement within the intervention, "*It was helpful because I was willing, and I had the desire to involve myself*" (Parker 2007). When they were "*really ready*", "*open*" (Parker 2007), "*believed in the possibility of feeling better*" (Beiza 2015), and "*wanted to find answers*" (Braxton 2017), survivors reported that interventions could "*profoundly change their lives*" (Parker 2007). This was dependent on acknowledgement that, as one young survivor noted, "*What comes now depends on me. I can't do anything with my past, but I can with my future*" (Carpenter 2016). When survivors did not feel ready to take on the intervention, they expressed ambivalence and inhibitions about the healing process "*There is a real resistance with me…not really wanting to do any work… letting the other person take it away*" (Asselstine 1997). For some survivors, not being ready was linked to the guilt and shame that often accompanies experiences of sexual abuse and violence (San Diego 2011; Silverberg 2019). This had impacted on confidence to engage with the intervention and feelings of unworthiness "*you can't really give yourself love and nurturing if you have no sense of yourself*" (McLean 2021). Survivors who were not ready often found the early phases of the intervention/therapy challenging (DiCesare 2015), and demonstrated 'avoidance' or 'frustration' in talking about or taking steps towards processing the trauma.

Finding 12: preparedness to start and end interventions impacted on survivors' abilities to derive benefit from them

Introductory sessions and/or assessment processes combined with regular communication helped survivors feel prepared to start the intervention (Mead 2019). This assisted in the development of trust and feelings of safety, which enabled positive change to happen (see Finding 13). Survivors reported that inadequate preparation raised anxieties around the suitability of

the intervention, confidentiality, fear of being pressured to talk about the sexual abuse and violence, and the composition of the intervention group (Carpenter 2016; Taylor 2018). Not knowing what to expect impacted on survivors' abilities to engage with the change process "*it was a new way of doing something, and it didn't make sense*" (Shaw 2015). This was particularly the case for survivors who had preconceived ideas of what the intervention may involve, based on prior experiences with other mental health services (Kane 2003). Preparing children, young people and their carers/parents for the receipt of online or telehealth interventions throughout the COVID-19 pandemic was considered critical to managing expectations for care (Polk 2021).

Preparation to end the intervention was considered just as important as preparation to start. Many survivors reported that the duration of the intervention was 'too short' (DiCesare 2015; Shaw 2015), and the end of treatment was a change that "*felt too sudden*" or "*abrupt*" (Beiza 2015). In these cases, survivors expressed concerns about being able to sustain change (Silverberg 2019), or felt their recovery was "*incomplete*" (Parker 2007).

Finding 13: establishing an open, accepting, and non-judgemental therapeutic relationship with a facilitator is key to healing

The relationship between survivor and facilitator across intervention types was critical to enabling recovery. Survivors reported that a positive therapeutic relationship was one that was trusting, non-judgemental, and where they felt safe and empowered (Forde 2021). This did involve times where it was appropriate for the facilitator to encourage/push survivors, but this was distinctly different to the facilitator 'leading' the intervention. Solidarity with the facilitator had a normalising effect that enabled survivors to move closer to recovery by not 'feeling alone' (Braxton 2017). Maintaining equality and respecting boundaries between the survivor (and family members included in the intervention) and the facilitator was critical to the success of the intervention (Heberling 2006).

Finding 14: interventions that help survivors to establish boundaries and be assertive enabled positive change to occur

Learning how to set and maintain boundaries within the intervention was identified by survivors as a key mechanism that enabled movement towards recovery. Survivors felt that being able to say "No" (Heberling 2006; Hoffman 2016), and assert personal boundaries contributed to their sense of empowerment, self-worth, and connection to others, "*I've learned to set boundaries to protect myself*" (Asselstine 1997). Interventions that helped survivors to be assertive enabled them to build confidence in their own decision making (Kahan 2020; Walker 2020). After intervention completion, these skills helped them to establish boundaries and be more assertive outside of the intervention context, such that this led to re-integration across other areas of survivors' lives; for example, in relationships, the community, and workplace (Hoffman 2016; Mead 2019; Shaw 2015).

Finding 15: participants identified risks and harms associated with participating in interventions

Some survivors reported that they experienced anxiety from activating traumatic memories (flashbacks and dissociation), as a reaction to stories or emotions told by themselves or others in the group, or as a response to the intervention content (Kahan 2020; Margain 2020; Røberg 2018). One risk of harm was survivors experiencing trauma responses as a result of engaging in certain intervention activities; for example, through music or touch. Survivors felt that this was challenging to experience, and it was difficult to know how to deal with this during an intervention (Mills 2002). However, overall, survivors felt that these activities were necessary to enable recovery (Magnuson 2003), *"I needed to experience this activation of stored negative experiences to resolve the trauma"* (Jones-Smith 2018), *"the pain might linger, but that healing and recovery was ongoing"* (Braxton 2017). Survivors felt that therapies involving movement or touch could involve risks whereby the facilitator was too comfortable in initiating certain activities, *"she and her therapist had "worked so far away from… monitoring and asking for permission for every movement" and that she believed "on that particular day [therapist] was more comfortable with touch than I was", which left her feeling "sad and a little unseen that she wasn't as wary as I needed her to be""* (Hoffman 2016).

In relation to interventions for children, parents were initially worried about how they would be perceived by facilitators. Parents valued the non-judgemental attitude of facilitators. Whilst parents welcomed their support, some reported feeling excluded because of the relationship between their child and the facilitator (Carpenter 2016).

Survivors shared that there were harms associated with what happened after an intervention ended. Some survivors felt anxious and upset at the prospect of ending their therapeutic relationships (Carpenter 2016), and felt abandoned (Kane 2003). Survivors reported that they struggled to find similar sources of support once the intervention ended, especially when a connection had been made with specific individuals during the intervention. For example, survivors found it difficult to continue yoga outside of a highly supportive group environment that they had established at the intervention (Silverberg 2019), and outside the context in which the intervention was situated, *"Many participants, in follow-up emails, described that they had found it hard to continue their yoga practice outside of the highly supportive environment provided by the classes organised by the Rape Crisis centre"* (Stevens 2019). Other survivors felt that they were still struggling post-intervention (Kerlin 2013). Thus, the intervention was limited in its sustainability of change, and this could be harmful because the benefits were perceived as being confined to the boundaries of the intervention (Carpenter 2016).

Finding 16: survivors recognised that even though it was difficult, they needed to face and process the trauma within interventions

Survivors identified the importance of seeing the intervention as a process that has different stages. They described the most emotionally challenging aspect of this as the need to "*face the monster*" or "*push through*" trauma symptoms to allow the processing work to take place (Sigurdardottir 2016). This was often accompanied by the resurfacing of difficult emotions and memories related to the abuse that could impact on engagement with therapy (Horton 2021). However, it was recognised that getting through uncomfortable feelings was a necessary step that enabled survivors to move towards recovery "*You need to take charge. It's worthless to come here to the psychologist's office and tell him things if I know I'm not gonna get better, if I'm gonna stay the same, first you have to know yourself and face your fears, your worries"*

(Capella 2018). Survivors who derived benefit from interventions highlighted that there is a need to be simultaneously "*strong and vulnerable*" (Silverberg 2019). Even though 'opening up' (Røberg 2018) the trauma narrative was described as "*terrifying*" (Edwards 2015), it created a sense of power and resilience that enabled survivors to remain engaged with the therapeutic process by increasing distress tolerance and 'acquire skills' for overcoming the trauma (DiCesare 2015; Taylor 2018).

Finding 17: survivors' abilities to engage with interventions were dependent on the level of trauma symptomology

High levels of trauma symptomology, particularly flashbacks and disassociation, prevented some survivors from engaging with the intervention. This was more likely to occur as survivors moved towards opening the trauma narrative or began processing work (Jones-Smith 2018): "*When I first started having even the slightest amount of contact with [my therapist] it would be like, a full-on flooding fear response… it would be full-on heart pounding, eyes starting to fog, vision starting to fog*" (Hoffman 2016). Among survivors with higher levels of trauma symptomology, avoidance and resistance was cited by facilitators as characteristics that prevented processing of the trauma narrative (Edwards 2015). Some survivors expressed frustration and anger with the facilitators/interventions' focus on things that happened in the past: "*I do not want to look back to these events, it's hurtful. My time is getting nowhere in this session*" (San Diego 2011). Readiness to begin therapy or to move past the stabilising stage within the intervention (or both) was also related to engagement and attendance, "*I didn't want to do it. Too risky. I literally ran out of the office when my therapist told me about CPT [cognitive processing therapy]*" (Mead 2019).

Finding 18: the influence of family, friends, and wider social networks can be an enabler or barrier to healing

Support from partners, family, and a peer network outside of the intervention was identified as facilitating change. 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 (Heberling 2006). Children and young people identified that "*being able to have fun and play*" with friends generated a sense of well-being that helped them to forget the sexual abuse and violence and reduce its presence in their everyday lives (Carpenter 2016). By contrast, the lack of family support was described as a barrier to healing. This was often linked to family members not believing the survivors' first disclosure, which impacted on their abilities and readiness to engage with the intervention (Bluntzer 2016; Capella 2018). Survivors who were socially isolated often struggled when the intervention came to an end, and with sustaining change and accessing further help (Beiza 2015). Children dependent on parents/carers' involvement to access the intervention faced difficulty in moving towards change if this involvement was inconsistent (Carpenter 2016), or if parents/carers' were resistant to the intervention (Farr 2021). Facilitators delivering online support or telehealth throughout the COVID-19 pandemic noted that this could be challenging when parents/carers interrupted their sessions (Polk 2021).

Subgroup and specialism

There were some characteristics that affected how individuals experienced the intervention and these were associated with specific components of the intervention type, or held particular relevance for specific subgroups of survivors. Whilst these are presented here, we recognise that many intervention types and subgroups are not represented.

Finding 19: the extent to which professionals could tailor interventions to meet the individual needs of participants impacted intervention suitability and effectiveness

Survivors expressed that it was important for professionals to see them 'holistically' and tailor the intervention to suit their needs (Sigurdardottir 2016). Professionals highlighted that cognitive capacity, verbal comprehension and communication skills are necessary for children to engage with processing trauma narratives (Carpenter 2016). Cognitive limitations and developmental issues prevented some children from engaging with, and deriving benefit from, the intervention. These issues were sometimes compounded by the effects of trauma "*damaging the child's ability to maintain focused attention, remember aspects of the trauma or the treatment, and affect their ability to maintain levels of emotional and behavioural regulation.*" (Carpenter 2016). As such, professionals stressed the importance of interventions that could be shaped to the cognitive capacity of survivors; this was particularly important for children and young people (Heberling 2006; McLean 2021). For some, the extent to which the intervention encouraged flexibility facilitated the extent to which facilitators could tailor interventions "*expressive therapy encouraged flexibility for Tumnus and Lucy to have an organic process during which they make changes or try things according to the need at the moment, and playfulness is inherently flexible*" (Horton 2021).

Finding 20: relationships with peers can be 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. This was established through acceptance, openness, and non-judgemental attitudes from other group members, "*What you tell stays in the group. You are not being judged by the others".* In this way, group interventions could provide a supportive environment and helped to model healthy relationships – "*like a healthy family*" (Shaw 2015). Identifying with, and listening to, other individuals in the group had the effect of normalising the trauma experience (Carey 1996; Visser 2015; Walker-Williams 2017). This was shaped by feedback and conversation with survivors who had similar experiences and was described as "*transformational*" (Braxton 2017). Survivors identified that being together and sharing similar experiences created a sense of solidarity (Braxton 2017). It helped them to feel "*stronger and more resilient"* (Fields 2019). "*Just having that affirmation that, "Oh my God, she feels the same way! And she thinks the same way!" That was huge for me"* (Silverberg 2019).

The extent to which survivors felt welcome within a group intervention was especially important to those who were from ethnic and gender minority groups (Braxton 2017; Shaw 2015). Survivors felt apprehensive about whether they would be accepted by others and the extent to which they felt unified with others in the group, "*I was the only Black person in the class, and I was not comfortable in the class…If you walk into a yoga class and its always women in the class you're going to feel like, okay, I'm the only man here…I might be willing to unify, but everyone else in the room isn't looking at me like I'm one with them"* (Braxton 2017). One survivor reported he had accessed a specialist group intervention

because he hoped that members of the LGBTQ+ (lesbian, gay, bisexual, transgender, queer or questioning) community would be more accepting of his history of "*being abused as a girl but living as a man*" than the "*mostly straight women*" in other groups (Shaw 2015).

Time since trauma and differences in distance travelled within the recovery journey were important features that shaped effective group composition. For survivors in the early stages of help-seeking, being in a group with survivors further along in their recovery could be inspiring: "*What inspired me was to see the difference in them and knowing that this can work if you work [at] it*" (Kahan 2020; Silverberg 2019). By contrast, other survivors struggled to establish relationships within the group if the trauma experiences were dissimilar or they considered that others' "*wounds were too raw*" (Silverberg 2019).

When survivors did not feel safe in their relationship with peers this created a barrier to engagement with the intervention. Feelings of safety could also be damaged if peers' comments were perceived as judgemental, or peers' experiences were too dissimilar within the group, "*I think we're all on different paths, going at different paces, and we have different obstacles in our way… I don't want to be told how to drive my road*" (Silverberg 2019). Inconsistent attendance from peers within closed groups could also destabilise feelings of safety and trust (Kane 2003; Røberg 2018), as could comments from peers that were considered judgemental or if they "*steered the conversation*" (Shaw 2015).

Finding 21: survivors' faiths can impact recovery when receiving faith-based interventions

For faith-based interventions, resolving spiritual struggles and finding faith were critical aspects of recovery (Kerlin 2013; Magnuson 2003). Faith-based teachings and practices that were learned during the intervention were key to developing survivors' faith and resolving damaging beliefs about themselves. Resolving these facilitated healing. This was often facilitated in group interventions when individuals could demonstrate their faith to others, such as praying for others in the group, or survivors who could be peer mentors demonstrating that recovery was possible (Kahan 2020; Margain 2020).

Finding 22: ongoing abuse can hinder engagement with interventions

Survivors who were experiencing ongoing abuse at the start or during the intervention were often excluded from participation. For example, it was recommended that participation in a conjoint couple's intervention whilst individuals were in an abusive relationship was inappropriate (Heberling 2006). Some facilitators noted that survivors who had experienced revictimisation, multiple traumas and/or reported complex trauma found achieving stabilisation within the intervention challenging (Jones-Smith 2018). This was particularly the case for children and young people living in homes where abuse was ongoing or who were under emotional stress caused by being removed from their family into a foster home or residential treatment facility. In this case, children could present with 'severe behavioural problems' (Carpenter 2016), which meant that the therapeutic process could not begin. In interventions for children, and where professionals assessed whether a carer was safe and in a position to support the child in the intervention, some practitioners were concerned that this criterion led them to turn children away who may otherwise have benefitted from the intervention (Carpenter 2016). Professionals felt that it would be beneficial to have more flexibility to work with the carer or family to address any wider problems as this would allow them to stabilise the home environment and then be able to work with the child.

Results of linking the review findings to Cochrane Reviews on effectiveness

Our fifth objective was to explore how the findings of this review can enhance our understanding of the findings from the linked Brown 2019 and related reviews (Gillies 2016; Macdonald 2012), assessing the effectiveness of interventions aimed at supporting survivors and preventing negative health outcomes.

We found only two studies (Bowland 2011; Sikkema 2018) from our linked Brown 2019 quantitative evaluation that had also published qualitative data/analyses that met our eligibility criteria, but which were not included in our sampled studies. There seems to be a wider range of interventions evaluated with qualitative studies than quantitative, with some types of interventions (e.g. yoga) being more likely to be assessed qualitatively, and others (e.g. CBT) being more likely to be evaluated quantitatively. In order to fully understand, however, how interventions work, the reasons for dropout, or lack of uptake of the intervention (which was not examined in any of the quantitative or qualitative studies in this QES or our linked Brown 2019 study), we need a combined approach to the evaluation of interventions.

We used two methods to integrate the synthesised qualitative findings: a narrative discussion and a matrix model.

Narrative discussion

The evidence base does not represent all survivors of sexual violence and abuse, with the 'missing voices' being highlighted in the related study (Caswell 2019), and this QES. In addition, we found few studies that assessed intervention facilitators' and survivors' families' views of specifically identifiable interventions. It is important to understand the views and perspectives of all stakeholders to fully appreciate the impact of interventions and the ways in which they work, particularly if the type of intervention is not the *key* aspect that drives change, as we might expect. We need to understand what the mechanisms of change actually are, whether these are the same across all groups of survivors, and the conditions under which these mechanisms can be optimised, so that the full benefits of the interventions can be realised.

All results of this QES and the linked Brown 2019 study and related Gillies 2016 and Macdonald 2012 reviews suggested that interventions were effective immediately after the end of the intervention and up to 3 months, for both adults and children (although there was less confidence in respect of the findings for interventions for children). The range of interventions was more limited in the linked and related reviews (Brown 2019; Gillies 2016; Macdonald 2012), compared to this QES, but the studies in the QES typically assessed survivors' views immediately after the intervention and few interventions were assessed in more than one study. This QES revealed a wider range of positive impacts, including impacts on survivors' understandings of trauma, re-engagement in a wide range of areas of their lives,physical health, and interpersonal relationships that were not assessed in the linked and related reviews (Brown 2019; Gillies 2016; Macdonald 2012), as they have not been typically assessed in

randomised trials; hence, a wider range of potential benefits could be included, which may require the development of appropriate standardised measures in future quantitative evaluations. All studies revealed that interventions needed evaluation over longer follow-up periods.

The results from this QES highlighted that survivors did not discuss aspects of the intervention (e.g. the areas addressed in CBT, or aspects of yoga), but they did describe a range of aspects associated with the interventions that were important, such as being prepared for the intervention, the approach of the therapist/intervention facilitators, and the impact of being a member of the group in group interventions and feeling safe. Arguably, many of our findings (e.g. those that relate to the value of survivor-led interventions; open, accepting, and non-judgemental therapeutic relationships; and readiness and preparedness to start and end interventions) are not specific to survivors of sexual abuse and violence; however, as far as we are aware, this is the first review specifically of survivors of sexual violence and abuse who raised these points in their discussion of the interventions they received; and hence, the QES is important in highlighting these issues for this population. The QES findings are related to the results of the related mixed-methods study (Caswell 2019), which revealed that trauma-informed communication was important, and stressed that the initial context with survivors was crucial; a finding also observed in this QES. Both studies demonstrate that 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 (Caswell 2019).

Our linked evaluation found no evidence of harm as a result of receiving interventions (Brown 2019); neither did we find evidence of harm in our QES results; however, we did find areas where there were potential risks of 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 composition of the group), and not allowing them to drop out of interventions where they were not able to form a good relationship with the therapist(s)/facilitators. As noted in our linked evaluation (Brown 2019), although dropout from an intervention is often seen in a negative light, enabling survivors to make choices in respect of their care, means that we should view exiting an intervention as an important means of survivors taking control over their treatment. This also means that a range of treatment options need to be available, so that survivors can fully exercise opportunities to make decisions regarding the most appropriate intervention for them, at the most appropriate time. It also means that they should have the opportunity to stop an intervention they do not feel comfortable with, knowing that they have the ability to start another one if they do this. Limited provision and long waiting times for interventions precludes this.

All studies highlighted the limitations of the evidence base and stressed the need for more evaluation and good quality studies. As well as conducting good quality studies, it is also important to provide clear details about the interventions being evaluated, methodology adopted and its justification, and ethical procedures in reports.

Matrix model

The matrix model (Table 6) shows how our synthesised QES findings are reflected in the interventions for survivors of sexual violence and abuse examined in the studies in the linked and related reviews (Brown 2019; Gillies 2016; Macdonald 2012). The matrix shows that the studies did not routinely report the details relating to the findings we identified in this QES. None of the studies specifically reported whether interventions were survivor-centred. Where this was applicable, only one study reported that staff in the organisation were aware that they might interact with survivors of sexual violence and abuse and felt equipped to interact with them in a trauma-informed way. Only one study stated that it had measures in place to minimise staff turnover or changes in intervention providers. Four studies reported that the context in which the intervention was delivered made survivors feel safe. Nine studies reported how the intervention could be tailored to support the needs of survivors, such as enabling flexibility in the number of sessions survivors could engage in depending on their trauma symptomology. Seven studies reported on whether measures were in place to prepare survivors for the start and end of interventions, and in cases where they did, the focus was usually on preparation to start the intervention, rather than the end it. Eleven studies did not provide details about the extent to which facilitators were open, accepting and non-judgemental. Five studies provided details about how the intervention helped survivors establish boundaries and be assertive. Twelve studies specifically shared how survivors' networks were considered in the design and delivery of the intervention, and this was especially important in interventions for children.

Review authors' reflexivity

All authors of this QES and of the larger MESARCH study believe in the importance of supporting and empowering all survivors 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 reviewed progress and drafts of materials and reports. We hope that these teams, representing a wide range of perspectives, experiences, contexts and backgrounds, and the regular review processes by the different groups encouraged reflexivity, as well as ensuring that practitioner and lived experiences perspectives were represented. Our work was 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 Brown 2019 or related reviews (Caswell 2019; Gillies 2016; Macdonald 2012), the review authors used refutational analysis techniques (‘disconfirming analyses’), to explore and try to understand contradictory findings between studies. These analyses were reviewed by other members of the QES team and wider MESARCH group as per its review processes.

We also presented an overview of our initial research findings and themes to the Lived Experience Group, in a Study Steering Committee meeting and at a MESARCH project webinar, of which there were approximately 200 participants, including practitioners, researchers and individuals with lived experience of sexual abuse and violence. Feedback from the Lived Experience

Group highlighted the importance of recognising the influence of contextual features (e.g. relationship with facilitator, survivor-centred interventions) and the impact of previous service use on the evaluation of interventions included in our QES. The Lived Experience Group talked about the importance of group dynamics within group interventions, particularly the influence of new group members, non-attendance and survivors learning from peers further along in the recovery journey. Following the Lived Experience Group meeting, we re-examined our findings across all the sampled studies. We reviewed whether survivors had reported differences between individual and group therapies, and if the composition of the group had influenced outcomes for survivors. We also looked at voices that could be missing from the research (e.g. survivors from Black, Asian and minority ethnic backgrounds, older survivors, those with a disability), and this process helped us to nuance both our key findings and directions for future research.

Our drafts were reviewed by members of the investigators team, the Lived Experience Group and Study Steering Committee.

DISCUSSION

Summary of main findings

For a summary of the main findings, please see the Plain Language Summary.

Overall completeness and applicability of the evidence

Overall, in the studies we analysed, there was good completeness and applicability of the evidence in terms of the range of interventions, including individual compared to group interventions. We also had a good range of high-quality studies in terms of methodology, with rich data that researchers analysed and presented in detail. There was also a good range of settings and intervention types; however, there were few studies of interventions delivered in low- and middle-income countries (n = 7).

Included studies were made up largely of samples of women (n = 22), aged in their 30s and early 40s, consistent with research that shows women carry a disproportionate burden of sexual abuse and violence globally (WHO 2005). We did not identify any study that emphasised, through its approach to sampling or recruitment, characteristics of survivors that are associated with poor access to sources of help (e.g. gender minorities, people affected by different forms of disability, or older adults) and studies generally overrepresented Caucasian women. Hence, the perspectives of those more at risk of marginalisation in this context have been missed. In addition, there were fewer studies of professionals' and families' and partners' experiences of interventions (n = 10). There was also less completeness in respect of child survivors (n = 5) and survivors from some communities including men (n = 10 studies with male and female participants, n = 2 studies with male participants only), LGBTQ+ (n = 2), cultural and ethnic minorities (n = 9), and those who are disabled, and older aged.

We did not synthesise all the studies that met the inclusion criteria. Although we had a clear rationale for our sampling framework and limiting the number of studies, we are mindful that the studies we selected to analyse may not reflect the diversity of experiences. For example, a further eight studies designed and delivered in low- and middle-income countries were not included in our sampled studies. In addition, there were many more studies in which specific interventions were not able to be identified that we excluded from this review. Given the orientation of the studies and data, our findings are not intervention-specific, limiting what we can conclude about different intervention types.

Although we had high confidence in more than half our findings (n = 12), with no or minor concerns for all findings in respect to methodological limitations and coherence, we had moderate or serious concerns for nine of our findings in respect to adequacy, and moderate concerns for three studies in respect to relevance. These concerns were that our findings did not represent all survivors of sexual violence and abuse (e.g. with minority groups or male participants not represented, or the findings not representing all our stakeholder groups). Our concerns in respect to relevancy related to the studies being conducted in a narrow range of countries (e.g. USA or high-income countries) or limited range of intervention contexts.

Comparison with other reviews and implications for the field

Previous reviews have explored the experiences of survivors of sexual violence and abuse in disclosing the abuse and the reactions of others to these disclosures (e.g. Alaggia 2019; Tener 2015), barriers in seeking support (e.g. Anderson 2020a; Donne 2018), and the impact of delivering interventions to support survivors of sexual violence and abuse on practitioners (e.g. Chouliara 2009). However, we are not aware of other reviews that have examined survivors' experiences of psychosocial interventions, nor those of their family, friends and social support networks, nor the views of intervention practitioners in terms of what helps and hinders survivors' attending their interventions. Our linked Brown 2019 review demonstrated that studies tend to focus on evaluating outcomes for individual interventions that reflect one part of the recovery process for survivors. We are not aware of any other reviews that have considered why these interventions may be effective, including barriers and facilitators to engagement and recovery outcomes.

RCTs usually measure intervention effectiveness by focusing on mental health outcomes such as PTSD and depression (Brown 2019). Our findings identified that survivors experienced a wider range of benefits that were not captured in RCTs. Whilst this included improvements to mental health, it was not limited to it, and survivors experienced benefits to physical health, having an improved understanding about their trauma, being able to engage in a wide range of areas of their lives, and having better interpersonal relationships. In a systematic review of qualitative studies that explored the effectiveness of interventions for children who had experienced domestic abuse (Howarth 2016), it was identified that children, parents and professionals also identified a wider range of benefits to an intervention that were not captured in RCTs. It was also observed that RCTs of interventions tended to focus on a narrow set of health outcomes that did not fully capture the range of ways in which interventions were effective. This shows the value of qualitative evidence when informing intervention effectiveness.

The findings of this review support those of a related review by Caswell 2019 indicating that it is generally important to allow survivors to have control over intervention decisions. This includes providing options around a wide range of interventions (e.g. traditional trauma approaches as well as faith-based interventions,

and alternatives to 'talking' therapies such as trauma-sensitive yoga), to allow survivors the opportunity to interact with an approach that feels appropriate for them, or that they feel most comfortable with, and at a time when they feel ready. Readiness of an individual is critical and shapes engagement with interventions, and part of enabling survivors to feel ready is the role that services play in effectively preparing survivors to start and end interventions. Our review indicates that preparation to start an intervention (e.g. through assessment, effective waitlist management) is perhaps as important as the content of the intervention. In this context, assessment processes may act as an intervention in and of themselves, enabling an opportunity for survivors to exercise choice as to whether the service being offered is appropriate for them, and if they feel ready for it.

Notably, a key finding within our review was that survivors did not talk about the modality or type of intervention as a feature in their recovery, but rather broader contextual characteristics (e.g. readiness, flexibility, survivor-centred care, location and consistency of care) that could hinder or enhance engagement. Typically, non-engagement with interventions, either survivors not starting or dropping out, are seen in the literature as a challenge that services need to overcome (Zinlow 2021). Our review highlights, however, that this is a part of the recovery process for survivors, who at different stages of their journeys, need to exercise choice over whether interventions are right for them.

Choice can be enhanced further by ensuring that interventions are co-produced in partnership with survivors, the benefits of which are demonstrated by studies that have explored the importance of survivor-centred care (Bovarnick 2021; Fisher 2018). Allowing survivors to take an active role in the design and delivery of their own care needs is an important step in recovery. Co-producing services in partnership with survivors provides an opportunity to address any 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. This helps survivors to engage with services, ensures that services address survivors needs and enables a therapeutic alliance to develop.

An open, warm, empathic, accepting and non-judgemental approach is the cornerstone of therapeutic and clinical practice (Baeir 2020), and so it is not surprising that this finding was also identified in this QES as being important for survivors' recoveries. However, survivors of sexual violence and abuse are often subject to pervasive forms of victim-blaming (e.g. they are questioned and challenged about their behaviours leading up to and during the abuse) (Anderson 2020b) from a range of people, including professionals (Crowe 2015), and social stigma and stigmatising reactions from others in response to their disclosures (Kennedy 2018; Lowe 2017). Stigma and stigmatisation play a critical role in shaping survivors' thoughts, feelings, and behaviours as they recover (Kennedy 2012); it is therefore important to reiterate that the participants from all stakeholder groups in our review noted that this was an important approach, not just from the providers, but other staff/practitioners within the organisation/context. In addition, this approach should extend to the survivors' families, friends and support networks.

While there are few studies exploring professionals', families' and partners' experiences of interventions, our analysis demonstrated that the influence of family, friends, and wider social networks can be an enabler or barrier to healing. Key barriers included survivors not being believed and ongoing abuse, which was particularly problematic for interventions designed to support children and young people. Similar barriers were identified by a review that explored barriers to treatment for childhood sexual abuse and non-offending caregivers (Theimer 2020). As our findings demonstrate, 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. This is because sexual violence and abuse is not an individual act, but intimately connected to a social and political context that can influence how survivors interpret their own experiences and engage with treatment (Peters 2019).

Limitations of the review

Virtually all studies conducted in this area canvassed the experiences and opinions of people who completed the interventions. We found no studies that had examined the views of individuals who had been offered the intervention but chose not to take it up. Furthermore, there were only a small number of studies examining the views of those who started the intervention and dropped out.

Although not recommended, due to the overlapping timeframes for this QES and our linked Brown 2019 review, we purposively sampled the eligible studies independent of, and prior to the final selection of all the studies in the linked Brown 2019 review. When we were able to synthesis the findings of the QES and linked Brown 2019 review, we found only two studies from the linked Brown 2019 review that had also published qualitative data/analyses that met our eligibility criteria; however, neither of these studies were included in the sample analysed in the QES. Insights from a qualitative sibling study can be really helpful, as sibling studies assess the same population and intervention in the same context and setting. Hence, in conducting our sampling blind to the linked Brown 2019 review, we potentially lost some advantages of including these sibling studies in the QES. However, one study examined CBT (Sikkema 2018), which was the only intervention evaluated by more than one of the analysed studies, and the other study involved a spiritual intervention (Bowland 2011), with similar interventions examined in our analysed studies (see Table 1). The studies were conducted in the USA and South Africa, which were also the locations of 17 and 2 (respectively) studies included in our analysis. The female survivors and professionals included in the two sibling studies were also similar to those included in the majority of our analysed studies (see Table 2).

Evidence from our linked Brown 2019 review into mental health outcomes after psychosocial interventions for sexual assault, rape and abuse in adults suggested there may be higher dropout from CBT interventions that are focused directly on the trauma, relative to those that are not trauma-focused. As highlighted in recent guidance from the UK Medical Research Council, the purely quantitative approach (e.g. RCT) with no additional elements, such as a process evaluation, is rarely adequate for understanding complex interventions (Skivington 2021), such as those that are offered to survivors of sexual abuse and violence across the lifespan. We found in our analyses that giving survivors control over decisions regarding interventions was important, so it is important that we understand why survivors elected not to begin interventions or quit them early.

Given the proximity of data collection to the completion of interventions, there is a lack of information about long-term impacts and reflections over time.

The conclusions of this review are those of the authors and the MESARCH research team.

AUTHORS' CONCLUSIONS

Implications for practice

It was notable that participants - victims and survivors of sexual abuse and violence, their supporters, and therapists - did not tend to discuss features and mechanisms related to the type of intervention (e.g. CBT, EMDR, counselling); elements of the intervention did not have salience for participants to the degree that context, timing and other issues that made them feel safe, supported and in control had. The review findings therefore point to the importance of flexibility in terms of intervention provision, so survivors can receive support that is viewed as relevant and appropriate to their own personal circumstances. Dropout from an intervention is often perceived as negative; however, our findings indicate that survivors should be involved in decisions regarding whether the approach fits their psychological and social needs at that time. Therefore, we have derived questions from our findings that may help policy makers, commissioners, programme leaders, managers and staff, and other key stakeholders assess the provision of interventions for survivors of sexual violence and abuse.

The first set of questions related to the overall level of provision, and are more likely to be relevant to stakeholders working in policy and commissioning.

A: Are there a range of different types and formats of interventions that are available and accessible to survivors?
B: Working 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?
C: Are survivors supported to access an alternative if an intervention is not right for them, or it is not the right time for them?
D: Is alternative support provided for survivors who might not be suited to interventions due to ongoing abuse and/or levels of trauma?
E: Is feedback about interventions sought from those who decline them, start them and drop out, as well as those who complete them?

The following questions relate to the provision and delivery of each intervention, and are therefore relevant for programme developers, leaders, managers and staff working both in the specific delivery of the intervention, but also managers and staff working in the wider context, and organisations in which interventions are delivered.

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 turnover, 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 appropriate the dynamics of group members (i.e. survivors attending group interventions), make all survivors feel safe?
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. Do interventions 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?

Implications for future research

Researchers and authors could be more consistent in their reports and papers about ethical approvals and practices and approaches employed for mitigating risks. While we understand the importance of protecting the identities of the survivors, it is important to try to include as much information about the survivors as possible (e.g. cultural and ethnic background, sexual identity, gender identity, disability), so we can understand the extent to which the samples capture the breadth of people's experiences and how future research needs to adapt. In addition, many studies lacked clear information about the intervention(s) that survivors completed, which limits the potential impact of the work; those taking up interventions will not always know precisely the type of therapy they accessed, but it is certainly worth exploring and reporting details, where possible. It also helps to report settings and locations to aid interpretations about generalisability. Although there has been a substantial improvement over time, it is important that the methodology, including the way data were coded and analysed, is reported clearly. In addition, a clear justification as to why a qualitative approach and the specific methodology employed is warranted.

None of the 37 sampled studies alluded to co-production, participatory methods or involvement of survivors in their design or data collection, analysis or interpretation of findings. In line with our call for practice settings to promote survivor engagement in service development and evaluation, we urge researchers working in this field to prioritise the co-production of research. Our own primary research has derived considerable benefit from collaboration with a dedicated, co-ordinated and funded group made up of individuals with lived experience of sexual abuse and violence (e.g. the MESARCH project, within which the current evidence synthesis review is situated).

The findings of the study suggest that more research is needed in respect of male, LGBTQ+, older-aged survivors and people with learning problems, chronic mental health problems or physical or health-related disability. Similarly, the evidence base can be strengthened through strategies that encourage greater participation among minority ethnic communities. Interventions in low- and middle-income settings rarely featured in the studies we identified, leaving many regions of the world excluded from the review; hence, we recommend future research from these regions. Inclusive recruitment can be aided through engagement with individuals who are experts through their own experiences.

In addition, more qualitative research with children and young people and their families is recommended. It is also important to address perspectives over time and the longer-term impacts of interventions from survivors' and their supporters' perspectives, and to consider examining the impact of repeat victimisation and the completion of more than one intervention over time. It is also important to undertake research into the nature and benefits of follow-up support or top-up sessions, where provided, post-intervention.

Across the quantitative review and this synthesis of evidence from qualitative research, we identified only two studies in which quantitative evaluation and qualitative evaluation were conducted and reported or published. It is important that researchers conducting RCTs and other quantitative research studies, also consider the perspectives of the survivors, their supporters and practitioners, and adopt a mixed-methods approach. Furthermore, studies assessing the effectiveness of these interventions could consider assessing a broader range of potential benefits than impacts on mental health, as this study indicated a wide range of benefits. In addition, the perspectives of those who do not take up, or complete the intervention are needed to fully understand the utility and accessibility of the intervention.

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* Indicates the major publication for the study

CHARACTERISTICS OF STUDIES

Characteristics of included studies *[ordered by study ID]*

Ahrens 2000

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to explore how sexual assault nurse examiner programmes are created and implemented

Data analysis: thematic analysis

Intervention

Sexual assault nurse examiner programme

Duration: not specified

Setting: hospital

Participants

Total study population: not reported but all participants were professionals

Ahrens 2000 *(Continued)*

Gender: not reported

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Ajema 2018

Study characteristics

Notes

Resources

Lower-middle-income country

Country

Kenya

Methods

Qualitative interviews

Study aimed to assess the quality and comprehensiveness of services provided to child survivors of sexual violence at two public health facilities in Kenya

Data analysis: thematic analysis

Intervention

Post-rape care, including counselling

Duration: not reported

Setting: public health facility

Participants

Total study population: 64 participants

1. Survivors (n = 14)
2. Wider family/partner (n = 19)
3. Professionals (n = 31)

Gender: not reported

Age: not reported, but survivors were children and young people

Ethnicity: not reported

Sexuality: not reported

Anderson 2018

Study characteristics

Notes

Resources

High-income country

Anderson 2018 *(Continued)*

Country

USA

Methods

One open-ended qualitative measure in a mixed-methods interview

Study aimed to explore the effect of an integrative, dual-modality therapy, involving hypnosis and emotional freedom technique in the treatment of sexual assault-related post-traumatic stress disorder

Data analysis: thematic analysis

Intervention

Dual-modality therapy involving hypnosis and emotional freedom technique

Duration: 5 x 60 minute sessions 1 session per week

Setting: community

Participants

Total study population: 30 participants

1. Survivors (n = 30)

Gender: not reported

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Anderson 2020c

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

In-depth interviews and survey

Study aimed to explore providers experiences and outcomes related to implementing the Giving Information for Trauma Support and Safety intervention

Data analysis: content analysis

Intervention

Giving Information for Trauma Support and Safety intervention

Duration: not reported

Setting: university campuses

Anderson 2020c *(Continued)*

Participants

Total study population: 14 participants

1. Professional (n = 14)

Gender: not reported, but majority were female participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Arend 2013

Study characteristics

Notes

Resources

Middle-income country

Country

South Africa

Methods

Qualitative interviews

Study aimed to examine survivors' experiences of post-exposure prophylaxis and their participation in an observational study

Data analysis: grounded theory

Intervention

Post-exposure prophylaxis and post-sexual assault care

Duration: 28 days of post-exposure prophylaxis, referral for counselling, psychosocial support provided as part of clinical care

Setting: hospital

Participants

Total study population: 10 participants

1. Survivors (n = 10)

Gender: not reported, but majority were female participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Asselstine 1997

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Qualitative interviews

Study aimed to explore the body experiences of women survivors within a verbal body-focused intervention that did not involve touch or movement therapy

Data analysis: comparative case study and picture analysis

Intervention

Verbal body-focused intervention

Duration: 1 session (2 hours)

Setting: community

Participants

Total study population: 5 participants

1. Survivors (n = 5)

Gender: 5 female participants

Age: 28 to 44 years

Ethnicity: not reported

Sexuality: not reported

Atira 2012

Study characteristics

Notes

Resources

Low-income country

Country

Cambodia

Methods

Case studies

Study aimed to examine the effectiveness of art therapy by analysing the subjective psychological and emotional experiences of trafficked women before, during and after being sold into the sex trade

Data analysis: narrative analysis

Intervention

Atira 2012 *(Continued)*

Art therapy

Duration: not reported

Setting: community

Participants

Total study population: 12 participants

1. Survivors (n = 12)

Gender: female participants

Age: 16-28 years

Ethnicity: not reported

Sexuality: not reported

Avilés 1997

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Open-ended qualitative question

Study aimed to implement a time-limited group treatment approach to help adult women improve ways of coping after experiencing incest

Data analysis: not reported

Intervention

Time-limited group therapy

Duration: 12 x 2-hour sessions for 12 weeks

Setting: women's post-treatment centre

Participants

Total study population: 9 participants

1. Survivors (n = 9)

Gender: female participants

Age: 23-41 years

Ethnicity: Aboriginal (n = 1), Caucasian (n = 8)

Sexuality: not reported

Bedard-Gilligan 2020

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Interviews and focus groups

Study aimed to explain the iterative treatment development process for refining a brief intervention targeting post-traumatic stress disorder and alcohol misuse for women with recent sexual assault experiences

Data analysis: comparative analysis

Intervention

Cognitive processing therapy-brief restructuring intervention after trauma exposure

Duration: 90-minute in-person sessions and 4 follow-up coaching phone calls

Setting: not reported

Participants

Total study population (not fully reported)

1. Survivors (n = 6)
2. Professionals (n = 6 and 3 focus groups)

Gender: female survivors

Age: mean = 20.83 years (survivors)

Ethnicity: Caucasian (n = 4)

Sexuality: heterosexual (n= 5), lesbian (n = 1)

Beiza 2015

Study characteristics

Notes

Resources

Middle-income country

Country

Chile

Methods

Qualitative interviews

Beiza 2015 *(Continued)*

Study aimed to examine narratives associated with healing from sexual abuse among teenagers in long-term residential care programmes who had successfully completed specialised psychotherapy

Data analysis: thematic narrative analysis

Intervention

Specialised psychotherapy

Duration: 12-38 months

Setting: centre for treatment of sexual abuse and maltreatment

Participants

Total study population: 5 participants

1. Survivors (n = 5)

Gender: female participants (n = 4), male participants (n = 1)

Age: 13 to 17 years

Ethnicity: not reported

Sexuality: not reported

Berman 2020

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Open-ended qualitative question

Study aimed to explore relations between distress tolerance and treatment persistence, engagement, and improvement in incarcerated women

Data analysis: thematic analysis

Intervention

Exposure-based treatment

Duration: 8 weeks; 1.5 hours weekly

Setting: minimum security prison

Participants

Total study population: 85 participants

1. Survivors (n = 85)

Gender: female participants

Berman 2020 *(Continued)*

Age: mean age 31.55 years

Ethnicity: African American (n = 3), Native American (n = 7), Other (n = 4), White (n = 70)

Sexuality: not reported

Black 2019

Study characteristics

Notes

Resources

High-income country

Country

Australia

Methods

Interviews, facilitator journals, observations

Study aimed to explore the findings of a cultural healing programme designed, developed and delivered by an aboriginal community-controlled organisation

Data analysis: not reported

Intervention

Cultural healing programme

Duration: 5-day cultural healing camp, a fortnightly women's healing programme, a 3-day cultural healing gathering and a 5-day women's cultural healing gathering

Setting: community

Participants

Total study population: 75 participants

1. Survivors (n = 36)
2. Wider family/partners (n = 26)
3. Professionals (n = 13)

Gender: female participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Bluntzer 2016

Study characteristics

Notes

Resources

High-income country

Bluntzer 2016 *(Continued)*

Country

USA

Methods

Qualitative interviews

Study aimed to examine the way in which Black women survivors of child sexual abuse experienced kemetic yoga in their recovery and coping processes

Data analysis: content analysis

Intervention

Kemetic yoga

Duration: not reported

Setting: community

Participants

Total study population: 8 participants

1. Survivors (n = 8)

Gender: female participants

Age: 23-46 years

Ethnicity: African American (n = 8)

Sexuality: not reported

Bowland 2011

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Focus group

Study aimed to explore the experiences of older female survivors who participated in a randomised controlled trial testing the effectiveness of a spiritually-focused intervention

Data analysis: thematic analysis

Intervention

Spiritually-focused intervention

Duration: 11 weekly sessions

Setting: community

Bowland 2011 *(Continued)*

Participants

Total study population: 36 participants

1. Survivors (n = 36)

Gender: female participants

Age: over 55 years

Ethnicity: not reported

Sexuality: not reported

Braun 2021

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Collective case series

Study aimed to test the feasibility, acceptability and perceived effects of mindful yoga therapy

Data analysis: thematic analysis

Intervention

Mindful yoga therapy

Duration: 75-minute class, once a week

Setting: New England vet centre

Participants

Total study population: 7 participants

1. Survivors (n = 7)

Gender: female participants

Age: 25-57 years

Ethnicity: not reported

Sexuality: not reported

Braxton 2017

Study characteristics

Notes

Resources

Braxton 2017 *(Continued)*

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to explore how and if aspects of kemetic yoga could support healing in survivors of childhood sexual abuse

Data analysis: content analysis

Intervention

Kemetic yoga

Duration: not reported

Setting: not reported

Participants

Total study population: 8 participants

1. Survivors (n = 8)

Gender: female participants

Age: 23-46 years

Ethnicity: African American (n = 8)

Sexuality: not reported

Brooker 2018

Study characteristics

Notes

Resources

High-income country

Country

UK

Methods

Survey

Study aimed to elicit forensic physicians' views about the assessment of mental health in a sexual assault referral centre

Data analysis: thematic analysis

Intervention

Sexual assault referral centre

Duration: not reported

Brooker 2018 *(Continued)*

Setting: not reported

Participants

Total study population: 45 participants

1. Professionals (n = 45)

Gender: female participants (n = 36), male participants (n = 9)

Age: 23-46 years

Ethnicity: not reported

Sexuality: not reported

Buck 2017

Study characteristics

Notes

Resources

High-income country

Country

UK

Methods

Qualitative interviews, focus group, and self-completion booklets

Study aimed to explore how young people make sense of peer mentoring

Data analysis: thematic analysis

Intervention

Peer mentoring

Duration: not reported

Setting: not reported

Participants

Total study population: 11 participants

1. Survivors (n = 11)

Gender: female participants

Age: 11-18 years

Ethnicity: not reported

Sexuality: not reported

Burt 2002

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Qualitative interviews, focus group, and self-completion booklets

Study aimed to examine the experience of self during the recovery process of women with a history of childhood sexual abuse

Data analysis: thematic analysis

Intervention

Art therapy

Duration: not reported

Setting: not reported

Participants

Total study population: 6 participants

1. Survivors (n = 6)

Gender: female participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Campbell 2011a

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to examine how sexual assault nurse examiners balance patient care and law enforcement collaboration

Data analysis: thematic analysis

Intervention

Campbell 2011a *(Continued)*

Sexual assault nurse examiners programme

Duration: not reported

Setting: community

Participants

Total study population: 6 participants

1. Professionals (n = 6)

Gender: female

Age: 30-55 years

Ethnicity: Caucasian (n = 6)

Sexuality: not reported

Campbell 2011b

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to examine how survivors experience quality of care from sexual assault nurse examiner nursing practice for their healing

Data analysis: a range of qualitative analyses

Intervention

Sexual assault nurse examiner programme

Duration: not reported

Setting: community

Participants

Total study population: 20 participants

1. Survivors (n = 20)

Gender: female participants

Age: 14-17 years

Ethnicity: African American (n = 3), Asian American (n = 1), White (n = 15), Multiracial (n = 1)

Sexuality: not reported

Capella 2018

Study characteristics

Notes	**Resources** Middle-income country **Country** Chile **Methods** Qualitative interviews and drawings Study aimed to gain an in-depth understanding of the participants' meanings regarding psychotherapeutic change at different moments in the process Data analysis: thematic narrative and visual narrative analysis **Intervention** Psychotherapy Duraction: 14-26 sessions Setting: public centres specialised in the treatment of sexual abuse **Participants** Total study population: 10 participants 1. Survivors (n = 10) Gender: 8 female participants, 2 male participants Age: 6-16 years Ethnicity: not reported Sexuality: not reported

Capri 2013

Study characteristics

Notes	**Resources** Low-income country **Country** South Africa **Methods** Qualitative interviews, analysis of case files, ethnography Study aimed to examine survivors' and professionals' experiences of therapy for children in a low-income South African community Data analysis: thematic analysis

Capri 2013 *(Continued)*

Intervention

Therapy

Duration: 9 sessions

Setting: community

Participants

Total study population: 6 participants

1. Survivors (n = 3)
2. Professionals (n = 3)

Gender: female participants

Age: 8-12 years (survivors)

Ethnicity: Black (n = 3) survivors

Sexuality: not reported

Carey 1996

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to construct detailed description of participants' perceptions of group treatment

Data analysis: thematic analysis

Intervention

Adelphi rape counselling group programme

Duration: 23-63 sessions

Setting: Adelphi rape counselling programme

Participants

Total study population: 9 participants

1. Survivors (n = 9)

Gender: 9 female participants

Age: 18-55 years

Ethnicity: not reported

Carey 1996 *(Continued)*

Sexuality: not reported

Carpenter 2016

Study characteristics

Notes

Resources

High-income country

Country

UK

Methods

Qualitative interviews

Study aimed to establish how Letting the Future In was delivered, and key stakeholders' experiences and perceptions of the intervention

Data analysis: thematic analysis

Intervention

Letting the Future in

Duration: 4 assessment sessions and 20 sessions for children and young people; 8 sessions for carers

Setting: National Society for the Prevention of Cruelty to Children treatment centres

Participants

Total study population: 26 participants

1. Survivors (n = 6; 6 female participants, 11-18 years)
2. Facilitators (n = 13; 11 female participants, 2 male participants)
3. Wider family/partner (n = 7; 6 female participants, 1 male participant)

Ethnicity: all White British

Sexuality: not reported

Carter 2002

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Carter 2002 *(Continued)*

Study aimed to examine bodyworks' influences on dissociation and disembodiment in adult female incest survivors

Data analysis: thematic analysis

Intervention

Psychotherapy and touch therapy

Duration: not reported

Setting: community

Participants

Total study population: 6 participants

1. Survivors (n = 6)

Gender: female participants

Age: 30-55 years

Ethnicity: American (n = 1), British (n = 1), South Euro-Americans (n = 4)

Sexuality: not reported

Choi 2021

Study characteristics

Notes

Resources

High-income country

Country

South Korea

Methods

Qualitative interviews

Study aimed to examine how survivors of sexual violence benefitted from mutual disclosure

Data analysis: grounded theory techniques

Intervention

2 South Korean support groups (Small Talk and Ehoo)

Duration: not reported

Setting: community

Participants

Total study population: 25 participants

1. Survivors (n = 25)

Gender: female participants

Age: not reported

Choi 2021 *(Continued)*

Ethnicity: Korean (n = 25)

Sexuality: not reported

Clukey 2003

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Videotapes, art work, intake histories, therapist notes

Study aimed to describe what art mediums sexually abused adults select and how they used those art mediums in the therapeutic and counselling situations

Data analysis: case study comparison

Intervention

Art therapy

Duration: 8 x 55-minute sessions

Setting: community

Participants

Total study population: 8 participants

1. Survivors (n = 8)

Gender: female participants

Age: All above 18 years

Ethnicity: not reported

Sexuality: not reported

Cole 2008

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Cole 2008 *(Continued)*

Telephone survey; open-ended questions

Study aimed to examine sexual assault nurse examiner programmes' relationships with victim advocacy organisations

Data analysis: thematic analysis

Intervention

Sexual assault nurse examiner programme and victim advocacy

Duration: majority of programmes provided service 24 hours a day, 7 days a week and used staff on a part-time on-call basis

Setting: hospital, rape crisis centre, police department, private clinic, child advocacy centre, prosecutor office

Participants

Total study population: 231 participants

1. Professionals (n = 231)

Gender: female participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Crandall 2003

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews and focus group

Study aimed to examine the impact of sexual assault nurse examiners on health care, victim services, law enforcement and prosecution

Data analysis: content analysis

Intervention

Sexual assault nurse examiner programme

Duration: not reported

Setting: hospital

Participants

Total study population: 28 participants

Crandall 2003 *(Continued)*

1. Professionals (n = 28)

Gender: not reported

Age: not reported

Ethnicity: not reported

Sexuality: not reported

DiCesare 2015

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to investigate how often trauma-focused cognitive behavioural therapy-trained clinicians were able to successfully complete the 5 main components of the treatment, with a particular emphasis on the trauma narrative component; to identify what factors, either of the client, the therapeutic relationship, or the systems surrounding the client, prevented or facilitated the successful completion of the trauma narrative

Data analysis: modified grounded theory approach

Intervention

Trauma focused cognitive behavioural therapy

Duration: 8-16 sessions

Setting: community mental health agency

Participants

Total study population: 8 participants

1. Facilitators (n = 8)

Gender: 7 female participants, 1 male participant

Age: 26-67 years

Ethnicity: not reported

Sexuality: not reported

Downing 2012

Study characteristics

Downing 2012 *(Continued)*

Notes	**Resources** High-income country **Country** USA **Methods** Qualitative interviews Study aimed to examine the perception of role conflict in sexual assault nursing and its impact on sexual assault nurse examiners and on care delivery Data analysis: descriptive interpretive methodology **Intervention** Sexual assault nurse examiner programme Duration: not reported Setting: hospital **Participants** Total study population: 14 participants 1. Professionals (n = 14) Gender: not reported Age: not reported Ethnicity: not reported Sexuality: not reported

Edmond 2004

Study characteristics

Notes	**Resources** High-income country **Country** USA **Methods** Qualitative interviews Study aimed to examine survivor perspectives of the effectiveness of eye movement desensitisation and reprocessing, and eclectic therapy for different treatments for trauma symptoms among adult female survivors of childhood sexual abuse Data analysis: not specified but refers to coding and themes **Intervention**

Edmond 2004 *(Continued)*

Eye movement desensitisation and reprocessing and eclectic therapy

Duration: 6 x 90-minute sessions of either therapy

Setting: community

Participants

Total study population: 38 participants

1. Survivors (n = 38)

Gender: not reported

Age: not reported

Ethnicity: majority White

Sexuality: not reported

Edwards 2015

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to examine the experiences of clinicians using mindfulness as a framework for their treatment of adult childhood sexual abuse victims

Data analysis: grounded theory

Intervention

Mindfulness-based therapy

Duration: not reported

Community setting

Participants

Total study population: 6 participants

1. Facilitators (n = 6)

Gender: not reported

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Ericksen 2002

Study characteristics

Notes	**Resources** High-income country **Country** Canada **Methods** Qualitative interviews Study aimed to understand the experience of women who were sexually assaulted and then cared for in an emergency setting by professionals associated with a specialised sexual assault service Data analysis: latent content analysis **Intervention** Specialised sexual assault service in emergency department setting Duration: not reported Emergency department **Participants** Total study population: 8 participants 1. Facilitators (n = 8) Gender: female participants Age: mean 25.7 years Ethnicity: not reported Sexuality: not reported

Farr 2021

Study characteristics

Notes	**Resources** High-income country **Country** UK **Methods** Qualitative interviews Study aimed to explore experience of counselling for young people and parents affected by child sexual exploitation Data analysis: thematic analysis

Farr 2021 *(Continued)*

Intervention

Time2talk counselling

Duration: not reported

Setting: community, third sector organisation

Participants

Total study population: 38 participants

1. Survivors (n = 10)
2. Wider family/partners (n = 8)
3. Professionals (n = 7)

Gender: not reported

Age: 12-25 years (survivors)

Ethnicity: not reported

Sexuality: not reported

Fehler-Cabral 2011

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to explore adult sexual assault survivors' experiences with sexual assault nurse examiners during a forensic examination

Data analysis: thematic analysis

Intervention

Sexual assault nurse examiner programme

Duration: not reported

Setting: rape crisis centre

Participants

Total study population: 20 participants

1. Survivors (n = 20)

Gender: female participants

Age: All above 18 years

Fehler-Cabral 2011 *(Continued)*

Ethnicity: White (n = 17), missing (n = 3)

Sexuality: not reported

Fields 2019

Study characteristics

Notes

Reources

Low-income country

Country

Nicaragua

Methods

Qualitative interviews

Study aimed to explore how practicing trauma-informed yoga could reduce enduring physical and clinical symptoms and promote positive growth

Data analysis: thematic analysis

Intervention

Trauma-informed yoga

Duration: 4 weekly pilot sessions, followed by 14 weekly sessions

Community setting

Participants

Total study population: 5 participants

1. Survivors (n = 5)

Gender: 5 female participants

Age: 21-31 years

Ethnicity: not reported

Sexuality: not reported

Forde 2021

Study characteristics

Notes

Resources

High-income country

Country

Republic of Ireland

Methods

Forde 2021 *(Continued)*

Qualitative interviews

Study aimed to examine the role of rape crisis centre specialist psychotherapy in addressing the psychophysiological impact of child sexual abuse in Ireland

Data analysis: thematic analysis

Intervention

Integrative humanistic psychotherapy

Duration: 1-5 years

Setting: rape crisis centres

Participants

Total study population: 23 participants

1. Survivors (n = 11, 8 female participants; 3 male participants)
2. Facilitators (n = 12, 10 female participants; 2 male participants)

Age: 21-47 years (survivors, not reported for facilitators)

Ethnicity: not reported

Sexuality: not reported

Gibbs 2015

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews and case narratives

Study aimed to evaluate three programmes serving domestic minor victims of human trafficking

Data analysis: not specified

Intervention

Standing against global exploitation everywhere; Salvation Army trafficking outreach; street work project at Safe Horizon

Duration: not reported

Setting: community

Participants

Total study population: unclear

1. Survivors (unclear)
2. Professionals (unclear)

Gibbs 2015 *(Continued)*

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Gilmore 2019

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to assess the usability of a mobile health intervention for individuals who experienced recent sexual assault

Data analysis: thematic analysis

Intervention

Mobile health intervention SC-Safe

Duration: not reported although there are 5 modules

Setting: community

Participants

Total study population: 38 participants

1. Survivors (n = 13)
2. Professionals (n = 25)

Age: > 18 years

Gender: 11 female participants; 1 male participant ; 1 other participant (survivors)

Ethnicity: White (n = 8)

Sexuality: not reported

Gonzalez 1991

Study characteristics

Notes

Resources

High-income country

Country

Gonzalez 1991 *(Continued)*

Canada

Methods

Discussion groups

Study aimed to examine the effectiveness of a support group for women survivors of childhood sexual abuse

Data analysis: not specified

Intervention

Self-help groups

Duration: 1 x weekly, 2-hour sessions over 10 weeks

Setting: community

Participants

Total study population: unclear

1. Survivors (unclear)

Age: 17-64 years

Gender: not reported

Ethnicity: majority White

Sexuality: not reported

Hall 1997

Study characteristics

Notes

Resources

High-income country

Country

UK

Methods

Survey

Study aimed to examine the experiences of a slow open analytic group for women survivors of child sexual abuse

Data analysis: not specified

Intervention

Slow open analytic group

Duration: not reported

Setting: not reported

Participants

Hall 1997 *(Continued)*

Total study population: 54 participants

1. Survivors (n = 54)

Age: not reported

Gender: female participants

Ethnicity: not reported

Sexuality: not reported

Harper 2008

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Qualitative interviews

Study aimed to understand perspectives of adults who have been abused as children, the aspects of community mental health interventions that are experienced as helpful and less helpful after discharge from inpatient trauma treatment

Data analysis: ethnographic/thematic

Intervention

Specialised trauma treatment programme

Duration: 6-week inpatient programme

Setting: hospital

Participants

Total study population: 30 participants

1. Survivors (n = 30)

Age: 20-54 years

Gender: 25 female participants, 5 male participants

Ethnicity: not reported

Sexuality: not reported

Healey 2016

Study characteristics

Healey 2016 *(Continued)*

Notes	**Resources** High-income country **Country** USA **Methods** Qualitative interviews Study aimed to describe the use of shamanic healing as a complementary health approach for adult child sexual abuse survivors from the perspectives of shamanic healers Data analysis: content analysis **Intervention** Shamonic healing Duration: not specified Setting: not specified **Participants** Total study population: 15 participants 1. Professionals (n = 15) Gender: 12 female participants, 3 male participants Age: 45 to 74 years Ethnicity: mixed-race (n = 1), White (n = 1) Sexuality: not reported

Heberling 2006

Study characteristics

Notes	**Resources** High-income country **Country** USA **Methods** Qualitative interviews Study aimed to understand the lived experience of childhood sexual abuse survivors and their partners who participated in conjoint therapy as a part of the treatment protocol for addressing issues related to the abuse Data analysis: phenomenological analysis **Intervention**

Heberling 2006 *(Continued)*

Conjoint therapy based on emotional focused therapy and social learning approaches

Duration: not reported

Setting: community

Participants

Total study population: 8 participants

1. Survivors (n = 4)
2. Wider family/partner (n = 4)

Age: 21-56 years

Gender: 4 female participants, 4 male participants

Ethnicity: White Caucasian (n = 8)

Sexuality: heterosexual relationship (n = 3); homosexual relationship (n = 1)

Hester 2018

Study characteristics

Notes

Resources

High-income country

Country

UK

Methods

Qualitative interviews

Study aimed to explore the involvement of specialist sexual violence services, including independent sexual violence advisors in supporting victims/survivors of rape and sexual abuse engage with the criminal justice system

Data analysis: thematic

Intervention

Independent sexual violence advisor service

Duration: not specified

Setting: community

Participants

Total study population: 32 participants

- Professionals (n = 14), 13 female participants, 1 male participant
- Survivors (n = 15), 12 female participants, 3 male participants
- Parents/carers (n = 3), 3 female participants

Age: not reported

Ethnicity: not reported

Hester 2018 *(Continued)*

Sexuality: not reported

Ho 2015

Study characteristics

Notes

Resources

High-income country

Country

Hong Kong

Methods

Survey with open-ended questions

Study aimed to evaluate a dance movement therapy programme designed to address the adaptive issue of building healthy relationships with the self and others among Chinese childhood sexual abuse survivors

Data analysis: thematic

Intervention

Dance/movement therapy

Duration: 2 hours per week for 5 weeks

Setting: not specified

Participants

Total study population: 25 participants

1. Survivors (n = 25)

Gender: female

Age: 25 to 52 years

Ethnicity: not reported

Sexuality: not reported

Hoffman 2016

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Hoffman 2016 *(Continued)*

Qualitative interviews

Study aimed to examine the experience of touch as a part of the psychotherapeutic process for 7 survivors of sexual abuse or trauma, or both

Data analysis: transcendental phenomenological analysis

Intervention

Touch inclusive therapy

Duration: not reported

Community setting

Participants

Total study population: 7 participants

1. Survivors (n = 7)

Gender: 5 female participants; 2 male participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Hopper 2018

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Process notes from group observation, interviews, focus group

Study aimed to present the Stars experiential group treatment programme, a structured body-based group intervention designed to address complex trauma in survivors of human trafficking

Data analysis: thematic

Intervention

Stars experiential body-based trauma group

Duration: 60 to 120 minutes, 6 weekly sessions

Setting: residential

Participants

Total study population: 17 participants

1. Survivors (n = 17)

Hopper 2018 *(Continued)*

Gender: female participants

Age: 14 to 32 years

Ethnicity: Biracial (n = 2), Black (n = 6), White (n = 9)

Sexuality: not reported

Horton 2021

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Interviews

Study aimed to present the findings of a single-case study comprising 1 adult survivor of childhood sexual abuse and their counsellor regarding their experiences of expressive therapy for the treatment of childhood sexual abuse

Data analysis: thematic

Intervention

Expressive therapy

Duration: 30 minutes of expressive therapy in a 50-minute session

Setting: not specified

Participants

Total study population: 2 participants

1. Professional (n = 1)
2. Survivor (n = 1)

Gender: female participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Horvath 2020

Study characteristics

Notes

Resources

High-income country

Horvath 2020 *(Continued)*

Country

UK

Methods

Interviews and focus group

Study aimed to investigate staff's perspectives on the characteristics required to work in a sexual assault referral centre and the support and training they believe sexual assault referral centres should provide to minimise the negative impacts of the work and provide a supportive working environment

Data analysis: thematic

Intervention

Sexual assault referral centre

Duration: not specified

Setting: not specified

Participants

Total study population: 16 participants

1. Professional (n = 16)

Gender: female participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Houser 2015

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Interviews and field notes

Study aimed to investigate staff's perspectives on the characteristics required to work in a sexual assault referral centre and the support and training they believe sexual assault referral centres should provide to minimise the negative impacts of the work and provide a supportive working environment

Data analysis: content analysis

Intervention

Yoga group

Duration: 60 to 90 minutes, 8 weekly sessions

Houser 2015 *(Continued)*

Setting: hospital

Participants

Total study population: 34 participants

1. Survivors (n = 34)

Gender: female participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Hung 2010

Study characteristics

Notes

Resources

High-income country

Country

Taiwan

Methods

Group discussion and observation

Study aimed to explore the role of drama therapy in the process of recovery from trauma

Data analysis: not specified

Intervention

Drama therapy

Duration: 10 hours over 2 days

Setting: not specified

Participants

Total study population: 4 participants

1. Survivors (n = 4)

Gender: female participants

Age: 74 to 90 years

Ethnicity: not reported

Sexuality: not reported

Hutschemaekers 2019

Study characteristics

Notes	**Resources** High-income country **Country** Netherlands **Methods** Interviews Study aimed to examine the short-term and long-term responses of sexual assault victims who attended a sexual assault centre Data analysis: thematic **Intervention** Sexual assault referral centre Duration: not specified Setting: sexual assault referral centre **Participants** Total study population: 12 participants 1. Survivors (n = 12) Gender: female participants Age: 18 to 54 years Ethnicity: not reported Sexuality: not reported

Janocko 1994

Study characteristics

Notes	**Resources** High-income country **Country** USA **Methods** Interviews Study aimed to gain understanding of the experience of clients in an inpatient group for sexual abuse survivors Data analysis: thematic **Intervention**

Janocko 1994 *(Continued)*

Inpatient trauma group

Duration: 50 minutes twice weekly for 14 weeks

Setting: inpatient

Participants

Total study population: 9 participants

1. Survivors (n = 9)

Gender: female participants

Age: 20 to 29 years

Ethnicity: Black (n = 5), Caucasian (n = 3), Hispanic (n = 1)

Sexuality: not reported

Jensen 2010

Study characteristics

Notes

Resources

High-income country

Country

Norway

Methods

Interviews, videos of sessions and therapist notes

Study aimed to examine how working alliance between therapist and child can be established in sessions of psychotherapy for sexual abuse

Data analysis: case-by-case content analysis

Intervention

Psychotherapy

Duration: weekly (mean attendance 7.5 sessions)

Setting: inpatient

Participants

Total study population: 15 participants

1. Survivors (n = 15)

Gender: 9 female participants, 6 male participants

Age: 5 to 16 years

Ethnicity: not reported

Sexuality: not reported

Jones-Smith 2018

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Interviews

Study aimed to explore the perceptions of therapists about eye movement desensitisation and reprocessing as a tool to assist adult women survivors of child sexual abuse through the healing process and to regain their abilities to function and behave appropriately

Data analysis: phenomenological analysis (thematic)

Intervention

Eye movement desensitisation and reprocessing

Duration: not reported

Community setting

Participants

Total study population: 10 participants

1. Survivors (n = 10)

Gender: 8 female participants; 2 male participants

Age: not reported

Ethnicity: African American (n = 3), Caucasian (n = 4); Puerto Rican (n = 1), White Italian (n = 1), White Russian (n = 1)

Sexuality: not reported

Kahan 2020

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Interviews

Kahan 2020 *(Continued)*

Study aimed to examine service user and provider experiences of a trauma-informed, peer-facilitated group psychosocial intervention (Peer Education and Connection through Empowerment), targeting female identified youth experiencing homelessness and gender-based violence

Data analysis: thematic

Intervention

Peer support psychosocial trauma-informed group intervention

Duration: 3 months

Setting: social service agency

Participants

Total study population: 19 participants

1. Professionals (n = 7)
2. Survivors (n = 12)

Gender: 11 female survivors, 1 bigender survivor

Age: 5 to 16 years

Ethnicity: not reported

Sexuality: not reported

Kallivayalil 2013

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to examine the shifts in trauma narratives over time to determine whether survivors have different understandings of their experiences during the course of treatment

Data analysis: grounded theory

Intervention

Trauma-informed outpatient psychotherapy

Duration: 8 months

Setting: trauma outpatient clinic

Participants

Total study population: 14 participants

1. Survivors (n = 14)

Kallivayalil 2013 *(Continued)*

Gender: 13 female participants; 1 male participant

Age: 24-62 years

Ethnicity: Asian (n = 1), Caucasian (n = 13)

Sexuality: not reported

Kane 2003

Study characteristics

Notes

Resources

High-income country

Country

Northern Ireland

Methods

Qualitative interviews

Study aimed to examine the views and experiences of participants in a series of education/support groups for adult survivors of child sexual abuse over a 3-year period

Data analysis: thematic analysis

Intervention

Education/support group

Duration: 20 sessions over 3-year period

Setting: community

Participants

Total study population: 12 participants

- Survivors (n = 12)

Gender: 12 female participants

Age: 19-60 years

Ethnicity: not reported

Sexuality: not reported

Karatzias 2014

Study characteristics

Notes

Resources

High-income country

Country

Karatzias 2014 *(Continued)*

UK

Methods

Interviews

Study aimed to report on the effectiveness and acceptability of a brief psychoeducational group for survivors of child sexual abuse to stabilise mental health and behavioural outcomes while on the waiting list for mental health services

Data analysis: interpretative phenomenological analysis

Intervention

Psychoeducational group cognitive behavioural therapy-informed

Duration: 1.5 hours, 10 weekly sessions

Setting: outpatient setting

Participants

Total study population: 16 participants

1. Survivors (n = 16)

Gender: 14 female participants, 2 male participants

Age: 18 to 65 years

Ethnicity: not reported

Sexuality: not reported

Kellner 1994

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Focus group

Study aimed to evaluate whether, and how, a programme based on constructivist principles helped to empower a group of sexually abused boys and their families by creating a collaborative, rather than a hierarchical, therapeutic relationship

Data analysis: content analysis

Intervention

Tandem constructivist group for young male survivors and their parents

Duration: 6 sessions weekly (initially) then bi-monthly

Setting: not specified

Kellner 1994 *(Continued)*

Participants

Total study population: 9 participants

1. Survivors (n = 4)
2. Parent/carers (n = 5)

Gender: 4 male survivors, parent/carers not reported

Age: 18 to 65 years

Ethnicity: not reported

Sexuality: not reported

Kenny 2018

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Open-ended survey

The aim of the study was to evaluate the Girls Owning Their Lives and Dreams (GOLD) programme, a comprehensive group counselling programme providing psychoeducational, growth, support, and counselling groups to adolescent victims of commercial sexual exploitation

Data analysis: thematic

Intervention

Psychoeducational and therapeutic group integrating coping skills, art therapy, lifestyle, substance use treatment, peer mentoring and peer support

Duration: evening groups drop-in (not time limited)

Setting: outpatient centre

Participants

Total study population: 16 participants

1. Survivors (n = 16)

Gender: 16 female participants

Age: 15 to 18 years

Ethnicity: Black (n = 7), Hispanic (n = 3)

Sexuality: not reported

Kerlin 2013

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to explore the recovery experiences of women with a history of childhood sexual abuse who completed spiritually-integrated residential treatment

Data analysis: interpretative phenomenological analysis

Intervention

Spiritually-integrated residential treatment

Duration: 6 months to a year

Setting: inpatient setting

Participants

Total study population: 10 participants

1. Survivors (n = 10)

Gender: female participants

Age: 21-56 years

Ethnicity: Caucasian (n = 9), Hispanic (n = 1)

Sexuality: not reported

Knettel 2019

Study characteristics

Notes

Resources

Middle-income country

Country

South Africa

Methods

Open-ended survey and workbook responses

The aim of the study was to examine the mechanisms, facilitators, and barriers to change through content analysis of clinical notes and qualitative feedback of participants in the Impact pilot trial.

Data analysis: thematic

Intervention

Knettel 2019 *(Continued)*

Impact: a psychoeducational and coping skills intervention

Duration: 4 weekly sessions

Setting: health centre

Participants

Total study population: 31 participants

1. Survivors (n = 31)

Gender: 31 female participants

Age: 18 to 44 years

Ethnicity: Black African (n = 31)

Sexuality: not reported

MacIntosh 2008

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Observation and interviews

Study aimed to explore emotionally-focused therapy for couples with childhood sexual abuse survivors and their partners

Data analysis: thematic

Intervention

Emotion focused couples therapy

Duration: 19 weekly sessions

Setting: not specified

Participants

Total study population: 20 participants

1. Survivors (n = 10)
2. Partners (n = 10)

Gender: 10 female survivors, partners not reported

Age: 18 to 44 years

Ethnicity: Black African (n = 31)

Sexuality: not reported

Magnuson 2003

Study characteristics

Notes	**Resources** High-income country **Country** Canada **Methods** Qualitative interviews Study aimed to uncover the experiences and benefits of Reiki, a holistic spiritual touch therapy, when used as a complement to traditional group therapy for mothers healing from the impact of child sexual abuse Data analysis: content analysis **Intervention** One-to-one reiki and group/individual psychotherapy Duration: not reported Setting: not reported **Participants** Total study population: 10 participants 1. Survivors (n = 10) Gender: female participants Age: not reported Ethnicity: not reported Sexuality: not reported

Margain 2020

Study characteristics

Notes	**Resources** High-income country **Country** USA **Methods** Interviews Study aimed to examine female sexual abuse survivors' experience of participating in a Christian-based sexual abuse church support group

Margain 2020 *(Continued)*

Data analysis: thematic

Intervention

Christian-based support group

Duration: not specified

Setting: church

Participants

Total study population: 10 participants

1. Survivors (n = 10)

Gender: female participants

Age: 20 to 69 years

Ethnicity: Asian American (n = 1), Hispanic (n = 1), White (n = 8)

Sexuality: not reported

Mattsson 1998

Study characteristics

Notes

Resources

High-income country

Country

Sweden

Methods

Focus group and interviews

Study aimed to evaluate a body awareness group therapy delivered to adult survivors of childhood sexual abuse

Data analysis: thematic

Intervention

Body awareness group therapy

Duration: not specified

Setting: not specified

Participants

Total study population: 7 participants

1. Survivors (n = 7)

Gender: female participants

Age: 22 to 49 years

Ethnicity: not reported

Mattsson 1998 *(Continued)*

Sexuality: not reported

McLean 2021

Study characteristics

Notes

Resources

High-income country

Country

Australia

Methods

Qualitative interviews

Study aimed to understand adult female survivors of childhood sexual abuse to inform the development of a compassion-focused therapy-based intervention

Data analysis: consensual analysis

Intervention

Compassion focused therapy

Duration: not reported

Setting: not reported

Participants

Total study population: 14 participants

1. Survivors (n = 7)
2. Facilitators (n = 7)

Gender: female participants

Age: 31-61 years

Ethnicity: Caucasian (n = 14)

Sexuality: not reported

Mead 2019

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Mead 2019 *(Continued)*

Written open-ended questionnaire

Study aimed to understand and explore military sexual trauma survivors' experiences and perceptions of cognitive processing therapy

Data analysis: thematic

Intervention

Cognitive processing therapy

Duration: 14 sessions

Setting: military veteran centre

Participants

Total study population: 21 participants

1. Survivors (n = 21)

Gender: cisgender female participants

Age: 20-40 years

Ethnicity: not reported

Sexuality: not reported

Meekums 1998

Study characteristics

Notes

Resources

High-income country

Country

UK

Methods

Interviews, therapist, and researcher notes

Study aimed to explore experiences of recovery from trauma of chronic child sexual abuse within the context of a group arts therapies programme

Data analysis: grounded theory

Intervention

Creative therapies (dance movement, drama therapy, art therapy)

Duration: 2 hours weekly for 20 weeks

Setting: mental health service

Participants

Total study population: 14 participants

1. Survivors (n = 14)

Meekums 1998 *(Continued)*

Gender: female participants

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Mills 2002

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Narrative analysis

Study aimed to explore the experiences of dance therapy among women who have been sexually abused as children

Data analysis: narrative analysis

Intervention

Dance therapy

Duration: minimum of 6 sessions

Setting: not reported

Participants

Total study population: 5 participants

1. Survivors (n = 5)

Gender: female participants

Age: 25-48 years

Ethnicity: Caucasian (n = 5)

Sexuality: not reported

O'Malley 2019

Study characteristics

Notes

Resources

High-income country

Country

O'Malley 2019 *(Continued)*

Northern Ireland

Methods

Case studies, case notes and interviews

Study aimed to build understanding of the clinical approach used in supporting individuals with intellectual disability who have been sexually abused within a community residential service

Data analysis: thematic

Intervention

Community-based residential care eidetic (image-based) psychotherapy

Duration: not specified

Setting: community-based residential care

Participants

Total study population: 9 participants

1. Facilitators (n = 4)
2. Survivors (n = 5)

Gender: 4 female participants, 2 male participants, 3 not reported

Age: 60 to 65 years

Ethnicity: not reported

Sexuality: not reported

Parker 2007

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Qualitative interviews

Study aimed to understand how women with a history of child maltreatment experienced the Women Recovering from Abuse Programme

Data analysis: phenomenological analysis

Intervention

Women Recovery from Abuse Programme; interdisciplinary group, including elements of trauma-informed psychoeducation, cognitive behavioural therapy, holistic therapies, process-orientated

Duration: 8 weekly group sessions and 1 individual therapy session per participant per week

Setting: outpatient setting

Parker 2007 *(Continued)*

Participants

Total study population: 7 participants

1. Survivors (n = 7)

Gender: female participants

Age: 31-40 years

Ethnicity: not reported

Sexuality: not reported

Polk 2021

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Focus group

Study aimed to explore the experiences and perspectives of trauma-informed licensed social workers and counsellors who use a combined approach to trauma-informed cognitive behavioural therapy and play therapy in treating children who were sexually abused and to understand factors that increase resiliency in child sexual abuse survivors

Data analysis: thematic

Intervention

Trauma-informed cognitive behavioural therapy and play therapy

Duration: not specified

Setting: not specified

Participants

Total study population: 6 participants

1. Facilitators (n = 6)

Gender: 5 female participants, 1 male participant

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Price 2005

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Open-ended survey

Study aimed to examine the efficacy and the perceived influence on abuse recovery of body-oriented therapy

Data analysis: content analysis

Intervention

Body-orientated therapy

Duration: 1 hour for 8 weekly sessions

Setting: university mental health services

Participants

Total study population: 32 participants

1. Survivors (n = 32)

Gender: 5 female participants, 1 male participant

Age: 26 to 56 years

Ethnicity: Black (n = 2), Hispanic (n = 2), native American (n = 1), White (n = 20), missing (n = 7)

Sexuality: not reported

Rhodes 2014

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Interviews

Study aimed to examine whether yoga is a useful component of treatment for adult survivors of trauma and considers how women with complex trauma histories experience practising yoga, its role in their coping and healing processes over time

Data analysis: phenomenological analysis

Rhodes 2014 *(Continued)*

Intervention

Trauma-informed yoga

Duration: 1 hour a week for 10weeks

Setting: community setting

Participants

Total study population: 39 participants

1. Survivors (n = 39)

Gender: 5 female participants, 1 male participant

Age: mean 42.8 (SD 11.8) years

Ethnicity: White (n = 31), missing (n = 8)

Sexuality: not reported

Røberg 2018

Study characteristics

Notes

Resources

High-income country

Country

Norway

Methods

Qualitative interviews

Study aimed to explore how men participating in a gender-specific, trauma-stabilising intervention experienced the treatment approach

Data analysis: interpretative phenomenological analysis

Intervention

Psychoeducational group

Duration: 22 weekly sessions

Setting: outpatient clinic

Participants

Total study population: 5 participants

1. Survivors (n = 5)

Gender: 5 male participants

Age: 29-64 years

Ethnicity: Norwegian (n = 5)

Røberg 2018 *(Continued)*

Sexuality: not reported

San Diego 2011

Study characteristics

Notes

Resources

Low-income country

Country

Philippines

Methods

Qualitative interviews

Study aimed to explore the trauma experiences and trauma healing of survivors of childhood or adolescent sexual abuse and exploitation within a trauma-focused cognitive behaviour therapy

Data analysis: interpretative phenomenological analysis

Intervention

Trauma-focussed Cognitive Behavioural Therapy

Duration: 15 individual and group sessions

Setting: college campus

Participants

Total study population: 5 participants

1. Survivors (n = 5)

Gender: 5 female participants

Age: 15-18 years

Ethnicity: not reported

Sexuality: not reported

Schwarz 2020

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Interviews

Schwarz 2020 *(Continued)*

Study aimed to assess the efficacy of eye movement desensitisation and reprocessing for women who experienced trauma due to sexual or domestic violence

Data analysis: thematic analysis

Intervention

Eye movement desensitisation reprocessing

Duration: 8 sessions

Setting: not specified

Participants

Total study population: 29 participants

1. Facilitators (n = 4)
2. Survivors (n = 25)

Gender: 5 female participants, 1 male participant

Age: survivors: 20 to 65 years; facilitators: 25 to 45 years

Ethnicity: survivors: African American (n = 1), Asian (n = 3), Latina (n = 4), mixed (n = 1), White (n = 12); counsellors: Indian (n = 1), Latina (n = 1), White (n = 2)

Sexuality: not reported

Shaw 2015

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interview

Study aimed to examine the experiences in the Trauma Recovery Group of sexual violence survivors identifying as lesbian, bisexual, or gay who sought group mental health services in an urban lesbian, bi-sexual, gay, transgender, queer, or questioning community centre

Data analysis: cross-case comparison and thematic

Intervention

Trauma recovery group; psychotherapy based

Duration: 16 weekly sessions

Setting: community

Participants

Total study population: 3 participants

Shaw 2015 *(Continued)*

1. Survivors (n = 3)

Gender: transgender (n = 2), cisgender female (n = 1)

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Sigurdardottir 2016

Study characteristics

Notes

Resources

High-income country

Country

Iceland

Methods

Qualitative interviews

Study aimed to present a description of the Wellness-Program for female child sexual abuse survivors, the participating women's evaluation of the different therapies in the programme as well as a qualitative study on their experiences of the programme's effects on their life, health and well-being

Data analysis: framework analysis

Intervention

Intensive multi-modal holistic therapy (including 1-to-1 psychotherapy, psychosomatic therapy, group therapy, mindfulness, health-based advocacy)

Duration: 5 consecutive days

Setting: healthcare setting

Participants

Total study population: 12 participants

1. Survivors (n = 12)

Gender: female participants

Age: 21-53 years

Ethnicity: not reported

Sexuality: not reported

Sikkema 2018

Study characteristics

Notes

Resources

Sikkema 2018 *(Continued)*

Middle-income country

Country

South Africa

Methods

Interviews and focus groups

Study aimed to describe the development and preliminary trial run of the ImpACT (Improving AIDS Care after Trauma), a brief coping intervention to address traumatic stress and HIV care engagement among South African women with sexual trauma histories

Data analysis: not specified

Intervention

ImpACT a psychoeducational and coping skills (HIV and sexual trauma focus)

Duration: 4 weekly sessions

Setting: health centre

Participants

Total study population: 36 participants

1. Facilitators (n = 11)
2. Survivors (n = 25)

Gender: 25 female survivors

Age: 18 to 44 years

Ethnicity: not reported

Sexuality: not reported

Silverberg 2019

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to explore the subjective experiences of women who participated in a 12-week trauma centre trauma-sensitive yoga peer support group for sexual violence survivors utilising a feminist approach to trauma treatment at a rape crisis centre

Data analysis: narrative analysis/thematic

Intervention

Silverberg 2019 *(Continued)*

Trauma sensitive yoga peer support group

Duration: 12 weekly sessions

Setting: community

Participants

Total study population: 7 participants

1. Survivors (n = 7)

Gender: female participants

Age: 24-53 years

Ethnicity: not reported

Sexuality: not reported

Stevens 2019

Study characteristics

Notes

Resources

High-income country

Country

UK

Methods

Qualitative interviews

Study aimed to explore the experience of a group-based forest yoga programme for women recovering from experiences of sexual violence

Data analysis: interpretative phenomenological analysis

Intervention

Group forest yoga

Duration: 10 weekly sessions

Setting: rape crisis centre

Participants

Total study population: 5 participants

1. Survivors (n = 5)

Gender: female participants

Age: 21-55 years

Ethnicity: Haitian (n = 1), White British (n = 4)

Sexuality: not reported

Tanabe 2013

Study characteristics

Notes

Resources

Middle-income country

Country

South Africa

Methods

Focus groups

Study aimed to examine the safety and feasibility of community-based medical care for survivors of sexual assault to contribute to building an evidence base on alternative models of care in humanitarian settings

Data analysis: thematic

Intervention

Community-based medical care and basic psychosocial-educational support

Duration: not specified

Setting: not specified

Participants

Total study population: not reported; 10 focus groups ranging from 6 to 11 participants (facilitators)

Gender: not reported

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Taylor 2018

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Qualitative interviews

Study aimed to present qualitative evaluative feedback from sexual minority men who participated in a cognitive-behavioural therapy-trauma and sexual health intervention

Data analysis: cross-case analysis/thematic

Taylor 2018 *(Continued)*

Intervention

Trauma-informed cognitive behavioural therapy with a sexual health component

Duration: 10 sessions

Setting: community

Participants

Total study population: 9 participants

1. Survivors (n = 9)

Gender: male participants

Age: mean 38.2 years

Ethnicity: Black African (n = 2), Caucasian (n = 4), Latino (n = 2), missing (n = 1)

Sexuality: homosexual (n = 5), unsure (n = 1), missing (n = 3)

Thomas 2016

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Interviews

Study aimed to examine male partners experiences of conjoint couples therapy with a female survivor of childhood sexual abuse

Data analysis: transcendental phenomenology

Intervention

Couples conjoint therapy

Duration: not specified

Setting: not specified

Participants

Total study population: 10 participants

1. Partners (n = 10)

Gender: male participants

Age: 28 to 59 years

Ethnicity: Caucasian (n = 8), African American (n = 1), Middle Eastern (n = 1)

Thomas 2016 *(Continued)*

Sexuality: not reported

Trute 2001

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Comparative case study, interviews, and therapy observation notes

Study aimed to examine the use of conjoint couple therapy with a cohort of women who were survivors of child sexual abuse and who are in addiction recovery and with their partners

Data analysis: comparative case study

Intervention

Couples therapy in substance treat

Duration: not specified

Setting: not specified

Participants

Total study population: 17 participants

1. Facilitators (n = 1)
2. Survivors (n = 8)
3. Partners (n = 8)

Gender: mixed across groups (n = not reported)

Age: not reported

Ethnicity: not reported

Sexuality: heterosexual

Tsai 2021

Study characteristics

Notes

Resources

High-income country

Country

Canada

Methods

Tsai 2021 *(Continued)*

Interviews

Study aimed to explore the perspectives of survivors of human trafficking and sexual exploitation on their own experiences pertaining to trafficking-specific shelter services

Data analysis: interpretative phenomenological analysis

Intervention

Shelter-based services, including counselling

Duration: not specified

Setting: anti-trafficking shelter

Participants

Total study population: 79 participants

1. Survivors (n = 79)

Gender: female participants

Age: 12 to 25 years

Ethnicity: Khmer (n = 45), Vietnamese (n = 15), Khmer and Vietnamese (n = 7), Other (n = 7), Missing (n = 5)

Sexuality: heterosexual

Visser 2015

Study characteristics

Notes

Resources

Middle-income country

Country

South Africa

Methods

Qualitative interviews and group process notes

Study aimed to evaluate the value of an expressive art group intervention for sexually abused adolescent females

Data analysis: thematic

Intervention

Expressive art therapy group

Duration: 10 weekly sessions

Setting: community

Participants

Total study population: 8 participants

1. Survivors (n = 8)

Visser 2015 *(Continued)*

Gender: female participants

Age: 13-18 years

Ethnicity: not reported

Sexuality: not reported

Walker 2020

Study characteristics

Notes

Resources

High-income country

Country

UK

Methods

Qualitative interviews

Study aimed to understand adult clients' experiences of the specific support services accessed in the aftermath of sexual assault; to provide further understanding into the professional care, support and recovery needs of adult sexual assault clients who had accessed sexual assault referral centres

Data analysis: thematic

Intervention

Sexual assault referral centre and integrated independent sexual violence advisor

Duration: not reported

Setting: sexual assault referral centre

Participants

Total study population: 7 participants

1. Survivors (n = 7)

Gender: female participants

Age: over 18 years

Ethnicity: not reported

Sexuality: not reported

Walker-Williams 2017

Study characteristics

Notes

Resources

Middle-income country

Walker-Williams 2017 *(Continued)*

Country

South Africa

Methods

Interviews

Study aimed to evaluate the benefits of a "survivor to thriver" strengths-based group intervention programme to facilitate post-traumatic growth in women survivors of child sexual abuse

Data analysis: thematic

Intervention

Strengths-based group intervention

Duration: 6 sessions

Setting: not reported

Participants

Total study population: 10 participants

1. Survivors (n = 10)

Gender: female participants

Age: 22-50 years

Ethnicity: Black (n = 4), Caucasian (n = 6)

Sexuality: not reported

Wilson 2010

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Interviews

Study aimed to examine the experience of stress management training for 35 adult survivors of childhood sexual abuse

Data analysis: thematic

Intervention

Stress management group with emotion-focussed and mindfulness coping skills

Duration: 1.5 hours over 4 sessions

Setting: community setting

Wilson 2010 *(Continued)*

Participants

Total study population: 35 participants

1. Survivors (n = 35)

Gender: 33 female participants, 2 male participants

Age: 18 to 55 years

Ethnicity: not reported

Sexuality: not reported

Zielinski 2021

Study characteristics

Notes

Resources

High-income country

Country

USA

Methods

Interviews

Study aimed to describe implementing a group therapy for survivors of sexual violence within a women's prison and evaluate contextual factors and strategies that led to successful sustainment of the group

Data analysis: thematic

Intervention

Group-based therapy

Duration: 8 sessions and 20 hours of programme time

Setting: prison

Participants

Total study population: 22 participants

1. Facilitators (n = 19)
2. Survivors (n = 3)

Gender: 3 female survivors; facilitators not reported

Age: not reported

Ethnicity: not reported

Sexuality: not reported

Characteristics of excluded studies *[ordered by study ID]*

Study	Reason for exclusion
Aguila 2016	No specific intervention
Allnock 2015	No specific intervention
Chouliara 2011	No specific intervention
Collings 2011	No specific intervention
Dittmann 2014	Ineligible participants (does not relate to individuals who have been sexually victimised)
Dognin 2017	Ineligible intervention
Draucker 1997	No specific intervention
Goddard 2019	No specific intervention
Hill 2012	No specific intervention
Kearney 2017	No specific intervention
Koehn 1995	No specific intervention
Landis 2014	No specific intervention
McDonagh 1997	No specific intervention
McLean 2018	No specific intervention
Middle 2001	No specific intervention
Mrkaljevic 2017	No specific intervention
Murray 2017	Ineligible study design
Palmer 2004	Ineligible participants (does not relate to individuals who have been sexually victimised)
Phillips 2004	No specific intervention
Rapsey 2020	No specific intervention
Reeves 2015	No specific intervention
Reid 1993	Ineligible intervention
Scott 2015	No specific intervention
Smith 2015	No specific intervention
Stige 2013	Ineligible participants (does not relate to individuals who have been sexually victimised)
Yarrow 2009	No specific intervention

Characteristics of studies awaiting classification *[ordered by study ID]*

Agbuis 1996

Notes	This study explored imagery rescripting therapy with adult survivors of child sexual abuse.

Carman 2004

Notes	This study examined the positive and negative experiences of the caregivers of children who alleged sexual abuse and were referred to the Stepping Stone programme.

Narring 2002

Notes	This study qualitatively evaluated support and group therapy for adolescents with a history of sexual abuse.

Price 2004

Notes	This study examined perceived experiences of two body-oriented therapies in a sample of women with histories of child sexual abuse. We have been unable to locate this dissertation; however two papers that seem to be a result of the dissertation research are included as an eligible but not sample study in our review (see Price 2005).

Robinson 1996

Notes	This study examined users' views of therapeutic groups for adult female survivors of childhood sexual abuse.

Characteristics of ongoing studies *[ordered by study ID]*

NCT03966963

Study name	**Public title:** Systematic case series investigating Eye Movement Desensitization Reprocessing (EMDR) efficacy with childhood sexual abuse survivors (EMDR) **Scientific title:** A systematic case series study investigating the effectiveness of Eye Movement Desensitization Reprocessing (EMDR) in the treatment of childhood sexual abuse in adolescents and adult survivors
Starting date	17 September 2019
Contact information	Halima Bibi, University of Salford
Notes	September 2021: awaiting publication of PhD thesis

ADDITIONAL TABLES

Table 1. Stratification of included studies: study context and intervention characteristics

Study	Year study conducted	Country	Country income level	Urban or rural	Intervention	Intervention duration	Intervention setting	Intervention completion	Intervention professionals' level of experience or training
Ahrens 2000	N/R	USA	High-income	N/R	2 sexual assault nurse examiner (SANE) programmes	N/R	Hospital/Young Women's Christian Association	N/R	N/R
Ajema 2018	2015	Kenya	Low- to middle-income	N/R	Post-rape care including trauma counselling	N/R	Public health facility	No survivors received full package of services	Mixed professionals e.g. administrators, social workers, counsellors
Anderson 2018	2017-2018	USA	High-income	N/R	Dual modality therapy, involving hypnosis and emotional freedom technique	5 x 60-minute sessions 1 session/week	Psychotherapy setting; university campuses	30 completers	Researcher was a licensed mental health counsellor and a certified trauma specialist
Anderson 2020c	2015-2017	USA	High-income	N/R	GIFTSS (Giving Information for Trauma Support and Safety) intervention: universal patient education concerning sexual violence	N/R	University campuses	N/R	Mixed: subsample of campus health and counselling staff, e.g. clinic directors and direct care staff
Arend 2013	N/R	South Africa	Middle-income	N/R	Post-exposure prophylaxis and post-sexual assault care	28 days of post-exposure prophylaxis, referral for counselling, psychosocial support as part of clinical care	Hospital	N/R	N/R
Asselstine 1997[a]	N/R	Canada	High-income	N/R	Verbal, body-focused intervention	1 x body focused verbal experiential session	N/R	All completers	N/R

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

						no longer than 2 hours			
Atira 2012	2005	Cambodia	Low-income	N/R	Art therapy	N/R	N/R	N/R	N/R
Avilés 1997	N/R	Canada	High-income	N/R	Time-limited group therapy	12 x 2-hour sessions for 12 weeks	Women's post-treatment centre	N/R	2 therapists, one had a background in social work
Bedard-Gilligan 2020	N/R	USA	High-income	N/R	Cognitive processing therapy- brief restructuring intervention after trauma exposure	90 minutes, in-person sessions and 4 follow-up coaching phone calls	N/R	N/R	Clinicians, experts in trauma/cognitive processing therapy/alcohol use
Beiza 2015[a]	N/R	Chile	Middle-income	Urban	Specialised psychotherapy	12-38 months	Centre for treatment of sexual abuse and maltreatment	N/R	N/R
Berman 2020	2018	USA	High-income	Urban	Exposure-based treatment	8 weeks; 1.5 hours weekly	Minimum security prison	N/R	N/R
Black 2019	N/R	Australia	High-income	N/R	Cultural healing programme with 4 subprogrammes	5-day cultural healing camp, a fortnightly women's healing programme, a 3-day cultural healing gathering and a 5-day women's cultural healing gathering	Community	N/R	4 facilitators were involved in delivering intervention, 3 of whom were Aboriginal and the non-Aboriginal facilitator was strongly connected to Aboriginal community and has worked in community for over 35 years. Facilitators were either social work- or family therapy-trained.

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

Bluntzer 2016[a]	N/R	USA	High-income	Urban, sub-urban, rural	Yoga complementing traditional psychotherapy	6 weeks	Private, non-profit agency	4 completers	Experienced yoga instructor
Bowland 2011	N/R	USA	High-income	N/R	Spiritually focused intervention	N/R	Community	N/R	N/R
Braun 2021	N/R	USA	High-income	N/R	Mindful yoga therapy	75-minute class, once/week	New England vet centre	5 completers	Certifed yoga therapist and experienced registered Kripalu yoga instructor
Braxton 2017[a]	N/R	USA	High-income	N/R	Kemetic yoga	N/R	N/R	N/R	N/R
Brooker 2018	N/R	UK	High-income	N/R	Sexaul assault referral centre	N/R	N/R	N/R	Professionals worked in a sexual assault referral centre for an average of 9 years.
Buck 2017	N/R	UK	High-income	N/R	Peer mentoring	N/R	N/R	N/R	All mentors received training in mentoring and child safeguarding, and reflective supervision.
Burt 2002	N/R	Canada	High-income	N/R	Art therapy (group and individual)	N/R	N/R	N/R	Trained art therapists
Campbell 2011a	N/R	USA	High-income	N/R	SANE programme	N/R	SANE setting	N/R	Average of 6.75 years experience in forensic nursing
Campbell 2011b	N/R	USA	High-income	N/R	SANE programme	N/R	SANE setting	N/R	N/R
Capella 2018[a]	N/R	Chile	Middle-income	Urban	Psychotherapy	14-26 sessions	N/R	N/R	N/R
Capri 2013	N/R	South Africa	Low-income	N/R	Therapy sessions	9 sessions observed	Low-income community	N/R	Social workers

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

Carey 1996[a]	N/R	USA	High-income	Urban, sub-urban, rural	Adelphi rape counselling group programme	Range between 23-43 sessions per member	N/R	N/R	N/R
Carpenter 2016[a]	N/R	UK	High-income	N/R	Letting the future in (National Society for the Prevention of Cruelty to Children)	Children: 4 assessment sessions + 20 1-1 sessions; Carers: 8 sessions	N/R	Range from 6-30 sessions attended (from linked study)	Childrens' specialist workers (social workers with additional child sexual abuse training)
Carter 2002	N/R	USA	High-income	N/R	Psychotherapy	Participants were either in psychotherapy and/or body-oriented therapy or had been in psychotherapy and/or body-oriented therapy, ranging from 2 to 12 years	N/R	N/R	Psychotherapists
Choi 2021	2015-2016	South Korea	High-income	N/R	2 South Korean support groups (Small Talk and Ehoo)	N/R	N/R	N/R	N/R
Clukey 2003	N/R	USA	High-income	N/R	Art therapy	8 x 55-minute sessions	N/R	N/R	Researcher was the art therapist
Cole 2008	N/R	USA	High-income	N/R	SANE and victim advocacy	Majority of programmes provided service 24 hours/day, 7 days/week and used staff on a part-time on-call basis	SANE setting	N/R	85% nurses, others include social service backgrounds, law enforcement
Crandall 2003	N/R	USA	High-income	N/R	SANE	N/R	SANE setting	N/R	Representatives from health care, victim services, law enforcement and prosecution

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

DiCesare 2015[a]	N/R	USA	High-income	N/R	Trauma-focused Cognitive Behavioural Therapy (CBT)	8-16 sessions	Community mental health agency	19.94% of clients dropped out before completion	Trained therapists in trauma-focused CBT and have Bachelors degree and working towards/completed graduate degree in psychology/counselling/social work
Downing 2012	N/R	USA	High-income	N/R	SANE	N/R	SANE setting	N/R	All trained SANE and had conducted at least 5 exams and at least 1 exam in the previous 12 months
Edmond 2004	N/R	USA	High-income	N/R	Eye movement desensitisation and reprocessing (EMDR) and eclective therapy	6 x 90-minute sessions of either therapy	N/R	N/R	N/R
Edwards 2015[a]	N/R	USA	High-income	N/R	Mindfulness-based therapy	N/R	N/R	N/R	Licensed mental health professional with a minimum of three years' experience post-graduation
Ericksen 2002	N/R	Canada	High-income	N/R	Specialised sexual assault service in emergency department setting	N/R	Emergency department	N/R	N/R
Farr 2021[a]	N/R	UK	High-income	N/R	Time2Talk- counselling for young people	N/R	Charity	N/R	3 worked within the counselling service in service delivery or management; 4 worked at local services (police, social services, probation, and health)
Fehler-Cabral 2011	N/R	USA	High-income	N/R	SANE	N/R	SANE	N/R	Forensic nurses with associates or Bachelors degree, and on average

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

									6.95 years' experience in forensic nursing
Fields 2019[a]	2017-2018	Nicaragua	Low-income	N/R	Trauma informed yoga	4 x weekly pilot sessions, and then 14 weekly sessions	N/R	Attendance ranged between 8-13 sessions our of a possible 18	Programme designed with a Hatha yoga instructor
Forde 2021[a]	N/R	Republic of Ireland	High-income	N/R	Integrative humanistic psychotherapy	Minimum 1 year ranging to 5 years	Rape crisis centre	N/R	Rape crisis psychotherapist
Gibbs 2015	N/R	USA	High-income	N/R	3 programmes funded by Office for Victims of Crime at US Department of Justice-Standing against global exploitation everywhere; Salvation Army trafficking outreach; Streetwork project at Safe Horizon	N/R	N/R	N/R	N/R
Gilmore 2019	N/R	USA	High-income	N/R	Mobile health intervention- SC(South Carolina)-Safe	Not specified but there are 5 modules	Community	N/R	From a wide variety of service providers including, advocacy, judiciary, law, health
Gonzalez 1991	N/R	Canada	High-income	N/R	Self-help groups	1 x weekly 2 hour sessions over 10 weeks	N/R	N/R	N/R
Hall 1997	N/R	UK	High-income	N/R	Slow open analytic group	N/R	N/R	N/R	N/R
Harper 2008	N/R	Canada	High-income	N/R	Specialised trauma treatment programme	6-week inpatient programme	Hospital	N/R	N/R
Healey 2016	N/R	USA	High-income	N/R	Shamonic healing	N/R	N/R	N/R	Shamonic practitioners completed the Four Winds Society's Light Body School of Energy Medicine certification

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

									programme (7 weeks) and who are practicing shamanic healing, specifically shamanic healing related to fragmentation/soul loss with adult child sexual abuse survivors. They have a range of backgrounds and qualifications.
Heberling 2006[a]	N/R	USA	High-income	N/R	Conjoint therapy based on emotional-focused therapy and social learning approaches	Not specified but they must have attended in the last 5 years	N/R	N/R	N/R
Hester 2018	N/R	UK	High-income	N/R	ISVA	N/R	Community	N/R	Trained ISVAs across SARC/third sector settings
Ho 2015	N/R	Hong Kong	High-income	N/R	Dance movement therapy	2 hours once a week for 5 weeks	Provided by social workers from non-governmental organisation that offers rehabilitation programmes to survivors	N/R	Board-certified dance movement therapist with Doctoral degree facilitated the sessions
Hoffman 2016[a]	N/R	USA	High-income	N/R	Touch inclusive therapy	N/R	N/R	N/R	N/R
Hopper 2018	N/R	USA	High-income	N/R	Stars experiential, body-based, complete trauma group treatment	6 sessions, each 60-120 minutes	2 groups in residential treatment facility, 1 group in safe house of adult	N/R	Groups administered by project Reach programme of the trauma centre at the Justice Resource Institute

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

							survivors of sex trafficking		
Horton 2021[a]	N/R	USA	High-income	N/R	Expressive therapy	30 minutes of expressive therapy in a 50-minute session; 6 months minimum	N/R	N/R	N/R
Horvath 2020	N/R	UK	High-income	N/R	SARC	N/R	SARC	N/R	Forensic physicians, crisis workers and ISVAs
Houser 2015	2015	USA	High-income	N/R	Group yoga intervention	Based on a model of 8 weeks, 60-90 minutes each session	Hospital	N/R	Therapists (Masters and Doctoral level) and 200-hour trained yoga instructor
Hung 2010	N/R	Taiwan	High-income county	N/R	Drama therapy	10 hours over 2 days	N/R	N/R	Researcher and 4 other professionals
Hutschemaekers 2019	2016-2017	Netherlands	High-income	N/R	Sexual assault centre based at the Centre of Sexual and Family Violence	N/R	SARC	N/R	Medical, psychosocial and legal service professionals
Janocko 1994	N/R	USA	High-income	N/R	Inpatient trauma group	Twice weekly for 14 x 50-minute sessions	Psychiatric hospital	N/R	N/R
Jensen 2010	N/R	Norway	High-income	N/R	Psychotherapy (social constructivist and narrative approach) for children and parents	Ranged between 3-17 sessions, mean number was 7.5 sessions; sessions were weekly	N/R	N/R	Psychotherapists
Jones-Smith 2018[a]	N/R	USA	High-income	Urban	EMDR	N/R	N/R	N/R	EMDR clinicians; minimum of 2 years' experience

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

Kahan 2020[a]	2017-2018	Canada	High-income	Urban	Peer education and connection through empowerment programme	2 hours weekly over 16 weeks	Covenant House Toronto: social service agency	N/R	Direct service provider, programme manager, youth worker, 1 transitional housing team lead and 3 peer mentors Peer mentors receive 12 hours of training
Kallivayalil 2013[a]	N/R	USA	High-income	N/R	Trauma-informed, outpatient psychotherapy, one to one and group support	Average of 8 months	Outpatient clinic	N/R	N/R
Kane 2003[a]	N/R	Northern Ireland	High-income	N/R	Education/support group	20 sessions	Community	N/R	N/R
Karatzias 2014	N/R	UK	High-income	N/R	Psychoeducational group (wait-list design); CBT informed	10 weeks; 1.5 sessions	National Health Service provider	16 completers, 6 dropouts Average of 5.7 sessions attended	Mental health professionals (mixed)
Kellner 1994	1993	USA	High-income	N/R	Tandem constructivist group for young child sexual abuse male survivors and their parents	6 sessions; weekly initially then bimonthly	N/R	N/R	Clinicians
Kenny 2018	N/R	USA	High-income	N/R	Psychoeducational/therapeutic groups(s) integrating coping skills, art therapy, cooking, substance use, peer mentoring and peer support	Different group every evening; weekly cadence; of 16 participants over 300 sessions attended, over an average of 21 months	Outpatient clinic	N/R	Child advocacy centre counsellors/volunteers

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

Kerlin 2013[a]	N/R	USA	High-income	Urban	Spiritually integrated residential treatment	Less than 6 months to 1 year	Inpatient setting	N/R	N/R
Knettel 2019	2016	South Africa	Middle-income	N/R	Impact coping and skills-based group counselling (HIV & sexual violence focus)	4 weekly sessions	Healthcare clinic	64 recruited, 31 attended, 67.8% completers; 25.8% attended at least 1 session	Healthcare providers/ counsellors
MacIntosh 2008	N/R	Canada	High-income	N/R	Emotion-focussed couples therapy	Average of 19 weekly sessions, ranging from 11-26	N/R	N/R	Emotion-focussed therapists (mixed expertise)
Magnuson 2003[a]	2000	Canada	High-income	N/R	Reiki (1-1 session) + group/individual psychotherapy	N/R	N/R	N/R	Reiki practitioner
Margain 2020[a]	N/R	USA	High-income	N/R	Christian-based support group	Minimum: 3 sessions; Maximum: N/R	Church	N/R	N/R
Mattsson 1998	N/R	Sweden	High-income	N/R	Body awareness group therapy	N/R	N/R	N/R	Health professionals (psychiatric psychotherapist and psychosomatic gynaecologist)
McLean 2021[a]	N/R	Australia	High-income	N/R	Compassion-focussed therapy (CFT)	N/R	N/R	N/R	CFT counsellors
Mead 2019[a]	2018	USA	High-income	Urban	Cognitive processing therapy (CPT); for sexual assault within military service	12 sessions + 2 follow-up	Miltary veteran centre	N/R	Social workers
Meekums 1998	N/R	UK	High-income	N/R	Creative therapies: dance movement, drama therapy, art therapy	20 weeks; on average 2 hours each sessions	N/R	4 cycles: Cycle 1: 4 completers 3	Researcher creative therapist

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

								dropouts; Cycle 2: 5 completers, 2 dropouts; Cycle 3: 4 completers, 3 dropouts; Cycle 4: 4 completers, 3 dropouts	
Mills 2002[a]	N/R	Canada	High-income	N/R	Dance therapy	Minimum: 6 sessions	N/R	N/R	Dance therapist
O'Malley 2019	N/R	Northern Ireland	High-income	N/R	Community-based residential care; eidetic (image-based) psychotherapy	Median: 19.7 years; ranged between 6-33 years in treatment	Community-based residential care	N/R	Eidetic psychotherapist
Parker 2007[a]	N/R	Canada	High-income	N/R	Women Recovering from Abuse Programme; interdisciplinary: trauma-informed psychoeducation, CBT, holistic therapies, process-orientated group	8 weeks; 4 hours per week + 1 hour individual therapy	Outpatient clinic	N/R	N/R
Polk 2021[a]	N/R	USA	High-income	Urban	Trauma-informed CBT and play therapy	N/R	N/R	N/R	N/R
Price 2005	N/R	USA	High-income	N/R	Body-oriented therapy	8 sessions weekly; 1 hour each	Treatment room at a University	N/R	N/R
Rhodes 2014	2008	USA	High-income	N/R	Trauma informed yoga	10 weeks; 1 hour	Community	N/R	Trauma-informed yoga teacher
Røberg 2018[a]	2013	Norway	High-income	N/R	Psychoeducational group	22 weeks; 2 hours/week	Outpatient clinic	6 completers, 5 interviewed	N/R

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

San Diego 2011[a]	N/R	Phillippines	Low-income	Urban	Trauma-focussed CBT	15 sessions; individual and then group; 1-2 hours each session	College	N/R	Therapist
Schwarz 2020	N/R	USA	High-income	N/R	EMDR	8 sessions	N/R	21 completers, 4 dropouts	Licensed EMDR counsellor
Shaw 2015[a]	N/R	USA	High-income	Urban; sub-urban; rural	Trauma recovery group psychotherapy for LGBTQ survivors	16 weeks; 90 minutes each session	Community mental health	N/R	Peer support group; co-produced
Sigurdardottir 2016[a]	N/R	Iceland	High-income	N/R	5-day intensive multimodal therapy 1-1; group including psychotherapy, psychosomatic therapy, health. mindfulness and holistic	20 hours/week; 10 am-2 pm each day; over 10 weeks; x 2 follow-up sessions 2 weeks later	Healthcare centre	80% attendance	Mixed; nurses, psychotherapists, health practitioners, nutritionist, mindfulness, well-being coaches, employment counsellor
Sikkema 2018	N/R	South Africa	Middle-income	N/R	CBT individual & group intervention for sexual violence and HIV	4 x 1-1 sessions + 2 group sessions; 60-90 minutes each session	Primary healthcare clinic	100% attendance at 1-1 sessions; 78% attendance at group sessions	Psychologist trainee
Silverberg 2019[a]	N/R	USA	High-income	Urban	Trauma centre, trauma sensitive yoga peer support group	12 weeks; 90 minutes each	Rape crisis centre	N/R	Therapist; trauma centre trauma sensitive yoga facilitator
Stevens 2019[a]	N/R	UK	High-income	N/R	Group forest yoga	10 weeks; 90 minutes each	Yoga studio	N/R	N/R
Tanabe 2013	N/R	Burma	Low-income	N/R	Community-based medical care; medical services + basic psychosocial/educational support	N/R	N/R	N/R	Healthcare workers, birth attendants
Taylor 2018[a]	N/R	USA	High-income	N/R	Trauma-informed CBT with sexual health component	10 sessions	Community health clinic	23 completers,	N/R

Table 1. Stratification of included studies: study context and intervention characteristics *(Continued)*

								9 interviewed	
Thomas 2016	N/R	USA	High-income	N/R	Conjoint therapy	Minimum 1 session; ranged between 2-26	N/R	N/R	N/R
Trute 2001	N/R	Canada	High-income	N/R	Couples therapy in substance treatment	N/R	Substance treatment service	8 completers	Therapist (no tradition specified)
Tsai 2021	2011-2016	Canada	High-income	N/R	Shelter-based services, including counselling	N/R	Anti-trafficking shelter	N/R	N/R
Visser 2015[a]	N/R	South Africa	Middle-income	Urban	Expressive art therapy group	10 weekly sessions	Community clinic	6 completers; 2 dropouts	Masters psychology students
Walker 2020[a]	N/R	UK	High-income	N/R	SARC/ISVA (integrated)	Forensic medical examination; ISVA support (duration of support not specified)	SARC	N/R	ISVA; SARC staff not specified
Walker-Williams 2017[a]	2012	South Africa	Middle-income	N/R	Strengths-based group intervention	6 sessions; 2 hours each; over maximum of a 3-month period	N/R	12 completers; 6 dropouts	Social worker and clinical psychologist
Wilson 2010	N/R	USA	High-income	N/R	Stress management-emotion/problem-focussed; mindfulness	4 x 1.5-hour sessions	Rape and sexual abuse centre; community education centre	N/R	Nurse psychologist; 20 years experience in stress management
Zielinski 2021	N/R	USA	High-income	Urban; sub-urban; rural	Group-based therapy	8 sessions and 20 hours of programme time	Prison	N/R	N/R

[a]Study was included in the main analysis

CBT: cognitive behavioural therapy; CFT: compassion focused therapy; CPT: cognitive processing therapy; EMDR: eye movement desensitisation and reprocessing; HIV: human immunodeficiency virus; ISVA: independent sexual violence advisor; LGBTQ: lesbian, gay, bisexual, transgender, and queer; N/R: not reported; SANE: sexual assault nurse examiner; SARC: sexual assault referral centre

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating

Study	Participants	Participants' gender	Participants' ages	Participants' ethnicities	Participants' sexualities	Data collection method	Type of data analysis	Rating of quality of analysis (see Table 3)
Ahrens 2000	Programme director, SANE co-ordinator and programme staff: numbers unknown	N/R	N/R	N/R	N/R	Interviews	Thematic analysis	2
Ajema 2018	Child survivors: n = 14 Caregivers: n = 19 Professionals: n = 31	N/R	N/R	N/R	N/R	In-depth interviews (mixed-method study)	Thematic analysis	2
Anderson 2018	Survivors: n = 30	N/R	N/R	N/R	N/R	One open question in an interview: "What did you think of this experience?"	Thematic analysis	2
Anderson 2020c	Intervention providers: n = 14	Majority were female, but no exact number	N/R	N/R	N/R	In-depth interviews and also a survey (mixed-method study)	Content analysis	2
Arend 2013	Survivors: n = 10	98% of 135 survivors in wider study were female	Mean: 21 years based on wider study	N/R	N/R	Interviews	Grounded theory	2
Asselstine 1997[a]	Survivors: n = 5	Participants: 5 female	Range: 28-44 years	N/R	N/R	Interview 1 week and 1 year post-intervention	Comparative case study + picture analysis	4

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

Atira 2012	Survivors: n = 12	Participants: 12 female	Range: 16-28 years	N/R	N/R	N/R	Narrative analysis	2
Avilés 1997	Survivors: n = 9	Participants: 9 female	Range: 23-41 years Mean: 33 years	Aboriginal (n = 1) Caucasian (n = 8)	N/R	Qualitative description of satisfaction after quantitative measures	Not specified	1
Bedard-Gilligan 2020	Experts in trauma/CBT/alcohol use: n = 6 3 focus groups with clinicians Survivors: n = 6	Participants: all female	Mean: 20.83 years (survivors)	Caucasian survivors (n = 4) Others: N/R	Heterosexual (n = 5) Lesbian (n = 1)	Interviews and focus groups	Used coding and categorisation, comparative analysis and data summarisation	1
Beiza 2015[a]	Survivors: n = 5	Participants: 4 female, 1 male	Range: 13-17 years	N/R	N/R	Interviews	Narrative analysis	4
Berman 2020	Survivors: n = 85	Participants: all female	Mean: 31.55 years	African American (n = 3) Native American (n = 7) Other (n = 4) White (n = 70)	N/R	Open-ended qualitative question	Thematic analysis	2
Black 2019	Survivors: n = 36 Family members: n = 26 Facilitators: n = 13	Participants: all female	N/R	N/R	N/R	Interviews, facilitator journals, observations	Not specified	2
Bluntzer 2016[a]	Survivors: n = 7	Participants: 7 female	Range: 29-66 years	Black (n = 1) Latina (n = 2)	N/R	Interviews	Phenomenological analysis - thematic	5

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

				White (n = 1)				
Bowland 2011	Survivors: n = 36	Participants: 36 female	55 years and over	N/R	N/R	Focus group	Thematic analysis	3
Braun 2021	Survivors: n = 7	Participants: all female	Range: 25-57 years	N/R	N/R	Collective case series	Thematic analysis	3
Braxton 2017[a]	Survivors: n = 8	Participants: 8 female	Range: 23-46 years Mean: 36 years	African American (n = 8)	N/R	Interviews	Content analysis	4
Brooker 2018	Professionals: n = 45	Participants: 36 female, 9 male	N/R	N/R	N/R	Survey (short)	Thematic analysis	2
Buck 2017	Survivors: n = 11	Participants: 11 female	Range: 11-18 years	N/R	N/R	Self-completion booklet, interviews, focus group	Thematic analysis and Gilligans listening guide	3
Burt 2002	Survivors: n = 6	Participants: 6 female	N/R	N/R	N/R	Interviews	Thematic analysis	3
Campbell 2011a	Professionals: n = 6	Participants: 6 female	Range: 30-55 years Mean: 46 years	Caucasian (n = 6)	N/R	Interviews	Thematic analysis	3
Campbell 2011b	Survivors: n = 20	Participants: 20 female	N/R	African American (n = 3) Asian American (n = 1) White (n = 15) Multiracial (n = 1)	N/R	Interviews	Not one specific analysis; utilised different approaches	3
Capella 2018[a]	Survivors: n = 10	Participants: 8 female, 2 male	Range: 6-16 years	N/R	N/R	Interviews and drawings to complement	Thematic narrative and visual narrative analysis	5

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

Capri 2013	Survivors: n = 3 Professionals: n = 3	Participants: 6 female	Range: 8-12 years (survivors)	Black (n = 3) survivors	N/R	Interviews, analysis of case file documents, ethnography	Thematic analysis	2
Carey 1996[a]	Survivors: n = 9	Participants: 9 female	Range: 18-55 years	N/R	N/R	Interviews	Thematic	5
Carpenter 2016[a]	Survivors: n = 6 Parents: n = 7 Professionals: n = 13 From linked publication: Survivors: n = 12 Parents: n = 17	Survivors: 6 female Parents: 6 female, 1 male Professionals: 11 female, 2 male From linked publication: Survivors: 9 female, 3 male	Range: 5-18 years (survivors)	All White British	N/R	Interviews	Thematic analysis	4
Carter 2002	Survivors: n = 6	Participants: 6 female	Range: 30-55 years	British (n = 1) Euro-Americans (n = 4) South American (n = 1)	N/R	Interviews	Thematic and generates these into profiles for each participant	3
Choi 2021	Survivors: n = 25	Participants: 25 female	N/R	Korean (n = 25)	N/R	Interviews	Grounded theory techniques	3
Clukey 2003	Survivors: n = 8	Participants: 8 female	> 18 years	N/R	N/R	Videotapes, art work, intake histories, therapist notes	Case study comparison	2
Cole 2008	Professionals: n = 231	N/R	N/R	N/R	N/R	Telephone survey with open-ended questions	Thematic analysis	2

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

Crandall 2003	Professionals: n = 28	N/R	N/R	N/R	N/R	Interviews and advocate focus group	Content analysis	2
DiCesare 2015[a]	Professionals: n = 8	Participants: 7 female, 1 male	Range: 26-67 years Mean: 34.62 years	Asian American (n = 1) Caucasian (n = 7)	N/R	Semi-structured interviews	Modified grounded theory approach	4
Downing 2012	Professionals: n = 14	N/R	N/R	N/R	N/R	Semi-structured interviews	Descriptive interpretive methodology	2
Edmond 2004	Survivors: n = 38	N/R	N/R	Majority white	N/R	Interviews	Not specified but refers to coding and themes	3
Edwards 2015[a]	Professionals: n = 6	N/R	N/R	N/R	N/R	Interviews	Grounded theory	4
Ericksen 2002	Survivors: n = 8	Participants: 8 female	Mean: 25.7 years	N/R	N/R	Interviews	Latent content analysis	3
Farr 2021[a]	Survivors: n = 10 Parents: n = 8 Professionals: n = 7	Survivors: 9 female, 1 male Parents: 7 female, 1 male	Range: 12-25 years	N/R	N/R	Interviews	Thematic analysis	5
Fehler-Cabral 2011	Survivors: n = 20	N/R	N/R	White (n = 17) N/R (n = 3)	N/R	Interviews	Thematic analysis	3
Fields 2019[a]	Survivors: n = 5	Survivors: 5 female	Range: 21-31 years	N/R	N/R	Interviews	Thematic analysis	4
Forde 2021[a]	Survivors: n = 11 Professionals: n = 12	Survivors: 8 female, 3 male Professionals: 10 female, 2 male	Range: 21-47 years (survivors)	N/R	N/R	Interviews	Thematic analysis	4

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

Gibbs 2015	Survivors: n = 45 Professionals: N/R	N/R	N/R	N/R	N/R	Interviews and case narratives	Not specified but coding is mentioned	2
Gilmore 2019	Survivors: n = 13 Professionals: n = 25	Participants: 11 female, 1 male, 1 'other'	N/R	White (n = 13)	N/R	Interviews	Thematic analysis	3
Gonzalez 1991	Survivors: N/R	N/R	Range 17-64 years	Majority white	N/R	Discussion groups	N/R	3
Hall 1997	Survivors: n = 54	N/R	N/R	N/R	N/R	Survey	N/R	2
Harper 2008	Survivors: n = 30	Participants: 25 female, 5 male	Range: 20-54 years	N/R	N/R	Interviews	Ethnographic/thematic	3
Healey 2016	Professionals: n = 15	Participants: 12 female, 3 male	Range: 45-74 years	Mixed (n = 1) White (n = 1)	N/R	Interviews	Content analysis	3
Heberling 2006[a]	Survivors: n = 4 Partners: n = 4	Participants: 5 female, 3 male	Range: 21-56 years	Caucasian (n = 8)	Heterosexual relationship (n = 3) Homosexual relationship (n = 1)	Interviews (conjoint and then individual at a later time point)	Phenomenological analysis	5
Hester 2018	Survivors: n = 15 Parents: n = 3 Professionals: n = 14	Participants: 15 female, 2 male (survivors and parents) Professionals: N/R	N/R	N/R	N/R	Interviews	Thematic analysis	2
Ho 2015	Survivors: n = 25	Participants: 25 female	Range: 25-52 years Mean: 36.2 years	N/R	N/R	Survey, using open-ended questions	Thematic analysis	3
Hoffman 2016[a]	Survivors: n = 7	Participants: 5 female, 2 male	N/R	N/R	N/R	Interviews	Transcendental phenomenological analysis	4

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

Hopper 2018	Survivors: n = 17	Participants: 17 female	Range: 14-32 years	Black (n = 6) Biracial (n = 2) White (n = 9)	N/R	Process observations, post-group interviews, focus group	Thematic analysis	3
Horton 2021[a]	Survivor: n = 1 Professional: n = 1	Participants: all female	N/R	N/R	N/R	Interview	Thematic analysis	4
Horvath 2020	Professionals: n = 16	Participants: 16 female	N/R	N/R	N/R	Interviews and focus groups	Thematic analysis	3
Houser 2015	Survivors: n = 34	Participants: 34 female	All adolescents: ages not specified	N/R	N/R	Weekly survey, interviews, field notes	Content analysis	3
Hung 2010	Survivors: n = 4	Participants: 4 female	Range: 74-90 years	N/R	N/R	Group discussion/observations	N/R	2
Hutschemaekers 2019	Survivors: n = 12	Participants: 12 female	Range: 18-54 years	N/R	N/R	Interviews	Thematic analysis	2
Janocko 1994	Survivors: n = 9	Participants: 9 female	Range 20-29 years	Black (n = 5) Caucasian (n = 3) Hispanic (n = 1)	N/R	Interviews and therapist observations	Constant comparative method	3
Jensen 2010	Survivors: n = 15	Participants: 9 female, 6 male	Range: 5-16 years	N/R	N/R	Interviews; video of sessions; therapist notes	Case-by-case content analysis	2
Jones-Smith 2018[a]	Professionals: n = 10	Participants: 8 female, 2 male	N/R	African American (n = 3) Caucasian (n = 4) Puerto Rican (n = 1) White Russian (n = 1) White Italian (n = 1)	N/R	Interviews	Phenomenological analysis - thematic	5

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

Kahan 2020[a]	Survivors: n = 12 Professionals: n = 7 Linked publication: n = 18 survivors	Participants: 11 female Survivors: 1 bigender Professionals: N/R 18 female survivors (linked publication)	Mean: 16-24 years Linked publication- Mean: 21.75 years (survivors)	Linked publication: Asian (n = 3) Black (n = 6) Caucasian (n = 3) Mixed (n = 4) Other (n = 2)	N/R	Interviews	Thematic analysis	5
Kallivayalil 2013[a]	Survivors: n = 14	Participants: 13 female, 1 male	Range: 24-62 years Mean: 42 years	Asian (n = 1) Caucasian (n = 13)	N/R	Interviews	Grounded theory	4
Kane 2003[a]	Survivors: n = 12	Participants: 12 female	Range: 19-60 years	N/R	N/R	Interviews	Thematic analysis	4
Karatzias 2014	Survivors: n = 16	Participants: 14 female, 2 male	Mean: 38.3 years	N/R	N/R	Interviews	IPA	2
Kellner 1994	Survivors: n = 4 Parents: n = 5	Survivors: 4 male Parents: 5 not specified	N/R	N/R	N/R	Focus group with survivors	Content analysis	3
Kenny 2018	Survivors: n = 16	Participants: 16 female	Range: 15-18 years Mean: 16.3 years	Black (n = 7) Hispanic (n = 3)	N/R	Open-ended survey	Thematic analysis	2
Kerlin 2013[a]	Survivors: n = 10	Participants: 10 female	Range: 21-56 years	Caucasian (n = 9) Hispanic (n = 1)	N/R	Interviews	IPA	5
Knettel 2019	Survivors: n = 31	Survivors: 31 female	Range: 18-44 years Mean: 30 years	Black African (n = 31)	N/R	Open-ended survey; analysis of workbooks	Thematic analysis	1

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

MacIntosh 2008	Survivors: n = 10 Partners: n = 10	Survivors: 10 female Partners; 10 male	Mean: 43.0 years (female), mean: 40.5 years (male)	N/R	N/R	Case study; therapist observation; exit interview	Thematic analysis	3
Magnuson 2003[a]	Survivors: n = 10	Participants: 10 female	N/R	N/R	N/R	Interviews	Content analysis	4
Margain 2020[a]	Survivors: n = 10	Participants: 10 female	Range: 20-69 years	Asian American (n = 1) Hispanic (n = 1) White (n = 8)	N/R	Interviews	Thematic analysis	4
Mattsson 1998	Survivors: n = 7	Participants: 7 female	Range: 22-49 years	N/R	N/R	Focus group/interviews	Thematic analysis	2
McLean 2021[a]	Survivors: n = 7 Professionals: n = 7	Participants: 14 female	Range: 31-61 years Mean: 50 years	Caucasian (n = 14)	N/R	Interviews	Consensual qualitative	4
Mead 2019[a]	Survivors: n = 21	Participants: 21 cisgender female	Range: 20-40 years	N/R	N/R	Written, open-ended questionnaire	Thematic analysis	5
Meekums 1998	Survivors: n = 14	Participants: 14 female	N/R	N/R	N/R	Interviews; therapist notes; researcher notes; researcher journal	Grounded theory	3
Mills 2002[a]	Survivors: n = 5	Participants: 5 female	Range: 25-48 years Median: 39 years	Caucasian (n = 5)	N/R	Interviews	Narrative analysis - thematic	4
O'Malley 2019	Survivors: n = 5 Professionals: n = 5	Participants: 4 female, 2 male, 3 N/R	Range: 60-65 years	N/R	N/R	Case study; interviews and review of case notes	Thematic analysis	3

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

Parker 2007[a]	Survivors: n = 7	Participants: 7 female	Range: 31-40 years	N/R	N/R	Interviews	Phenomenological analysis - thematic	4
Polk 2021[a]	Professionals: n = 6	Participants: 5 female, 1 male	N/R	N/R	N/R	Focus group	Thematic analysis	4
Price 2005	Survivors: n = 32	Participants: 32 female	Range: 26-56 years	Black (n = 2) Hispanic (n = 2) Native American (n = 1) White (n = 20) Missing (n = 7)	N/R	Open-ended questions in questionnaire	Content analysis	2
Rhodes 2014	Survivors: n = 39	Participants: 39 female	Range: 18-59 years	White (n = 31) Missing (n = 8)	N/R	Interviews; 1.5 years after intervention	Phenomenological analysis - thematic	2
Røberg 2018[a]	Survivors: n = 5	Participants: 5 male	Range: 29-64 years	Norweigan (n = 5)	N/R	Interviews	IPA	4
San Diego 2011[a]	Survivors: n = 5	Participants: 5 female	Range: 15-18 years	N/R	N/R	Interviews	IPA	5
Schwarz 2020	Survivors: n = 25 Professionals: n = 4	Participants: 25 female	Survivors range: 20-65 years Professionals range: 25-45 years	Survivors: African American (n = 1) Asian (n = 3) Latina (n = 4) Mixed (n = 1) White (n = 12) Professionals: Indian (n = 1) Latina (n = 1)	N/R	Interviews	Thematic analysis	3

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

				White (n = 2)				
Shaw 2015[a]	Survivors: n = 3	Participants: 2 transgender, 1 cisgender female	N/R	N/R	N/R	Interviews	Cross-case comparison/thematic	5
Sigurdardottir 2016[a]	Survivors: n = 12	Participants: 12 female	Range: 22-53 years	N/R	N/R	Interviews	Framework	4
Sikkema 2018	Survivors: n = 25 Professionals: n = 11	Participants: 36 female	N/R	N/R	N/R	Interviews and focus groups	N/R	2
Silverberg 2019[a]	Survivors: n = 7	Participants: 7 female	Range: 24-53 years	N/R	N/R	Interview	Narrative thematic	5
Stevens 2019[a]	Survivors: n = 5	Participants: 5 female	Range: 21-55 years	Haitian (n = 1) White British (n = 4)	N/R	Interview	IPA	4
Tanabe 2013	Professionals: N/R, however there were 10 focus groups ranging from 6 to 11 participants	N/R	N/R	N/R	Focus group	Thematic	Thematic analysis	1
Taylor 2018[a]	Survivors: n = 23	Survivors: 23 male	Mean: 38.2 years	Black African (n = 2) Caucasian (n = 4) Latino (n = 2) Missing (n = 1)	Homosexual (n = 5) Unsure (n = 1) Missing (n = 3)	Interview	Cross-case analysis/thematic	4
Thomas 2016	Partners: n = 10	Participants: 10 male	Range: 28-59 years	African American (n = 1) Caucasian (n = 8) Middle East (n = 1)	N/R	Interview	Transcendental phenomenology	1

Table 2. Stratification of included studies: participant characteristics, study methodology and overall rating *(Continued)*

Trute 2001	Survivors: n = 8 Partners: n = 1 Professionals: n = 1	N/R	N/R	N/R	All heterosexual	Comparative case study; interviews; therapy observation notes	Comparative case study (8 individual cases)	2
Tsai 2021	Survivors: n = 79	Participants: all female	Range: 12-25 years	Khmer (n = 45) Vietnamese (n = 15) Khmer and Vietnamese (n = 7) Other (n = 7) Missing (n = 5)	All heterosexual	Interviews	IPA	3
Visser 2015[a]	Survivors: n = 8	Participants: 8 female	Range: 13-18 years Mean: 15.8 years	N/R	N/R	Interviews; group process notes	Thematic analysis	5
Walker 2020[a]	Survivors: n = 7	Participants: 7 female	> 18 years	N/R	N/R	Semi-structured interviews	Thematic analysis	4
Walker-Williams 2017[a]	Survivors: n = 10	Participants: 10 female	Range: 18-50 years	Black (n = 4) Caucasian (n = 6)	N/R	Participatory talk and draw/write; audio recordings of group transcribed; written activities	Thematic analysis	5
Wilson 2010	Survivors: n = 35	Survivors: 33 female, 2 male	Range: 18-55 years Mean: 38 years	N/R	N/R	In-depth interviews (mixed-method study)	Thematic analysis	2
Zielinski 2021	Survivors: n = 3 Facilitators: n = 3	Survivors: 3 female Facilitators: N/R	N/R	N/R	N/R	Interviews	Thematic analysis	3

[a]Study was included in the main analysis

CBT: cognitive behavioural therapy; IPA: interpretative phenomenological analysis; n: number; N/R: not reported; SANE: sexual assault nurse examiner

Table 3. Purposeful sampling ratings

	Measure	Example
1	Very little qualitative data presented that relate to the synthesis objective; those findings that are presented are fairly descriptive	A mixed-methods study using open-ended survey questions or a more detailed qualitative study where only part of the data relate to the synthesis objective
2	Some qualitative data presented that relate to the synthesis objective	A limited number of qualitative findings from a mixed-methods or qualitative study
3	A reasonable amount of qualitative data that relate to the synthesis objective	A typical qualitative research article in a health services journal
4	A good amount and depth of qualitative data that relate to the synthesis objective	A qualitative research article in a social sciences journal with more context and setting descriptions
5	A large amount and depth of qualitative data that relate in depth to the synthesis objective	From a detailed ethnography or a published qualitative article with the same objectives as the synthesis

Table 4. Methodological limitations

	Is the qualitative research approach appropriate for the research question?	Is the qualitative research approach stated clearly?	Is the qualitative research approach justified clearly?	Are ethical issues considered and is formal ethical approval granted?	Is the sampling method described clearly?	Is the sampling method appropriate for the research question?
Asselstine 1997	Yes	Yes	Yes	Yes	Yes	Yes
Beiza 2015	Yes	Yes	Yes	Yes	Yes	Yes
Bluntzer 2016	Yes	Yes	Yes	Yes	Yes	Yes
Braxton 2017	Yes	Yes	Yes	Yes	Yes	Yes
Capella 2018	Yes	Yes	Yes	Yes	Yes	Yes
Carey 1996	Yes	Yes	Yes	Yes	Yes	Yes
Carpenter 2016	Yes	Yes	Yes	Yes	Yes	Yes
DiCesare 2015	Yes	Yes	Yes	Yes	Yes	Yes
Edwards 2015	Yes	Yes	Yes	Yes	Yes	Yes
Farr 2021	Yes	Yes	Yes	Yes	No	Cannot tell
Fields 2019	Yes	Yes	Yes	Yes	Yes	Yes
Forde 2021	Yes	Yes	Yes	Yes	Yes	Yes

Table 4. Methodological limitations *(Continued)*

Heberling 2006	Yes	Yes	Yes	Yes	Yes	Yes
Hoffman 2016	Yes	Yes	Yes	Yes	Yes	Yes
Horton 2021	Yes	Yes	Yes	Yes	Yes	Yes
Jones-Smith 2018	Yes	Yes	Yes	Yes	Yes	Yes
Kahan 2020	Yes	Yes	Yes	Yes	Yes	Yes
Kallivayalil 2013	Yes	Yes	Yes	Cannot tell	Yes	Yes
Kane 2003	Yes	Yes	Yes	Cannot tell	No	Cannot tell
Kerlin 2013	Yes	Yes	Yes	Yes	Yes	Yes
Magnuson 2003	Yes	Yes	Yes	Yes	Yes	Yes
Margain 2020	Yes	Yes	Yes	Yes	Yes	Yes
McLean 2021	Yes	Yes	Yes	Yes	Yes	Yes
Mead 2019	Yes	Yes	Yes	Yes	Yes	Yes
Mills 2002	Yes	Yes	Yes	Cannot tell	Yes	Yes
Parker 2007	Yes	Yes	Yes	Yes	Yes	Yes
Polk 2021	Yes	Yes	Yes	Yes	Yes	Yes
Røberg 2018	Yes	Yes	Yes	Yes	Yes	Yes
San Diego 2011	Yes	Yes	Yes	Cannot tell	Yes	Yes
Schwarz 2020	Yes	Yes	Yes	Cannot tell	Yes	Yes
Shaw 2015	Yes	Yes	Yes	Yes	Yes	Yes
Sigurdardottir 2016	Yes	Yes	Yes	Yes	Yes	Yes
Silverberg 2019	Yes	Yes	Yes	Yes	Yes	Yes
Stevens 2019	Yes	Yes	Yes	Yes	Yes	Yes
Taylor 2018	Yes	Yes	No	Yes	Yes	Yes
Visser 2015	Yes	Yes	Yes	Yes	Yes	Yes
Walker 2020	Yes	Yes	Yes	Yes	Yes	Yes
Walker-Williams 2017	Yes	Yes	Yes	Yes	Yes	Yes

Table 5. Methodological limitations continued

	Is the method of data collection appropriate for the research question?	Does the approach to data analysis address the research question?	Is the approach to data analysis described clearly?	Are the researchers' findings supported by sufficient evidence?
Asselstine 1997	Yes	Yes	Yes	Yes
Beiza 2015	Yes	Yes	Yes	Yes
Bluntzer 2016	Yes	Yes	Yes	Yes
Braxton 2017	Yes	Yes	Yes	Yes
Capella 2018	Yes	Yes	Yes	Yes
Carey 1996	Yes	Yes	Yes	Yes
Carpenter 2016	Yes	Yes	Yes	Yes
DiCesare 2015	Yes	Yes	Yes	Yes
Edwards 2015	Yes	Yes	Yes	Yes
Farr 2021	Yes	Yes	Yes	Yes
Fields 2019	Yes	Yes	Yes	Yes
Forde 2021	Yes	Yes	Yes	Yes
Heberling 2006	Yes	Yes	Yes	Yes
Hoffman 2016	Yes	Yes	Yes	Yes
Horton 2021	Yes	Yes	Yes	Yes
Jones-Smith 2018	Yes	Yes	Yes	Yes
Kahan 2020	Yes	Yes	Yes	Yes
Kallivayalil 2013	Yes	Yes	Yes	Yes
Kane 2003	Yes	Yes	No	Yes
Kerlin 2013	Yes	Yes	Yes	Yes
Magnuson 2003	Yes	Yes	Yes	Yes
Margain 2020	Yes	Yes	Yes	Yes
McLean 2021	Yes	Yes	Yes	Yes
Mead 2019	Yes	Yes	Yes	Yes
Mills 2002	Yes	Yes	Yes	Yes

Table 5. Methodological limitations continued *(Continued)*

Parker 2007	Yes	Yes	Yes	Yes
Polk 2021	Yes	Yes	Yes	Yes
Røberg 2018	Yes	Yes	Yes	Yes
San Diego 2011	Yes	Yes	Yes	Yes
Schwarz 2020	Yes	Yes	Yes	Yes
Shaw 2015	Yes	Yes	Yes	Yes
Sigurdardottir 2016	Yes	Yes	Yes	Yes
Silverberg 2019	Yes	Yes	Yes	Yes
Stevens 2019	Yes	Yes	Yes	Yes
Taylor 2018	Yes	Yes	Yes	Yes
Visser 2015	Yes	Yes	Yes	Yes
Walker 2020	Yes	Yes	Yes	Yes
Walker-Williams 2017	Yes	Yes	Yes	Yes

Table 6. Matrix model applying key findings from the qualitative evidence synthesis to studies in the linked and related Cochrane Reviews

Studies	Was the intervention designed to address the following factors?								
	1	2	3	4	5	6	7	8	9
Abrahams 2010 (in Brown 2019)	?	N/A	?	?	Y	?	?	?	Y
Acierno 2021 (in Brown 2019)	?	?	?	?	Y	?	?	?	?
Anderson 2010 (in Brown 2019)	?	?	?	?	?	?	Y	?	?
Baker 1985 (in Gillies 2016)	?	?	?	?	N	Y	Y	?	?
Barron 2013 (in Gillies 2016)	?	?	Y	?	N	?	?	?	?
Bass 2013 (in Brown 2019)	?	?	?	?	Y	?	?	?	?
Bass 2016 (in Brown 2019)	?	N/A	N/A	Y	?	?	N/A	?	?
Bell 2019 (in Brown 2019)	?	?	?	?	N	?	?	?	N
Belleville 2018 (in Brown 2019)	?	?	?	?	N	?	?	?	?
Berkowitz 2011 (in Gillies 2016)	?	?	?	?	?	?	?	?	Y
Berliner 1996 (in Gillies 2016; Macdonald 2012)	?	?	?	?	N	Y	?	?	?
Burke 1988 (in Macdonald 2012)	?	?	N	?	?	?	?	?	?
Bomeyea 2015 (in Brown 2019)	?	N/A	N/A	?	N/A	?	N/A	?	?
Bowland 2012 (in Brown 2019)	?	?	?	?	N	?	?	?	?
Carbonell 1999	?	?	?	?	?	Y	?	Y	?

Table 6. Matrix model applying key findings from the qualitative evidence synthesis to studies in the linked and related Cochrane Reviews *(Continued)*

(in Gillies 2016)									
Celano 1996 (in Gillies 2016; Macdonald 2012)	?	?	?	?	N	?	?	?	Y
Cohen 1996 (in Gillies 2016; Macdonald 2012)	?	?	?	?	N	?	Y	Y	Y
Cohen 1998 (in Macdonald 2012)	?	?	?	?	N	?	Y	Y	Y
Cohen 2005 (in Gillies 2016; Macdonald 2012)	?	?	?	?	N	?	Y	Y	Y
Damra 2014 (in Gillies 2016)	?	?	?	?	?	?	?	?	Y[1]
Danielson 2012 (in Gillies 2016)	?	?	?	?	N	?	?	?	Y[1]
Deblinger 1996 (in Gillies 2016; Macdonald 2012)	?	?	?	?	?	Y[2]	?	?	?
Deblinger 2001 (in Gillies 2016; Macdonald 2012)	?	?	?	?	N	?	Y	?	Y[1]
Deblinger 2011 (in Gillies 2016)	?	?	?	?	?	Y	?	?	?
Diele 2014 (in Gillies 2016)	?	?	?	?	N	?	?	?	Y[3]
Dominguez 2001 (in Gillies 2016; Macdonald 2012)	?	?	?	?	N	Y[2]	Y	?	?

Table 6. Matrix model applying key findings from the qualitative evidence synthesis to studies in the linked and related Cochrane Reviews *(Continued)*

Echeburua 1996 (in Brown 2019)	?	?	?	?	?	?	?	?	?
Falsetti 2008 (in Brown 2019)	?	?	?	?	N	?	?	?	?
Farkas 2010 (in Gillies 2016)	?	?	?	?	N	?	?	?	?
Feske 2008 (in Brown 2019)	?	?	?	?	Y[4]	?	?	?	?
Foa 1991 (in Brown 2019)	?	?	?	?	N	?	Y	?	?
Foa 1999 (in Brown 2019)	?	?	?	?	N	?	?	?	?
Foa 2005 (in Brown 2019)	?	?	?	?	Y[5]	Y	?	?	?
Foa 2006 (in Brown 2019)	?	?	?	?	N	?	Y	?	?
Galovski 2016 (in Brown 2019)	?	?	?	?	N	?	?	?	?
Glodich 2000 (in Gillies 2016)	Y	?	?	Y	N	?	?	?	?
Gray 2020 (in Brown 2019)	?	?	?	?	N	?	?	?	?
Jaberghaderi 2004 (in Gillies 2016)	?	?	N	?	N	Y	?	?	Y
Katz 2014 in (Brown 2019)	?	?	?	?	N	?	Y	?	?
Kelly 2021 (in Brown 2019)	?	?	?	?	?	?	?	?	?
King 2000 (in Macdonald 2012)	?	?	?	?	N	?	?	Y	?
Krakow 2001 (in Brown 2019)	?	?	?	?	N	?	?	?	?
Littleton 2016 (in Brown 2019)	?	?	?	?	Y	?	Y	?	?
Miller 2015 (in Brown 2019)	?	?	?	?	N	?	?	?	?

Table 6. Matrix model applying key findings from the qualitative evidence synthesis to studies in the linked and related Cochrane Reviews *(Continued)*

Nixon 2016 (in Brown 2019)	?	?	?	?	Y	?	?	?	?
O'Callaghan 2013 (in Gillies 2016)	?	?	?	Y	N	?	?	?	?
Raider 2008 (in Gillies 2016)	?	?	?	Y	N	?	?	?	?
Rajan 2020 (in Brown 2019)	?	Y	?	?	N	?	?	?	?
Resick 2002 (in Brown 2019)	?	?	?	?	N	?	?	?	?
Resick 2008 (in Brown 2019)	?	?	?	?	N	?	Y	?	?
Rothbaum 1997 (in Brown 2019)	?	?	?	?	?	?	?	?	?
Rothbaum 2005 (in Brown 2019)	?	?	?	?	N	?	?	?	?
Schnurr 2007 (in Brown 2019)	?	?	?	?	Y[6]	?	?	?	?
Shirk 2014 (in Gillies 2016)	?	?	?	?	N	?	?	?	?
Sikkema 2018 (in Brown 2019)	?	?	?	?	?	?	?	?	?
Suris 2013 (in Brown 2019)	?	?	?	?	?	?	?	?	?
Trowell 2002 (in Gillies 2016)	?	?	?	?	Y	Y	?	?	Y[7]
Walsh 2017 (in Brown 2019)	?	?	?	?	N/A	?	?	?	?

Y = Yes
N = No
N/A = not applicable
? = not reported
[1]Children and parent intervention.
[2]Preparation/assessment sessions although no information on ending.
[3]Child and parental involvement in intervention.

[4]At specific sessions in an intervention survivors who reported an improvement in trauma symptoms of less than 70% were encouraged to participate in three additional intervention sessions.

[5]Survivors who at the end of eight sessions reached at least 70% improvement in self-reported trauma symptoms completed treatment after session 9; the rest were offered up to 12 sessions.

[6]Additional 4 weeks were given for survivors to complete intervention if therapist and survivor felt it was needed.

[7]Support available for parents and siblings.

1. Was the intervention survivor-centred?
2. Were 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. Were measures in place to minimise staff turnover, support the availability of the same therapist(s) throughout the intervention, and to manage changes in providers when necessary?
4. Did the location, setting, format, organisational structure, delivery of the intervention and, where appropriate the dynamics of group members (i.e. survivors attending group interventions), make all survivors feel safe?
5. Could the intervention, its format and delivery style, be tailored to meet the needs of all survivors and their changing levels of trauma? And were intervention providers supported and given confidence in making such changes?
6. Were measures in place to help prepare survivors for both the start and end of the intervention?
7. Were intervention practitioners open, accepting and non-judgemental in their practice?
8. Did interventions help survivors establish boundaries and be assertive?
9. Was the level of support from survivors' friends, family and wider social networks considered in the design and delivery of the intervention?

APPENDICES

Appendix 1. Search strategies

MEDLINE Ovid

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.

Searched 6 August 2020 (7599 records)
Searched 9 August 2021 (823 records)

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 intimate partner violence.tw,kf.
10 (rape or raped or incest$).tw,kf.
11 (sex$ adj3 (abuse$ or assaul$ or attack$ or aggress$ or coerc$ or CSA or exploit$ or force$ or molest$ or offen$ or traffick$ or trauma $ or unlawful$ or unwanted or violen$)).tw,kf.
12 (intercourse adj3 (coer$ or force$ or unwanted)).tw,kf.
13 (sex$ adj3 (victim$ or revictim$ or re-victim$ or survivor$)).tw,kf.
14 human trafficking.tw,kf.
15 or/1-14
16 Adaptation, Psychological/
17 exp Behavior Therapy/
18 Combined Modality Therapy/
19 community networks/
20 exp Complementary therapies/
21 exp Counseling/
22 Exercise/
23 Exercise therapy/
24 Health Education/
25 Health Knowledge, Attitudes, Practice/
26 Interview, Psychological/
27 exp mind body therapies/
28 Psychological adjustment/
29 psychosocial support systems/
30 exp psychotherapy/
31 "Referral and Consultation"/
32 Self-Help Groups/
33 Social Support/
34 video recording/ or videotape recording/
35 Writing/
36 ((abreaction or desensitization or exposure or implosive) adj3 therap$).tw,kf.
37 "acceptance and commitment therapy".tw,kf.
38 (advisor$ or advocate$ or advocacy).tw,kf.
39 ((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$)).tw,kf.
40 (autogenic or autosuggestion$ or auto-suggestion$ or breathing exercise$ or hypnosis or hypno-therapy or hypnotherapy).tw,kf.
41 behavio$ activation.tw,kf.
42 (behavio?r$ adj3 (intervention$ or program$ or therap$ or training or treatment$)).tw,kf.
43 ((biofeedback or feedback or imagery) adj3 (intervention$ or therap$ or train$ or treatment$)).tw,kf.
44 (body adj2 (therap$ or psychotherap$)).tw,kf.
45 ((brief or combination or compass$ focus$ or integrated or integrative or time-limited) adj3 (intervention$ or therap$ or treatment $)).tw,kf.
46 ((client focus$ or non-direct$ or nondirect$ or solution focus$ or trauma$ or talking) adj3 therap$).tw,kf.
47 (cognitiv$ or cognition).tw,kf.

48 CBT.tw,kf.
49 ((cope or coping) adj1 (intervention$ or mechanism$ or skill$ or technique$)).tw,kf.
50 (counsel$1 or counsel?ing or counsel?or$1).tw,kf.
51 ((couple$ or family or group or systemic$ or multimodal$ or multi-modal$) adj3 (program$ or intervention$ or therap$ or treat$)).tw,kf.
52 dialectical behavio?r$ therap$.tw,kf.
53 (exercise$ or physical training).tw,kf.
54 ((existential or gestalt or humanistic or interpersonal or milieu or person-centred or residential or socioenvironmental or socio-environmental) adj therap$).tw,kf.
55 expressive writing.tw,kf.
56 ("Eye Movement Desensitization and Reprocessing" or EMDR).tw,kf.
57 (meditat$ or mental training or mindfulness$ or mind training or brain training or yoga).tw,kf.
58 motivational interview$.tw,kf.
59 (narrative$1 or story or stories).tw,kf.
60 (reality therap$ or problem solving).tw,kf.
61 (psycho$ therap$ or psychotherap$).tw,kf.
62 (psychoanalytic$ or psycho-analytic$ or psychodynamic$ or psycho-dynamic$).tw,kf.
63 (psychodrama or psycho-drama or acting out or role play).tw,kf.
64 (psychosocial or psycho-social or psychoeducation$ or psycho-education$).tw,kf.
65 rational emotive.tw,kf.
66 ((Relax$ or stress management) adj3 (training$ or therap$)).tw,kf.
67 (self care or self compassion).tw,kf.
68 (stress inoculation training or SIT or prolonged exposure therapy or PET or cognitive processing therapy or CPT).tw,kf.
69 ((support or advice or advis$1 or advisory) adj1 (centre$1 or center$1 or community or group$ or network$ or social or staff$)).tw,kf.
70 (therapeutic allianc$ or therapeutic relationship$ or therapeutic communit$).tw,kf.
71 Third wave.tw,kf.
72 (th or rh).fs.
73 (advocate$1 or advocacy or care or caring or heal or healing or intervention$ or program$ or recover$ or rehabilit$ or support$ or therap $ or treat$).ti,kf.
74 (victim$ adj3 (centre$ or center$ or service$ or support)).tw,kf.
75 (survivor$ adj3 (centre$ or center$ or service$ or support)).tw,kf.
76 (referral adj3 (centre$ or center$ or service$ or support)).tw,kf.
77 or/16-76
78 Interview/ or interview$.mp.
79 Qualitative research/ or qualitative.tw,kf.
80 experience$.mp.
81 or/78-80
82 15 and 77 and 81 [Annotation. Final line 2020]
83 (202008* or 202009* or 202010* or 202011* or 202012* or 2021*).dt,ez,da.
84 82 and 83 [Annotation. Final line 2021]

MEDLINE In-Process & In-Data-Review Citations Ovid

Searched 6 August 2020 (1422 records)
Searched 9 August 2021 (322 records)

1 (rape or raped or incest$).tw,kf.
2 (sex$ adj3 (abuse$ or assaul$ or attack$ or aggress$ or coer$ or CSA or exploit$ or force$ or molest$ or offen$ or traffick$ or trauma$ or unlawful$ or unwanted or violen$)).tw,kf.
3 (intercourse adj3 (coer$ or force$ or unwanted)).tw,kf.
4 (sex$ adj3 (victim$ or revictim$ or re-victim$ or survivor$)).tw,kf.
5 intimate partner violence.tw,kf.
6 Spouse abuse.tw,kf.
7 human trafficking.tw,kf.
8 1 or 2 or 3 or 4 or 5 or 6 or 7
9 (qualitative or experience$ or interview$).tw.
10 8 and 9
11 (advocate$1 or advocacy or care or caring or heal or healing or intervention$ or program$ or recover$ or rehabilit$ or support$ or therap $ or train$ or treat$).tw,kf.
12 (autogenic or autosuggestion$ or auto-suggestion$ or breathing exercise$ or hypnosis or hypno-therapy or hypnotherapy).tw,kf.
13 behavio$ activation.tw,kf.
14 (client focus$ or non-direct$ or nondirect$ or solution focus$).tw,kf.
15 (cognitiv$ or cognition or CBT).tw,kf.
16 ((cope or coping) adj1 (intervention or mechanism$ or skill$ or technique$)).tw,kf.

17 (counsel$1 or counsel?ing or counsel?or$1).tw,kf.
18 (exercise$ or physical training).tw,kf.
19 ((expressive or creative) adj1 writing).tw,kf.
20 ("Eye Movement Desensitization and Reprocessing" or EDMR).tw,kf.
21 (meditat$ or mental training or mindfulness$ or mind training or brain training or yoga).tw,kf.
22 motivational interview$.tw,kf.
23 (narrative$1 or story or stories).tw,kf.
24 problem solving.tw,kf.
25 (psycho$ therap$ or psychotherap$).tw,kf.
26 (psychoanalytic$ or psycho-analytic$ or psychodynamic$ or psycho-dynamic$).tw,kf.
27 (psychodrama or psycho-drama or acting out or role play).tw,kf.
28 (psychosocial or psycho-social or psychoeducation$ or psycho-education$).tw,kf.
29 rational emotive.tw,kf.
30 (referral adj3 (centre$ or center$ or service$ or support)).tw,kf.
31 (relax$ or self care or self compassion or self help).tw,kf.
32 (stress inoculation or SIT or prolonged exposure or PET or CPT).tw,kf.
33 ((support or advice or advis$1 or advisory) adj1 (centre$1 or center$1 or community or group$ or network$ or social or staff$)).tw,kf.
34 (survivor$ adj3 (centre$ or center$ or service$ or support)).tw,kf.
35 (therapeutic allianc$ or therapeutic relationship$ or therapeutic communit$).tw,kf.
36 Third wave.tw,kf.
37 (victim$ adj3 (centre$ or center$ or service$ or support)).tw,kf.
38 or/11-37
39 10 and 38 [Annotation. Final line 2020]
40 limit 39 to yr="2020 -Current" [Annotation. Final line 2021]

MEDLINE Epub Ahead of Print Ovid

Searched 6 August 2020 (788 records)
Searched 9 August 2021 (632 records)

1 (rape or raped or incest$).tw,kf.
2 (sex$ adj3 (abuse$ or assaul$ or attack$ or aggress$ or coer$ or CSA or exploit$ or force$ or molest$ or offen$ or traffick$ or trauma$ or unlawful$ or unwanted or violen$)).tw,kf.
3 (intercourse adj3 (coer$ or force$ or unwanted)).tw,kf.
4 (sex$ adj3 (victim$ or revictim$ or re-victim$ or survivor$)).tw,kf.
5 intimate partner violence.tw,kf.
6 Spouse abuse.tw,kf.
7 human trafficking.tw,kf.
8 1 or 2 or 3 or 4 or 5 or 6 or 7
9 (qualitative or experience$ or interview$).tw.
10 8 and 9
11 (advocate$1 or advocacy or care or caring or heal or healing or intervention$ or program$ or recover$ or rehabilit$ or support$ or therap$ or train$ or treat$).tw,kf.
12 (autogenic or autosuggestion$ or auto-suggestion$ or breathing exercise$ or hypnosis or hypno-therapy or hypnotherapy).tw,kf.
13 behavio$ activation.tw,kf.
14 (client focus$ or non-direct$ or nondirect$ or solution focus$).tw,kf.
15 (cognitiv$ or cognition or CBT).tw,kf.
16 ((cope or coping) adj1 (intervention or mechanism$ or skill$ or technique$)).tw,kf.
17 (counsel$1 or counsel?ing or counsel?or$1).tw,kf.
18 (exercise$ or physical training).tw,kf.
19 ((expressive or creative) adj1 writing).tw,kf.
20 ("Eye Movement Desensitization and Reprocessing" or EDMR).tw,kf.
21 (meditat$ or mental training or mindfulness$ or mind training or brain training or yoga).tw,kf.
22 motivational interview$.tw,kf.
23 (narrative$1 or story or stories).tw,kf.
24 problem solving.tw,kf.
25 (psycho$ therap$ or psychotherap$).tw,kf.
26 (psychoanalytic$ or psycho-analytic$ or psychodynamic$ or psycho-dynamic$).tw,kf.
27 (psychodrama or psycho-drama or acting out or role play).tw,kf.
28 (psychosocial or psycho-social or psychoeducation$ or psycho-education$).tw,kf.
29 rational emotive.tw,kf.
30 (referral adj3 (centre$ or center$ or service$ or support)).tw,kf.
31 (relax$ or self care or self compassion or self help).tw,kf.

32 (stress inoculation or SIT or prolonged exposure or PET or CPT).tw,kf.
33 ((support or advice or advis$1 or advisory) adj1 (centre$1 or center$1 or community or group$ or network$ or social or staff$)).tw,kf.
34 (survivor$ adj3 (centre$ or center$ or service$ or support)).tw,kf.
35 (therapeutic allianc$ or therapeutic relationship$ or therapeutic communit$).tw,kf.
36 Third wave.tw,kf.
37 (victim$ adj3 (centre$ or center$ or service$ or support)).tw,kf.
38 or/11-37
39 10 and 38 [Annotation. Final line 2020]
40 limit 39 to yr="2020 -Current" [Annotation. Final line 2021]

Embase Ovid

Searched 6 August 2020 (7579 records)
Searched 9 August 2021 (876 records)

1 sexual assault/
2 rape/
3 child sexual abuse/
4 childhood sexual abuse survivor/
5 incest/
6 partner violence/
7 marital rape/
8 human trafficking/
9 intimate partner violence.tw,kw.
10 (rape or raped or incest$).tw,kw.
11 (sex$ adj3 (abuse$ or assaul$ or attack$ or aggress$ or coerc$ or CSA or exploit$ or force$ or molest$ or offen$ or traffick$ or trauma $ or unlawful$ or unwanted or violen$)).tw,kw.
12 (intercourse adj3 (coer$ or force$ or unwanted)).tw,kw.
13 (sex$ adj3 (victim$ or revictim$ or re-victim$ or survivor$)).tw,kw.
14 human trafficking.tw,kw.
15 or/1-14
16 coping behavior/
17 exp behavior therapy/
18 Combined Modality Therapy.mp.
19 "acceptance and commitment therapy".mp. or dialectical behavior therapy/ or implosive therapy/ or shock wave therapy/ or "acceptance and commitment therapy"/ or emotion-focused therapy/ or recreational therapy/ or exposure therapy/ or early goal-directed therapy/ or therapy/ or pet therapy/ or anger management therapy/ or systemic therapy/ or cognitive remediation therapy/ or animal assisted therapy/ or computer assisted therapy/ or color therapy/ or cognitive therapy software/
20 exp alternative medicine/
21 exp counseling/
22 kinesiotherapy/
23 psychological adjustment/
24 survivorship/
25 psychosocial care/ or psychosocial rehabilitation/
26 exp psychotherapy/
27 interpersonal psychotherapy/ or short term psychotherapy/
28 patient referral/
29 exp self help/ or self care/
30 exp self care/
31 exp psychosocial care/
32 social care/
33 videorecording/ or audiovisual recording/
34 writing/
35 ((abreaction or desensitization or exposure or implosive) adj3 therap$).tw,kw.
36 "acceptance and commitment therapy".tw,kw.
37 (advisor$ or advocate$ or advocacy).tw,kw.
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$)).tw,kw.
39 (autogenic or autosuggestion$ or auto-suggestion$ or breathing exercise$ or hypnosis or hypno-therapy or hypnotherapy).tw,kw.
40 behavio$ activation.tw,kw.
41 (behavio?r$ adj3 (intervention$ or program$ or therap$ or training or treatment$)).tw,kw.
42 ((biofeedback or feedback or imagery) adj3 (intervention$ or therap$ or train$ or treatment$)).tw,kw.
43 (body adj2 (therap$ or psychotherap$)).tw,kw.

44 ((brief or combination or compass$ focus$ or integrated or integrative or time-limited) adj3 (intervention$ or therap$ or treatment $)).tw,kw.
45 ((client focus$ or non-direct$ or nondirect$ or solution focus$ or trauma$ or talking) adj3 therap$).tw,kw.
46 (cognitiv$ or cognition).tw,kw.
47 CBT.tw,kw.
48 ((cope or coping) adj1 (intervention$ or mechanism$ or skill$ or technique$)).tw,kw.
49 (counsel$1 or counsel?ing or counsel?or$1).tw,kw.
50 ((couple$ or family or group or systemic$ or multimodal$ or multi-modal$) adj3 (program$ or intervention$ or therap$ or treat$)).tw,kw.
51 dialectical behavio?r$ therap$.tw,kw.
52 (exercise$ or physical training).tw,kw.
53 ((existential or gestalt or humanistic or interpersonal or milieu or person-centred or residential or socioenvironmental or socio-environmental) adj therap$).tw,kw.
54 ((expressive or creative) adj writing).tw,kw.
55 ("Eye Movement Desensitization and Reprocessing" or EMDR).tw,kw.
56 (meditat$ or mental training or mindfulness$ or mind training or brain training or yoga).tw,kw.
57 motivational interview$.tw,kw.
58 (narrative$1 or story or stories).tw,kw.
59 (reality therap$ or problem solving).tw,kw.
60 (psycho$ therap$ or psychotherap$).tw,kw.
61 (psychoanalytic$ or psycho-analytic$ or psychodynamic$ or psycho-dynamic$).tw,kw.
62 (psychodrama or psycho-drama or acting out or role play).tw,kw.
63 (psychosocial or psycho-social or psychoeducation$ or psycho-education$).tw,kw.
64 rational emotive.tw,kw.
65 ((Relax$ or stress management) adj3 (training$ or therap$)).tw,kw.
66 (self-help or self care or self compassion).tw,kw.
67 (stress inoculation training or prolonged exposure therapy or cognitive processing therapy).tw,kw.
68 ((support or advice or advis$1 or advisory) adj1 (centre$1 or center$1 or community or group$ or network$ or social or staff$)).tw,kw.
69 (therapeutic allianc$ or therapeutic relationship$ or therapeutic communit$).tw,kw.
70 third wave.tw,kw.
71 (advocate$1 or advocacy or care or caring or heal or healing or intervention$ or program$ or recover$ or rehabilit$ or support$ or therap $ or treat$).ti,kw.
72 (victim$ adj3 (centre$ or center$ or service$ or support)).tw,kw.
73 (survivor$ adj3 (centre$ or center$ or service$ or support)).tw,kw.
74 (referral adj3 (centre$ or center$ or service$ or support)).tw,kw.
75 or/16-74
76 15 and 75
77 qualitative research/
78 exp health care organization/
79 interview$.tw.
80 experiences.tw.
81 77 or 78 or 79 or 80
82 76 and 81 [Annotation. Final line 2020]
83 limit 82 to yr="2020 -Current" [Annotation. Final line 2021]

CINAHL Plus EBSCOhost

Searched 10 August 2020 (3223 records)
Searched 10 August 2021 (309 records)

S1 (MH "Sexual Abuse") OR (MH "Child Abuse, Sexual") OR (MH "Child Abuse Survivors")
S2 (MH "Incest")
S3 (MH "Rape")
S4 (MH "Intimate Partner Violence")
S5 (MH "Human Trafficking")
S6 TI(intimate partner violence) OR AB (intimate partner violence)
S7 TI(rape or raped or incest*) or AB (rape or raped or incest*)
S8 TI (sex* N3 (abuse* or assaul* or attack* or aggress* or coerc* or CSA or exploit* or force* or molest* or offen* or traffick* or trauma* or unlawful* or unwanted or violen*)) OR AB (sex* N3 (abuse* or assaul* or attack* or aggress* or coerc* or CSA or exploit* or force* or molest* or offen* or traffick* or trauma* or unlawful* or unwanted or violen*))
S9 TI(intercourse N3 (coer* or force* or unwanted)) OR AB(intercourse N3 (coer* or force* or unwanted))
S10 TI(sex* N3 (victim* or revictim* or re-victim* or survivor*)) or AB (sex* N3 (victim* or revictim* or re-victim* or survivor*))
S11 TI(human trafficking) OR AB (human trafficking)
S12 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11

S13 (MH "Alternative Therapies+")
S14 (MH "Adaptation, Psychological")
S15 (MH "Behavior Therapy")
S16 (MH "Combined Modality Therapy")
S17 (MH "Community Networks")
S18 (MH "Alternative Therapies+")
S19 (MH "Counseling+")
S20 (MH "Exercise") OR (MH "Therapeutic Exercise") OR (MH "Breathing Exercises+")
S21 (MH "Health Education")
S22 (MH "Mind Body Techniques+")
S23 (MH "Support, Psychosocial+")
S24 (MH "Psychotherapy+")
S25 (MH "Referral and Consultation")
S26 (MH "Support Groups")
S27 (MH "Videorecording")
S28 (MH "Writing" OR MH "Narratives")
S29 TI((abreaction or desensitization or exposure or implosive) N3 therap*) OR AB((abreaction or desensitization or exposure or implosive) N3 therap*)
S30 TI("acceptance and commitment therapy") OR AB("acceptance and commitment therapy")
S31 TI(advisor* or advocate* or advocacy) or AB(advisor* or advocate* or advocacy)
S32 TI((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) N3 (program* or intervention* or therap*)) OR AB((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) N3 (program* or intervention* or therap*))
S33 TI(autogenic or autosuggestion* or auto-suggestion* or breathing exercise* or hypnosis or hypno-therapy or hypnotherapy) OR AB (autogenic or autosuggestion* or auto-suggestion* or breathing exercise* or hypnosis or hypno-therapy or hypnotherapy)
S34 TI("behavio* activation") OR AB("behavio* activation")
S35 TI(behav* N3 (intervention* or program* or therap* or training or treatment*)) OR AB(behav* N3 (intervention* or program* or therap* or training or treatment*))
S36 TI((biofeedback or feedback or imagery) N3 (intervention* or therap* or train* or treatment*)) OR AB((biofeedback or feedback or imagery) N3 (intervention* or therap* or train* or treatment*))
S37 TI(body N2 (therap* or psychotherap*)) OR AB(body N2 (therap* or psychotherap*))
S38 TI((brief or combination or compass* focus* or integrated or integrative or time-limited) N3 (intervention* or therap* or treatment*)) OR AB((brief or combination or compass* focus* or integrated or integrative or time-limited) N3 (intervention* or therap* or treatment*))
S39 TI(("client focus*" or "non-direct*" or nondirect* or "solution focus*" or trauma* or talking) N3 therap*) OR AB(("client focus*" or non-direct* or nondirect* or "solution focus*" or trauma* or talking) N3 therap*)
S40 TI(cognitiv* or cognition OR CBT) OR AB(cognitiv* or cognition OR CBT)
S41 ((cope or coping) N1 (intervention* or mechanism* or skill* or technique*)) OR AB ((cope or coping) N1 (intervention* or mechanism* or skill* or technique*))
S42 TI(counsel? or counsel?ing or counsel?or*) OR AB(counsel? or counsel?ing or counsel?or*)
S43 TI((couple* or family or group or systemic* or multimodal* or multi-modal*) N3 (program* or intervention* or therap* or treat*)) OR AB((couple* or family or group or systemic* or multimodal* or multi-modal*) N3 (program* or intervention* or therap* or treat*))
S44 TI("dialectical behavio#r* therap*") OR AB(dialectical behavio#r* therap*)
S45 TI(exercise* or physical training)
S46 TI((existential or gestalt or humanistic or interpersonal or milieu or person-centred or residential or socioenvironmental or socio-environmental) N3 therap*)) OR AB ((existential or gestalt or humanistic or interpersonal or milieu or person-centred or residential or socioenvironmental or socio-environmental) N3 therap*)
S47 TI(CREATIVE OR expressive) N1 writing)) OR AB(CREATIVE OR expressive) N1 writing))
S48 TI("Eye Movement Desensitization and Reprocessing" or EMDR) OR AB("Eye Movement Desensitization and Reprocessing" or EMDR)
S49 TI(meditat* or "mental training" or mindfulness* or "mind training" or "brain training" or yoga) OR AB(meditat* or "mental training" or mindfulness* or "mind training" or "brain training" or yoga)
S50 TI("motivational interview*") OR AB("motivational interview*")
S51 TI(narrative* or story or stories) OR AB(narrative* or story or stories)
S52 TI("reality therap*" or "problem solving") OR AB("reality therap*" or "problem solving")
S53 TI("psycho* therap*" or psychotherap*) OR AB(("psycho* therap*" or psychotherap*)
S54 TI(psychoanalytic* or psycho-analytic* or psychodynamic* or psycho-dynamic*) OR AB(psychoanalytic* or psycho-analytic* or psychodynamic* or psycho-dynamic*)
S55 TI(psychodrama or psycho-drama or "acting out" or "role play") OR AB(psychodrama or psycho-drama or "acting out" or "role play")
S56 TI(psychosocial or psycho-social or psychoeducation* or psycho-education*) OR AB(psychosocial or psycho-social or psychoeducation* or psycho-education*)
S57 TI "rational emotive" OR AB "rational emotive"
S58 TI((Relax* or "stress management") N3 (training* or therap*)) OR AB ((Relax* or "stress management") N3 (training* or therap*))
S59 TI("self care" or "self compassion") OR AB("self care" or "self compassion")

S60 TI ("stress inoculation training" or "prolonged exposure therapy" or "cognitive processing therapy" OR AB ("stress inoculation training" or "prolonged exposure therapy" or "cognitive processing therapy")
S61 TI((support or advice or advis* or advisory) N1 (centre* or center* or community or group* or network* or social or staff*) OR AB((support or advice or advis* or advisory) N1 (centre* or center* or community or group* or network* or social or staff*)
S62 TI("therapeutic allianc*" or "therapeutic relationship*" or "therapeutic communit*") OR AB("therapeutic allianc*" or "therapeutic relationship*" or "therapeutic communit*")
S63 TI "Third wave" OR AB "Third wave"
S64 TI(advocate* or advocacy or care or caring or heal or healing or intervention* or program* or recover* or rehabilit* or support* or therap* or treat*)
S65 TI(victim* N3 (centre* or center* or service* or support)) OR AB(victim* N3 (centre* or center* or service* or support))
S66 TI(survivor* N3 (centre* or center* or service* or support)) OR AB(survivor* N3 (centre* or center* or service* or support))
S67 TI(referral N3 (centre* or center* or service* or support)) OR AB(referral N3 (centre* or center* or service* or support))
S68 S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62 OR S63 OR S64 OR S65 OR S66 OR S67
S69 S12 AND S68
S70 (MH "Qualitative Studies+")
S71 (MH "Audiorecording")
S72 TI interview* OR AB interview*
S73 TI qualitative OR AB qualitative
S74 S70 OR S71 OR S72 OR S73
S75 S69 AND S74 [Annotation. Final line 2020]
S76 EM 20200801-
S77 S75 AND S76 [Annotation. Final line 2021]

APA PsycInfo Ovid

Searched 10 August 2020 (7868 records)
Searched 9 August 2021 (689 records)

1 exp sex offenses/
2 exp abuse reporting/
3 intimate partner violence/
4 human trafficking/
5 exp Child Abuse/ and survivors/
6 intimate partner violence.tw.
7 (rape or raped or incest$).tw.
8 (sex$ adj3 (abuse$ or assaul$ or attack$ or aggress$ or coerc$ or CSA or exploit$ or force$ or molest$ or offen$ or traffick$ or trauma$ or unlawful$ or unwanted or violen$)).tw.
9 (intercourse adj3 (coer$ or force$ or unwanted)).tw.
10 (sex$ adj3 (victim$ or revictim$ or re-victim$ or survivor$)).tw.
11 human trafficking.tw.
12 or/1-11
13 adaptation/
14 anxiety management/
15 community mental health services/
16 exp alternative medicine/
17 anxiety management/
18 exp behavior therapy/
19 exp cognitive behavior therapy/
20 community mental health services/
21 exp counseling/
22 creative writing/ or self-expression/ or storytelling/
23 exercise/ or movement therapy/
24 health education/
25 mental health services/
26 mind body therapy/
27 mindfulness-based interventions/
28 Online Therapy/
29 exp psychotherapy/
30 exp self-help techniques/
31 Self-Referral/ or Professional Referral/
32 social networks/

33 social support/
34 "stress and coping measures"/
35 Support Groups/
36 ((abreaction or desensitization or exposure or implosive) adj3 therap$).tw.
37 "acceptance and commitment therapy".tw.
38 (advisor$ or advocate$ or advocacy).tw.
39 ((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$)).tw.
40 (autogenic or autosuggestion$ or auto-suggestion$ or breathing exercise$ or hypnosis or hypno-therapy or hypnotherapy).tw.
41 behavio$ activation.tw.
42 (behavio?r$ adj3 (intervention$ or program$ or therap$ or training or treatment$)).tw.
43 ((biofeedback or feedback or imagery) adj3 (intervention$ or therap$ or train$ or treatment$)).tw.
44 (body adj2 (therap$ or psychotherap$)).tw.
45 ((brief or combination or compass$ focus$ or integrated or integrative or time-limited) adj3 (intervention$ or therap$ or treatment$)).tw.
46 ((client focus$ or non-direct$ or nondirect$ or solution focus$ or trauma$ or talking) adj3 therap$).tw.
47 (cognitiv$ or cognition).ti.
48 ((cognitive or cognition) adj5 (intervention$ or mechanism$ or skill$ or technique$ or treat$ or therap$)).ab
49 CBT.tw.
50 ((cope or coping) adj1 (intervention$ or mechanism$ or skill$ or technique$)).tw.
51 (counsel$1 or counsel?ing or counsel?or$1).tw.
52 ((couple$ or family or group or systemic$ or multimodal$ or multi-modal$) adj3 (program$ or intervention$ or therap$ or treat$)).tw.
53 dialectical behavio?r$ therap$.tw.
54 (exercise$ or physical training).tw.
55 ((existential or gestalt or humanistic or interpersonal or milieu or person-centred or residential or socioenvironmental or socio-environmental) adj therap$).tw.
56 expressive writing.tw.
57 ("Eye Movement Desensitization and Reprocessing" or EMDR).tw.
58 (meditat$ or mental training or mindfulness$ or mind training or brain training or yoga).tw.
59 motivational interview$.tw.
60 (narrative$1 or story or stories).tw.
61 (reality therap$ or problem solving).tw.
62 (psycho$ therap$ or psychotherap$).tw.
63 (psychoanalytic$ or psycho-analytic$ or psychodynamic$ or psycho-dynamic$).tw.
64 (psychodrama or psycho-drama or acting out or role play).tw.
65 (psychosocial or psycho-social or psychoeducation$ or psycho-education$).tw.
66 rational emotive.tw.
67 ((Relax$ or stress management) adj3 (training$ or therap$)).tw.
68 (self care or self compassion).tw.
69 (stress inoculation training or SIT or prolonged exposure therapy or PET or cognitive processing therapy or CPT).tw.
70 ((support or advice or advis$1 or advisory) adj1 (centre$1 or center$1 or community or group$ or network$ or social or staff$)).tw.
71 (therapeutic allianc$ or therapeutic relationship$ or therapeutic communit$).tw.
72 Third wave.tw.
73 (advocate$1 or advocacy or care or caring or heal or healing or intervention$ or program$ or recover$ or rehabilit$ or support$ or therap $ or treat$).ti.
74 (victim$ adj3 (centre$ or center$ or service$ or support)).tw.
75 (survivor$ adj3 (centre$ or center$ or service$ or support)).tw.
76 (referral adj3 (centre$ or center$ or service$ or support)).tw.
77 or/13-76
78 12 and 77
79 exp qualitative methods/
80 experiences.tw.
81 interview$.tw.
82 qualitative.tw.
83 or/79-82
84 78 and 83 [Annotation. Final line 2020]
85 limit 84 to up=20200801-20210802 [Annotation. Final line 2021]

Epistemonikos

Searched 10 August 2020 (159 records)

Searched 10 August 2021. Limited by date added 10082020-10082021 (25 records)

title:("sex* abuse*" OR "sex* Assault*" OR "sex* attack*" OR " sex coerc*" OR "sex* exploit*" OR "sex* violen*" OR rape* OR incest* OR "intimate partner violence" OR (survivor* AND sex*) OR (survivor* AND abuse*) OR (victim* AND sex*) OR (victim* AND abuse*) OR (revictim* AND sex*) OR (revictim* AND abuse*)) AND (title:(qualitative OR experience* OR perception* OR interview*) OR abstract:(qualitative OR experience* OR perception* OR interview*))

PDQ-Evidence

Searched 10 August 2020 (91 records)
Searched 10 August 2021. Limited by date added 10082020-10082021 (2 records)

(title:((title:((title:(("sex* abuse*" OR "sex* Assault*" OR "sex* attack*" OR " sex coerc*" OR rape* OR incest* OR "intimate partner violence")) OR abstract:(("sex* abuse*" OR "sex* Assault*" OR "sex* attack*" OR " sex coerc* "OR rape* OR incest* OR "intimate partner violence"))) OR (title:((survivor* AND abuse*) OR (survivor* AND sex*) OR (survivor* AND assault*) OR (survivor* AND intimate*)) OR abstract:((survivor* AND abuse*) OR (survivor* AND sex*) OR (survivor* AND assault*) OR (survivor* AND intimate*) OR (victim* AND sex*) OR (victim* AND assault*) OR (victim* AND abuse*)))) OR abstract:((title:(("sex* abuse*" OR "sex* Assault*" OR "sex* attack*" OR " sex coerc*" OR rape* OR incest* OR "intimate partner violence")) OR abstract:(("sex* abuse*" OR "sex* Assault*" OR "sex* attack*" OR " sex coerc* "OR rape* OR incest* OR "intimate partner violence"))) OR (title:((survivor* AND abuse*) OR (survivor* AND sex*) OR (survivor* AND assault*) OR (survivor* AND intimate*)) OR abstract:((survivor* AND abuse*) OR (survivor* AND sex*) OR (survivor* AND assault*) OR (survivor* AND intimate*) OR (victim* AND sex*) OR (victim* AND assault*) OR (victim* AND abuse*))))))) OR abstract:((title:((title:(("sex* abuse*" OR "sex* Assault*" OR "sex* attack*" OR " sex coerc*" OR rape* OR incest* OR "intimate partner violence")) OR abstract:(("sex* abuse*" OR "sex* Assault*" OR "sex* attack*" OR " sex coerc* "OR rape* OR incest* OR "intimate partner violence"))) OR (title:((survivor* AND abuse*) OR (survivor* AND sex*) OR (survivor* AND assault*) OR (survivor* AND intimate*)) OR abstract:((survivor* AND abuse*) OR (survivor* AND sex*) OR (survivor* AND assault*) OR (survivor* AND intimate*) OR (victim* AND sex*) OR (victim* AND assault*) OR (victim* AND abuse*)))) OR abstract:((title:(("sex* abuse*" OR "sex* Assault*" OR "sex* attack*" OR " sex coerc*" OR rape* OR incest* OR "intimate partner violence")) OR abstract:(("sex* abuse*" OR "sex* Assault*" OR "sex* attack*" OR " sex coerc* "OR rape* OR incest* OR "intimate partner violence"))) OR (title:((survivor* AND abuse*) OR (survivor* AND sex*) OR (survivor* AND assault*) OR (survivor* AND intimate*)) OR abstract:((survivor* AND abuse*) OR (survivor* AND sex*) OR (survivor* AND assault*) OR (survivor* AND intimate*) OR (victim* AND sex*) OR (victim* AND assault*) OR (victim* AND abuse*)))))))

Social Services Abstracts Proquest

Searched 10 August 2020 (1366 records)
Searched 10 August 2021. Limited by PY 2020-2021 (74 records)

((MAINSUBJECT.EXACT("Child Sexual Abuse") OR MAINSUBJECT.EXACT("Sexual Abuse") OR TI(sex* NEAR/3 (abuse* OR assaul* OR attack* OR aggress* OR coer* OR CSA OR exploit* OR force* OR molest* OR offen* OR traffick* OR trauma* OR unlawful* OR unwanted OR violen*)) OR AB(sex* NEAR/3 (abuse* OR assaul* OR attack* OR aggress* OR coer* OR CSA OR exploit* OR force* OR molest* OR offen* OR traffick* OR trauma* OR unlawful* OR unwanted OR violen*)) OR TI(rape OR raped OR incest*) OR AB(rape OR raped OR incest*) OR TI(sex* NEAR/3 (victim* OR revictim* OR re-victim* OR survivor*)) OR AB(sex* NEAR/3 (victim* OR revictim* OR re-victim* OR survivor*)) OR TI (intercourse NEAR/3 (coer* OR force* OR unwanted)) OR AB(intercourse NEAR/3 (coer* OR force* OR unwanted))) AND (MAINSUBJECT.EXACT("Qualitative Methods") OR TI(QUALITATIVE OR EXPERIENCE* OR INTERVIEW*) OR AB(QUALITATIVE OR EXPERIENCE* OR INTERVIEW*))) AND (MAINSUBJECT.EXACT.EXPLODE("Conjoint Therapy") OR MAINSUBJECT.EXACT("Treatment") OR MAINSUBJECT.EXACT("Sociotherapy") OR MAINSUBJECT.EXACT.EXPLODE("Group Therapy") OR MAINSUBJECT.EXACT.EXPLODE("Psychotherapy") OR MAINSUBJECT.EXACT("Psychoanalysis") OR MAINSUBJECT.EXACT.EXPLODE("Family Therapy") OR TI(advocate* OR advocacy OR care OR caring OR heal OR healing OR intervention* OR program* OR recover* OR rehabilit* OR support* OR therap* OR train* OR treat*))

Social Science Citation Index Clarivate

Searched 10 August 2020 (4674 records)
Searched 10 August 2021 (756 records)

# 34 #32 AND #31 [Annotation. Final line 2021]
Indexes=SSCI Timespan=2020-2021
# 33 #32 AND #31 [Annotation. Final line 2020]
Indexes=SSCI Timespan=All years
# 32TI=(qualitative or experience* or interview*) OR AB=(qualitative or experience* or interview*)
Indexes=SSCI Timespan=All years
# 31 #30 AND #6
Indexes=SSCI Timespan=All years
# 30 #29 OR #28 OR #27 OR #26 OR #25 OR #24 OR #23 OR #22 OR #21 OR #20 OR #19 OR #18 OR #17 OR #16 OR #15 OR #14 OR #13 OR #12 OR #11 OR #10 OR #9 OR #8 OR #7
Indexes=SSCI Timespan=All years

# 29 TI=(victim* NEAR/3 (centre* or center* or service* or support)) OR AB=(victim* NEAR/3 (centre* or center* or service* or support)) Indexes=SSCI Timespan=All years
# 28TI=("third wave") OR AB=("third wave")
Indexes=SSCI Timespan=All years
# 27TI=("therapeutic allianc*" or "therapeutic relationship* "or "therapeutic communit*) "OR AB=("therapeutic allianc*" or "therapeutic relationship* "or "therapeutic communit*) "
Indexes=SSCI Timespan=All years
# 26TI=(survivor* N R/3 (centre* or center* or service* or support)) OR AB=(survivor* NEAR/3 (centre* or center* or service* or support)) Indexes=SSCI Timespan=All years
# 25TI=((support or advice or advisory) NEAR/1 (centre* or center* or community or group* or network* or social or staff*)) OR AB=((support or advice or advisory) NEAR/1 (centre* or center* or community or group* or network* or social or staff*))
Indexes=SSCI Timespan=All years
# 24 TI=("stress inoculation" or "prolonged exposure ") OR AB=("stress inoculation" or "prolonged exposure ")
Indexes=SSCI Timespan=All years
# 23TI=(relax* or "self care "or "self compassion "or "self help) "OR AB=(relax* or "self care "or "self compassion "or "self help) "
Indexes=SSCI Timespan=All years
# 22TI=(referral NEAR/3 (centre* or center* or service* or support)) OR AB=(referral NEAR/3 (centre* or center* or service* or support)) Indexes=SSCI Timespan=All years
# 21TI=("rational emotive") OR AB=("rational emotive") Indexes=SSCI Timespan=All years
# 20TI=("psycho* therap*" or psychotherap* OR psychoanalytic* or psycho-analytic* or psychodynamic* or psycho-dynamic* OR psychodrama or psycho-drama or "acting out "or "role play "OR psychosocial or psycho-social or psychoeducation* or psycho-education*) or AB=("psycho* therap*" or psychotherap* OR psychoanalytic* or psycho-analytic* or psychodynamic* or psycho-dynamic* OR psychodrama or psycho-drama or "acting out "or "role play "OR psychosocial or psycho-social or psychoeducation* or psycho-education*)
Indexes=SSCI Timespan=All years
# 19TI=(narrative* or story or stories) OR AB=((narrative* or story or stories) near/3 (intervention* or program* or therap* or train* or treat*))
Indexes=SSCI Timespan=All years
# 18TI=("motivational interview*") Indexes=SSCI Timespan=All years
# 17 TI=(meditat* or "mental training " or mindfulness* or "mind training "or "brain training "or yoga) OR AB=(meditat* or "mental training " or mindfulness* or "mind training " or "brain training" or yoga) Indexes=SSCI Timespan=All years
# 16TI=("Eye Movement Desensitization and Reprocessing" or EDMR) OR AB= ("Eye Movement Desensitization and Reprocessing" or EDMR)
Indexes=SSCI Timespan=All years
# 15 TI= ((expressive or creative) NEAR/1 writing) OR AB=((expressive or creative) NEAR/1 writing)
Indexes=SSCI Timespan=All years
# 14AB=(exercise* near/3 (intervention* or program* or therap* or train* or treat*))
Indexes=SSCI Timespan=All years
# 13TI= (counsel or counseling or counselling or counselor* or counsellor*) or AB= (counsel or counseling or counselling or counselor* or counsellor*)
Indexes=SSCI Timespan=All years
# 12TI= ((cope or coping) NEAR/1 (intervention or mechanism* or skill* or technique*)) OR AB= ((cope or coping) NEAR/1 (intervention or mechanism* or skill* or technique*))
Indexes=SSCI Timespan=All years
# 11 TI=(cognitiv* or cognition or CBT) OR AB=((cognitiv* or cognition) near/5 (intervention or mechanism* or technique* or therap* or treat*))
Indexes=SSCI Timespan=All years
# 10TI=("client focus*" or non-direct* or nondirect* or "solution focus*) "OR AB=("client focus*" or non-direct* or nondirect* or "solution focus*) "
Indexes=SSCI Timespan=All years
# 9 TI=("behavio* activation") OR AB=("behavio* activation")
Indexes=SSCI Timespan=All years
# 8 TI=(autogenic or autosuggestion* or auto-suggestion* or breathing exercise* or hypnosis or hypno-therapy or hypnotherapy) OR AB=(autogenic or autosuggestion* or auto-suggestion* or "breathing exercise* " or hypnosis or hypno-therapy or hypnotherapy)
Indexes=SSCI Timespan=All years
# 7 TI=(advocate* or advocacy or care or caring or heal or healing or intervention* or program* or recover* or rehabilit* or support* or therap* or train* or treat*)
Indexes=SSCI Timespan=All years
# 6 #5 OR #4 OR #3 OR #2 OR #1
Indexes=SSCI Timespan=All years
# 5 TI=("intimate partner violence" or "spouse abuse "or "human trafficking") or AB=("intimate partner violence" or "spouse abuse" or "human trafficking")
Indexes=SSCI Timespan=All years
# 4TI=(sex* NEAR/3 (victim* or revictim* or re-victim* or survivor*)) OR AB=(sex* NEAR/3 (victim* or revictim* or re-victim* or survivor*))

Indexes=SSCI Timespan=All years
# 3TI= (intercourse NEAR/3 (coer* or force* or unwanted)) OR AB=(intercourse NEAR/3 (coer* or force* or unwanted))
Indexes=SSCI Timespan=All years
# 2 TI=(rape or raped or incest*) OR AB=(rape or raped or incest*)
Indexes=SSCI Timespan=All years
# 1 TI=(sex* NEAR/3 (abuse* or assaul* or attack* or aggress* or coer* or CSA or exploit* or force* or molest* or offen* or traffick* or trauma* or unlawful* or unwanted or violen*)) OR AB=(sex* NEAR/3 (abuse* or assaul* or attack* or aggress* or coer* or CSA or exploit* or force* or molest* or offen* or traffick* or trauma* or unlawful* or unwanted or violen*)) Indexes=SSCI Timespan=All years
Indexes=SSCI Timespan=All years

PTSDpubs PROQUEST

Searched 10 August 2020 (1548 records)
Searched 10 August 2021. Narrowed by: Entered date: 2020-08 - 2021-12 (6 records)

((MAINSUBJECT.EXACT.EXPLODE("Victim Services") OR MAINSUBJECT.EXACT("Psychosocial Rehabilitation") OR MAINSUBJECT.EXACT.EXPLODE("Self Help Techniques") OR MAINSUBJECT.EXACT("Psychotherapeutic Processes") OR MAINSUBJECT.EXACT.EXPLODE("Social Support Networks") OR MAINSUBJECT.EXACT("Psychotherapy") OR MAINSUBJECT.EXACT("Recreation Therapy") OR MAINSUBJECT.EXACT("Therapeutic Writing") OR MAINSUBJECT.EXACT.EXPLODE("Psychotherapy") OR MAINSUBJECT.EXACT("Therapeutic Writing") OR TI(advocate* OR advocacy OR care OR caring OR heal OR healing OR intervention* OR program* OR recover* OR rehabilit* OR support* OR therap* OR train* OR treat*)) AND (MAINSUBJECT.EXACT("Interpersonal Abuse") OR MAINSUBJECT.EXACT("Incest") OR MAINSUBJECT.EXACT.EXPLODE("Rape") OR TI(sex* NEAR/3 (abuse* OR assaul* OR attack* OR aggress* OR coer* OR CSA OR exploit* OR force* OR molest* OR offen* OR traffick* OR trauma* OR unlawful* OR unwanted OR violen*)) OR AB(sex* NEAR/3 (abuse* OR assaul* OR attack* OR aggress* OR coer* OR CSA OR exploit* OR force* OR molest* OR offen* OR traffick* OR trauma* OR unlawful* OR unwanted OR violen*)) OR TI(rape OR raped OR incest*) OR AB(rape OR raped OR incest*) OR TI(sex* NEAR/3 (victim* OR revictim* OR re-victim* OR survivor*)) OR AB(sex* NEAR/3 (victim* OR revictim* OR re-victim* OR survivor*)) OR TI (intercourse NEAR/3 (coer* OR force* OR unwanted)) OR AB(intercourse NEAR/3 (coer* OR force* OR unwanted)))) AND (TI(QUALITATIVE OR EXPERIENCE* OR INTERVIEW* OR PERSPECTIVE*) OR AB(QUALITATIVE OR EXPERIENCE* OR INTERVIEW* OR PERSPECTIVE*))

Proquest Dissertations & Theses

Searched 10 August 2020 (62 records)
Searched 10 August 2021. Limited by PY 2020-2021 (8 records)

ti("sex* abuse" OR "sex* violence" OR "sex* assault*" OR rape*) AND ti(survivor* or family or partner* or spouse* or husband* or wife* or professsional) AND (TI(qualitativ* OR interview* OR perception* OR perspectiv* OR opinion*) OR AB(qualitativ* OR interview* OR perception* OR perspectiv* OR opinion*))

Website site search for unpublished reports

The following search was used where it was possible to use AND/OR booleans:

(victims OR survivors) AND (“child sex* abuse” OR “sexual abuse” OR “sexual assault” OR “sexual violence”)

each keyword was searched seperately when AND/OR booleans could not be used.

Searched 25 November 2020.

Appendix 2. GRADE-CERQual evidence profiles

Assessment for each GRADE-CERQual component

Summary of review finding	Studies contributing	Methodological limitations	Coherence	Adequacy	Relevance	Overall CERQual assessment and explanation
Contextual features						
Finding 1: contextual features	18 studies Beiza 2015	No or very minor concerns	Minor concerns re-	Minor concerns regarding adequacy,	Minor concerns regarding relevance, as the	**High confidence**

(Continued)

can affect survivors' access to and experiences of interventions	Carpenter 2016 DiCesare 2015 Farr 2021 Heberling 2006 Hoffman 2016 Horton 2021 Jones-Smith 2018 Kahan 2020 Kerlin 2013 Margain 2020 Mills 2002 Røberg 2018 Parker 2007 Polk 2021 Silverberg 2019 Stevens 2019 Walker 2020		garding coherence: some concerns about the fit between the data from primary studies and the review finding as the finding did not reflect nuances between different types of interventions	as the 18 studies offered rich data, but the finding was not evident across every study and in relation to different participant groups	findings were based on a range of stakeholder groups across a range of relevant intervention settings; however, the studies were all conducted in high-income countries with the exception of one study based in a middle-income country	No or very minor concerns regarding methodological limitations Minor concerns regarding coherence, adequacy, and relevance
Finding 2: organisational features can impact on survivors' engagement with interventions	11 studies Beiza 2015 Carpenter 2016 Capella 2018 Farr 2021 Kahan 2020 Margain 2020 Parker 2007 Røberg 2018 Stevens 2019 Visser 2015 Walker 2020	No or very minor concerns	No or very minor concerns	Moderate concerns regarding adequacy. Eleven studies contributed to this finding; moderate concerns as data were not highly rich and studies usually focused on one participant group (survivors) who had participated in group-based interventions; the data had poor representation regarding age and ethnicity of participants	Minor concerns regarding relevance, as the findings were based on a range of stakeholder groups across a range of relevant intervention settings; however, the studies were all conducted in high-income countries with the exception of two studies based in a middle-income country	**Moderate confidence** Moderate concerns regarding adequacy Minor concerns regarding relevance No or very minor concerns regarding methodological limitations and coherence
Finding 3: the format and delivery of interventions played an	31 studies Asselstine 1997 Beiza 2015	Minor concerns, as one study did not clearly justify the qualitative research	Minor concerns regarding coherence, as there were some con-	No or very minor concerns	Minor concerns, as the finding was based on a range of stakeholder groups across a range	**High confidence**

(Continued)

important role in their acceptability to survivors	Bluntzer 2016 Braxton 2017 Carey 1996 Carpenter 2016 Edwards 2015 Farr 2021 Fields 2019 Forde 2021 Heberling 2006 Hoffman 2016 Horton 2021 Kahan 2020 Kane 2003 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Parker 2007 Polk 2021 Røberg 2018 Schwarz 2020 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Taylor 2018 Visser 2015 Walker 2020	approach; three studies did not clearly specify considerations to ethical issues and state ethical approval had been granted; one study did not describe the sampling methods; one study did not explain why the approach to sampling was appropriate for the research question; and one study did not clearly describe the approach to data analysis	cerns about the fit between the data from primary studies and the review finding, as the finding was usually descriptive and did not explore in depth the acceptability issues around intervention format and delivery		of relevant intervention settings; however, the studies were all conducted in high-income countries with the exception of one study based in a middle-income country and one study based in a low-income country	No or very minor concerns regarding adequacy Minor concerns regarding methodological limitations, coherence, and relevance

Effectiveness

Finding 4: interventions improved survivors' understand-	33 studies Asselstine 1997 Beiza 2015 Bluntzer 2016	Minor concerns, as one study did not clearly justify the qualitative research	Minor concerns regarding coherence, as the studies did	Minor concerns regarding adequacy, as the studies together offered rich data but par-	No or very minor concerns	**High confidence** No or very minor concerns

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ing of trauma	Braxton 2017 Carey 1996 Carpenter 2016 DiCesare 2015 Edwards 2015 Fields 2019 Heberling 2006 Hoffman 2016 Horton 2021 Jones-Smith 2018 Kahan 2020 Kallivayalil 2013 Kane 2003 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Parker 2007 Polk 2021 Røberg 2018 San Diego 2011 Schwarz 2020 Shaw 2015 Silverberg 2019 Stevens 2019 Taylor 2018 Visser 2015 Walker 2020 Walker-Williams 2017	approach; five studies did not clearly specify considerations to ethical issues and state ethical approval had been granted; one study did not describe the sampling methods; one study did not explain why the approach to sampling was appropriate for the research question; and one study did not clearly describe the approach to data analysis	not reflect nuances across the different intervention types	ticipant voices could have been more fully represented regarding age, gender and the ethnicity of participants		regarding relevance Minor concerns regarding methodological limitations, coherence, and adequacy
Finding 5: interventions enabled survivors to re-engage in a wide range	16 studies Asselstine 1997 Braxton 2017 Bluntzer 2016	No or very minor concerns	No or very minor concerns	Moderate concerns regarding adequacy, as the studies provided a reasonable amount of data, but poor	Minor concerns regarding adequacy, as the findings were based on a range of stakeholder groups across	**Moderate confidence** No or very minor con-

(Continued)

of areas of their lives	Carey 1996 Edwards 2015 Fields 2019 Heberling 2006 Hoffman 2016 Horton 2021 Kahan 2020 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Shaw 2015 Silverberg 2019			ly represented views of young people and professionals	a range of relevant intervention settings; however, all but one of the studies were based in the USA and Canada, with one study based in a low-income country in Central America	cerns regarding methodological limitations and coherence Minor concerns regarding relevance Moderate concerns regarding adequacy
Finding 6: interventions helped improve survivors' interpersonal relationships	29 studies Asselstine 1997 Bluntzer 2016 Braxton 2017 Capella 2018 Carey 1996 Edwards 2015 Farr 2021 Fields 2019 Heberling 2006 Hoffman 2016 Horton 2021 Jones-Smith 2018 Kahan 2020 Kane 2003 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Parker 2007	Minor concerns regarding methodological limitations, as one study did not clearly justify the qualitative research approach clearly; three studies did not clearly specify considerations to ethical issues and state ethical approval had been granted; two studies did not describe the sampling methods; two studies did not explain why the approach to sampling was appropriate for the research question; one study did not clearly describe the ap-	Minor concerns regarding coherence, as the studies did not highlight nuances; for example, how reductions in anxiety or depression helped to improve relationships	No or very minor concerns	No or very minor concerns	**High confidence** No or very minor concerns regarding adequacy and relevance Minor concerns regarding methodological limitations and coherence

(Continued)

	Polk 2021 Røberg 2018 Schwarz 2020 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Taylor 2018 Visser 2015	proach to data analysis				
Finding 7: interventions helped improve survivors' mental health	30 studies Asselstine 1997 Beiza 2015 Bluntzer 2016 Braxton 2017 Capella 2018 Carey 1996 Carpenter 2016 Farr 2021 Fields 2019 Forde 2021 Hoffman 2016 Jones-Smith 2018 Kahan 2020 Kallivayalil 2013 Kane 2003 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Parker 2007 Polk 2021 Røberg 2018 San Diego 2011	Minor concerns regarding methodological limitations, as five studies did not clearly specify considerations to ethical issues and state ethical approval had been granted; two studies did not describe the sampling methods; two studies did not explain why the approach to sampling was appropriate for the research question; and one study did not clearly describe the approach to data analysis	No or very minor concerns	No or very minor concerns	No or very minor concerns	**High confidence** No or very minor concerns regarding coherence and adequacy Minor concerns regarding methodological limitations

(Continued)

	Schwarz 2020 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Visser 2015					
Finding 8: interventions helped improve survivors' mood	23 studies Asselstine 1997 Beiza 2015 Bluntzer 2016 Braxton 2017 Capella 2018 Carey 1996 Carpenter 2016 Farr 2021 Fields 2019 Forde 2021 Heberling 2006 Horton 2021 Kane 2003 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Parker 2007 Røberg 2018 Schwarz 2020 Shaw 2015 Sigurdardottir 2016 Silverberg 2019	Minor concerns regarding methodological limitations, as three studies did not clearly specify considerations to ethical issues and state ethical approval had been granted; two studies did not describe the sampling methods; two studies did not explain why the approach to sampling was appropriate for the research question; and one study did not clearly describe the approach to data analysis	Minor concerns regarding coherence, as the finding was interpretive, as we have understood or interpreted a range of things to encompass mood	Minor concerns regarding adequacy, as the 23 studies offered rich data but there were minor concerns as the views of professionals could have been represented more and the studies included a wider range of intervention types	Minor concerns regarding relevance because the finding was based on studies where there was variation in intervention types, in different settings and across the stakeholder groups; however, all studies were conducted in high-income countries with the exception of two middle-income and one low-income country	**High confidence** Minor concerns regarding methodological limitations coherence, adequacy, and relevance
Finding 9: interventions helped improve survivors'	20 studies Asselstine 1997 Bluntzer 2016 Braxton 2017	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	**High confidence** No or very minor con-

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physical health	Capella 2018 Carey 1996 Carpenter 2016 Edwards 2015 Fields 2019 Hoffman 2016 Jones-Smith 2018 Kahan 2020 Magnuson 2003 Mills 2002 Mead 2019 Parker 2007 Schwarz 2020 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Taylor 2018					cerns regarding methodological limitations, coherence, adequacy and relevance
Characteristics that enabled or hindered change						
Finding 10: interventions that were survivor-centred and flexible were considered beneficial	9 studies Bluntzer 2016 Edwards 2015 Carpenter 2016 DiCesare 2015 Heberling 2006 Kahan 2020 Mills 2002 Shaw 2015 Walker-Williams 2017	No or very minor concerns	No or very minor concerns	Moderate concerns regarding adequacy due to the finding being based on studies with a limited representation of participants	Minor concerns regarding relevance, as studies were relevant to the aims of the review but were conducted in the high-income countries of Australia, the UK and USA, with the exception of one study based in a low-income country (the Philippines)	**Moderate confidence** No or very minor concerns regarding methodological limitations and coherence Minor concerns regarding relevance Moderate concerns regarding adequacy
Finding 11: readiness to enter therapy/support is central to survivors	13 studies Asselstine 1997 Beiza 2015 Braxton 2017	No or very minor concerns	No or very minor concerns	Moderate concerns about adequacy, as the finding was largely based on a limited representation	Minor concerns about relevance, as the findings were based on a range of intervention settings that were rele-	**Moderate confidence** No or very minor con-

(Continued)

feeling able to engage with interventions	Carpenter 2016 DiCesare 2015 Edwards 2015 Farr 2021 Forde 2021 McLean 2021 Parker 2007 San Diego 2011 Shaw 2015 Silverberg 2019			of participants, mainly female survivors	vant to the review aims; however, all but one study was based in a high-income country	methodological limitations and coherence Minor concerns regarding relevance Moderate concerns regarding adequacy
Finding 12: preparedness to start and end interventions impacted on survivors' abilities to derive benefit from them	16 studies Beiza 2015 Carpenter 2016 DiCesare 2015 Edwards 2015 Farr 2021 Heberling 2006 Kane 2003 Mills 2002 Mead 2019 Parker 2007 Polk 2021 Røberg 2018 Shaw 2015 Silverberg 2019 Taylor 2018 Walker-Williams 2017	Minor concerns regarding methodological limitations, as one study did not clearly justify the research approach; three studies did not describe whether ethical issues had been considered and/or formal ethical approval granted; one study did not describe the sampling method clearly; one study did not describe if the sampling method was appropriate for the research question; one study did not describe the analysis approach clearly; and in one study the findings were not supported by sufficient evidence	No or very minor concerns	Minor concerns regarding adequacy, as the 15 studies together offered rich data regarding ending interventions and moderately rich data regarding starting interventions	No or very minor concerns	**High confidence** No or very minor concerns regarding coherence and relevance Minor concerns regarding methodological limitations and adequacy

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Finding 13: establishing an open, accepting, and non-judgemental therapeutic relationship with a facilitator is key to healing	23 studies Asselstine 1997 Beiza 2015 Braxton 2017 Capella 2018 Carpenter 2016 DiCesare 2015 Edwards 2015 Farr 2021 Fields 2019 Forde 2021 Heberling 2006 Hoffman 2016 Jones-Smith 2018 Magnuson 2003 McLean 2021 Parker 2007 Røberg 2018 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Visser 2015 Walker 2020	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	**High confidence** No or very minor concerns regarding methodological limitations, coherence, adequacy, and relevance
Finding 14: interventions that help survivors to establish boundaries and be assertive enabled positive change to occur	11 studies Asselstine 1997 Hoffman 2016 Heberling 2006 Kahan 2020 Magnuson 2003 Mead 2019 Parker 2007	No or very minor concerns	No or very minor concerns	Minor concerns regarding adequacy, as the 11 studies together offered moderately rich data; but there were minor concerns, as there was limited representation of participants, e.g. seven of 11 stud-	Minor concerns regarding relevance, as the findings were based on a range of intervention settings that were relevant to the review aims; however, no studies represented the experiences of chil-	**High confidence** No or very minor concerns regarding methodological limitations and coherence Minor concerns regarding ade-

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	Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Walker 2020			ies included female survivors	dren and young people; all but one study was conducted in a high-income country	quacy and relevance
Finding 15: participants identified risks and harms associated with participating in interventions	23 studies Asselstine 1997 Beiza 2015 Braxton 2017 Capella 2018 Carey 1996 Carpenter 2016 Fields 2019 Forde 2021 Hoffman 2016 Jones-Smith 2018 Kahan 2020 Kane 2003 Kerlin 2013 Magnuson 2003 Margain 2020 Mead 2019 Mills 2002 Polk 2021 Røberg 2018 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019	No or very minor concerns	No or very minor concerns	No or very minor concerns	No or very minor concerns	**High confidence** No or very minor concerns regarding methodological limitations, coherence and adequacy
Finding 16: survivors recognised that, even though it was difficult, they needed to face and	15 studies Beiza 2015 Capella 2018 DiCesare 2015 Fields 2019	No or very minor concerns	No or very minor concerns	Minor concerns regarding adequacy, as the 15 studies together offered rich data, but the finding was not evident across every study	No or very minor concerns	**High confidence** No or very minor concerns regarding methodologi-

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process the trauma within the interventions	Forde 2021 Heberling 2006 Horton 2021 Jones-Smith 2018 Margain 2020 Mills 2002 Røberg 2018 Sigurdardottir 2016 Silverberg 2019 Taylor 2018 Visser 2015					cal limitations, coherence, and relevance Minor concerns regarding adequacy
Finding 17: survivor's ability to engage with the intervention was dependent on the level of trauma symptomology	8 studies Asselstine 1997 DiCesare 2015 Edwards 2015 Hoffman 2016 Jones-Smith 2018 Kahan 2020 Mead 2019 San Diego 2011	No or very minor concerns	No or very minor concerns	Moderate concerns regarding adequacy, as the eight studies together offered moderately rich data, but this finding was not evident across every study and the experiences of family members were not included in any of the studies	Moderate concerns regarding relevance, as the findings were based on a range of intervention settings that were relevant to the review aims; however, all but one study was conducted in a high-income country	**Moderate confidence** No or very minor concerns regarding methodological limitations and coherence Moderate concerns regarding adequacy and relevance
Finding 18: the influence of family, friends, and wider social networks can be an enabler or barrier to healing	10 studies Beiza 2015 Bluntzer 2016 Capella 2018 Carpenter 2016 DiCesare 2015 Farr 2021 Heberling 2006 Kerlin 2013 McLean 2021 Polk 2021	No or very minor concerns	No or very minor concerns	Moderate concerns regarding adequacy, as the 10 studies together offered moderately rich data, but this finding was not evident across every study and the experiences of family members were not included in any of the studies	Moderate concerns regarding relevance, as as but all but two studies were conducted in high-income countries and findings were evident across a limited range of intervention contexts; all but one study was conducted in community-based services	**Moderate confidence** No or very minor concerns regarding methodological limitations and coherence Moderate concerns regarding adequacy and relevance
Subgroup and specialism						

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Finding 19: the extent to which professionals could tailor interventions to meet the individual needs of participants impacted intervention suitability and effectiveness	11 studies Carpenter 2016 Edwards 2015 Farr 2021 Heberling 2006 Horton 2021 Jones-Smith 2018 Kahan 2020 McLean 2021 Polk 2021 Sigurdardottir 2016 Walker-Williams 2017	No or very minor concerns	Minor concerns regarding coherence, as the finding did not reflect nuances across participant groups, particularly friends and family members who we less present across studies	Moderate concerns regarding adequacy, as the 11 studies together offered moderately rich data, but this finding was not evident across every study and there was limited representation across participant groups - all but three studies were focussed on the experiences of female participants	Minor concerns regarding relevance because of the limited range of contexts in which the studies were conducted - one study was conducted in a community-based setting and no information was provided about the context of the intervention in the remaining 10 studies	**Moderate confidence** No or very minor concerns regarding methodological limitations Minor concerns regarding coherence and relevance Moderate concerns regarding adequacy
Finding 20: relationships with peers can be an enabler or barrier to recovery	16 studies Bluntzer 2016 Hoffman 2016 Kahan 2020 Kane 2003 Kerlin 2013 Margain 2020 McLean 2021 Mills 2002 Parker 2007 Røberg 2018 Shaw 2015 Sigurdardottir 2016 Silverberg 2019 Stevens 2019 Visser 2015 Walker-Williams 2017	No or very minor concerns	No or very minor concerns	Moderate concerns regarding adequacy, as the 16 studies together provided moderately rich data, but this finding is only relevant to group-based interventions	Minor concerns regarding relevance because of the limited range of contexts in which the studies were conducted - all but one study was conducted in a community-based setting	**Moderate confidence** No or very minor concerns regarding methodological limitations and coherence Minor concerns regarding relevance Moderate concerns regarding adequacy
Finding 21: survivors' faiths can impact recovery	4 studies Kahan 2020 Kerlin 2013	No or very minor concerns	Minor concerns regarding coherence, as this find-	Minor concerns regarding adequacy, as the four studies together offered	Moderate concerns regarding relevance, as studies were conducted most-	**Moderate confidence**

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when receiving faith-based interventions	Magnuson 2003 Margain 2020		ing is largely interpretative and does not reflect nuances within spirituality or across different faiths	rich data, but there was limited representation across participant groups - all studies related to the experiences of female survivors	ly in the USA and there were a limited range of contexts in which the intervention was conducted	Moderate concerns about adequacy Moderate concerns about relevance Minor concerns about coherence No or very minor concerns regarding methodological limitations
Finding 22: ongoing abuse can hinder engagement with the intervention	3 studies Carpenter 2016 Heberling 2006 Jones-Smith 2018	No or very minor concerns	No or very minor concerns	Serious concerns regarding adequacy, as the three studies together provided a limited view of the data, and serious concerns related to the limited representation across participant groups as two of the three studies related to the experiences of children and young people	Minor concerns regarding relevance, as all studies were conducted in high-income settings - two studies were conducted in the USA and one in the UK	**Low confidence** No or very minor concerns regarding methodological limitations and coherence Minor concerns regarding relevance Serious concerns regarding adequacy

Footnotes

CERQual: Confidence in the Evidence from Reviews of Qualitative research

HISTORY

Protocol first published: Issue 6, 2020

CONTRIBUTIONS OF AUTHORS

Conception of the review: SB and LOD

Design of the review: SB

Co-ordination of the review: SB

Search strategy: SB

Selection of studies: SB, KB, GC, RC, GH and LOD

Stratification of included studies: GC and GH; reviewed by SB

Extraction of data: GC and GH; reviewed by SB

Appraisal of methodological limitations in the included studies: GC and GH; reviewed by SB

Assessment of confidence in the synthesis findings: SB, GC and GH

Data analysis: GC and GH; reviewed and discussed with SB (and MESARCH Investigators team, MESARCH LEG group, and MESARCH Steering Committee)

Interpretation of analysis: SB, KB, GC, GH, GF and LOD (and MESARCH Investigators team, MESARCH LEG group, and MESARCH Steering Committee)

Drafting of review: SB, GC and GH

Topic expertise and editing: KB, GF, EH and LOD (and MESARCH Investigators team, MESARCH LEG group, and MESARCH Steering Committee)

Updating of review: SB, GC, GH and LOD

SB is the guarantor for the review.

DECLARATIONS OF INTEREST

SB: declares that she has no conflicts of interest.

GC: declares that she has no conflicts of interest.

GH declares that between January 2020 and March 2022 she was an unpaid Fiduciary Officer for the Green House, UK. From 1 April 2022, GH reports that she is now in paid role as the CEO of the Green House, UK, and no longer a Research Fellow at the University of Bristol. This role commenced when the review team were responding to feedback from external reviewers.

KB: declares that she has no conflicts of interest.

RC declares she works as a Consultant in HIV and Sexual Health Medicine at University Hospitals Birmingham (UHB). RC also declares she is an unpaid member of the Sexual Violence Special Interest Group of BASHH (British Association for Sexual Health and HIV) and is the unpaid Treasurer and Board Member of the charity STIRF (Sexually Transmitted Infection Research Foundation).

EH: declares a grant from the Big Lottery fund for an evaluation of services delivered by Women's Aid and Safe Lives; paid to the University of East London. EH also reports writing a chapter for publication in the *Encyclopedia on Early Childhood Development*; personal payment (honorarium of CAD 500), though the copyright holder is the University of East London, London, UK.

GF declares that he has written editorials and blogs on the healthcare response to domestic violence. GF also declares that he works as a GP at Montpelier Health Centre, Bristol, UK, and is an unpaid board member of IRISi (irisi.org).

LOD reports being the Chief (Principal) Investigator on a grant from the NIHR, UK (16/117/04), which includes travel expenses and payment for writing this Cochrane Review; paid to Coventry University.

SOURCES OF SUPPORT

Internal sources

- Coventry University, UK

  20% of the MESARCH (Multidisciplinary Evaluation of Sexual Assault Referral Centres for better Health) project is funded by Coventry University.

External sources

- National Institute for Health Research (NIHR) Health Services and Delivery Research (HS&DR) Programme, UK

  80% of the MESARCH project is funded by the NIHR HS&DR Programme. The funder had no role in the design, conduct or publication of the review.

DIFFERENCES BETWEEN PROTOCOL AND REVIEW

In developing our strand 2 search, we identified additional free-text search terms from the strand 1 searches, and added these to the core search strategy published in the protocol: human trafficking; counsel* or counsellor*; body psychotherapy; self care or self compassion; advocacy or advocate*; terms to describe victim or survivor services, or referral to services.

The strand 1 and 2 searches were effective in identifying a wide range of studies that met our inclusion criteria and we did not find ideas or themes from the eligible studies identified from the strand 1 and 2 searches that we wanted to explore in more depth. Consequently, we did not undertake a strand 3 search as the strand 1 and 2 searches revealed sufficient qualitative studies that met our criteria and were feasible to examine within the time and resources available for the review.

In addition to using the sampling framework described in the protocol to select studies for analysis, we completed an appraisal (on a scale of 1 to 5) of data richness and quality of the 97 studies (EPOC 2017; see Table 3), as we saw this in Houghton 2020b, and determined that it would be a helpful addition to our sampling strategy given the large number of eligible studies.

We used RevMan Web (RevMan Web 2022), rather then Review Manager 5 (Review Manager 2020), as we needed to use RevMan Web in our linked Brown 2019 review and it was easier to use the same approach with both reviews.

Rather than use the EPPI-Reviewer 4 (Thomas 2008; Thomas 2010), as outlined in the protocol, we used Covidence to screen studies, resolve disagreements, generate a PRISMA diagram and export information about the included and excluded studies into RevMan Web. This was because we had used Covidence in our linked Brown 2019 review and it was easier to use a consistent approach across both reviews. We imported data from the analysed studies and analysed the data in NVivo (Version 12, Release 1.3; QSR International 2020).