Supporting adult victim-survivors of sexual violence & abuse: An international scoping review to inform service development in Northern Ireland

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August 2023

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ACKNOWLEDGEMENTS

We are hugely grateful to Catherine Gallagher, Clinical Practice Manager, START, New Zealand and Vivienne Carson, Head of Therapy, Dublin Rape Crisis Centre who shared their experience and knowledge to help inform this review.

Recommended citation: McCartan, C., Campbell, U., Cassidy, A., Davidson, G., McGlinchey, R., Shannon, C. & Mulholland, C. (2023). *Supporting adult victim-survivors of sexual violence & abuse: An international scoping review to inform service development in Northern Ireland*. Antrim: Northern Health & Social Care Trust.

SUMMARY

- Sexual violence and abuse is extremely common and will affect most women and many men over their lifetime. The number of reports of sexual violence and abuse in Northern Ireland is growing.
- Crisis as a result of sexual trauma can happen at any stage and across the lifecourse no matter when the abuse occurred.
- Experiencing sexual assault at any time in your life is strongly associated with a range of poor mental health outcomes including anxiety and depression, PTSD, eating disorders, sleep disorders, dementia, and psychosis.
- Being sexually assaulted can also have long-term negative impacts on education and employment. There is a role for occupational therapy to help improve outcomes in early intervention approaches.
- Sexual violence and abuse is also associated with a number of physical health problems including cardiovascular disease, diabetes, cancer, chronic pain – screening for sexual trauma in physical health presentations could better inform treatment plans and help reduce stigma, creating additional opportunities for people to disclose their experience of violence and abuse.
- Early intervention is key and can significantly help prevent the onset or progression of serious mental health problems.
- Different therapeutic approaches are recommended for sexual violence and abuse, the research quality is variable but there is some evidence that they are effective e.g. CBT-based interventions.
- There isn't a 'one size fits all' approach however establishing a strong therapeutic relationship that builds on the skills and expertise of individual therapists to deliver a person-centred tailored approach will likely be of most benefit to victim-survivors.
- There is no recommended length of treatment – treatment should be available for as long as required allowing for exit and re-entry as required. Re-entry into therapy at different developmental stages in one's life and at points of high stress is normal and to be expected.
- Best practice models offer wraparound care offering support from the immediate aftermath of an assault, provide therapy/counselling, support the criminal justice process, and offer social and welfare advice. This is the gold standard. Where support services are siloed and people have to go to different places and deal with different people to access support can increase the risk of re-traumatisation because of a lack of integration and the need to re-tell their stories each time.

- Resourcing needs to be made available for services to communicate, collaborate and integrate interventions in a planned way, as opposed to reactively, or not at all.
- Survivors need a range of different supports including practical help and advice – often this role is provided by volunteers in the absence of adequate resourcing. Support is vital and should not rely on people's good will to volunteer. Volunteer roles that draw on lived experience require careful management and support to avoid re-traumatising the volunteer and/or service user.
- Services should be available for partners/family members who require support.
- This is difficult and complex work, staff need to work in compassionate, trauma-informed settings, and have protected time for their own support, supervision and ongoing professional development.
- Peer support may be beneficial for some victim-survivors but clear boundaries in how this can be delivered and supported are required. There is a real danger of re-traumatisation for peer support workers and service users if not managed and supported appropriately. Good practice and safety recommendations are available and should be closely observed.
- There is little economic evidence for the cost effectiveness of interventions however the research is compelling regarding how detrimental sexual violence and abuse can be for every aspect of people's lives not only affecting mental and physical health, but educational and employment outcomes and the intergenerational impact of trauma transmission in children and young people.
- There is a growing need to develop an evidence-based response to digital sexual abuse and exploitation particularly affecting young people.
- It is clear that responding to sexual violence, prevention, early intervention and appropriate treatment is an interdepartmental responsibility and the funding model should reflect this.

GLOSSARY

The definitions of sexual violence and abuse and its associated use of language are very important.

Definitions	
Sexual violence & abuse	Sexual violence and abuse describes any sexual activity, act or attempt (including online) that happened without consent. There are lots of different types of sexual violence including child sexual abuse, rape and sexual assault but also includes unwanted behaviour of a sexual nature e.g. a person's body being stared at or being sent messages with sexual content.
Victim	Victim describes anyone who has experienced sexual violence and is commonly used by the police, criminal justice system, in law and social contexts. There are some negative associations that have been made, portraying victims as weak, powerless, and stigmatised.
Survivor	In response to some of the backlash relating to the term 'victim', the use of 'survivor' was an attempt to empower those who have been subjected to sexual violence and recognises that recovery is possible. It is not universally accepted and has been criticised that it undermines the impact of sexual violence and places pressure on individuals to 'survive'.
Victim or survivor/ Victim-survivor	This is intended to be a more inclusive term, recognising the importance of discussing and choosing appropriate language with individuals. We use this term in our review.
Abbreviations	
ACEs	Adverse Childhood Experiences
ALSPAC	Avon Longitudinal Study of Parents & Children
ASA	Adult Sexual Abuse
BD	Bipolar Disorder
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
CI	Confidence Intervals
CPT	Cognitive Processing Therapy
CPTSD	Complex Post-Traumatic Stress Disorder
CSA	Child Sexual Abuse
CSWE	Crime Survey for England and Wales
DBT	Dialectical Behavioural Therapy
ED	Eating Disorder
ELAs	Early Life Adversities
EMDR	Eye Movement Desensitisation & Reprocessing
IRT	Imagery Rehearsal Therapy
RTN	Regional Trauma Network
N	Number
OCD	Obsessive Compulsive Disorder
ONS	Office for National Statistics
OR	Odds Ration
PE	Prolonged Exposure
PTSD	Post-Traumatic Stress Disorder
SIT	Stress Inoculation Therapy
TF-CBT	Trauma Focused Cognitive Behavioural Therapy

BACKGROUND

This independent scoping review was commissioned by the Strategic Planning and Performance Group at the Department of Health to help inform the development and delivery of services for victims-survivors of sexual violence and abuse in Northern Ireland.

DEFINING SEXUAL VIOLENCE AND ABUSE

Sexual violence and abuse describes any sexual activity, act or attempt (including online) that happened without consent (Rape Crisis England & Wales, 2023). It includes where a person is forced, coerced, or manipulated into any unwanted sexual activity, sexual harassment, intimidation, forced marriage, trafficking for sexual exploitation, being made to have sex with other people, sexual assault and rape. Being forced to watch or engage in pornography and the non-consensual sharing of intimate images are also considered acts of sexual violence. Examples include (but are not limited to):

- Stalking – repeatedly being followed or watched by someone
- Rape
- Unwanted touching
- Sexual harassment – telling sexually offensive jokes or rude comments about a person's sex life
- Obscene gestures
- Voyeurism
- Unwanted sexual comments or jokes – comments about a person's body or relationships
- Sex-related insults
- Pressuring for dates or demand for sex
- Indecent exposure
- Being forced to watch or participate in pornography – taking a photo without permission, forcing someone to be on video, making someone watch a pornographic movie
- Offensive written material – dirty notes, letters, phone messages, emails, SMS, pictures

In Northern Ireland, sexual violence and abuse is detailed under the Sexual Offences (Northern Ireland) Order 2008, and the legislation covers:

- Rape
- Assault
- Causing sexual activity without consent

- Rape and other offences against children under 13 including abuse of position of trust and familial child sex offences
- Offences against persons with a mental disorder impeding choice
- Indecent photographs of children
- Trafficking
- Exposure and voyeurism

Other legislation covers sexual communication or indecent photographs including the Criminal Justice and Courts Act 2015 and the Justice Act (Northern Ireland) 2015. While there are clear legal definitions of what constitutes rape and sexual assault, there are many other types of sexual violence and abuse that can have impact on someone's wellbeing.

PREVALENCE

Internationally, the reporting of sexual violence and abuse has significantly increased over the last decade (Full Stop Australia, 2022; ONS, 2023). Sexual violence and abuse is gendered, with women and girls much more likely to be affected, and although younger people are at higher risk, "sexual violence can be experienced at any life stage, and is perpetrated in different spaces…households, institutions, public spaces, politics and online." (Full Stop Australia, 2022).

Recent data from the Crime Survey for England and Wales (CSWE) estimated that 1.6 million adults aged between 16-74 years old had experienced sexual assault by rape or penetration from the age of 16 (Office for National Statistics, 2020). Of these victim-survivors, almost half (49%) had been sexually assaulted more than once and been victimised by a partner or ex-partner (44%). More than half (54%) had been assaulted using physical force including threat to kill (6%). In the Republic of Ireland, nationally representative survey data published in 2022 reported that one in three Irish adults had experienced some sort of sexual violence, 14.8% had been raped and 31.1% had been sexually harassed, with significantly higher rates of female victim-survivors compared to men (Vallieres et al., 2022). All types of sexual violence were associated with increased risk of mental health problems. Sexual abuse by a parent was associated with a range of outcomes including poorer educational achievement, experiences of state care, salary and employment status.

Despite the increasing rates of reports of sexual violence and abuse, when considering prevalence it is important to acknowledge the possible levels of under-reporting. Less than one in six victims will report an assault to the police and a tiny proportion will result in a conviction; many victim-survivors describe the justice system and its failures as re-traumatising (Full Stop Australia, 2022).

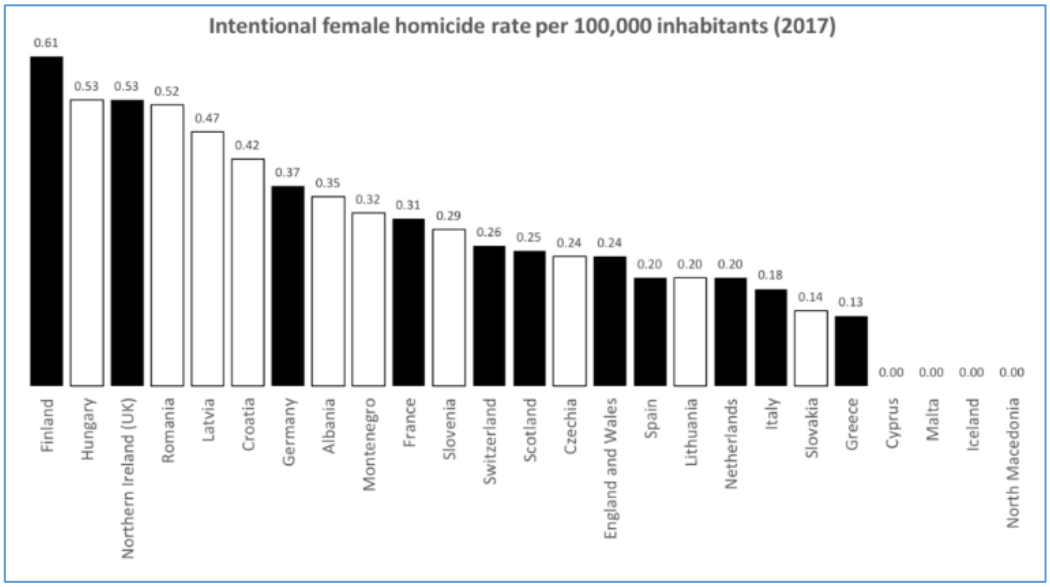
Women are more likely than men to experience sexual violence and abuse and more likely to know their perpetrator. Younger people are disproportionately at higher risk (Full Stop Australia, 2022) and there is some evidence that young people will experience more persistent symptoms, requiring the need for longer-term support and follow-up care (Oshodi et al., 2020). While over one third of victim-survivors experience some sort of physical injury, they are much more likely to experience 'mental or emotional problems' as a result of the assault, with both women and men experiencing high levels of psychological trauma (ONS, 2020). Around one in ten victim-survivors have attempted suicide (10% of women, 12% of men). Victim-survivors also report the negative impact on their relationship with others including breakdown in trust, and the detrimental effect on employment and social connections.

The CSEW statistics demonstrate that the majority of sexual assault crimes remain undetected – reasons for informal and formal non-disclosure are outlined in the international literature and include self-blame, embarrassment, fear of humiliation, reluctance to burden others or perceptions that criminal justice reporting is futile (Ullman et al., 2020). The reasons behind failure to report are equally relevant to help-seeking. Delays to seeking treatment can increase the impact and severity of the trauma experienced and may have long-term consequences for the wellbeing of victim-survivors (Dworkin & Schumacher, 2018; Oosterbaan et al., 2019).

THE NORTHERN IRELAND CONTEXT

- Since 2017, 39 women have died violently in Northern Ireland (BBC, 2023)
- Police are called to a domestic incident every 16 minutes (BBC, 2023)
- Northern Ireland's rate of female intentional homicide victims by intimate partner is one of highest in Europe and more than double the rate of Scotland, England and Wales (Fact Check NI, 2019)

Figure 1: Intentional female homicide rate in NI (Eurostat, 2017).



In recent research conducted in Northern Ireland, almost all of the women (N = 542; 98%) surveyed had experienced at least one form of violence or abuse in their lifetime (and across the life course), with around 70% of the sample experiencing some form of violence in the past 12 months (Lagdon et al., 2023). Only one third of participants felt able to speak about it or report their experience. Shame and embarrassment was the greatest barrier to reporting.

The End Violence Against Women and Girls Strategic Framework (currently out for consultation) and Action Plan has been co-designed by a range of stakeholders in Northern Ireland and focuses actions across four different domains (Figure 2).

Figure 2: End Violence Against Women and Girls Action Plan (The Executive Office, 2023)

Northern Ireland's history of conflict has led to significant population-level exposure to trauma. There is also growing recognition, and an emerging evidence base, of conflict-related sexual violence in Northern Ireland reflecting gendered violence and harm characteristic of other war and conflict settings (Swaine, 2023). Northern Ireland also has the

lowest disposable income, lowest saving levels and highest levels of debt of any region in the UK (Grant Thornton, 2022). The current cost of living crisis, exacerbated by high inflation, are placing many families under severe pressures that will have direct and indirect effects on mental health and wellbeing. In recent months there has been a marked increase in calls to the local domestic violence and sexual abuse helpline; 2022 data from Nexus reported more than 31,000 web chats or calls from people seeking help or advice, representing a 40% increase from 2021 (McCracken, 2023). This increased demand for support will still not reflect the full level of need as many people will not reach out for help.

The recently established Regional Trauma Network (RTN) is a specialist psychological trauma service representing a unique partnership between the statutory, community and voluntary sectors delivering high quality trauma-informed care to victims and survivors of the conflict. While the focus of the work is on Troubles victims and survivors for “not less than three years”, the expert knowledge and experience available in the RTN are helping to build a local evidence and skill base that will inform the treatment and support of victim-survivors of many different types of trauma.

METHODS

A rapid scoping review of relevant international and grey literature, and conversations with practitioners/service providers in other jurisdictions form the basis of this report. While this was not exhaustive, it identified some examples of good practice and builds on the experience of other settings that have developed effective approaches to supporting victim-survivors of sexual violence and abuse.

The scoping review had a number of key objectives, namely to:

- consider the psychological, social and environmental impacts of sexual violence to help inform service design that meets all the needs of survivors;
- identify appropriate assessment processes to understand need at the point of referral;
- identify recommended therapeutic treatment approaches for the different types and contexts of sexual violence and abuse;
- explore treatments and interventions that consider the profile of individual victim-survivors (taking into consideration gender identity, sexual identity, other risk factors including disability, ethnicity, age, child sexual abuse, period of time since assault);
- outline the evidence for the co-production of the design and delivery of services including peer workforce/experts by experience models;
- recommend training and skill-base of treatment providers;
- present examples of guidelines for trauma-informed services;
- recommend outcome measures used to evaluate and improve service delivery;
- explore the evidence for the cost-effectiveness of treatment options;
- consider family-focused practice; and
- provide some examples of international best practice models of care.

INCLUSION CRITERIA

This review focuses on the recommended provision for adult victim-survivors (excluding perpetrator victims) of sexual violence and abuse. The risk of suicide and substance use in victim-survivors are not specifically covered in this review. Strategic guidance and information on specialist services for reducing the risk of suicide (Protect Life 2) and substance use (Preventing Harm, Empowering Recovery – Substance Use Strategy) are also available.

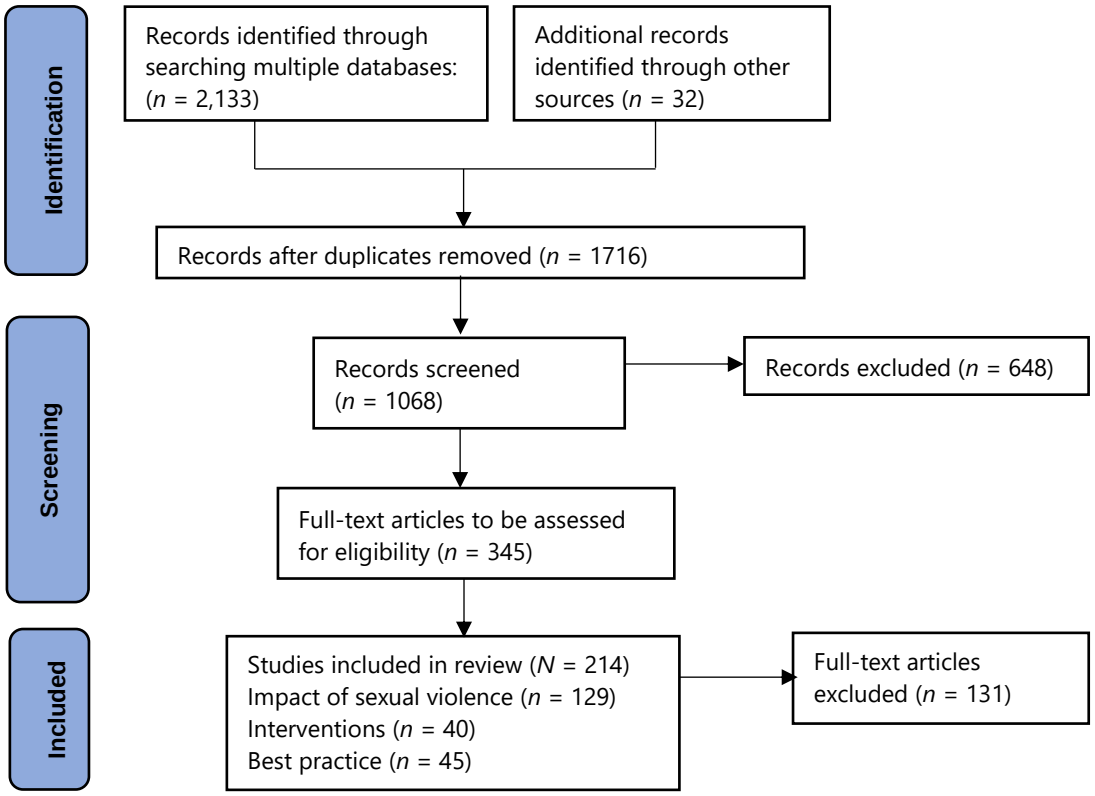
SEARCHES

Two search strategies (see Appendix 1) were devised to explore the psychological, physical, social and economic impact of sexual violence/abuse and psychosocial interventions designed to support the therapeutic treatment of sexual trauma. Four databases were identified as being most relevant (Medline, EMBASE, PsycINFO and SCCI) and were searched to May 2023. Search results were retrieved and exported to referencing software EndNote and duplicates were removed. Two review authors (AC, UC, CMcC) independently screened the titles and abstracts, we obtained full-text reports for all titles that appeared to meet the inclusion criteria or where there was any uncertainty. Review author pairs (AC, UC, CMcC) screened the full-text reports and decided whether they met the inclusion criteria.

RESULTS

A total of 2,133 records were retrieved in the searches and 214 were included in the scoping review. Given the number of intervention-focused records returned in the search, we concentrated on reporting results of systematic reviews and meta-analyses of recognised therapeutic approaches. Where systematic review evidence was not available, results from high quality randomised controlled trials are reported. Online meetings with services in New Zealand and the Republic of Ireland provided additional data.

Figure 3. PRISMA Diagram



FINDINGS

The findings have been organised into six sections:

- firstly, we explore the international evidence for the psychological impact of sexual violence and abuse;
- then we assess the literature on physical, social and economic wellbeing and functioning;
- present the systematic review evidence for psychosocial interventions;
- consider some of the barriers to help-seeking/accessing services;
- look at some of the approaches to the design and delivery of services; and
- demonstrate some international best practice models of care.

PSYCHOLOGICAL IMPACT OF SEXUAL VIOLENCE & ABUSE

Burgess and Holmstrom's (1974) research identified 'rape trauma syndrome' capturing the wide ranging and severe impact following sexual assault. Subsequent research has established the link between rape and post-traumatic stress disorder (Kessler et al., 1995), with 94% of rape victims meeting the criteria for PTSD in the two weeks following assault and 47% continuing to do so after 3 months (Rothbaum et al., 1992). Victim-survivors of sexual violence and abuse have an increased risk of multiple psychological disorders including trauma and stressor-related disorders, depression, anxiety, bipolar disorders, dissociative disorders, sexual functioning disorders, eating disorders, obsessive-compulsive disorders, sleep disorders and substance use disorders (Dworkin, 2020; Littleton et al., 2018). Epidemiological data from the World Health Organisation (Liu et al., 2017) has established that rape, compared to any other type of trauma, carries the highest conditional risk for PTSD (19%). A recent systematic review and meta-analysis of risk for mental disorders associated with sexual violence based on a sample of N = 88,539 victims (k = *39)* found that PTSD and suicidality is most strongly associated with sexual violence and abuse (Dworkin, 2020). Sexual violence and abuse is also associated with a range of physical health problems (e.g. sexually transmitted infections, reproductive health and gastrointestinal problems) and risk taking behaviours including smoking, sexual risk taking, poor diet, avoidance of preventative healthcare, and sedentary behaviour that can have a long-term negative impact on wellbeing (Littleton et al., 2018).

It is important to consider that many victim-survivors of sexual violence and abuse are also exposed to higher levels of poverty, poorer social support, and levels of community violence that can further compound the impact of the assault and limit available resources necessary to meet their needs (Serrata et al., 2020).

We also acknowledge that many empirical studies that explore the impact of sexual violence do so in particular populations e.g. veterans, college students or differentiate between child sexual abuse and adult sexual abuse. Where data are drawn from subgroup populations in this review, this is clearly stated, recognising the potential limitations of generalising results to whole population samples. Other authors have attempted to address this in their analyses (Dworkin, 2020). Dworkin tackled data comparison issues between groups and the timing of the assault by calculating effect sizes using pooled lifetime and past-year prevalence of a number of different mental health problems in sexually assaulted populations versus non-assaulted populations.

Table 1. Pooled prevalence rates for lifetime and past-year mental health problems in sexually abused populations vs. non-abused populations (Dworkin 2020).

Anxiety disorders				
	Lifetime (95% CI)	*Odds Ratio*	*Past-year (95% CI)*	*Odds Ratio*
SA	**20%** (12-28%)	2.59*	**7%** (5-10%)	2.79*
Non SA	**10%** (6-13%)		**3%** (2-4%)	
Bipolar disorder				
SA	**9%** (0-18%)	3.51*	**9%** (2-15%)	4.33*
Non SA	**10%** (0-6%)		**3%** (3-3%)	
Depressive disorders				
SA	**39%** (29-48%)	3.44*	**24%** (13-35%)	3.10*
Non SA	**17%** (23-23%)		**11%** (5-16%)	
Eating disorders				
SA	**8%** (3-13%)	1.92*	**1%** (0-4%)	1.51
Non SA	**2%** (1-3%)		**1%** (0-4%)	
Obsessive Compulsive Disorder				
SA	**6%** (3-8%)	4.54	**8%** (2-14%)	5.80*
Non SA	**2%** (1-3%)		**2%** (0-3%)	
PTSD				
SA	**36%** (31-41%)	7.57*	**26%** (20-32%)	3.01*
Non SA	**9%** (6-11%)		**18%** (11-26%)	
Substance Use Disorder				
SA	**19%** (15-24%)	2.14*	**13%** (7-19%)	1.75*
Non SA	**9%** (6-12%)		**7%** (4-11%)	

*p<.001

Nationally representative prevalence studies from the UK and the USA demonstrate the link between sexual abuse and violence and depressive symptoms. Population-level data from the Adult Psychiatric Morbidity Survey identified child sexual abuse (CSA) as one of the significant predictors of antidepressant use in adults in England (Odds Ratio (*OR)* = 1.53) (Boyle et al., 2020). Chaplin et al.'s (2021) analysis of the *N* = 151,396 UK Biobank data reported that recalled childhood sexual and physical abuse were associated with depressive

symptoms in adulthood, and particularly with suicidal behaviours, in both women and men. In the US, multivariate logistic regression of the sexual violence and depression and anxiety modules of the Behavioral Risk Factor Surveillance System (*n* = 61,187) reported that 28.3% of sexual violence victims had been diagnosed with a depression/anxiety disorder (Choudhary et al., 2012). Research from Northern Ireland has also identified high rates of childhood trauma in adult mental health outpatients with depression (Marshall et al., 2018).

Some groups may be more vulnerable to developing depressive symptoms following sexual violence and abuse. Feelings of shame and guilt following assault is associated with depression and research has identified the importance of addressing rape-related shame and experiential avoidance in targeting depression in survivors (Bhuptani et al., 2019). Drug use history has also been identified as a potential risk factor for clinically significant depressive symptoms following assault (Dir et al., 2021).

Risk of depression after sexual violence exposure spans the life course. Childhood trauma and poor parental bonding with mothers were significant predictors of higher rates of depressive mood and interpersonal difficulties in a Northern Irish sample (Marshall et al., 2018). Higher rates of depression in young women compared to young men are partly explained by their increased risk of experiencing interpersonal violence (Dunn et al., 2012). Studies exploring the long-term impact of adverse childhood experiences (ACEs) have demonstrated a significant correlation between depression in later-life in adults aged 60+ and childhood exposure to repeated physical abuse and forced sexual intercourse (Ege et al., 2015).

EATING DISORDERS

The relationship between disordered eating and sexual violence and abuse is well established (Reyes-Rodriguez et al., 2011) but complex (Dubosc et al., 2012) and variance in symptoms may present depending on whether the assault has been recently experienced or as a result of historical child sexual abuse (Fischer et al., 2010). In the UK, the Avon Longitudinal Study of Parents and Children (ALSPAC) has provided a hugely rich source of community-based data for more than two decades. Using a nested study design, eating disorders diagnoses were obtained using validated structured interviews and of the 5,658 women in the sample, enrolled 20 years earlier, 15.3% met the criteria for an eating disorder (ED) by mid-life (95% confidence intervals, 13.5-17.4%) (Micali et al., 2017). Past-year prevalence was 3.6%. CSA was prospectively associated with all binge/purge type disorders and better maternal care was protective for bulimia nervosa. While a significant proportion of women in the sample had experienced an ED by midlife, help seeking or health care access was low. Secondary analysis of the 2007 British National Psychiatric Morbidity Survey, a

nationally representative sample of a community dwelling adults aged 50 and over in the UK, reported a slightly lower 12-month prevalence of 2.61% but again the relationship between stressful life events and EDs was observed, as well as comorbidity with anxiety disorder, agoraphobia, panic disorder, obesity and cancer (Ng et al., 2013).

Multiple exposure to trauma also increases the risk of eating disorders. In a female US veterans sample (*N* = 186), Arditte Hall et al. (2018) explored the relationship between childhood, adult, and military trauma exposure, and reported that multiple traumatisation increased the likelihood of eating disorders and that adult physical assault, adult sexual assault, and military-related trauma was individually associated with more severe eating disorder symptomatology. Forman-Hoffman et al.'s (2012) telephone interviews with female veterans from two Veteran Affairs Medical Centres in the American mid-west also found strong associations between PTSD, sexual trauma and eating disorders; the authors recommend that screening for eating disorders should be conducted with female veterans with PTSD or sexual trauma histories. Senior et al.'s (2005) exploration of maternal eating disorder symptoms, during pregnancy and lifetime prevalence also raises important public health considerations of ED risks during antenatal care and the opportunity for early intervention.

A number of studies have attempted to understand how sexual trauma can predict eating disorder pathology in different populations including female veterans and undergraduate students with differences observed in types of trauma, including combat-related, multiple forms of childhood trauma that may affect emotional regulation processes and could help inform treatment of EDs (Breland et al., 2018; Gomez et al., 2021; Moulton et al., 2015).

SELF-HARM & SUICIDE

CSA and adult sexual trauma is associated with a long-term increased suicide risk in the general population (Chaplin et al., 2021; Stansfeld et al., 2017; Turgumbayev et al., 2023; Yates et al., 2022) and in specific sub populations including military personnel and veterans (Bryan et al., 2015), people with learning difficulties (Campbell et al., 2007), prescription opioid use (Gilmore et al., 2018) and substance use disorders (Ilgen et al., 2010).

Repeated deliberate self-harm was used as a coping mechanism for distressing life events in a small qualitative sample of adults presenting at hospital emergency departments in Ireland (Chakraborti et al., 2021).

OBSESSIVE COMPULSIVE DISORDER (OCD)

A growing body of evidence has established a link between sexual violence and posttraumatic stress symptoms that can lead to the development (or worsening) of obsessive compulsive symptoms relating to perceptions of contamination, with or without meeting the criteria for a clinical diagnosis of obsessive compulsive disorder (OCD) (Adams et al., 2014; Badour et al., 2012; Barzilay et al., 2019; Rachman, 2004). Sexual trauma can be associated with feelings of being unclean or dirty and compelling urges to wash. In a small scale study (*N* = 50), 70% of women reported feelings of uncleanliness following their assault which continued for many months for 25% victim-survivors (Fairbrother & Rachman, 2004). Deliberate recall of the event during therapy can also invoke an urgent need to wash/decontaminate oneself. Feelings of disgust following an assault have been associated with developing PTSD, with evidence of greater difficulty ignoring contamination cues and re-experiencing in greater detail during disclosure (Pinciotti et al., 2023). In prolonged exposure therapy, Foa et al. (2007) describe 'hot spots' in the trauma memory highlighting the need to address disgust and contamination during the therapeutic process.

POST-TRAUMATIC STRESS DISORDER (PTSD)

PTSD comprises three core symptom clusters of: re-experiencing; avoidance and emotional numbing; and hyperarousal. These can have a significant impact on day-to-day living. Sexual violence and abuse is associated with higher and more severe rates of PTSD than other types of trauma and the first three months following an assault may be critical in promoting recovery (Dworkin et al., 2023; Dworkin & Schumacher, 2018; Oosterbaan et al., 2019). Chen et al.'s (2010) comprehensive systematic review and meta-analysis of 37 longitudinal observational comparative studies including 3,162,318 participants found an association between a history of sexual abuse and a lifetime diagnosis of PTSD (and a number of other mental health problems). The association between sexual abuse and psychiatric disorders persisted regardless of the sex of the abuse survivor or age at which abuse occurred. History of rape strengthened the associations between history of abuse and depression, eating disorders, and PTSD.

Dworkin et al.'s (2023) recent meta-analysis of 22 prospective studies (*N* = 2,106) reporting PTSD in the year following sexual assault indicated that 74.58% (95% confidence interval [CI]: [67.21, 81.29]) of sexual assault survivors met diagnostic criteria for PTSD in the first month following the assault, and 41.49% (95% CI: [32.36, 50.92]) meeting criteria at the 12th month. PTSD severity at month one was 47.94% (95% CI: [41.27, 54.61]), and 29.91% (95% CI: [23.10, 36.73]) at month 12. Greatest symptom recovery happened within the first three months, after which the recovery rate slowed.

COMPLEX POST-TRAUMATIC STRESS DISORDER (CPTSD)

Complex Post-Traumatic Stress Disorder (CPTSD) was added as a diagnosis to the ICD-11 in 2018. The profile of CPTSD includes the core PTSD symptoms and emotional dysregulation, negative self-concept, and interpersonal problems. Empirical research suggests it leads to greater functional impairment than PTSD alone (Brewin et al., 2017; Cloitre et al., 2013; Karatzias et al., 2017). Exposure to abuse in early development is associated with a greater likelihood of CPTSD than PTSD (Hyland et al., 2017). Using data from a treatment-seeking sample attending the Trauma Resource Centre in Belfast, Dorahy et al. (2009) identified increased CPTSD symptom severity in individuals with comorbid childhood sexual abuse and Troubles-related trauma. Hyland et al. (2021) measured past-month prevalence of PTSD at 5.0% (95% CI 3.7%, 6.3%) and CPTSD at 7.7% (95% CI 6.1%, 9.4%) in a community sample of Irish adults (*N* = 1,020); the most common index trauma for the highest levels of PTSD (12.5%) and CPTSD (37.5%) was for 'sexual assault by a parent or guardian'.

BIPOLAR DISORDER

Many diagnosed with Bipolar Disorder (BD) will have experienced a traumatic event prior to the onset of the condition, with PTSD often comorbid in people with BD (prevalence estimates anywhere between 4-40% (Aldinger & Schulze, 2017; Cerimele et al., 2017)). Hogg et al.'s (2022) multi-centre study conducted clinical interviews with 79 adult participants with BD and psychological trauma histories reported that sexual abuse significantly predicted rapid cycling symptoms. Marshall et al.'s (2018) sample of Northern Irish mental health outpatients with BD also reported high rates of childhood trauma but did not specify sexual trauma (74%).

PERSONALITY DISORDER

de Aquino Ferreira et al. (2018) conducted a systematic review of the research on borderline personality disorder (BPD) and sexual abuse. They included forty articles and concluded "Sexual abuse plays a major role in borderline personality disorder, particularly in women. Childhood sexual abuse is an important risk factor for BPD. ASA rates are significantly higher in borderline personality disorder patients compared with other personality disorders. Sexual abuse predicts more severe clinical presentation and poorer prognosis of borderline personality disorder. Suicidality has the most consistent evidence, followed by self-mutilation, Post-Traumatic Stress Disorder, dissociation and chronicity of borderline personality disorder." (p. 75)

The developments in research and understanding of the role of trauma, especially in childhood, on a wide range of outcomes is also highly relevant to the debates about personality disorder and how services should respond. The Consensus Statement (Centre for Mental Health et al., 2020, p. 8) argues that "The critical importance of childhood and adolescence in setting the course for a healthy adult life make it essential that early signs are recognised and effectively addressed. The good news is that if we ask people routinely about adverse childhood experiences as part of an assessment or care review process, people tell us about their childhood experiences and then start to make sense of their current difficulties in the context of their childhood adversity. A history of trauma is so common that we have placed special emphasis on it, but it is important to recognise that some people may have similar difficulties without this."

PSYCHOSIS

Analysis of the 2007 Adult Psychiatric Morbidity Survey set out to test the hypothesis that childhood sexual abuse is linked to psychosis and concluded that the association was large and may be causal (Bebbington et al., 2011). The strongest associations were for non-consensual sex (OR = 10.14%, 95% CI 4.8-21.3). A number of studies have been criticised for methodological limitations such as the inability to establish the temporal ordering of events, not controlling for pre-existing psychotic symptoms in childhood or poor mental health which may place some children at higher risk for victimisation, relying on self-report or other mediators such as cannabis use (Daly, 2011; Elklit & Shevlin, 2011; Houston et al., 2011; Murphy et al., 2013). Further analysis of these data established simple associations between different psychotic symptoms (auditory hallucinations and paranoid beliefs) and sexual trauma, physical abuse, bullying, experiences of out of home care (Bentall et al., 2012). Childhood rape was associated only with hallucinations (OR 8.9, CI 5 1.86-42.44) once co-occurring paranoia was controlled for. A dose response relationship for each symptom was observed between the number of childhood traumas and the risk of the symptom. Other UK-based studies in community-based population have established similar associations (Freeman & Fowler, 2009). Nonetheless, this raises the importance of considering childhood trauma where mental health problems present and a better understanding of the underlying mechanisms that lead to psychosis including the role of dissociation and depersonalisation (Longden et al., 2016; O'Neill et al., 2021; Schafer & Fisher, 2011).

Using data from routinely collected electronic health records in Camden and Islington NHS Foundation Trust (Werbeloff et al., 2020; Werbeloff et al., 2021) identified patients with serious mental illness (SMI) and a recorded history of CSA. Of the 7,000 patients with SMI,

8.8% had CSA. Logistic regression was used to explore outcomes of inpatient admission and receipt of antipsychotic medication and those with a history of CSA were more likely to be diagnosed with major depressive disorder (13.4% vs. 7.6%), PTSD (4.7% vs. 1.4%) and personality disorder (22.0% vs. 5.8%) than those without a CSA history. The CSA group also reported higher rates of moderate-severe psychotic symptoms, depressed mood, self-harm, substance use and aggression as well as problems with relationships and accommodation. Patients with a CSA history were twice as likely to have an inpatient admission (adjusted OR=1.95, 95% CI: 1.64-2.33), spend at least 10 days a year as inpatients (adjusted OR=1.32, 95% CI: 1.07-1.62) and be prescribed antipsychotic medication (adjusted OR=2.48, 95% CI: 1.69-3.66). Those prescribed antipsychotics were more likely to be given over 75% of the maximum recommended dose (adjusted OR=1.72, 95% CI: 1.44-2.04) compared to individuals without a history of CSA. The authors highlight the need for clinicians to be trained to recognise and address childhood adversity in clinical settings.

SCHIZOPHRENIA

Matheson et al.'s (2013) systematic meta-analysis of the relationship between childhood adversity and schizophrenia included data from case-control, cohort and cross-sectional studies and identified medium to high quality evidence that increased rates of childhood adversity were observed in schizophrenia compared to controls. No differences in rates of childhood adversity were found between schizophrenia and affective psychosis, depression and personality disorders and decreased rates of childhood adversity were found in schizophrenia relative to dissociative disorders and post-traumatic stress disorder (OR 0.03, $p<0.0001$). Further research is required to explore causality and longitudinal outcomes.

Substance use was associated with an aggravated course of schizophrenia in sexual assault survivors attending Israel's largest medical centre for sexual assault care and data from the Israel National Psychiatric Case Registry on lifetime psychiatric schizophrenia hospitalisations (Rabinovitz et al., 2019). The authors suggest that substance use may be a modifiable factor for the prevention, assessment, treatment formulation for schizophrenia following sexual assault.

SLEEP DISORDERS

Women with a history of sexual violence and abuse are at increased risk of sleep difficulties (Astbury et al., 2011; Kendall-Tackett et al., 2013) including nightmares, sleep paralysis, nightly awakenings, restless sleep, and tiredness (Steine et al., 2011).

SUBSTANCE USE & ADDICTION

There is a well-established and consistent association between sexual violence and abuse and substance use problems (Campbell et al., 2009; Ullman et al., 2013). Other presenting issues may be apparent when a victim-survivor seeks treatment and it is important to consider how these may influence treatment engagement or the recommended pathway or treatment modality. For many victim-survivors of sexual violence, substance use may be used as a maladaptive coping mechanism and this will have implications for treatment options. For many existing treatment models, convention suggests that abstinence is required before embarking on treatment, however, emerging evidence would suggest that for trauma-exposed populations, integrated treatment approaches that address both the trauma and substance use can be effective. Screening for substance use problems and trauma is recommended in the assessment process but caution is required to avoid any additional stigma particularly when parents may be accessing support. Women who have experienced sexual trauma have an increased risk of alcohol and substance use problems (Husain et al., 2016; Johnson et al., 2011).

In a German study, Schafer and colleagues (2014) used a case-control design (*N* = 3531; 68.3% male) to compare opioid dependent patients with experience of sexual violence to patients without a sexual violence and abuse history across a wide range of clinical and social outcomes. Almost two thirds of female patients reported experiences of sexual violence, and just over 10% of males. Sexual violence and abuse survivors differed from non-victims across a variety of domains e.g. more psychiatric symptoms and suicide attempts, more legal problems, financial and family problems, as well as a higher use of services. No gender differences were observed. The authors conclude that experiences of sexual violence indicate more complex needs in opioid-dependent patients. In separate study, Williams et al. (2021) identified the interaction between intimate partner violence and sexual assault increased the odds of opioid use in women.

A systematic review (*k* = 107) of the identification and treatment of mental health and substance misuse problems in sexual assault services concluded that there is wide variation in provision across service models and no robust evidence about how services can promote better mental health and substance misuse outcomes for service users (Stefanidou et al., 2020). The authors call for clearer guidance for service planners and commissioners, informed by robust evidence about optimal service organisations and pathways.

Plant et al. (2005) explored the relationship between sexual abuse before, and after, the age of 16 in a general population of UK women and men. Prevalence rates for under 16s were fairly similar for boys (11.7%) and girls (12.5%), and rates remained similar for women aged 16 but the proportion of men reporting sexual assault aged 16+ dropped to 3.2%. Sexual

abuse at all ages was associated with ‘addictive’ or ‘problem’ behaviours including overeating (for women), sexual activity and internet use (for men).

DEMENTIA

A number of studies have explored the association between PTSD and increased risk of developing dementia in later life. Wang et al.’s (2016) regression analysis of the Taiwan National Health Insurance Research Database indicated a significant dose-dependent relationship between PTSD, its severity and increased risk of dementia in later life. In a systematic review and meta-analysis of 57 studies exploring the longitudinal associations between depression, anxiety, PTSD, BD, psychotic disorders and dementia, people with psychiatric disorders represent high-risk groups for dementia, highlighting the importance of ongoing symptom monitoring and further research to understand whether mental health problems are causal risk factors or are early markers for the risk of developing dementia (Stafford et al., 2022).

IMPACT ON SOCIAL, EDUCATIONAL & ECONOMIC WELLBEING

IMPACT ON RELATIONSHIPS

Sexual violence and abuse affects day-to-day living and is likely to have an impact on family members and friends, as people experience changes to their social lives, feeling uncomfortable in their home environment, or affecting their ability to work or attend to other practical daily living tasks. We know that the quality of survivors’ relationships with family can affect recovery (Woodward et al., 2015) and better understanding of how violence can impact on others may help to inform early intervention approaches to reduce the impact of the harm.

A recent narrative review of the literature of the effect of trauma and abuse on family members (Russin & Stein, 2022) identified individual-, interpersonal- and environmental-level impacts. Individual family members reported poor psychological health, carer burden, secondary traumatic stress, poorer physical health. These related to the need to adopt new roles within a relationship such as becoming a carer, taking on additional daily routines within the household, or having new financial responsibilities. The toll of monitoring and managing the emotional states of victim-survivors has been well evidenced in the literature. Some family members spoke of the loss and sadness associated with the forced changes to their lifestyle, changing expectations, personal freedom and the decline of social networks. Supporters of victim-survivors may also have their own therapeutic or psychoeducation needs that might help them address their own trauma symptoms and/or learn to effectively

support their family member who may be dealing with PTSD or suicidal ideation. Misunderstanding of the power relationships involved in sexual violence may also encourage an unhelpful narrative around blame and guilt that can impede the recovery process.

SEXUAL INTIMACY

Sexual abuse victim-survivors may experience a wide range of sexual difficulties including impaired sexual function which is associated with a co-occurring PTSD diagnosis (Hogbeck & Moller, 2021) or relating to physical harm (including sexually transmitted infections) as a result of the assault. Being intimate with partners can be extremely difficult for both partners and couples therapy is a recognised need in many relationships following assault.

PARENTING

ALSPAC data has also been interrogated to explore adulthood outcomes following child sexual abuse, Roberts et al. (2004) reported that after adjusting for other childhood adversities, prior child sexual abuse was associated with lone parent/blended families, poorer psychological well-being, teenage pregnancy, and adjustment problems in the survivors' children. Mediating factors included maternal mental health, mainly anxiety.

Perinatal care or dealing with a distressed infant can trigger a trauma response in some parents with a history of child maltreatment. Trauma can impede a normative nurturing response and potentially contribute to the cycle of intergenerational trauma (Chamberlain et al., 2019).

Lange, Condon and Gardner (2020) explored perceptions of CSA survivors on parenting and coping skills in a UK and Republic of Ireland sample using a mixed methods approach. Participants reported that CSA negatively affected a number of different aspects of their parenting and better evidence-based support was required.

Kendall-Tackett, Cong and Hale (2013) examined depression, sleep quality and maternal wellbeing in postpartum women with a history of sexual assault using data from the online Survey of Mothers' Sleep and Fatigue (N = 994). Women survivors that breastfeed their 0-12 month old infants reported lower risk on sleep and depression measures compared to those who mixed or formula fed.

RISK OF REVICTIMISATION

Victim-survivors of rape often experience feelings of guilt and shame following their assault and elevated levels of rape-related shame are associated with higher levels of PTSD and depression (Bhuptani & Messman, 2023) perhaps as a result of perceptions of 'burdensomeness and thwarted belongingness' (DeCou et al., 2019). Individuals can be at

increased risk of revictimisation from early childhood as a result of low self-esteem, depression and anxiety (Lalor & McElvaney, 2010), impaired risk detection (Chu et al., 2014), or maladaptive coping that increases risk taking (Cividanes et al., 2019). Lovell et al. (2021) describe the 'disproportionate vulnerability' of revictimised individuals using retrospective analysis of data from Saint Mary's Sexual Assault Referral Centre (SARC) in Manchester and particularly those who were repeat attenders. Significant differences were identified between new and repeat clients including higher numbers of unemployment, recent mental health problems, self-harm/suicide attempts and likelihood of a learning disability. All repeat clients had a history of alcohol abuse.

Those exposed to violence in childhood will often experience revictimisation in adult life, whether as a result of guilt or shame (Aakvaag et al., 2016) or sexual anxiety associated with higher frequency of sexual coercion experiences (Girard et al., 2020). Spohn, Wright and Peterson (2017) explored the moderating effect of 'healthy' levels of fear that may help protect female college students against revictimisation, which is in contrast to inadequate levels of fear that increases vulnerability or too much fear that may lead to social isolation and withdrawal.

EDUCATION & EMPLOYMENT

Data from the National College Health Assessment 2011-2014 sample (*N* = 84,734) in the US were used to examine the relationship between intimate partner violence (IPV) and health impediments to academic performance, reporting a significant detrimental effect across a range of outcome measures (Brewer & Thomas, 2019).

Potter et al. (2018) present rich data sourced from an online survey and telephone interviews with women who had been assaulted as American college students (N = 81) when aged between 18-24 years old. Participants ranged in age from 18 to 63 years and 67% said that the assault had had a negative impact on their academic performance (lower grades, missing classes) and 58% experienced disruption to their educational trajectory (having to take time off, drop classes or drop out). Others used their academic studies as a coping mechanism. Longer-term outcomes relating to career progress identified issues around perceived underachievement, poor self-esteem and derailed career goals,

"I don't know how I can compete in an industry like that if I can't talk to men without panicking, if I can't be alone in a room with a man without like getting thrown into this sort of dark place." Survivor, (Potter et al., 2018, p. 5).

Mental health problems relating to the assault continued to impact many women, missing work regularly or changing jobs frequently or not being able to work at all. Others were

reluctant to try new things or apply for jobs that would require interaction with strangers or lone working in public spaces. Poor physical as well as mental health could limit employment. What is most concerning is the long-term detriment the assault left on their human capital. Poor self-esteem, low confidence, lower grades/earning potential and seeking safety and security had significant negative effects on many of the women interviewed. Poor mental and physical health highlights the need for early support following an assault to try and mitigate the long-term impact on women's lives. Twinley (2017) encountered some of the same themes with victim-survivors of woman-to-woman rape, identifying work or education as risk and protective factors. Twinley's suggestion that occupational therapy could play an important role in supporting victim-survivors is a sensible one.

Loya (2015) conducted qualitative interviews with 27 adult female survivors of sexual assault examined to explore employment outcomes. Negative impacts were associated with having to take time off, diminished performance, redundancy and inability to work. The economic impact of loss of or reduced income had consequences for months and years after the assault. Female military survivors of sexual assault reported similar problems as a result of poor mental health affecting their employment (Millegan et al., 2015). This study drew on data from the Millennium Cohort Study of 13,001 US service women and highlighted concerns for women's ability for operational readiness as sexual trauma victim-survivors.

Adverse childhood experiences can have a significant and long-lasting impact on people's physical, mental and economic wellbeing. Grey et al. (2019) examined 2017 cross-sectional survey data to explore the relationship between ACEs and homelessness in a stratified random probability sample of adults aged 16-69 in Wales (N = 2,333). A dose response was observed, with the greater the number of ACEs significantly associated with later homelessness, with the strongest associations seen for physical neglect (adjusted odds ratio 8.0 [95% CI 4.98-12.87], p<0.0001), physical abuse (7.0 [5.00-9.87], p<0.0001), sexual abuse (7.1 [4.69-10.78], p<0.0001), and emotional neglect (6.9 [4.63-10.19], p<0.0001). Using a sample of adults (N = 56) using homelessness services in Ireland, McQuillan, Hyland and Vallieres (2022) measured PTSD and CPTSD, trauma exposure and the relationship between cumulative trauma and CPTSD. Prevalence of CPTSD was 33.9% compared to 3.6% for PTSD and lifetime sexual abuse was associated with a CPTSD diagnosis. In a separate, nationally representative study of Irish adults, Vallieres et al. (2022) measured the negative impact on education, employment and experiences of state care on victim-survivors of parental sexual abuse.

PHYSICAL HEALTH & WELLBEING

NEUROLOGICAL IMPACT

Different types of sexual violence have different physical health outcomes. Bichard et al. (2022) published a systematic review examining the neuropsychological outcomes of non-fatal strangulation in domestic and sexual violence reporting chilling results that would suggest a growing societal acceptance of these type of behaviours (2022). Thirty peer-reviewed studies were included in the analysis and impacts ranged from pathological changes such as arterial dissection and stroke to neurological affects including loss of consciousness, acquired brain injury, seizures, motor and speech disorders, and paralysis. Other cognitive and behavioural outcomes associated with events also reported memory loss, increased aggression, compliance and, of concern, a lack of help seeking.

Brain scans have also been able to detect smaller hippocampal volume in individuals with PTSD and sexual assault compared to healthy controls (Chalavi et al., 2015; Kim et al., 2012) and changes to the hypothalamic-pituitary-adrenal axis, DNA methylation, hormone levels, immune function, metabolic function and brain circuity (D'Elia et al., 2021, 2022; D'Elia et al., 2018; Gola et al., 2012; Kamiya et al., 2016; Nothling et al., 2021; Sinai et al., 2014). Medically unexplained neurological symptoms were also more likely in survivors of CSA in a Scottish hospital sample (Karatzias et al., 2017).

PREGNANCY & SEXUAL HEALTH

Unmet needs have been identified for rape survivors during pregnancy including physical care, pregnancy prevention, and sexually transmitted infection screening (Munro et al., 2012). Physical changes as a result of sexual trauma can be wide-ranging from severe genital trauma (McNair & Boisvert, 2021) to changes that lead to sexual dysfunction (Clephane et al., 2022). College women with a history of sexual violence and abuse were significantly more likely to experience gynaecological complaints (dysmenorrhea, dyspareunia, vaginal discharge, pain during urination and pelvic pain) in the past month than women with no sexual victimisation history. Anxiety and depression were identified as possible mechanisms of risk for gynaecological problems. The authors highlighted the need for trauma-informed approaches in gynaecological health care.

Data also suggests higher prevalence of sexually transmitted infections in sexually assaulted or exploited individuals such as victims of human trafficking (Ottisova et al., 2016).

COMORBID PHYSICAL HEALTH PROBLEMS

Other research has explored associations with clinical complexity and poor physical health outcomes including cardiovascular disease and stroke (Ho et al., 2021; Kronenberg et al., 2021; Soares et al., 2022), fibromyalgia (Gardoki-Souto et al., 2022) gastrointestinal disorders (Kamiya et al., 2016), migraine (Cripe et al., 2011), pain (Kamiya et al., 2016), frailty and functional mobility (Kamiya et al., 2016). Kamiya et al. used data from the Irish Longitudinal Study on Ageing (N = 8,178) to explore the effects of CSA on mental and physical health, and healthcare use in older age and those with a history of CSA were more likely to have depression, anxiety, worry, loneliness, and low quality of life. Poor self-reported health, lung disease, arthritis, peptic ulcer, chronic pain as well as high levels of total cholesterol and low-density lipoprotein were associated with CSA. Those who reported CSA were more likely to report doctor and hospital visits than those without a history of CSA.

Particular high risk groups such as trafficked individuals also report significant levels of physical health symptoms, including headaches, stomach pain and back pain (Ottisova et al., 2016).

PREMATURE MORTALITY

Using data from the 1958 British Birth Cohort survey, Rogers et al. (2021) examined the association between premature mortality (aged between 44-58 years old) and early life adversities (ELAs). Some ELAs were associated with increased risk of premature death; adjusted hazard ratios were 2.64 (95% CI 1.52 to 4.59) for sexual abuse, 1.93 (95% CI 1.45 to 2.58) for socioeconomic disadvantage, 1.73 (95% CI 1.11 to 2.71) for physical abuse and 1.43 (95% CI 1.03 to 1.98) for neglect.

TONIC IMMOBILITY

Peri-traumatic responses (an involuntary response to inescapable life-threatening events that can present as gross motor/vocal inhibition, analgesia, fixed/unfocused staring) known collectively as tonic immobility is more likely in sexual violence and abuse than other forms of trauma (Kalaf et al., 2017). Its association with the risk of developing PTSD following an assault has been the focus of research (Humphreys et al., 2010; TeBockhorst et al., 2015).

DISABILITY

The 2007 Adult Psychiatric Morbidity Survey provided opportunity to explore the relationship between childhood sexual and physical abuse with disability in adulthood in England (Jacob et al., 2020). Measures included experience of childhood sexual talk, sexual touching, sexual intercourse and physical abuse occurring before the age of 16 and disability in activities of daily living and instrumental activities of daily living in adulthood. Data were adjusted for age,

sex, ethnicity, and a positive association between different types of childhood abuse and adulthood disability was observed (sexual talk (OR 1.54; 95% CI 1.27-1.85); sexual touching (OR 1.82; 95% CI 1.49-2.22); sexual intercourse (OR 2.58; 95% CI 1.75-3.81); physical abuse (OR 2.84; 95% CI 2.20-3.68)). There was a dose response, with the number of types of childhood abuse increasing the odds of adulthood disability (largely anxiety disorders, chronic physical conditions, and loneliness).

INTERNATIONAL EVIDENCE FOR INTERVENTIONS

Findings from systematic reviews and meta-analyses have been selected in this review as the best representation of the body of evidence for the effectiveness of psychological interventions. While there may be promising findings from individual RCTs or other interventions that are being used in local services for treating trauma including Eco-therapy and psychotherapeutic approaches such as Gestalt Therapy, Narrative Exposure Therapy, Schema Therapy or interventions including 'Survive and Thrive' group psychotherapy, the supporting evidence is not yet well-established for sexual violence and abuse and therefore not included in this review (Jackson et al., 2023; Karatzias et al., 2016; Korkmaz & Soygut, 2023; Lely 2019).

Survivors of sexual violence and abuse are a diverse group of people, with differing needs and often complex trauma. A range of approaches and treatments are required to reflect this complexity, as a "one-size-fits-all" model is not appropriate (COSAI, 2012). How service providers respond to survivors can have a profound impact on their long-term recovery.

It is important to note the studied population involved in research when considering evidence-based interventions for sexual violence and abuse, as many studies involve largely female survivors, and may not have been trialled in male populations. Small sample sizes in qualitative research reflect the difficulties associated with 'hard to reach' populations, further limiting the overall applicability of findings (Silk, 2023).

Direct comparison of the effectiveness of treatment options in this field remains difficult, given the multiple different types of evidence available, and the lack of good quality studies such as double-blinded randomised controlled trials (RCTs), which aim to minimise potential bias and ensure that outcomes can be attributed to the intervention rather than other possible factors. However, findings from individual studies can still help develop our overall understanding of the topic.

Treatment of PTSD that often results from sexual violence and abuse is a vitally important issue given the condition's low response rate to treatment and high relapse rates (Liu et al., 2014). The larger body of research for people who have experienced any form of trauma can provide some guidance, however further research in the specific area of sexual violence and abuse trauma is urgently needed, particularly given that survivors can be at higher risk of mental health difficulties compared to other types of trauma (Parcesepe et al., 2015). Further to this, complex PTSD (CPTSD) is a recently recognised diagnosis, and the evidence base for interventions specific to it is still in the early stages (Niemeyer et al., 2022).

Creating a gold-standard framework of treatment for survivors remains a challenge due to this limited evidence base of varying quality, however there is some encouraging evidence for treatment modalities which can provide some guidance. In the absence of systematic evaluation of therapies, service providers should be encouraged to regularly evaluate the effectiveness of the interventions they offer to ensure they are having a beneficial effect (Parcesepe et al., 2015). It is also important to note that survivors' support needs are multiple and varied over time and it is not expected that a single type of intervention will meet all their needs (Silk, 2023).

SUPPORTIVE COUNSELLING

Counselling, generally referred to as therapy, provides a confidential and safe space to discuss issues and concerns with a trained professional (British Association for Counselling & Psychotherapy (BACP), 2021). It is a talking therapy that comes in many different forms and is often adapted to the problem at hand. Counselling involves exploration of an individual's thoughts, feelings and behaviours to try and help them improve their understanding and develop their own solutions – counsellors do not normally give formal advice or prescribe medication (BACP, 2021). Counselling typically involves regular sessions lasting 50-60 minutes at a time, with the number of sessions involved/provided being dependent on individual circumstances (BACP, 2021).

Much productive and useful counselling work currently takes place across the community and voluntary sector, and while the published evidence base requires improvement, anecdotal evidence suggests supportive counselling provides benefits for many different people.

A 2023 literature review conducted by the UK Ministry for Justice explored the evidence base for various forms of support offered to adult victim-survivors of sexual violence and reviewed 54 high-quality articles (Silk, 2023). It concluded that counselling is generally considered effective in England and Wales (Silk, 2023).

Research in Britain in 2013 was conducted to develop and pilot the 'Taking Back Control' tool to attempt to measure what impact rape-crisis counselling may have for victim-survivors of sexual violence (Silk, 2023; Westmarland & Alderson, 2013). The 15-item instrument was based on existing mental wellbeing measures and was developed in consultation with rape crisis centre staff (Westmarland & Alderson, 2013). It measured various factors including (but not limited to) the extent to which victim-survivors felt empowered, experienced panic attacks, and had feelings of depression. The tool was used in weeks 1 and 2 of counselling, then repeated every 6 weeks, indicating that counselling improved the extent to which victim-

survivors felt empowered and in control of their lives (61% of participants strongly disagreed at the start, compared to 31% at the last data point).

Research in 2019 from South Africa involving semi-structured interviews with 15 female rape victim-survivors aimed to understand their experiences of counselling and highlighted the need for counselling to be collaborative and led by the survivor, in a safe and professional environment (Vieweger, 2019).

A 2022 online survey was conducted by the UK Ministry for Justice to explore the formal support needs of adult victim-survivors of sexual violence in England and Wales (Silk et al., 2023). It aimed to gather both quantitative and qualitative data and collected responses from 1,110 survivors who self-selected to participate in the survey involving 57 closed and nine open-ended questions. It is important to note that this non-random sample (of mostly white, heterosexual women) may not reflect the views of all individuals who have experienced sexual violence, however bisexual and disabled survivors were also noted to be well-represented within the survey (Silk et al., 2023).

The findings noted that counselling, advocacy, and group work were rated as the three most important types of formal support offered to survivors (Silk et al., 2023). Despite recording an overall low level of satisfaction with services, the survey showed counselling was rated the highest form of support, with 63% of 404 respondents saying it ‘fully’ or ‘mostly’ met their needs (Silk et al., 2023). However, given the multiple models of counselling, more research is necessary to evaluate the specific effectiveness of each model for victim-survivors across different demographics and characteristics. The 2023 literature review suggested minority ethnic groups may not benefit as much from Western models of counselling used at some sexual violence support centres (Silk, 2023).

COGNITIVE BEHAVIOURAL THERAPY (CBT)

CBT refers to a group of talking therapies (often referred to as psychotherapies) developed by Dr Aaron Beck in the 1960s (Beck & Fleming, 2021). It comes in various forms and can:

- Help stop unhelpful behaviours
- Teach new ways of reacting to unhelpful thoughts
- Develop new ways of thinking
- Improve state of mind through recognising the links between thoughts, feelings and actions

Typically, individuals set goals with their CBT therapist for what they want to change, and work to find new ways of dealing with their problems, which often leads to an improved sense of control over one's life (Beck & Fleming, 2021). It can be delivered as a group or individual therapy.

A course of CBT usually lasts between 6 weeks and 6 months depending on the problem being addressed, with between 6-20 sessions lasting 30-60 minutes on a weekly or fortnightly basis. CBT comes in many forms and is often adapted for the issue at hand.

Trauma-focused CBT (TF-CBT) is a form of CBT specifically designed to target PTSD. It can include:

- Prolonged Exposure Therapy (PE)
- Cognitive Processing Therapy (CPT)
- Dialectical Behavioural Therapy (DBT)

CBT has a considerable evidence base for its effectiveness generally and is one of the more thoroughly studied psychological interventions available, but research on its benefits for survivors of sexual trauma specifically is difficult to isolate (Gorman, 2013). Its effectiveness in treating PTSD can help guide recommendations for survivors of sexual violence and abuse but further research is urgently needed.

CBT can be effective in reducing PTSD and other symptoms (e.g. depression, guilt, anxiety and dissociation) in adult survivors of sexual violence and abuse but the quality of evidence is reasonably sparse (Lomax & Meyrick, 2022).

Research has suggested CBT is comparable to medication for targeting PTSD, and is more effective than supportive counselling alone (Rauch et al., 2019; Short et al., 2020; Vickerman & Margolin, 2009). There is some evidence that benefits can be maintained up to 5-10 years post-treatment (Foa et al., 1991; Resick & Schnicke, 1992; Resick et al., 2012).

The most convincing support for CBT treatments involves those with exposure and processing of the trauma, such as in Prolonged Exposure therapy (Lomax & Meyrick, 2022). Most of the current available evidence for treating PTSD favours trauma-focused CBT over any other form of CBT (Melton et al., 2020).

A number of meta-analyses have highlighted TF-CBT as an effective treatment option for groups who are at risk of complex traumatization such as in sexual violence and abuse, which is in keeping with guidelines for treatment of PTSD in general (Niemeyer et al., 2022). Specifically, studies have suggested individual trauma-focused CBT is one of the most

effective interventions for PTSD in people exposed to childhood sexual abuse (Melton et al., 2020).

A review in 2019 suggested group TF-CBT is less effective than individual CBT for improving PTSD after a rape experience but other studies assert that group TF-CBT is still beneficial for people with post-rape PTSD (Sepeng & Makhado, 2019).

Research has suggested unlike some other psychological therapies, CBT promotes collaboration of participants and provides empathy and emotional support, which may decrease risk of treatment abandonment (Sarasua et al., 2013).

In terms of delivery of therapy for survivors of sexual violence and abuse, there is tentative evidence that CBT delivered by community-based master's level clinicians with minimal experience in CBT is as effective as CBT delivered by experts in the therapy (Foa et al., 2005; Taylor & Harvey, 2009). A meta-analysis on the effects of psychotherapy in survivors of sexual violence and abuse suggested that more favourable outcomes resulted from more intensive CBT sessions over a shorter period of time - specifically, twice a week for 10-16 sessions (Taylor & Harvey, 2009).

COGNITIVE PROCESSING THERAPY (CPT)

CPT is a form of CBT developed in the early 1990s, specifically aimed at reducing the burden of PTSD symptoms. It is a manualised form of therapy normally consisting of 12 sessions, each lasting 90 minutes, with the overall aim of providing an individual with the skills to handle distressing thoughts related to their trauma (Tran et al., 2016). It can be delivered in an individual or group setting, or in a combination of the two.

It is considered a form of "exposure therapy" – in which the exposure involves re-visiting the trauma and its associated emotional responses. In the case of rape, CPT can help to identify "stuck points" in the person's processing of the trauma, which are previous unsuccessful attempts to make sense of and process the events in their mind, and helps the person address these in the hopes it will decrease avoidance and distress (Vickerman & Margolin, 2009).

Studies examining psychological therapies for sexual violence and abuse victim-survivors have shown both individual and group CPT improved PTSD and depression for adult female survivors, with a large difference seen compared to a comparison group of women on a wait list (Resick et al., 2012; Vickerman & Margolin, 2009). Improvements were also noted in other symptoms such as self-blame, guilt and hopelessness and these improvements were sustained for several months following treatment (Vickerman & Margolin, 2009).

As previously mentioned, while it is difficult to reliably compare the effectiveness of interventions in this field, it remains notable that CPT was associated with long term improvements in psychological wellbeing, with one study noting benefits up to 6 years after treatment (Parcesepe et al., 2015).

DIALECTICAL BEHAVIOURAL THERAPY (DBT)

DBT is another form of talking therapy based on CBT and was first developed in the late 1970s (Chapman 2006). It arose as a form of CBT specially adapted for individuals with borderline personality disorder, though it can also help people with other conditions including PTSD, or those who feel emotions very intensely and may have difficulty regulating them.

The term “dialectical” means combining opposing ideas, and in this context DBT aims to help people change unhelpful behaviours in their lives whilst also helping them learn to accept the reality of their lives and current behaviours (Chapman, 2006).

DBT involves working through 4 stages, which begins with addressing the most serious or self-destructive behaviours first then leads on to target emotional regulation skills, interpersonal skills and ability to tolerate distress. The third stage involves improving self-esteem and the final goal is to try to help individuals get the most out of their lives and experience greater happiness (Chapman 2006).

DBT is normally delivered as weekly individual therapy sessions approximately one hour long, and a weekly group skills training meeting.

Some current evidence suggests DBT provides statistically significant improvement in PTSD symptoms both during and after treatment, and a systematic review of psychological therapies has demonstrated consistent results across three studies examining DBT (Sousa-Gomes et al., 2022).

A pilot study examining the use of DBT in adult survivors of CSA showed promise for reduction in distressing symptoms of severe and chronic PTSD related to the sexual trauma (Gorman, 2013; Steil et al., 2011). Whilst the number of people involved in the study was small (n = 29), it is interesting to note that the DBT programme involved in the study showed excellent acceptance rates, with no participants dropping out during therapy, suggesting there is likely a low risk of exacerbating PTSD or re-traumatising individuals through DBT in this case (Gorman, 2013; Steil et al., 2011).

PROLONGED EXPOSURE (PE)

Prolonged Exposure is a therapy specifically designed for the treatment of PTSD, based on cognitive behavioural therapy principles (Hembree et al., 2003).

“Exposure” is a technique often used in CBT to help people confront their fears – in PE individuals are taught to gradually re-approach their trauma-related feelings and memories (together with the therapist, from a place of safety) with the goal of reducing the power that these traumatic memories and triggers hold. It ultimately aims to reduce avoidance and teach individuals to better manage their behaviours and emotional responses associated with their trauma to lead them to a state of acceptance (Foa, 2011; Hembree et al., 2003). It is delivered as an individual therapy.

Before commencing PE, therapists often teach breathing techniques to promote a feeling of safety, and to aim to reduce the levels of heightened anxiety associated with re-visiting the trauma in detail. The primary focus is on in-session, imagined re-exposure to the traumatic event – often involving the individual describing it out loud as they relive it. PE can involve audio-recording this narration and having the individual listen to it on a regular basis to allow further exposure (Vickerman & Margolin, 2009).

It is important PE is carried out with the support of a trained professional to ensure the therapy does not become overwhelming or harmful. PE is strongly recommended for treatment of PTSD generally. It is normally delivered over a period of 3 months, with weekly sessions ranging from 60-120 minutes each (Foa, 2011).

Current research on PE and its variants indicates strong therapeutic benefits for victim-survivors of rape suffering from PTSD (Gorman, 2013). A 2022 meta-analysis of psychological therapies for victim-survivors of sexual violence and abuse noted that exposure-based approaches such as PE and CPT have the greatest efficacy in improving PTSD symptoms, and as with CPT it has been suggested that the benefits of PE may be observed as long as 6 years after treatment (Lomax & Meyrick, 2022; Parcesepe et al., 2015). Previously concerns have been highlighted that the level of distress that prolonged exposure may provoke in some individuals could worsen existing PTSD symptoms or contribute to increased abandonment of treatment - however research has suggested there is no evidence that this is true (Hembree, 2008; Parcesepe et al., 2015).

IMAGERY REHEARSAL THERAPY (IRT)

Imagery rehearsal therapy is a type of cognitive behavioural therapy with elements of exposure – it’s most commonly used for the treatment of chronic nightmares as a symptom of PTSD but is used to target nightmares in other conditions also (Krakow & Zadra, 2010).

Nightmares in PTSD are often very intense and distressing and can make it harder to move past the events as well as having a significant impact on sleep quality.

IRT involves documenting the nightmare in detail before re-writing it to be less threatening and create a more positive and less upsetting ending. The individual then attempts to vividly imagine this more positive ending before falling asleep to attempt to induce it rather than the original nightmare (Krakow & Zadra, 2010). Interestingly, the effectiveness of IRT was first demonstrated in a randomized controlled trial involving survivors of sexual assault (Krakow et al., 2000). It is suggested improvements were seen not only in nightmare frequency (and therefore sleep quality) but also in general PTSD symptomatology compared to controls (Gorman, 2013).

STRESS INOCULATION THERAPY (SIT)

Stress Inoculation Therapy is another form of CBT aimed at treating PTSD. It was developed in the late 1970s originally as a training program for reducing stress and anxiety (Meichenbaum & Deffenbacher, 1988). The theory is that people can be taught to recognise situations that trigger their stress and develop coping skills to help them better manage these situations in the future. This “inoculation” via exposure to milder forms of stress can help people cope when confronted with reminders of their trauma (Meichenbaum & Deffenbacher, 1988).

The coping skills involved can include deep breathing techniques, improving self-talk and muscle relaxation training (Meichenbaum & Deffenbacher, 1988). It’s normally delivered as an individual therapy involving 90 minute sessions over several weeks, but it can also be delivered in a group setting.

Research suggests SIT is associated with reduction in PTSD symptoms, with no difference in drop-out rates between SIT and exposure therapy or EMDR (Hembree, 2008; Parcesepe et al., 2015). However, SIT may be less effective in the treatment of rape survivors than other psychological treatment methods (Gorman, 2013).

EYE MOVEMENT DESENSITISATION & REPROCESSING (EMDR)

EMDR is a relatively new form of psychotherapy that was developed in the late 1980s by Francine Shapiro. It involves combining talking therapy with a bilateral stimulation of the brain (often side-to-side eye movements by following the therapist’s finger) in a structured format referred to as dual attention (Shapiro, 2014; Vickerman & Margolin, 2009). The eye movements are hypothesized to allow processing of traumatic or emotionally laden memories, the details of which are recalled by the client while the movements take place, and this task of

following the external stimulus at the same time reduces the emotional burden of the memory (Byrne, 2022; Shapiro, 2014).

Aspects of EMDR have attracted controversy since its conception, with some arguing that it borrows basic aspects from Prolonged Exposure therapy and that the dual attention eye movements involved are an unnecessary feature (Russell & Davis, 2007; Vickerman & Margolin, 2009). The available evidence on the importance of eye movements in the effectiveness of the therapy is conflicting (Parcesepe et al., 2015). Currently, only theories exist for how exactly EMDR works, and evidence for the exact mechanisms of its effectiveness remains lacking in comparison to other exposure-based therapies and CBT (Byrne, 2022).

A recent meta-analysis involving a sample of N=1543 (*k*=10) aimed to compare the effectiveness of psychosocial interventions for well-being outcomes specifically for adolescent/adult survivors of recent sexual violence and abuse or rape (Lomax & Meyrick, 2022). They found that interventions that had an exposure-based approach, which includes EMDR, have the strongest evidence base for treating these victims, however due to the methodological inconsistences and high risk of bias in the included studies, it is difficult to directly compare the effectiveness of each therapy (Lomax & Meyrick, 2022).

A 2006 meta-analysis comparing the efficacy of EMDR with trauma-focused CBT in the treatment of PTSD involved a sample of 209 individuals (*k*=7) and concluded that while both treatments showed efficacy for the general-trauma population, there is insufficient evidence to suggest one is superior to the other (Seidler & Wagner, 2006).

A small RCT in 2007 that involved N=88 participants with PTSD aimed to compare EMDR, fluoxetine, and a pill placebo by administering these therapies over an 8-week period with follow-up at 6 months (Van der Kolk et al., 2007). They found EMDR to be more successful than fluoxetine in targeting PTSD and depression symptoms, but that this benefit was seen in the participants who had experienced adult-onset trauma rather than childhood-onset trauma victim-survivors (75% of adult-onset victim-survivors achieving asymptomatic end-state functioning compared to 33% of childhood-onset).

A 2020 systematic review of meta-analyses for interventions for victim-survivors of complex trauma examined a sample of N=244 individuals across 7 trials (*k*=7) found some evidence of EMDR's effectiveness as reducing PTSD symptoms post-treatment, and suggested it may be more effective than mindfulness practices at addressing complex trauma symptoms (Melton et al., 2020). However, two trials (N=71) comparing EMDR directly with an active control did not find a significant difference in post treatment effects (Melton et al., 2020). Similarly, other reviews of meta-analyses have suggested EMDR (and other exposure-based interventions)

show efficacy for PTSD in complex trauma, but the accurate comparability of study results is not currently possible (Niemeyer et al., 2022).

In terms of the acceptability of EMDR as a therapy for victim-survivors, a 2003 study suggested that there was no difference in drop-out rates between EMDR, exposure therapy, cognitive therapy and SIT (Hembree et al., 2003).

GROUP THERAPY

Group therapy involves the treatment of multiple individuals simultaneously by one or more professionals. It can be used for a wide variety of conditions, including to address PTSD and emotional trauma. Given the increase in demand for mental health support generally, group therapy can provide a cost-effective, flexible option to offer support to multiple survivors at once, and as such can reduce waiting-list times and improve accessibility (Malhotra & Baker, 2019). Sessions tend range in duration and would normally involve a circle or horseshoe shaped seating arrangement to facilitate engagement (Malhotra & Baker, 2019).

Professionals should be mindful of which individuals are best suited to group therapy – research suggests people who score highly for extraversion and conscientiousness traits may be more suited to group therapy, whereas those who exhibit high levels of emotional reactivity may not (Lahey, 2009). In addition, survivors who are actively suicidal or in acute distress would be more appropriately managed individually (Malhotra & Baker, 2019). It is important not to adopt a set-in-stone exclusionary policy with group therapy, but to also bear in mind that inappropriate use could have negative effects not only on the individual but on the group as a whole (Malhotra & Baker, 2019).

There have been several suggested general benefits of group therapy for an individual, including comfort taken in a sense of community and universality of their symptoms that can facilitate acceptance (Brown et al., 2022). Interpersonal learning may also occur within the group, and individuals suffering from social fear may experience some improvement as a result of the therapy (Wolgensinger, 2022). The structure of group therapy also allows potential training of less experienced professionals, who can participate as co-facilitators under the supervision of a trained group leader (Deblinger et al., 2016).

A 2022 online survey was conducted by the UK Ministry for Justice to explore the formal support needs of adult survivors of sexual violence in England and Wales, and 1,110 survivors self-selected to participate (Silk et al., 2023)). Respondents (48%, N=88) rated group work as the 3rd highest form of formal support to meet their needs post-sexual violence (Silk et al., 2023).

However, group therapy also has areas of concern, including that only the therapy provider is bound to any legal confidentiality. The possibility of other group members repeating personal information may create a sense of unease amongst others, and providers are encouraged to develop guidelines for the group surrounding this (Lasky & Riva, 2006; Malhotra & Baker, 2019). Other issues that can arise include conflict between group members, lack of engagement, some individuals dominating the sessions to the detriment of others, and participants feeling their limits have been pushed to a psychologically unsafe level (Brown et al., 2022; Malhotra & Baker, 2019).

When assessing the evidence of group therapy for survivors of SA specifically, it was highlighted that facilitating a sense of safety within a group therapy session was critically important (Brown et al., 2022). A 2022 synthesis of qualitative evidence examining interventions for survivors of sexual violence and assault reported that they felt their communication skills and quality of personal relationships had improved as a direct result of participation in group therapy (Brown et al., 2022).

A small 2007 study involving 41 female survivors of sexual abuse, compared with 11 women in a wait-list control group found that not only did group intervention reduce psychological distress related to the abuse in survivors, but that these effects were maintained at a 3-month follow-up (Gorman, 2013; Hébert & Bergeron, 2007). Analysis of the findings suggested that concurrent individual therapies and variation in the elements of abuse between survivors were not linked to the positive outcomes (Gorman, 2013).

Group therapy is often offered to survivors of SA, and as such it is important to note that more research is needed to determine if the benefits provided are distinct to those found in individual counselling – however, it remains a valuable intervention particularly in the context of limited resources (Gorman, 2013; Russell & Davis, 2007; Sepeng & Makhado, 2019).

PSYCHOEDUCATION

Psychoeducation in the context of trauma following sexual violence and abuse is defined as the delivery of information or knowledge on the nature and course of post-SA psychological symptoms and how to adaptively respond to these – with the aim being increasing knowledge and reducing overall distress in the short or long term (Vechiu & Zimmermann, 2019). It is considered a “low-intensity” intervention in the sense that it requires less input from a professional than other treatments typically would.

In the context of SA, psychoeducation may involve providing information on expected psychological reactions and how best to manage them, normalising responses and

experiences, dispelling rape myths, coping with reactions of other people and detailing how to access support (Lomax & Meyrick, 2022; Wessely et al., 2008).

Psychoeducation has several advantages, including the potential to help an individual engage more effectively in psychotherapy, correcting misinformation, empowering survivors to seek self-help and in its inexpensive, easily accessible nature (Wessely et al., 2008).

Evidence for the effectiveness of psychoeducation as a stand-alone intervention is currently very limited despite its ubiquity – some researchers have suggested this may be because it is already presumed to be so clearly a positive thing, much like education is generally (Wessely et al., 2008). The lack of specific evidence may also be because psychoeducation is a built-in feature of many psychotherapies including trauma-focused CBT, CPT and Prolonged Exposure (Vechiu & Zimmermann, 2019; Vickerman & Margolin, 2009).

Some research does indicate psychoeducation may not be appropriate as a first-line treatment for individuals experiencing higher levels of distress, who should be referred to higher intensity interventions (Vechiu & Zimmermann, 2019).

Like previously mentioned inventions, more robust research is needed to accurately determine the efficacy of psychoeducation as a stand-alone intervention for this population, and to establish for whom it is most appropriate (Vechiu & Zimmermann, 2019). However, its ability to be easily disseminated at a low cost is a unique advantage.

TECHNOLOGY-BASED & DIGITAL INTERVENTIONS

Technology-based and digital interventions are increasing in use globally and across many aspects of healthcare. These therapies come in many forms and include telehealth services (including distance-counselling), phone and internet-based aids, eHealth interventions, online support groups, and text message interventions (Emezue et al., 2022).

Given how recent its use, the research and evidence on the specific benefits and long-term effectiveness of technology-based interventions (or in the case of technology being used for the delivery of evidence-based therapies, “technology-enhanced interventions”) particularly in comparison to traditional therapies, is still emerging. It is theorized to provide a level of social and emotional support, could facilitate psychoeducation, allow triage of survivors to other services and potentially improve psychological health outcomes (Emezue et al., 2022).

A 2022 systematic review and meta-analysis of 17 RCTs examining the short and long-term effectiveness of technology-based interventions in 4590 female survivors of intimate partner violence (IPV) has suggested these therapies do provide some initial benefit to survivors of IPV as an add-on rather than replacement therapy (Emezue et al., 2022). However, it is

important to note that this review found that these initial effects faded over time, and that digital interventions were not found to have any significant beneficial outcomes for the survivors of sexual violence specifically, or those suffering from PTSD related to IPV (Emezue et al., 2022). Another systematic review and meta-analysis in 2020 had similar findings – when examining two trials (N = 1029) reporting data on survivors of sexual violence, they found no significant effect of eHealth interventions compared to no intervention (Linde et al., 2020).

Distance counselling is a form of telehealth application where any type of psychotherapy is delivered remotely via phone or video conference, as the provider and client are in separate locations. It is a promising mode of delivery of therapy for survivors of SA and for underserved groups who may struggle to access face-to-face supports (Leroux et al., 2022). It allows access to support without the potentially limiting factors of transportation availability and costs, childcare needs, scheduling conflicts or any concerns of stigma or fears of safety that can arise from accessing in-person services (Leroux et al., 2022). When examining the comparative effectiveness of distance vs in-person counselling, studies indicated distance therapy was not inferior in terms of therapeutic outcomes or in the case of client satisfaction (Gray et al., 2015; Leroux et al., 2022). However, it is important that providers place the same emphasis on security, client experience and safety in a digital setting as they would in-person (Leroux et al., 2022).

Prior to the COVID-19 pandemic, there was little research on the use of distance counselling, but the nature of the pandemic resulted in a rapid uptake in distance care to provide therapy for survivors of sexual violence and abuse. Leroux et al. (2022) published a scoping review in 2022 examining the benefits and best practices in the use of distance counselling specifically for the survivors of sexual violence population and included 20 studies in this review. They found that several studies noted unexpected therapeutic benefits of distance care, including improved comfort and feelings of control due to being at home for clients, as well as feelings of privacy and improved flexibility.

PHYSICAL ACTIVITY

Exercise generally remains a low-cost intervention for targeting trauma symptoms in survivors of sexual violence. While the evidence remains sparse, a 2018 qualitative study highlighted some survivors' mixed feelings about the heightened bodily awareness that accompanied exercise (Smith-Marek et al., 2018). It is also notable that most female survivors expressed a preference for exercising individually and without the presence of men.

THERAPEUTIC DANCE

Therapeutic dance is an intervention inspired by the theory of Dance Movement Therapy (DMT) – a therapy that developed in the 1940s, defined as "the psychotherapeutic use of movement to promote emotional, social, cognitive, and physical integration of the individual, for the purpose of improving health and well-being" (Koch et al., 2019). Therapeutic dance involves connecting psychological significance to movement, and helping individuals express and process emotion via dance (Lee et al., 2022). For the purposes of this report, it refers to any type of creative movement or dance that is used to try to achieve therapeutic outcomes. It is a potentially promising type of therapy for survivors of sexual violence and abuse, given that it combines aspects of both physical activity with arts-based therapies, and can be delivered individually or as a group (Lee et al., 2022; Streater, 2022). Many non-profit organisations already offer dance therapy to individuals who are survivors of sexual violence (Lee et al., 2022).

The conceptual frameworks for the efficacy of dance therapy are still exploratory but growing. There is evidence supporting a link between the mind and the body, which directly relates to the idea of dance therapy specifically for sexual trauma – where there has been a striking violation of both the body and the mind (Lee et al., 2022; Muehsam et al., 2017). Studies have shown that these types of mind-body therapies can result in neuro-modulatory and immunomodulatory effects that lead to both improved mental functioning and physical health (Muehsam et al., 2017).

A 2022 systematic review (k=11, N= at least 233) on the evidence for dance therapy in sexual trauma noted the proposed psychological theory of a dissociation between mind and body as a result of trauma, in which interventions such as dance therapy may be of particular benefit (Lee et al., 2022). However, they noted that the empirical evidence for this sense of dissociation is currently lacking (Lee at al., 2022).

Dance therapy may be a good option when survivors come from a cultural background where survivors of sexual violence and abuse are more likely to experience stigma and shame as a result of sexual violence (Benuto et al., 2019). Current research suggests dance therapy may allow survivors to practice emotional regulation and can provide a sense of enhanced social connection when delivered as a group therapy (Lee et al., 2022). It is also well-suited for individuals who may struggle verbalising their trauma via talking therapy, or when language barriers may be an issue (Lee et al., 2022). A recent meta-analysis of the psychological outcomes of DMT and dance therapy involving 41 studies (N = 2,374) noted risks associated with the interventions, including retriggering of the trauma (particularly given the body-focused nature of dance), embarrassment and increased anxiety (Koch et al., 2019). The 2022 systematic review noted however that other studies have suggested dance

therapy itself could act as a grounding technique in the moment, in the event of re-triggering trauma (Lee et al., 2022).

Overall, the current lack of research – which is mostly exploratory, involves small sample sizes and is lacking in longitudinal follow-up – indicates that further research (including randomised controlled trials) is necessary to evaluate the effective and ineffective components of the intervention and attempt comparison to other available therapies (Koch et al., 2019). It is also important to note that dance therapy could be inaccessible to survivors with physical limitations due to disability, injury or age. While the research on dance therapy is currently suboptimal, it is notable that the 2022 systematic review on its effects for sexual trauma did not report any severe mental health outcomes for participants, and it remains a promising intervention in need of further exploration (Lee et al., 2022).

ARTS-BASED INTERVENTIONS

Only one trial with sexually abused population was included in a systematic review of arts-based interventions for traumatised adults (Schouten et al., 2015). Volker (1997)(1999) evaluated combined CBT and art therapy in the intervention all female group (N = 8) compared to a waitlist control (N = 9). A significant decrease in depression was observed.

Rouse, Jenkinson and Warner's (Rouse et al., 2023) qualitative systematic review reported findings from 16 included studies and concluded that arts-based activities can offer a safe space for people with a CSA history to help articulate their experience, and connect with others which could in turn be empowering and aid recovery. However the methodological quality was poor.

PHARMACOLOGY

Use of medication for the treatment of mental health conditions (depression, anxiety, PTSD) that have occurred as a result of sexual violence and abuse is dependent on many factors including the symptoms involved, the individual being treated, and the current evidence-based guidelines available for the location in question (NICE, 2018).

Current NICE guidance on drug treatments for PTSD in adults advises:

- "Do not offer drug treatments, including benzodiazepines, to prevent PTSD in adults.
- Consider venlafaxine or a selective serotonin reuptake inhibitor (SSRI), such as sertraline, for adults with a diagnosis of PTSD if the person has a preference for drug treatment. Review this treatment regularly.
- Consider antipsychotics such as risperidone in addition to psychological therapies to manage symptoms for adults with a diagnosis of PTSD if: they have disabling

symptoms and behaviours, for example severe hyperarousal or psychotic symptoms and their symptoms have not responded to other drug or psychological treatments.

- Antipsychotic treatment should be started and reviewed regularly by a specialist" (NICE, 2018)

It is important to note that when considering PTSD as an outcome of SA, most pharmacotherapies have been evaluated in a mixed-trauma or combat trauma study population, rather than a sexually assaulted one (Vickerman & Margolin, 2009).

When considering combining drug treatment with talking therapies for the treatment of PTSD generally, a Cochrane review was carried out to assess the evidence for this in 2010 involving 4 trials (N=124) – though it should be noted one of these trials (N=24) involved only children and adolescents (Hetrick et al., 2010). The overall findings suggested the evidence for comparing a combination of pharmacological measures and psychological therapies with either treatment alone, is currently insufficient to be able to draw reliable conclusions from (Hetrick et al., 2010). It is particularly important to note that this review considered PTSD generally and could not consider the multiple differing presentations of PTSD in clinical practice and was not specific for trauma as a result of sexual violence.

PEER SUPPORT

One of the limitations identified in this review is that many interventions have been designed to address the trauma presentation rather than the sexual nature of the traumatic experience which can have a multi-layered impact on victim-survivors. Acknowledging the range and depth of victim-survivors' needs has led to the development of a number of different approaches that offer peer support but the evidence base is varied (Gregory et al., 2022). The 2018 NICE guideline for PTSD identified two peer support interventions however their data were not included as deemed unusable. Guidance tends to offer advice for healthcare settings but many victim-survivor services are delivered within community and voluntary sector organisations, and in increasingly precarious funding environments.

Peer support models that focus on the importance of social relationships can offer benefits to victim-survivors with some evidence that there is a preference to access support from peers with similar experiences, and greater confidence that they will be believed, respected and understood (Gregory et al., 2022). A 2020 systematic review of peer group support for victim-survivors of sexual violence reported empathic witnessing, increased social connectedness, greater capacity for healing and opportunities to access resources and coping strategies (Konya et al., 2020) but the evidence base is dated and sparse. Gregory et al. interviewed a purposive sample of stakeholders exploring the range of approaches,

models and structures of peer support. The general view was that peer support is not for everyone, but could have potential for some individuals and has to only one element of a range of provision and services. Some considerations identified in their research included:

- Cultural appropriateness and sensitivity
- Readiness to engage with peer support services
- Concern that peer supporters are trained and skilled to provide support
- Peer support services should deliver evidence-based practice
- Professional oversight still required
- The power of sharing a space with others who have had similar experiences without the need to talk about the details of the abuse
- Reducing isolation
- Positive role modelling – important in the recovery approach
- Negative aspects of building relationships with peers – potential to trigger others

A number of good practice and safety considerations are recommended:

- Facilitators must have suitable qualifications (including trauma support) and be sufficiently supported to undertake the role
- Lived experience of trauma requires lesser emphasis than training and qualifications
- Close supervision and monitoring is required
- Group participants should be screened and assessed for suitability
- Regular monitoring, assessment and evaluation at organisational level
- Greater evidence base is required to establish its potential

CLINICAL GUIDELINES FOR TRAUMA CARE

Many victim-survivors of sexual violence and abuse will experience PTSD or CPTSD symptoms and the clinical guidance reflects the need to respond appropriately using evidence based approaches. Evidence-based international guidance is provided by the International Society for Traumatic Stress Studies (ISTSS), NICE and the UK Psychological Trauma Society and recommends the following therapeutic approaches:

- high intensity TF-CBT;
- Prolonged Exposure Therapy (PE);
- Family/Couples Therapy;
- EMDR; and
- Dialectical Behaviour Therapy

NICE GUIDELINE FOR PTSD

NICE clinical guidelines are developed by a guideline development group using a set method and are based on the best available evidence. Group membership is drawn from healthcare professionals (and occasionally from social care or education), researchers (with specialist skills in searching, systematic review, critical appraisal and health economics), patients and carers. The initial steps include a review of the clinical evidence, including clinical and economic effectiveness. If there is not enough clinical research evidence, the guideline development group will gather additional information to inform their recommendations. The NICE Guideline for PTSD (NG116) makes a number of different recommendations for assessment and treatment that are relevant in the context of sexual violence and abuse:

- Assessment and co-ordination of care
    - A comprehensive assessment including physical, psychological, social needs and a risk assessment.
    - Where management of care is shared between primary and secondary services, the healthcare professionals should agree who is responsible for monitoring people with PTSD, in writing, and involve the person and, if appropriate, their family or carers.
- Supporting transition between services
    - Give people information about the service they are moving to, including who will provide their care
    - Ensure there is effective information sharing between services
- Access to care
    - Reassure people that PTSD is treatable

    - Ensure that services take into account the needs of specific populations of people
    - Minimise the need to move between different services and providers
    - Provide multiple points of access to services
    - Offer flexible modes of delivery
    - Offer a choice of therapist that considers the person's trauma experience
    - Use proactive person-centred strategies to promote uptake and engagement
    - Assess the need for further treatment and support for those who haven't benefitted fully or have relapsed
- Principles of care
    - Give information and support people (and their family members or carers)
    - Offer access to peer support groups that are facilitated by suitably trained and qualified individuals
    - Maintain safe environments to reduce exposure and triggers
    - Involve and support families and carers
- Language and culture
    - Ensure screening and assessment and interventions and culturally and linguistically appropriate
    - Think about using interpreters or a choice of therapists
- Psychological interventions for adults
    - Offer individual TF-CBT to adults with acute stress disorder or clinically important symptoms of PTSD
    - Interventions include: cognitive processing therapy, cognitive therapy for PTSD, narrative exposure therapy, prolonged exposure therapy
    - Should be based on a validated manual and typically provided over 8-12 sessions, but more if clinically indicated (e.g. for multiple traumas)
    - Delivered by trained practitioners with ongoing supervision
    - Include psychoeducation
    - Involve elaboration and processing of the trauma memories
    - Involve restructuring trauma-related meanings for the individual
    - Provide help to overcome avoidance
    - Focus on re-establishing functioning
    - Prepare for the end of treatment
    - Include planning booster sessions if needed, especially in relation to significant dates (e.g. anniversaries of the trauma)
    - EMDR – 8-12 sessions

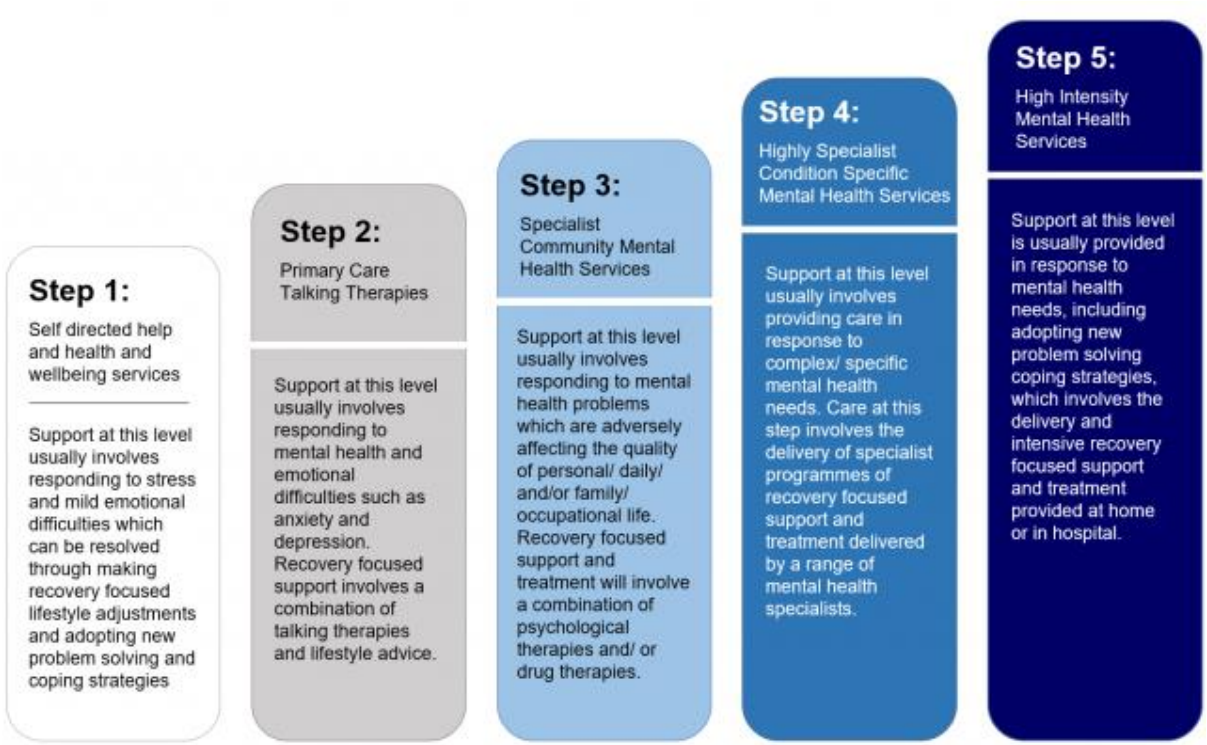
- TF-computerised CBT for clinically important symptoms more than 3 months after the traumatic event over 8-10 session

- Care for people with PTSD and complex needs
  - Comorbid depression and PTSD, usually treat the PTSD first unless the depression is severe
  - Do not exclude people from treatment based on comorbid drug/alcohol misuse
  - CPTSD will require extra time to build trust – either increasing the duration or number of therapy sessions based on need
  - Consider the safety and stability of the person's personal circumstances e.g. housing

THE STEPPED CARE MODEL

The Stepped Care Model is advocated by NICE and was first proposed for NI by the Bamford Review. It provides guidance on the steps of care that individuals can move up or down depending on individual need and seen as a mechanism to guarantee quality of service and consistency of care on a regional basis. The Stepped Care Model is appropriate for treatment of sexual trauma reflecting service delivery that can provided by the community and voluntary sector (Steps 1-3) and statutory services (Steps 3-5).

Figure 3. The Stepped Care Model



UK PSYCHOLOGICAL TRAUMA SOCIETY – COMPLEX PTSD GUIDELINE

Research suggests that a phased approach is beneficial for treating individuals with CPTSD (UKPTS, 2020). Phases will overlap and can be cyclical, requiring a return to earlier phases as therapy progresses:

- Phase 1: Stabilisation – symptom management, increasing emotion regulation skills and addressing current stressors);
- Phase 2: Trauma processing (focused processing of traumatic memories); and
- Phase 3: Reintegration (re-establishing social and cultural connections and addressing personal quality of life).

Although the research suggests that psychological therapies can be effective, the evidence base is insufficient to recommend any single intervention but it is generally agreed that treatment should address three domains: cognitive; affective; and sensorimotor.

INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES – NEW GUIDELINES FOR THE PREVENTION AND TREATMENT OF PTSD

The ISTSS based their latest guidance on 208 meta-analyses and generated 125 recommendations for the treatment of PTSD in adults and children and adolescents using an agreed definition of clinical importance and recommendation setting algorithm. These are recommended under four different categories: strong; standard; emerging evidence; and insufficient evidence (see Table 2).

Table 2. Recommendations for Psychological Treatment of PTSD in Adults (Bisson et al., 2019)

Recommendation Level	Recommendations
Strong recommendation	Cognitive processing therapy, cognitive therapy, EMDR, individual CBT with a trauma focus (undifferentiated), and prolonged exposure are recommended for the treatment of adults with PTSD.
Standard recommendation	CBT without a trauma focus, group CBT with a trauma focus, guided Internet-based CBT with a trauma focus, narrative exposure therapy, and present-centered therapy are recommended for the treatment of adults with PTSD.
Emerging evidence	Couples CBT with a trauma focus, group and individual CBT with a trauma focus, reconsolidation of traumatic memories, single-

	session CBT, written exposure therapy, and virtual reality therapy have emerging evidence of efficacy for the treatment of adults with PTSD.
Insufficient evidence to recommend	There is insufficient evidence to recommend brief eclectic psychotherapy for PTSD, dialogical exposure therapy, emotional freedom techniques, group interpersonal therapy, group stabilizing treatment, group supportive counseling, interpersonal psychotherapy, observed and experimental integration, psychodynamic psychotherapy, psychoeducation, relaxation training, REM desensitization, or supportive counseling for the treatment of adults with PTSD.

SUMMARY OF EVIDENCE-BASED INTERVENTIONS

Further and higher-quality research is required on interventions for this specific population. Interventions are generally developed to address the presentation (e.g. depression, psychosis etc.) and not necessarily the experience (i.e. sexual violence). The current methodological limitations of studies - including small sample sizes, risk of bias and lack of follow-up – creates difficulty in recommending therapies and interventions unreservedly, and in creating a gold-standard hierarchy of treatments. Further complexity arises when the diversity of background and experiences within this population is considered. Many victim-survivors will present with complex trauma and whatever approach is adopted needs to recognise and consider the developmental and individual needs of service users. However, there remains a pressing need to deliver effective, brief evidence-based and feasible interventions for this group (Vechiu & Zimmermann, 2019).

Based on the findings of a recent systematic review involving 10 studies with 1543 (overwhelmingly female) participants, it is reasonable to suggest that trauma-focused CBT should be used as a starting point for future research which should aim to be of higher scientific quality (Lomax & Meyrick, 2022; Niemeyer et al., 2022).

CBT, and therapies related to CBT, are currently the most empirically researched interventions and have the most support for their efficacy with benefits being maintained for 5-10 years after treatment in some cases (Gorman, 2013; Littleton et al., 2018; Lomax & Meyrick, 2022). The strongest evidence base is currently in support of exposure-based approaches (e.g., CPT, PE, EMDR) for targeting PTSD and depression, with some improvements also seen in anxiety and guilt depending on the intervention – findings in keeping with previous research on PTSD for general/mixed trauma (Littleton et al., 2018;

Lomax & Meyrick, 2022; Vickerman & Margolin, 2009). There is consistent suggestion in the existing literature that counselling may provide psychological benefits to victim-survivors however it is difficult to draw firm conclusions from the current published evidence (Silk, 2023).

Group therapy shows many benefits including the potential to facilitate acceptance in survivors, reduce social anxieties and allow training of other professionals in-session (Brown et al., 2022; Deblinger et al., 2016). It remains a valuable intervention particularly in the context of limited resources (Gorman, 2013; Russell & Davis, 2007; Sepeng & Makhado, 2019).

Given the different methodological approaches used in the current research, which are often lacking control groups, making comparisons between treatments is particularly difficult. However, it is notable that CBT-based interventions consistently lead to better outcomes in PTSD (and more quickly) than supportive counselling alone, with CPT and PE receiving the most support in the research (Littleton et al., 2018; Short et al., 2020; Vickerman & Margolin, 2009).

There is some evidence for the effectiveness of pharmacological treatment of PTSD in survivors of SA (Littleton et al., 2018). Evidence suggests nightmares (a common symptom in survivors of SA) may be effectively targeted with Imagery Rehearsal Therapy (Krakow et al., 2000).

Between 20-50% of survivors of SA may still meet the diagnostic criteria for PTSD even after receiving the most well-supported interventions, highlighting the urgent need for further research (Vickerman & Margolin, 2009). Many studies use treatment of PTSD symptoms as an outcome measure, prompting questions about what is best to provide for survivors who do not meet this diagnosis, given some researchers believe the PTSD diagnostic framework may be inherently limiting (Gorman, 2013; Vickerman & Margolin, 2009). It is also suggested that adult survivors of childhood SA may require longer periods of treatment and multiple modes of therapy for adequate symptom relief (Gorman, 2013).

Despite therapies that involve exposure being currently considered the most efficacious, treatment providers do not frequently offer them, citing concerns about “forcing” the survivor to relive the events and risks of re-traumatization (Cook et al., 2004; Vickerman & Margolin, 2009). The current literature does not suggest these risks are specific to exposure-based therapies, suggesting further knowledge and awareness of these therapies amongst treatment-providers could also be beneficial (Vickerman & Margolin, 2009).

Factors such as existing psychiatric conditions and individual background will likely also influence which interventions are most appropriate for an individual - current evidence is lacking in data for male survivors and gender/sexual minorities (Lomax & Meyrick, 2022).

Overall, this review has highlighted the urgent need for further, higher-quality research in this area to allow more generalisability of findings, and to better target the symptoms survivors experience.

HIGH RISK GROUPS

An important consideration for the planning and delivery of services will involve addressing the needs of high risk groups. The research evidence clearly identifies vulnerable populations, who not only may be more likely to experience sexual violence and abuse, but will have higher rates of compulsory psychiatric admissions, longer periods of care and also face increased odds of becoming revictimised. This will likely include victims of human trafficking (Oram et al., 2015), people experiencing homelessness (Grey et al., 2019; McQuillan et al., 2022), LGBTQ+ (ANROWS, 2020b), trans women (ANROWS, 2020a), and people with disabilities (Dowse et al., 2016; Plummer & Findley, 2012) and people with severe and enduring mental illness.

HELP & SUPPORT

The damage and long-lasting impact of sexual violence and abuse has been well documented however the availability and level of post-assault support is a crucial factor in the recovery and long-term wellbeing of survivors. Services that offer fragmented support and unclear referral pathways can risk re-traumatising victim-survivors (Dworkin & Schumacher, 2018; Quadara, 2015). Recognising that trauma-exposed victim-survivors will likely need to access to multiple services (e.g. health, criminal justice, substance use) only highlights the need for trauma-informed approaches (QCDFVR, 2022).

BARRIERS TO HELP-SEEKING

As already outlined, the research literature highlights some of the considerable barriers to help-seeking which include problems self-identifying as an assault victim, concerns about not being believed or taken seriously and the shame and guilt many victim-survivors experience.

Some individuals are at particular risk and may be even more reluctant to seek help and support. LGBTQ+ people remain under-represented in referral figures despite similar rates of

abuse to heterosexuals and research commissioned by the Welsh Government (Harvey et al., 2014) has highlighted some of the individual and structural barriers to help-seeking in this population including shame/guilt associated with their sexual identity, misconceptions about sexual violence and abuse in same-sex relationships, negative stereotyping and services that have been designed for heterosexuals (Miles-Johnson, 2013). Male victim-survivors of sexual violence are often more reluctant to report crime or seek help than women and the legacy of child sexual abuse often leaves many victim-survivors shamed and silenced for many decades after their assault. The intersectionality with other vulnerable groups have also been highlighted in the literature including race, disability, human trafficking and age (Littleton et al., 2018).

In Nguyen et al.'s (2017) study of Australian women with serious mental health problems accessing community mental health care, engagement with their GP was associated with sexual health help seeking.

Where there may comorbid alcohol or drug use, understanding the relationship between sexual violence and abuse and substance use is key and by building a safe, trusting and non-judgemental environment may create the opportunity for individuals to disclose their problems.

The Ministry of Justice commissioned a survey of adult victim-survivors about formal support needs in England and Wales (Silk et al., 2023) and highlighted a number of key recommendations:

1. Improve referral pathways – formal support services should be mapped and made available to victim-survivors and front-line workers. People should be reassured that they will be believed and not judged and that police will respond sensitively and empathetically to avoid re-traumatisation. This theme was also identified in recent research in NI (Lagdon et al., 2023).
2. Improve the inclusiveness of support services
3. Commission a range of support services across multiple landscapes to offer victim-survivors choice
4. Give reassurance about confidentiality and anonymity of services and independence from police processes
5. Offer access to group and peer support
6. Improve monitoring and evaluation
7. Ensure people are aware of their rights around legal support

Areas for future research included:

- Which types of counselling are effective, why and for whom?
- Understand why helplines are less effective in meeting needs, how can they be improved?
- How GPs can better meet needs of service users.

APPROACHES TO THE DESIGN AND DELIVERY OF SERVICES

RECOVERY-ORIENTED SYSTEMS

THE RECOVERY APPROACH

Personal recovery has been defined as 'a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness' (Anthony, 1993, p. 15). Whitley and Drake (2010) proposed a broader concept of mental health recovery incorporating five core domains:

- clinical (e.g. symptoms);
- physical (e.g. exercise);
- functional (e.g. employment);
- existential (e.g. self-determination); and
- social (e.g. social support)

Central to understanding the approach is the idea that people should not be defined or unnecessarily restricted by their mental health problems, recognising that many have experienced negative interactions with people and services and may need help to rebuild their self-esteem and restore hope and meaning. Fox et al. (2015) concluded that 'recovery-aware' carers feel more optimistic and hopeful about the future, feel more confident in the care they provide and therefore contribute better in promoting recovery in their relative. The Mental Health Strategy is centred on a recovery-oriented systems approach that should also underpin sexual violence and abuse service development. An important aspect of the recovery approach is being trauma-informed.

GUIDELINES FOR TRAUMA-INFORMED SYSTEMS

Becoming trauma-informed has been described as a stepped process (Mieseler & Myers, 2013):

1. Trauma-aware – raising awareness with staff about the effects and individual adaptations of trauma
2. Trauma-sensitive – operationalising the concept of trauma-informed practice and care within services
3. Trauma-responsive – both the service and staff understand and respond to trauma in an encouraging and supportive way to promote behaviour change, build resilience and strengthen protective factors
4. Trauma-informed – where the entire organisational culture, all work practices and settings are trauma-informed

The nine core principles of trauma-informed care are well established in the literature.

Figure 4. Core principles of TCIP (QCDFVR, 2022, p. 4)

System policies and procedures should be regularly reviewed and updated (Full Stop Australia, 2022).

INTERSECTIONAL DISCRIMINATION

The review of the literature has highlighted a number of groups that may be particularly at risk, not only to the risk of becoming a victim of sexual violence and abuse, but also how they might be treated when seeking help and justice (Maher et al., 2018). Awareness and addressing 'intersectional discrimination' may help better prepare services and treatment providers to respond in the most appropriate way. It will likely include disability, LGBTQ+, ethnicity and socioeconomic status.

Although data on the prevalence and incidence of violence and abuse against women with disabilities is limited, it does consistently indicate that they are more vulnerable to both physical and sexual abuse compared to other women (Dowse et al., 2016; Plummer & Findley, 2012). Research has also identified that they may experience problems being believed when reporting sexual violence, and typically will have greater difficulty achieving everyday economic and housing security increasing their vulnerability. Pathways to justice can be more complex too (Maher et al., 2018). Service challenges across specialist support services have also been highlighted including common misconceptions about disability and sexual violence

and siloed working that does not adequately meet the needs of individuals (Dyson et al., 2017; Maher et al., 2018).

Sexual violence in LGBTQ relationships can be more difficult to identify because of the often heterosexual face of domestic violence and can involve unique tactics of abuse, including identity-based abuse (ANROWS, 2020b). Greater recognition and understanding of sexual violence of both LGBTQ domestic/intimate partner violence is needed and tailored interventions may need to be developed in order to meet the needs of this population.

CO-PRODUCTION & THE DESIGN AND DELIVERY OF SERVICES

Sexual assault workers in Australia have co-produced a resource to help adult female sexual assault survivors 'navigate the journey' to recovery. It tracks the important processes in the immediate aftermath of an assault, contact with the police and court service but also carefully considers the recovery journey in the weeks, months and years following the attack. It discusses how to recognise and understand typical stress reactions following trauma, shares personal stories and experiences, including Meg's story,

> *I was raped by a guy I had been friends with. He was part of our group. I was in shock for days afterwards, telling myself I'd wake up and find it was just a nightmare, so I could pretend it didn't happen. I just shut down. I stayed away from people, made excuses I had to work. I felt numb inside…and like the part of me that was fun loving and enjoyed life had died. But I couldn't sleep. I kept dreaming what happened over and over and I was screaming, but no words would come out. I was a zombie in the day…didn't return friend's calls just wanted to be curled up in a ball and sleep. I drank to get it out of my mind. Finally, after about six weeks I told a friend. That was the beginning of breaking the cycle and getting my life back on track."*
>
> Meg's story (NSW Health Education Centre Against Violence, 2013a, p. 29)

The resource sets out a stepped process that may help contribute to recovery, beginning with paying attention to feeling safe again, physically, emotionally and learning how to manage fear, anxiety and panic. An example of a safety plan that can be developed and shared with other family members or friends is shared. Some of the practical challenges following assault, such as dealing with nightmares and sleep disturbance, expressing strong emotions and articulating the experience are explained. In addition, it provides advice and guidance to family members and friends supporting someone who has been assaulted, who can often be the most difficult people to confide in when there has been sexual violence,

'Survivors take a journey and navigate a path to recovery. They need to re-establish safety, to rebuild a positive view of themselves, to grieve for what is lost, and find hope and courage to move forward. You can help them with their journey. In a follow-up study of sexual assault survivors, it was found that the quality of their close relationships had the most influence on their recovery and the time it took to heal.' (NSW Health Education Centre Against Violence, 2013a, p. 46).

SURVIVORS OF CHILD SEXUAL ABUSE

Similar to the resource described above, the NSW Health Education Centre Against Violence has produced a booklet *Sharing the Un-shareable: A Resource for Women on Recovering from Child Sexual Abuse* (NSW Health Education Centre Against Violence, 2013b). Also co-produced with survivor of child sexual abuse (CSA), counsellors and research, it details the psychological and physical impacts of CSA and offers 'stories of strength and resilience' with practical advice for family and friends. A companion resource for men who have experienced sexual assault as children has also been co-produced with one of the aims to increase general community and professional awareness of male CSA (NSW Health Education Centre Against Violence, 2013d).

MALE SURVIVORS OF SEXUAL VIOLENCE AND ABUSE

Men constitute 10-15% of all reported adult sexual violence and abuse victims, this, however, is likely to underestimate prevalence as male-on-male sexual violence and abuse is more likely to go unreported (Scarce, 2008). Feeling 'feminised' following assault can create barriers to help seeking (NSW Health Education Centre Against Violence, 2013c). Male victim-survivors remain a hidden population and another co-produced resource, the NSW Health Education Centre Against Violence emphasises how crucial friends and family responses are if a disclosure is made by a male friend/relative. Most of the knowledge and understanding of sexual violence and abuse is based on studies of female victim-survivors with less known about the needs of male victim-survivors. There is however shared recognition that "the experience is traumatic and recovery from assault is significantly affected by the quality of the support, or the lack of support, received from family and friends..." (NSW Health Education Centre Against Violence, 2013c, p. 43).

RECOMMENDED TRAINING AND SKILL-BASE OF TREATMENT PROVIDERS

CULTURAL AND LINGUISTIC DIVERSITY

Maher and colleagues (2018) identified service challenges for women with disabilities, recommending that cross-sectoral knowledge is shared and developed to ensure best practice for women with additional vulnerabilities. Tackling misconceptions around disability and providing informed cross-sectoral support would also enable access to justice for women with disability.

The Full Stop Australia recommendations for criminal justice reform priorities recommend not only trauma-informed training but consultation with people with lived experience with culturally and linguistically diverse backgrounds, LGBTQ+ groups and people with disability.

Trans women experience some of the highest rates of sexual violence and lack of cultural competence supporting victim-survivors can increase stigma and discrimination and lead to unmet need (ANROWS, 2020a). Awareness and education about the experience of being transgender and gender transitioning is important.

In response to the growing number of asylum seekers requiring support, services in the Republic of Ireland are recruiting people with appropriate language skills.

UNDERSTANDING COMORBIDITIES

Trauma as a result of sexual violence and abuse may present in a number of different ways and having staff trained and sensitive to the ranges of needs of service users will be important. Substance use typically co-occurs with sexual violence and abuse and training staff to recognise and establish trust and respond in a non-judgemental way to disclosures of substance use problems is crucial, particularly when there may be children in the family.

PROFESSIONAL DEVELOPMENT

This can be challenging but rewarding work, and the importance of supporting staff and mitigating risks of vicarious trauma is essential. This should include the opportunity for professionals to create a supportive community of practice, vicarious trauma training and management (Full Stop Australia, 2022). The Australian National Standards of Practice Manual for Services Against Sexual Violence has recommended the training and development of a trauma-specialist sexual violence counselling workforce.

THE JUSTICE SYSTEM

The interface between victims-survivors and the criminal justice system has been heavily criticised, accused of systematic failure, with few people having confidence or positive experiences during the justice journey, not least because so few cases end in a criminal conviction.

Survivor advocates involved in Full Stop Australia's campaign to reform justice for victim-survivors of sexual violence and abuse and domestic violence have spoken extensively about the impact of the lack of trauma-informed practice across the justice system with one survivor concluding that, "for me the 'justice' process was worse than the experience itself" (Full Stop Australia, 2022, p. 6). In the UK, a recent report from the Criminal Justice Joint Inspectorate (2022) concluded that the criminal justice system "is failing victims of rape, and widespread reform is needed to build trust and secure justice" identifying a lack of collaboration between the police and prosecutors and raised significant concerns about poor communication with victim-survivors at every stage of the justice process. The report concluded that:

- Survivors put a lot at stake when reporting and testifying, yet most do not get the justice they deserve
- Police response and support is inconsistent

- A lack of safeguarding puts survivors and their families at risk
- Delays in reporting, investigation, arrests, and court hearings weaken cases and cause survivors to suffer
- Suspects are perceived to be treated more favourably than survivors
- The court process is traumatic for survivors
- The criminal justice system needs to be completely overhauled to put survivors first

There are a number of good models that provide volunteer helpers that offer support and advice to individuals during the justice process. Many rape crisis centres have specialist staff called advocacy workers or independent sexual violence advocates (ISVAs) that provide practical and emotional support if individuals are thinking about or want to report a crime to police. They will talk through the options and what might happen if an assault is reported, keep them informed and provide support.

Rape Crisis's 2023 *Breaking Point: the retraumatisation of rape and sexual abuse survivors in the Crown Court backlog* report highlighted the record number of cases awaiting trial (more than 7,800 sexual offence cases and 1,851 adult rape cases) and the impact this delay has on victims-survivors. The report calls for:

- The establishment of specialist sexual violence and abuse courts, where court staff and judiciary are trauma-trained and informed.
- Rape and sexual abuse cases should be given priority listings and progressed quickly through the system and given a guaranteed court date.
- A clear and formalised communication agreement between all criminal justice agencies so that survivors are told about any changes to the trial.

Systems should provide confidence that victim-survivors can report sexual violence and abuse without fear and supported by the provision of wrap around services or case management. Training across the judicial system to identify and respond appropriately and consistently to sexual violence is necessary, extending not only from specialist police officers, to lawyers, prosecutors, and court staff.

Following the high profile and controversial 'Rugby Rape Trial' in Northern Ireland, the Gillen Review (2019) made over 200 recommendations to the law and procedures in serious sexual offences. One of the recommendations has led to the implementation of a two-year pilot scheme for Sexual Offences Legal Advisers (SOLAs) providing free independent support for adult victims of sexual crime. Based in Victim Support NI, they are independent from police and prosecution services, and means that Northern Ireland is the first region in the UK to offer complainants legal advice in relation to the disclosure of evidence including medical records,

counselling records and personal digital information. They also provide specific legal advice in relation to the disclosure of previous sexual history and ensure that their clients' interests and wishes are communicated.

PHYSICAL ENVIRONMENT OF TREATMENT SETTINGS

A number of studies have explored the physical design of therapeutic spaces particularly for the treatment of PTSD, primarily in veteran populations. PTSD hyperarousal events are commonly triggered by environmental, social or urban elements and giving consideration to these can help create physical solutions to reduce stress. The design of indoor spaces can improve therapy response, taking into consideration reduced crowding, communal areas with movable seating, noise reduction design and creating spaces that create access to green spaces, higher daylight exposure and windows with views (Ulrich, 1991; Ulrich et al., 2018; Ventimiglia & Seedat, 2019). The use of colour can also be important (Connellan et al., 2013). Equally, outdoor spaces can promote wellbeing and recovery with evidence that access to green spaces can promote social interactions, improve focus, encourage physical activity and convey benefits via connecting with nature (McCartan et al., 2023; Ventimiglia & Seedat, 2019).

In New Zealand, the START service setting is located in a suburban neighbourhood, in an ordinary house with a garden and play area for children. All therapy rooms open out into the garden and clients are encouraged to use the recreational facilities, bring along their children or family members if appropriate and can use the kitchen area to make tea/coffee and toast. This is a deliberate approach to normalise the treatment setting and help reduce stress related to clinical environments.

Guidance produced by Australia's National Research Organisation for Women's Safety (ANROWS) for evaluating programmes involving people who have experienced domestic violence or sexual assault, highlighting some of the challenges and risks associated with consulting and engaging with participants with sexual trauma histories (McEwen, 2018). Evaluation processes can be intrusive and can risk retriggering traumatic experiences of not handled appropriately and it is also important that ethical, culturally sensitive and trauma-informed approaches are used. This will include establishing a clear and strong rationale for any questions included in the evaluation process and protocols for dealing with disclosure, violent behaviour and emotional distress. Anonymising data collection will be required in most cases and guidance has been established to help protect consent, confidentiality and participant identity. Acknowledging different minority groups within the evaluation will also require careful consideration to ensure that evaluation materials respect cultural experiences whether these relate to race, sexuality, disability etc. This includes using appropriate language and methods to collect data by a team with the relevant skills and experience. Recommended data collection methods include narrative/story telling approaches, visual/symbolic representation and non-direct questions. Having access to an interpreter may also be required. Women experiencing homelessness and those with a disability may have additional vulnerabilities and special approaches to recruit and maintain their engagement. The usual protocols to store data safely and securely should always be observed. Lastly, consideration is given to how to incorporate findings and recommendations, including when there may be negative results to report. It is important to encourage all outputs to be recorded and reported with the aim of improving services and organisational culture. Effective dissemination strategies needs to consider "the needs and habits of the intended audience" this might include journal articles, newsletters, social media/online forums and workshops. Feeding findings back into practice can be neglected due to time and resource constraints however ensuring the knowledge loop is closed will help to strengthen the impact and sustain the legacy of change.

A meta-evaluation of interagency relationships, integrated interventions and service responses to violence against women was conducted by ANROWS in 2016 (Breckenridge et al., 2016) and highlights a lack of empirical evidence on effective and efficient integrated models and the need for greater investment in evaluation. Supporting practitioners with appropriate training to develop the skills required to implement evaluation models was recommended including specialist training to support marginalised communities. To improve evaluation research, recommended use of a wide range of methodologies, mixed-methods

could help measure change over time and use the opportunity to exploit data sources to enhance understanding.

COST-EFFECTIVENESS

We have already discussed the educational and economic impact on some survivors of sexual violence and abuse, with evidence demonstrating significant lifelong outcomes for many women. There is little available data on the cost effectiveness of interventions.

EXAMPLES OF INTERNATIONAL MODELS OF CARE

AUSTRALIA

One of the over-reaching principles for victims and survivors of sexual violence and abuse in Australia is the need for a 'one-stop shop' approach that offers a streamlined, integrated trauma-informed service model that responds to disclosures quickly with wraparound services provided at a local level. The Standards of Practice Manual for Services Against Sexual Violence produced by the National Association of Services Against Sexual Violence (NASAV) in collaboration with the Gendered Violence Research Network at the University of New South Wales. An extensive literature review informed this work and the development of the standards has involved wide consultation with people with lived experience, practitioners and experts. The NASAV is an association of specialist sexual violence services across all states in Australia and as an organisation have a range of objectives, including:

- The co-ordinate the sharing of information, skills and resources between services and state networks on all aspects of service provision and co-ordination and assist governments with policy development, and lobby government.
- Promote an understanding of sexual violence in the context of gender/power relations
- Promote equality of access and community awareness of sexual violence and the wide ranging impact, personally and socially, at an individual, national and international level
- Research, training
- Monitor service models and promote best practice

In New South Wales, policy has been driven to deliver an integrated prevention and service response to violence, abuse and neglect across all health services, with a framework that offers a multi-sectoral response "that is mobilised at system, service and practice levels as part of a public health approach" (NSW Ministry of Health, 2019, p. 1). The framework has seven design principles that underpin implementation which incorporate the recommended response to those affected by sexual assault and violence:

“1. Prevention and response to violence, abuse and neglect is a central role of NSW Health.

2. Person and family-centred, holistic and seamless care is provided by NSW Health that prioritises the safety, well-being and unique needs and preferences of the person and their family.

3. Minimising the impact of trauma and supporting recovery from trauma are recognised and valued as primary outcomes of responses.

4. Early intervention is prioritised by NSW Health, because it can change the long-term trajectory of chronic disease and adverse health outcomes for people who have experienced violence, abuse or neglect.

5. Equitable, accessible and consistent service responses are provided.

6. ‘No wrong door’ — NSW Health workers will collaborate to support people and their families to access the most appropriate service response.

7. The best available evidence is used to guide NSW Health’s prevention of and response to violence, abuse and neglect.” (NSW Ministry of Health, 2019, p. 44).

This work recognises the importance of cross-sectoral collaboration and that no single service will be able to meet the needs of every client (Figure 1). The framework recommends that prevention and response services are integrated across a continuum which at the level of full integration offers integrated staffing, funding, technology applications, service delivery tools and case management that can provide simultaneous and coordinated provision of multidisciplinary care. In this model, health is described as a multidisciplinary response reflecting the wide range of services individuals/families will need

Figure 5. Key concepts and levels for effective integrated practice

In NSW, the Sexual Assault Service offer a continuum of support from offering information, crisis services, counselling, medical and forensic services, and court support for adults, young people and children who have experienced sexual violence and abuse and their families. This also includes therapeutic services for children under ten displaying problematic or engaging in harmful sexual behaviour. The Service also provides professionals the opportunity to consult and seek support, and a wider public health approach that addresses systems advocacy, and community engagement, development and prevention.

Recommendations for Sexual Violence Crisis Support Services have obvious read across for non-crisis services. These include:

- Provide accessible support – services which are both physically accessible and provide communication for hearing impaired and cognitive impairment. Services need to be flexible to meet disabled people's needs and not organised "based on the views and experiences of the non-disabled counsellors or professionals"

ANROWS, Australia's National Research Organisation for Women's Safety, have undertaken a wide programme of research associated with sexual violence including recommendations about the needs of vulnerable subpopulations among women such as those with disability and specific cultural and identity needs that can often be subjected to additional discrimination and prejudice. Their suite of research policy to practice publications provides straightforward and accessible recommendations to improve service response and delivery, including advice on the importance of evaluation and ongoing improvement.

USA

Boston City Hospital's Victim Counseling Program implemented in 1972 has inspired a number of initiatives globally (Bramsen et al., 2009). Provision of services in the United States in the early 1970s recognised the need for a centralised 'gate management model' that diverted victims from seeking help from multiple different agencies and instead were able to source collaborative treatment at a central location. The Sexual Assault Response Team (SART) model developed in the 1990s in San Diego, operates a multi-disciplinary/multi-jurisdictional team to provide the right kind of support to victim-survivors but also to gather and preserve evidence to support criminal prosecution.

DENMARK

The Scandinavian and Nordic models have been built upon the work of the US approach, one which is multidisciplinary and victim-focused. The Danish Center for Rape Victims (Center for Voldtagtsofre; CRV) has nine locations across Denmark. It was established in Aarhus in 1999 and has been the source of the development of guidelines for other rape trauma centres, prevention and early intervention programmes and ultimately improved care for many victims and survivors (Bramsen et al., 2009). The ethos underpinning service design and delivery is to avoid re-traumatising clients and operates under guidelines issued under the Danish National Board of Health (1999). The purpose of the centre "must ensure that women, men and young people who have been victims of rape or attempted rape only need to turn to one place to receive help." (https://www.voldtaegt.dk/om-os/). The Centre is linked with the Center for Sexual Assault and collectively conduct research, offer professional advice and training, and provide frontline services that offer crisis medical and psychosocial help and support as well as a psychological treatment unit regardless of long since the abuse happened. Recent research has included new treatment for victim-survivors with cognitive impairment, including a psychotherapeutic guide, and the effectiveness of CBT for PTSD following sexual violence and abuse.

ENGLAND & WALES

Independent Sexual Violence Advisers (ISVAs) have been working in local areas in England and Wales (and Northern Ireland) since 2005 providing specialist tailored support to victims and survivors of sexual violence. They have responsibility for providing accurate and impartial information about reporting the assault to police, attending SARC services, the criminal justice process and accessing therapeutic support. The Home Office (2017) has set out clear criteria for the 'essential elements' of this independent role and recognises the vulnerability of victim-survivors and the type of care they may require. This may involve emotional support but also recognises the importance of providing a single point of contact

that can facilitate access and connections to other services and agencies and offer practical support and advice dealing with safeguarding and creating safety, communicating with employers, attending meetings or medical appointments, and before, during and after a criminal trial.

A recent evaluation of ISVAs (Horvath et al., 2021) identified a number of recommendations to improve services:

- An urgent need for a national accredited standard for the first year of training for this specific role and quality supervision;
- Routine monitoring of impacts and wellbeing;
- National standards for maximum caseloads to help reduce psychological distress and vicarious trauma;
- The development of a professional network to improve consistency and quality of provision, share best practice and develop the role.

Other useful resources have been produced as part of the National IVSA Co-ordinator (NISVAC) Service pilot to promote culturally appropriate and sensitive working with minority groups including '*Working the victims and survivors from Gypsy, Roma and Traveller Communities'* (LimeCulture, 2023) and '*Guidance for professionals working with people with Learning Disabilities who have experienced sexual violence and abuse'* (LimeCulture, 2023).

IRELAND

The network of Rape Crisis Centres (RCCs) across Ireland provide a wraparound service with many clients referred directly from the Sexual Assault Treatment Unit (SATU). While SATUs offer a health check, medication, forensic examination and Gardaí involvement following an assault, often a volunteer from Rape Crisis will also be available to provide support and connect onto follow up services. Many people will be in shock in the immediate aftermath of an assault and while they may avail of one or two counselling sessions at the time, it is often around 6 months later that people ask for help processing their trauma and present for therapy.

RCCs in Ireland report a rise in much more complex trauma cases, with increasingly violent presentations, multiple incidents including child sexual abuse. The impact of Covid has also led to an increase in referrals and lengthening waiting lists. Active recruitment of additional, specialist staff is underway (including therapists to work with adolescents, ADHD/ASD, male therapists) however the monitored waiting list is actively managed. Current staffing levels have led to the temporary introduction of a guide to the number of therapy sessions, with a

general rule that around 30 sessions are offered to clients who have experienced a one-off sexual violence and abuse event to up to 80 sessions for those with more complex presentations. These are negotiable parameters that are needs-based and agreed with the experienced therapy team.

The Co-ordinators play an important role having responsibility for the intake process. They manage the waiting list, regularly check in with those waiting for treatment and assess their readiness for therapy, and match clients and therapists. The Co-ordinators are highly trained and experienced therapists.

Supervision is recognised as a crucial part of supporting staff in this difficult area of work and is offered at least 1 to 20 sessions and includes group, peer and one-to-one supervision. Dedicated team time is protected to help staff connect and promote self-care and most staff work flexi time with 3 days per week on average for therapeutic work. The Centres do not advocate more than 4 days a week for therapy.

A wide range of integrative approaches are delivered including sensorimotor, EMDR, art therapy, sand tray, ego states, polyvagal body-oriented psychotherapies and systemic family work. Treatment was described as '*People use what the client needs in that moment.*'

A holistic trauma-informed setting is considered important, with every staff member from kitchen staff and therapists receiving training in trauma-informed care. Concern was raised by the lack of undergraduate training in a range of professional disciplines on trauma and sex violence.

The Centres also have Client Support Officers who can offer help with housing, basic needs and practical support.

The National Helpline is one of the cornerstones of providing support.

Policy is an important aspect of their wider work and campaigns for justice and better legal processes have received support at Ministerial level where significant improvements have been achieved over the last ten years including stricter sentencing. Current focus for change includes ensuring there are appropriate penalties for online abuse and non-fatal strangulation and campaigning for the law to progress with rapid societal changes.

As well as the growing complexity of cases, other high risk groups have been identified in their work including asylum seekers that may have language barriers, members of the Traveller community who often don't seek support, and young people increasingly exposed

to online abuse and exploitation via online pornography. Other areas of work include the prison population and combined and co-ordinated substance use and trauma work.

NEW ZEALAND/AOTEAROA

New Zealand has a funding stream for those who have experienced sexual violence that sits within their civic contribution scheme, the Accident Compensation Corporation (ACC), which provides government funding for individuals with clinically significant symptoms. The ACC system was established for supporting those who have experienced injury with physical, emotional and behavioural interventions to aid their recovery. Historically, the Government has included sexual violence as an injury eligible for funding (even though this experience is not considered an accident). To be eligible for 'cover' a person has to have had an experience of sexual violence in NZ, they need to have clinically significant impacts as a result of that incident(s) and there needs to be a substantive link between the SV and these impacts. If a person receives 'cover' this support can be life long and allows the survivor to access and re-access a range of different services not confined to therapy including social work support.

One of the additional supports available through this scheme and considered vital is access to social work that can be crucial in the stabilisation phase in preparation for therapeutic work. As in Ireland, reduced capacity in staffing has impacted services, however approaches to support people waiting for treatment have been put in place including warm handovers, group therapy and the provision of social support. Skills-based group therapy will be available during the waiting list period. Currently, there is a review of the ACC contract for those who have experienced sexual violence and there is a drive to increase social work support made available during the earlier and stabilisation phases of treatment. This is especially important given that there can be long waiting times to engage in therapy. Services like START have been providing this wraparound social work support for many years and have been able to do so through accessing other government funding.

In Christchurch, the START independent service agency receives mainly self-referrals and will support them to engage with the ACC process. While there is no requirement to involve the police, people are encouraged to report the assault. Every person referred to the service will be allocated a named therapist/case manager who will remain with them through the ACC process.

THE TRIAGE PROCESS

At START, social workers carry out a detailed assessment that begins when they first meet a client but is reviewed, adjusted and updated as needed. This considers many aspects of need and support, including:

1. How are they, and, what has brought them to seek support at this time?
2. Who is aware of the sexual harm? Have these people been supportive or unsupportive.
3. Are or were the police involved. If it's an active investigation do they know where things are at currently? Do they need support getting an update?
4. Who are their supports? Both personal and professional.
5. Are they safe from the alleged offender?
6. What is their living situation, do they have children, a partner, etc. Any concerns or support required.
7. Any concerns regarding current or recent family violence.
8. Mental health history – any current concerns with self-harm or suicidal ideation.
9. Substance use/abuse
10. Sleep and eating
11. Are they currently working or studying, any concerns/struggles with this.
12. Any hobbies/extracurricular activities.
13. Have they tried counselling before or other supports in the past, what was their experience?
14. How do they normally cope with difficult times?
15. Any financial concerns?
16. Transport – how do they get around?
17. What do they feel would be most helpful for them currently?
18. Cultural and spiritual needs/concerns/aspects etc.
19. Any other worries or things that they would like to talk about.
20. Have their needs been met?

Treatment options are varied and often designed to help individuals with activities of daily living including occupational therapy, sensory support, physiotherapy, and trauma-informed equine therapy and yoga. The ACC process also allows for therapists to work in private practice providing these types of interventions, although their 'offer' may well be more limited given they are working more in isolation. ACC works hard to create systems that reduce this isolation for its contracted therapists. These options are particularly helpful for those waiting for one-to-one therapy. The START model of practice is based on introduction, stabilisation,

process, integration and maintenance. Many clients will never reach the processing stage and the focus will remain on stabilisation.

The suburban START Service in Christchurch offers a non-clinical setting for therapy. All doors open onto the garden, there is a communal kitchen for everyone to access and the Māori concept of 'whanau' (family/community) is central to support the significant people in someone's life.

There are no limits on the number of sessions offered. Once accepted onto the ACC scheme, clients will be assessed by psychiatry/psychology and package of care will be detailed in a treatment plan. There is generally an amount of clinical freedom to set goals linked to the 'covered injury' and work towards fulfilling these with the client. No stipulations are made for the kind of modalities on offer but will depend on the skill set of the practitioner and client needs. Although there are psychometric outcome measures required by the ACC, there is an agreed high trust contract to attempt to reduce heavy bureaucracy, this is also under review to continue to improve the high trust nature of this ACC/client/clinician relationship. Once the ACC has approved the plan, this will be reviewed mid-point. Part of the treatment plan will include 'active hours liaison' and maintenance hours will be automatically allocated when treatment has been completed to allow for reactivation if required. The aim is to be able to offer long term, easy access support when and if required. Although family work isn't officially funded, the service recognises the role and experience of extended family in recovery after sexual violence and abuse. The ACC contract recognises the need to support the people supporting clients and so partners and other family members (including parents if the client is a child or young person) are able to receive support. Couples work and sexual dysfunction is often supported. Family interventions are also available. The service also offers specialist sexual violence advocacy support for the criminal justice process as this can be a treatment goal for some people.

All clinical staff are trained and professionally registered. A peer support programme is not offered at this organisation.

RECOMMENDATIONS FOR NORTHERN IRELAND

- Trauma-informed systems are required that consider, evaluate and organise to recognise and respond appropriately to trauma and complex trauma.
- A one-stop shop providing early intervention services. Wrap-around care models that offer support from the immediate aftermath of an assault, provide therapy/counselling, support the criminal justice process, and offer social and welfare advice is recommended. Such services should be offering a range of therapeutic approaches based on presentation and choice and clear pathways to statutory mental health services based on the Stepped Care model.
- The body of evidence suggests that CBT-based interventions are recommended for sexual violence and abuse.
- Applying the recovery approach within sexual violence and abuse services.
- Compassionate leadership and workplaces that help protect and support staff from vicarious trauma.
- Building a trauma-informed community of practice.
- Creating culturally and linguistically appropriate responses.
- Services that recognise and understand intersectionality in people's experiences.
- Importance of lived experience in the design and delivery of not only services, but policy and training.
- Screening for childhood sexual abuse or trauma in mental health populations.
- Person-centred treatment pathways that are tailored to individual needs and build on the skills and experience of multi-disciplinary staff.
- Addressing the needs for individuals to function socially, and in education and employment – and how occupational therapy and social work services may contribute to the recovery process.
- Recognition of the importance of support services for processes following sexual violence including support during the criminal justice process, employment.
- Consider the physical environment of therapeutic settings and how they may contribute to recovery.
- Consider carefully how the implementation of the peer support role might best delivered and supported.
- Ensure that support for family and friends is central to the recovery approach
- Prevention approaches need to be developed and implemented in the Northern Ireland context which dovetail with other Government strategies e.g. End Violence Against Women and Girls.

APPENDIX 1 SEARCH STRATEGY

Ovid MEDLINE(R) ALL <1946 to May 11, 2023>

1	Sex* Assault.mp.	6651
2	rape.mp.	12668
3	sex* violence.mp.	5261
4	forced sex*.mp.	596
5	non-consensual sex*.mp.	116
6	coerced sex*.mp.	92
7	post-rape.mp.	81
8	Child Abuse, Sexual/ or sexual victim.mp.	11019
9	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8	30685
10	intervention.mp. or Psychosocial Intervention/	808089
11	counsell*.mp.	36401
12	(cognitive beh* therapy or CBT).mp.	42128
13	EMDR.mp. or Eye Movement Desensitization Reprocessing/	875
14	Psychotherapy/ or psychoeducation.mp.	61554
15	therapy.mp.	5950063
16	processing therapy.mp.	524
17	exposure therapy.mp.	3012
18	10 or 11 or 12 or 13 or 14 or 15 or 16 or 17	6500597
19	trauma.mp.	316170
20	Psychological Trauma/ or psych* trauma.mp. or Stress Disorders, Post-Traumatic/	43869
21	PTSD.mp.	33162
22	obsessive compulsive disorder.mp. or Obsessive-Compulsive Disorder/	21723
23	sleep disorder.mp. or Sleep Wake Disorders/	30528
24	Anxiety Disorders/px [Psychology]	14455
25	Depression/ or depression.mp.	488111
26	19 or 20 or 21 or 22 or 23 or 24 or 25	864356
27	9 and 18 and 26	1594
28	"Systematic Review"/	228202
29	Randomized Controlled Trials as Topic/ or RCT.mp.	186762
30	Qualitative Research/ or qualitative.mp.	338325
31	Focus Groups/ or focus groups.mp.	53811
32	Case-Control Studies/ or case control.mp.	381055
33	observational study.mp. or Observational Study/	203707
34	meta-analysis.mp. or Meta-Analysis/	274243
35	28 or 29 or 30 or 31 or 32 or 33 or 34	1403251
36	27 and 35	154

APA PsycExtra <1908 to April 10, 2023>

1	Sex* Assault.mp.	894
2	rape.mp.	972
3	sex* violence.mp.	456
4	forced sex*.mp.	23
5	non-consensual sex*.mp.	6
6	coerced sex*.mp.	13
7	post-rape.mp.	5
8	Child Abuse, Sexual/ or sexual victim.mp.	3
9	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8	1901
10	intervention.mp. or Psychosocial Intervention/	15495
11	counsell*.mp.	251
12	(cognitive beh* therapy or CBT).mp.	1914
13	EMDR.mp. or Eye Movement Desensitization Reprocessing/	147

14 Psychotherapy/ or psychoeducation.mp. 4149
15 therapy.mp. 16429
16 processing therapy.mp. 135
17 exposure therapy.mp. 393
18 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 32606
19 trauma.mp. 8005
20 Psychological Trauma/ or psych* trauma.mp. or Stress Disorders, Post-Traumatic/ 230
21 PTSD.mp. 4267
22 obsessive compulsive disorder.mp. or Obsessive-Compulsive Disorder/ 398
23 sleep disorder.mp. or Sleep Wake Disorders/ 264
24 Depression/ or depression.mp. 9968
25 "Systematic Review"/ 107
26 Randomized Controlled Trials as Topic/ or RCT.mp. 158
27 Qualitative Research/ or qualitative.mp. 4363
28 Focus Groups/ or focus groups.mp. 878
29 Case-Control Studies/ or case control.mp. 78
30 observational study.mp. or Observational Study/ 96
31 meta-analysis.mp. or Meta-Analysis/ 1331
32 25 or 26 or 27 or 28 or 29 or 30 or 31 6697
33 exp Anxiety/ 3152
34 19 or 20 or 21 or 22 or 23 or 24 or 33 22135
35 9 and 18 and 32 and 34 13
36 9 and 18 and 34 100
37 (rape* or sexu* traum* or sex traum* or sexu* abus* or sex abus* or sexu* assault* or sex assault* or sexu* viol* or sex viol*).mp. 4243
38 (psychotherap* or eye movement desensiti* or emdr or prevention or intervention or therap* or psychoeducation or education or treatment).mp. 99698
39 (ptsd or posttraumatic or post traumatic).mp. 5663
40 37 and 38 and 39 205

Embase <1974 to 2023 May 12>

1 Sex* Assault.mp. 9928
2 rape.mp. 14149
3 sex* violence.mp. 8291
4 forced sex*.mp. 729
5 non-consensual sex*.mp. 160
6 coerced sex*.mp. 115
7 post-rape.mp. 79
8 Child Abuse, Sexual/ or sexual victim.mp. 9677
9 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 36231
10 intervention.mp. or Psychosocial Intervention/ 1265556
11 counsell*.mp. 61238
12 (cognitive beh* therapy or CBT).mp. 49271
13 EMDR.mp. or Eye Movement Desensitization Reprocessing/ 1321
14 Psychotherapy/ or psychoeducation.mp. 107007
15 therapy.mp. 9263508
16 processing therapy.mp. 717
17 exposure therapy.mp. 4218
18 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 10083732
19 trauma.mp. 408729
20 Psychological Trauma/ or psych* trauma.mp. or Stress Disorders, Post-Traumatic/ 53141
21 PTSD.mp. 44346
22 obsessive compulsive disorder.mp. or Obsessive-Compulsive Disorder/ 35448
23 sleep disorder.mp. or Sleep Wake Disorders/ 91617
24 Anxiety Disorders.mp. or anxiety disorder/ 108190

25 Depression/ or depression.mp. 844327
26 19 or 20 or 21 or 22 or 23 or 24 or 25 1375138
27 9 and 18 and 26 2507
28 Systematic Review.mp. or randomized controlled trial/ or "systematic review"/ or clinical trial/ or controlled clinical trial/ 2067248
29 Qualitative Research/ or qualitative.mp. 445099
30 Focus Groups/ or focus groups.mp. 251250
31 Case-Control Studies/ or case control.mp. 291642
32 observational study.mp. or Observational Study/ 365404
33 meta-analysis.mp. or Meta-Analysis/ 417286
34 28 or 29 or 30 or 31 or 32 or 33 3365934
35 27 and 34 504

SSCI

(rape* OR sexu* traum* OR sex traum* OR sexu* abus* OR sex abus* OR sexu* assault* OR sex assault* OR sexu* viol* OR sex viol*) AND (psychotherap* OR emdr OR eye movement desensiti* OR prevention OR intervention OR therap* OR psychoeducation OR education OR treatment) AND (ptsd OR posttraumatic OR post traumatic) 124

MEDLINE

1 exp mental disorders/
2 mental health/
3 depression/
4 child development/
5 mentally disabled persons/
6 exp self-injurious behavior/
7 (mental health* or mental* ill* or mental* disorder* or mental* well*).ti,ab,kf.
8 ((substance or alcohol or opioid or morphine or marijuana or heroin or cocaine) adj2 (disorder? or illness* or dependence or abuse or misuse or "use")).ti,ab,kf.
9 (depressi* adj2 (sign* or symptom* or disorder?)).ti,ab,kf.
10 (depress* adj3 (acute or clinical* or diagnos* or disorder* or major or unipolar or illness or scale* or score* or adult* or child* or adolesc* or teen* or youth? or elder* or late* life* or patient* or participant* or people or inpatient* or inpatient* or outpatient* or out-patient*)).ti,ab,kf.
11 ((depress* or distress*) adj3 (postnatal* or post natal* or maternal*)).ti,ab,kf. 7599
12 (depression or anxiety or alzheimer? or schizoaffective or mania or manic or borderline personality or (stress adj2 disorder*) or adjustment disorder? Or (psychological adj1 trauma*) or schizophrenia or psychoses or psychosis or stress syndrome? or distress syndrome? or combat disorder? or war disorder? or ptsd or dementia).ti,ab,kf.
13 ((post-trauma* or posttrauma*) adj3 (stress* or disorder?)).ti,ab,kf.
14 (psychological trauma or psychotrauma*).ti,ab,kf.
15 (alcoholism or alcoholic? or drug addict* or drug abus* or drug misuse or drug user?).ti,ab,kf.
16 ((learning or mental* or intellectual) adj (disabled or disabilit* or disorder? or difficult*)).ti,ab,kf.
17 ((dissociative adj3 (disorder* or reaction*)) or dissociation).ti,ab,kf.
18 ((bipolar or behavio?ral or obsessive or panic or mood or delusional) adj2 (disorder? or illness* or disease?)).ti,ab,kf.
19 (trichotillomani* or OCD or obsess*-compulsi* or GAD or stress reaction? or acute stress or neuros#s or neurotic).ti,ab,kf.
20 (affective* adj (disorder? or disease? or illness* or symptom?)).ti,ab,kf.
21 ((mental or psychological or emotional or psycho-social or psychosocial) adj (stress* or distress*)).ti,ab,kf.
22 ((sub-syndrom* or sub-threshold or sub-clinical or subsyndrom* or subthreshold or subclinical or minor or brief) adj (symptom* or disorder* or condition*

or depress* or anxiety)).ti,ab,kf.

23 (mental relapse or fatigue or somatic symptom? or worry or worries or panic or low mood? or mood problem?).ti,ab,kf.

24 (anxiety disorder? or agoraphobi* or general* anxi* or separation anxiety or neurocirculatory asthenia or neurotic disorder? or social phobi* or self-harm* or self-injur* or suicid*).ti,ab,kf.

25 (slow* adj (thought? or think*)).ti,ab,kf.

26 (mental* adj develop*).ti,ab,kf.

APPENDIX 2 SAFETY PLAN

Developing a safety plan is a very important step in helping you feel safe. Work through these questions to develop a plan that will work for you.

Where do I feel safest?

When do I feel safest?

How safe are the environments I am in during the day?

How safe do I feel at night?

Do I feel safe at home?

If I do not feel safe, what could I do to change that?

Think about short and longer term – what can I do today, this week, over the next month?

Who do I feel safest being with?

Who do I want to know about what happened to me?

Who will respect my privacy?

Who will listen and not blame me?

Who will support my decisions and not tell me what to do?

Who can I contact/ring when I am not feeling OK?

When is the hardest time of the day for me?

What do I feel then?

Do I understand why?

What can I do to address those feelings?

A list of strategies for me to try?

Examples include calming music, imagine or go to safe place, contact a friend or crisis line, writing, distractions…

REFERENCES

Aakvaag, H. F., Thoresen, S., Wentzel-Larsen, T., Dyb, G., Roysamb, E., & Olff, M. (2016). Broken and guilty since it happened: A population study of trauma-related shame and guilt after violence and sexual abuse [Empirical Study; Quantitative Study]. *Journal of Affective Disorders*, *204*, 16-23. https://doi.org/https://dx.doi.org/10.1016/j.jad.2016.06.004

Adams, T. G., Badour, C. L., Cisler, J. M., & Feldner, M. T. (2014). Contamination aversion and posttraumatic stress symptom severity following sexual trauma. *Cognitive Therapy and Research*, *38*, 449-457.

Aldinger, F., & Schulze, T. G. (2017). Environmental factors, life events, and trauma in the course of bipolar disorder. *Psychiatry and Clinical Neurosciences*, *71*(1), 6-17.

ANROWS. (2020a). *Crossing the line: Lived experience of sexual violence among trans women of colour from culturally and linguistically diverse (CALD) backgrounds in Australia (Research to policy and practice, 14/2020)*.

ANROWS. (2020b). *Developing LGBTQ programs for perpetrators and victims/survivors of domestic and family violence (Research to policy and practice, 10/2020)*.

Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial rehabilitation journal*, *16*(4), 11.

Arditte Hall, K. A., Bartlett, B. A., Iverson, K. M., & Mitchell, K. S. (2018). Eating disorder symptoms in female veterans: The role of childhood, adult, and military trauma exposure [Empirical Study; Quantitative Study]. *Psychological Trauma: Theory, Research, Practice, and Policy*, *10*(3), 345-351. https://doi.org/https://dx.doi.org/10.1037/tra0000301

Astbury, J., Bruck, D., & Loxton, D. (2011). Forced sex: A critical factor in the sleep difficulties of young Australian women [Empirical Study; Longitudinal Study; Quantitative Study]. *Violence and victims*, *26*(1), 53-72. https://doi.org/https://dx.doi.org/10.1891/0886-6708.26.1.53

BACP. (2021). *Introduction to counselling and psychotherapy. Client information v2 10.3.2021*. British Association for Counselling & Psychotherapy. Retrieved 31st July from

Badour, C. L., Bown, S., Adams, T. G., Bunaciu, L., & Feldner, M. T. (2012). Specificity of fear and disgust experienced during traumatic interpersonal victimization in predicting posttraumatic stress and contamination-based obsessive–compulsive symptoms. *Journal of Anxiety Disorders*, *26*(5), 590-598.

Barzilay, R., Patrick, A., Calkins, M. E., Moore, T. M., Gur, R. C., & Gur, R. E. (2019). Association between early-life trauma and obsessive compulsive symptoms in community youth [Empirical Study; Quantitative Study]. *Depression and Anxiety*, *36*(7), 586-595. https://doi.org/https://dx.doi.org/10.1002/da.22907

BBC. (2023). *Claire Hanna: MP highlights 'devastating impact' of attacks on women*. Retrieved 19th July from

Bebbington, P., Jonas, S., Kuipers, E., King, M., Cooper, C., Brugha, T., Meltzer, H., McManus, S., & Jenkins, R. (2011). Childhood sexual abuse and psychosis: data from a cross-

sectional national psychiatric survey in England. *British Journal of Psychiatry*, *199*(1), 29-37. https://doi.org/https://dx.doi.org/10.1192/bjp.bp.110.083642

Beck, J. S., & Fleming, S. (2021). A brief history of Aaron T. Beck, MD, and cognitive behavior therapy. *Clinical Psychology in Europe*, *3*(2), 1-7.

Bentall, R. P., Wickham, S., Shevlin, M., & Varese, F. (2012). Do specific early-life adversities lead to specific symptoms of psychosis? A study from the 2007 the adult psychiatric morbidity survey [Empirical Study; Interview; Quantitative Study]. *Schizophrenia Bulletin*, *38*(4), 734-740. https://doi.org/https://dx.doi.org/10.1093/schbul/sbs049

Benuto, L. T., Gonzalez, F., Casas, J., Newlands, R., & Leany, B. D. (2019). Cultural considerations in sexual assault. *Handbook of sexual assault and sexual assault prevention*, 55-68.

Bhuptani, P. H., Kaufman, J. S., Messman-Moore, T. L., Gratz, K. L., & DiLillo, D. (2019). Rape disclosure and depression among community women: The mediating roles of shame and experiential avoidance [Empirical Study; Mathematical Model; Quantitative Study]. *Violence against women*, *25*(10), 1226-1242. https://doi.org/https://dx.doi.org/10.1177/1077801218811683

Bhuptani, P. H., & Messman, T. L. (2023). Role of blame and rape-related shame in distress among rape victims [Empirical Study; Quantitative Study]. *Psychological Trauma: Theory, Research, Practice, and Policy*, *15*(4), 557-566. https://doi.org/https://dx.doi.org/10.1037/tra0001132

Bichard, H., Byrne, C., Saville, C. W. N., & Coetzer, R. (2022). The neuropsychological outcomes of non-fatal strangulation in domestic and sexual violence: A systematic review [Review]. *Neuropsychological Rehabilitation*, *32*(6), 1164-1192. https://doi.org/10.1080/09602011.2020.1868537

Bisson, J. I., Berliner, L., Cloitre, M., Forbes, D., Jensen, T. K., Lewis, C., Monson, C. M., Olff, M., Pilling, S., & Riggs, D. S. (2019). The international society for traumatic stress studies new guidelines for the prevention and treatment of posttraumatic stress disorder: Methodology and development process. *Journal of Traumatic Stress*, *32*(4), 475-483.

Boyle, S., Murphy, J., Rosato, M., Boduszek, D., & Shevlin, M. (2020). Predictors of antidepressant use in the English population: analysis of the Adult Psychiatric Morbidity Survey [Research Support, Non-U.S. Gov't]. *Irish Journal of Psychological Medicine*, *37*(1), 15-23. https://doi.org/https://dx.doi.org/10.1017/ipm.2018.19

Bramsen, R. H., Elklit, A., & Nielsen, L. H. (2009). A Danish model for treating victims of rape and sexual assault: The multidisciplinary public approach. *Journal of Aggression, Maltreatment & Trauma*, *18*(8), 886-905.

Breckenridge, J., Rees, S., Valentine, K., & Murray, S. (2016). *Meta-evaluation of existing interagency partnerships, collaboration, coordination and/or integrated interventions and service responses to violence against women: Key findings and future directions* (ANROWS Compass: Research to policy and practice: 05/2016, Issue.

Breland, J. Y., Donalson, R., Li, Y., Hebenstreit, C. L., Goldstein, L. A., & Maguen, S. (2018). Military sexual trauma is associated with eating disorders, while combat exposure is not. *Psychological Trauma: Theory, Research, Practice, and Policy*, *10*(3), 276.

Brewer, N. Q., & Thomas, K. A. (2019). Intimate partner violence and academic performance: The role of physical, mental, behavioral, and financial health [Empirical Study; Quantitative Study]. *Social Work in Health Care*, *58*(9), 854-869. https://doi.org/https://dx.doi.org/10.1080/00981389.2019.1659905

Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., Humayun, A., Jones, L. M., Kagee, A., & Rousseau, C. (2017). A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clinical Psychology Review*, *58*, 1-15.

Brown, S. J., Carter, G. J., Halliwell, G., Brown, K., Caswell, R., Howarth, E., Feder, G., & O'Doherty, L. (2022). Survivor, family and professional experiences of psychosocial interventions for sexual abuse and violence: a qualitative evidence synthesis. *Cochrane Database of Systematic Reviews*, *2022(10) (no pagination)*, Article Cd013648.

Bryan, C. J., Bryan, A. O., & Clemans, T. A. (2015). The association of military and premilitary sexual trauma with risk for suicide ideation, plans, and attempts [Empirical Study; Interview; Quantitative Study]. *Psychiatry Research*, *227*(2-3), 246-252. https://doi.org/https://dx.doi.org/10.1016/j.psychres.2015.01.030

Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *American Journal of Psychiatry*, *131*, 981-986.

Byrne, G. (2022). A Systematic Review of Treatment Interventions for Individuals With Intellectual Disability and Trauma Symptoms: A Review of the Recent Literature [Systematic Review]. *Trauma Violence & Abuse*, *23*(2), 541-554.

Campbell, L., Keegan, A., Cybulska, B., & Forster, G. (2007). Prevalence of mental health problems and deliberate self-harm in complainants of sexual violence. *Journal of Forensic & Legal Medicine*, *14*(2), 75-78.

Cerimele, J. M., Bauer, A. M., Fortney, J. C., & Bauer, M. S. (2017). Patients with co-occurring bipolar disorder and posttraumatic stress disorder: A rapid review of the literature. *Journal of Clinical Psychiatry*, *78(5)*, e506-e514.

Chakraborti, K., Arensman, E., & Leahy, D. (2021). The Experience and Meaning of Repeated Self-Harm Among Patients Presenting to Irish Hospital Emergency Departments. *Issues in Mental Health Nursing*, *42(10)*, 942-950. https://doi.org/https://dx.doi.org/10.1080/01612840.2021.1913681

Chalavi, S., Vissia, E. M., Giesen, M. E., Nijenhuis, E. R. S., Draijer, N., Cole, J. H., Dazzan, P., Pariante, C. M., Madsen, S. K., Rajagopalan, P., Thompson, P. M., Toga, A. W., Veltman, D. J., & Reinders, A. (2015). Abnormal Hippocampal Morphology in Dissociative Identity Disorder and Post-Traumatic Stress Disorder Correlates with Childhood Trauma and Dissociative Symptoms [Article]. *Human Brain Mapping*, *36*(5), 1692-1704. https://doi.org/10.1002/hbm.22730

Chamberlain, C., Gee, G., Harfield, S., Campbell, S., Brennan, S., Clark, Y., Mensah, F., Arabena, K., Herrman, H., & Brown, S. (2019). Parenting after a history of childhood maltreatment: A scoping review and map of evidence in the perinatal period [Literature Review]. *PLoS ONE Vol 14(3), 2019, ArtID e0213460*, *14*(3). https://doi.org/https://dx.doi.org/10.1371/journal.pone.0213460

Chaplin, A. B., Jones, P. B., & Khandaker, G. M. (2021). Sexual and physical abuse and depressive symptoms in the UK Biobank [Observational Study Research Support, Non-U.S. Gov't]. *BMC Psychiatry*, *21*(1), 248. https://doi.org/https://dx.doi.org/10.1186/s12888-021-03207-0

Chapman, A. L. (2006). Dialectical behavior therapy: current indications and unique elements. *Psychiatry (Edgmont (Pa.: Township))*, *3*(9), 62-68.

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., Elamin, M. B., Seime, R. J., Shinozaki, G., & Prokop, L. J. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: systematic review and meta-analysis. Mayo Clinic Proceedings,

Choudhary, E., Smith, M., & Bossarte, R. M. (2012). Depression, anxiety, and symptom profiles among female and male victims of sexual violence [Empirical Study; Quantitative Study]. *American Journal of Men's Health*, *6*(1), 28-36. https://doi.org/https://dx.doi.org/10.1177/1557988311414045

Chu, A. T., DePrince, A. P., & Mauss, I. B. (2014). Exploring revictimization risk in a community sample of sexual assault survivors [Empirical Study; Quantitative Study]. *Journal of Trauma & Dissociation*, *15*(3), 319-331. https://doi.org/https://dx.doi.org/10.1080/15299732.2013.853723

Cividanes, G. C., Mello, A. F., & Mello, M. F. (2019). Revictimization as a high-risk factor for development of posttraumatic stress disorder: A systematic review of the literature [Literature Review; Systematic Review]. *Brazilian Journal of Psychiatry*, *41*(1), 82-89. https://doi.org/https://dx.doi.org/10.1590/1516-4446-2017-0013

Clephane, K., Wilson, M., Heiman, J. R., Craig, A. N., & Lorenz, T. (2022). Sexual violence history predicts changes in vaginal immune parameters during sexual arousal [Empirical Study; Quantitative Study]. *Brain, Behavior, and Immunity*, *104*, 171-180. https://doi.org/https://dx.doi.org/10.1016/j.bbi.2022.06.005

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European journal of psychotraumatology*, *4*(1), 20706.

Connellan, K., Gaardboe, M., Riggs, D., Due, C., Reinschmidt, A., & Mustillo, L. (2013). Stressed spaces: mental health and architecture. *HERD: Health Environments Research & Design Journal*, *6*(4), 127-168.

Cook, J. M., Schnurr, P. P., & Foa, E. B. (2004). Bridging the gap between posttraumatic stress disorder research and clinical practice: The example of exposure therapy. *Psychotherapy: Theory, Research, Practice, Training*, *41*(4), 374.

COSAI. (2012). *Models of intervention for women who have been sexually assaulted in Europe: A review of the literature*.

Criminal Justice Joint Inspectorate. (2022). *Exploring rape survivors' experiences of the police and other criminal justice agencies: Phase two*. https://www.justiceinspectorates.gov.uk/hmicfrs/publications/a-joint-thematic-inspection-of-the-police-and-crown-prosecution-services-response-to-rape-phase-two-post-charge/

Cripe, S. M., Sanchez, S. E., Gelaye, B., Sanchez, E., & Williams, M. A. (2011). Association between intimate partner violence, migraine and probable migraine [Empirical Study; Interview; Quantitative Study]. *Headache: The Journal of Head and Face Pain*, *51*(2), 208-219. https://doi.org/https://dx.doi.org/10.1111/j.1526-4610.2010.01777.x

D'Elia, A. T. D., Juruena, M. F., Coimbra, B. M., Mello, M. F., & Mello, A. F. (2021). Posttraumatic stress disorder (PTSD) and depression severity in sexually assaulted women: hypothalamic-pituitary-adrenal (HPA) axis alterations [Article]. *BMC Psychiatry*, *21*(1), 12, Article 174. https://doi.org/10.1186/s12888-021-03170-w

D'Elia, A. T. D., Juruena, M. F., Coimbra, B. M., Mello, M. F., & Mello, A. F. (2022). Increased immuno-inflammatory mediators in women with post-traumatic stress disorder after sexual assault: 1-Year follow-up [Article]. *Journal of Psychiatric Research*, *155*, 241-251. https://doi.org/10.1016/j.jpsychires.2022.08.028

D'Elia, A. T. D., Matsuzaka, C. T., Neto, J. B. B., Mello, M. F., Juruena, M. F., & Mello, A. F. (2018). Childhood Sexual Abuse and Indicators of Immune Activity: A Systematic Review [Review]. *Frontiers in Psychiatry*, *9*, 14, Article 354. https://doi.org/10.3389/fpsyt.2018.00354

Daly, M. (2011). Childhood psychotic symptoms: Link between non-consensual sex and later psychosis [Comment/Reply]. *The British Journal of Psychiatry*, *199*(3), 251-252. https://doi.org/https://dx.doi.org/10.1192/bjp.199.3.251a

de Aquino Ferreira, L. F., Queiroz Pereira, F. H., Neri Benevides, A. M. L., & Aguiar Melo, M. C. (2018). Borderline personality disorder and sexual abuse: A systematic review [Literature Review; Systematic Review]. *Psychiatry Research*, *262*, 70-77. https://doi.org/https://dx.doi.org/10.1016/j.psychres.2018.01.043

Deblinger, E., Pollio, E., & Dorsey, S. (2016). Applying trauma-focused cognitive–behavioral therapy in group format. *Child Maltreatment*, *21*(1), 59-73.

DeCou, C. R., Kaplan, S. P., Spencer, J., & Lynch, S. M. (2019). Trauma-related shame, sexual assault severity, thwarted belongingness, and perceived burdensomeness among female undergraduate survivors of sexual assault [Empirical Study; Quantitative Study]. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *40*(2), 134-140. https://doi.org/https://dx.doi.org/10.1027/0227-5910/a000549

Dir, A. L., Hahn, C., Jaffe, A. E., Stanton, K., & Gilmore, A. K. (2021). Depressive symptoms following recent sexual assault: The role of drug and alcohol use, acute stress, and assault characteristics [Empirical Study; Interview; Quantitative Study]. *Journal of Interpersonal Violence*, *36*(11-12), 5900-5913. https://doi.org/https://dx.doi.org/10.1177/0886260518803605

Dorahy, M. J., Corry, M., Shannon, M., Macsherry, A., Hamilton, G., McRobert, G., Elder, R., & Hanna, D. (2009). Complex PTSD, interpersonal trauma and relational consequences: findings from a treatment-receiving Northern Irish sample [Comparative Study]. *Journal of Affective Disorders*, *112*(1-3), 71-80. https://doi.org/https://dx.doi.org/10.1016/j.jad.2008.04.003

Dowse, L., Soldatic, K., Spangaro, J., & Van Toorn, G. (2016). Mind the gap: the extent of violence against women with disabilities in Australia. *Australian Journal of Social Issues*, *51*(3), 341-359.

Dubosc, A., Capitaine, M., Franko, D. L., Bui, E., Brunet, A., Chabrol, H., & Rodgers, R. F. (2012). Early adult sexual assault and disordered eating: The mediating role of posttraumatic stress symptoms [Empirical Study; Quantitative Study]. *Journal of Traumatic Stress*, *25*(1), 50-56. https://doi.org/https://dx.doi.org/10.1002/jts.21664

Dunn, E. C., Gilman, S. E., Willett, J. B., Slopen, N. B., & Molnar, B. E. (2012). The impact of exposure to interpersonal violence on gender differences in adolescent-onset major depression: Results from the National Comorbidity Survey Replication (NCS-R) [Empirical Study; Interview; Quantitative Study]. *Depression and Anxiety*, *29*(5), 392-399. https://doi.org/https://dx.doi.org/10.1002/da.21916

Dworkin, E. R. (2020). Risk for mental disorders associated with sexual assault: A meta-analysis. *Trauma, Violence, & Abuse*, *21*(5), 1011-1028.

Dworkin, E. R., Jaffe, A. E., Bedard-Gilligan, M., & Fitzpatrick, S. (2023). PTSD in the year following sexual assault: A meta-analysis of prospective studies. *Trauma, Violence, & Abuse*, *24*(2), 497-514.

Dworkin, E. R., & Schumacher, J. A. (2018). Preventing posttraumatic stress related to sexual assault through early intervention: A systematic review. *Trauma, Violence, & Abuse*, *19*(4), 459-472.

Dyson, S., Frawley, P., & Robinson, S. (2017). *"Whatever it takes": Access for women with disabilities to domestic and domestic violence services: Final report (ANROWS Horizons, 05/2017)*.

Ege, M. A., Messias, E., Thapa, P. B., & Krain, L. P. (2015). Adverse childhood experiences and geriatric depression: Results from the 2010 BRFSS [Empirical Study; Quantitative Study]. *The American Journal of Geriatric Psychiatry*, *23*(1), 110-114. https://doi.org/https://dx.doi.org/10.1016/j.jagp.2014.08.014

Elklit, A., & Shevlin, M. (2011). Female sexual victimization predicts psychosis: A case-control study based on the Danish Registry System [Empirical Study; Quantitative Study]. *Schizophrenia Bulletin*, *37*(6), 1305-1310. https://doi.org/https://dx.doi.org/10.1093/schbul/sbq048

Emezue, C., Chase, J. D., Udmuangpia, T., & Bloom, T. L. (2022). Technology-based and digital interventions for intimate partner violence: A systematic review and meta-analysis [Review]. *Campbell Systematic Reviews*, *18*(3), e1271.

Fact Check NI. (2019). *Does Northern Ireland have the highest femicide rate in Western Europe?* Retrieved 19th July from

Fairbrother, N., & Rachman, S. (2004). Feelings of mental pollution subsequent to sexual assault. *Behaviour Research and Therapy*, *42*(2), 173-189.

Fischer, S., Stojek, M., & Hartzell, E. (2010). Effects of multiple forms of childhood abuse and adult sexual assault on current eating disorder symptoms [Empirical Study; Quantitative Study]. *Eating Behaviors*, *11*(3), 190-192. https://doi.org/https://dx.doi.org/10.1016/j.eatbeh.2010.01.001

Foa, E., Hembree, E., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences*. Oxford University Press.

Foa, E. B. (2011). Prolonged exposure therapy: past, present, and future. *Depression and Anxiety*.

Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A. M., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005). Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology*, *73(5)*, 953-964.

Foa, E. B., Rothbaum, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of posttraumatic stress disorder in rape victims: a comparison between cognitive-behavioral procedures and counseling. *Journal of consulting and clinical psychology*, *59*(5), 715.

Forman-Hoffman, V. L., Mengeling, M., Booth, B. M., Torner, J., & Sadler, A. G. (2012). Eating disorders, post-traumatic stress, and sexual trauma in women veterans [Empirical Study; Interview; Quantitative Study]. *Military Medicine*, *177*(10), 1161-1168. https://doi.org/https://dx.doi.org/10.7205/MILMED-D-12-00041

Fox, J., Ramon, S., & Morant, N. (2015). Exploring the meaning of recovery for carers: Implications for social work practice. *British Journal of Social Work*, *45*(suppl_1), i117-i134.

Freeman, D., & Fowler, D. (2009). Routes to psychotic symptoms: trauma, anxiety and psychosis-like experiences [Research Support, Non-U.S. Gov't]. *Psychiatry Research*, *169*(2), 107-112. https://doi.org/https://dx.doi.org/10.1016/j.psychres.2008.07.009

Full Stop Australia. (2022). *Sexual Violence Reform Priorities*.

Gardoki-Souto, I., Redolar-Ripoll, D., Fontana, M., Hogg, B., Castro, M. J., Blanch, J. M., Ojeda, F., Solanes, A., Radua, J., Valiente-Gomez, A., Cirici, R., Perez, V., Amann, B. L., & Moreno-Alcazar, A. (2022). Prevalence and Characterization of Psychological Trauma in Patients with Fibromyalgia: A Cross-Sectional Study [Article]. *Pain Research & Management*, *2022*, 16, Article 2114451. https://doi.org/10.1155/2022/2114451

Gillen, S. J. (2019). *The Gillen Review: Report into the Law and Procedures in Serious Sexual Offences in Northern Ireland*.

Gilmore, A. K., Hahn, C. K., Jaffe, A. E., Walsh, K., Moreland, A. D., & Ward-Ciesielski, E. F. (2018). Suicidal ideation among adults with a recent sexual assault: Prescription opioid use and prior sexual assault [Empirical Study; Quantitative Study]. *Addictive behaviors*, *85*, 120-124. https://doi.org/https://dx.doi.org/10.1016/j.addbeh.2018.05.028

Girard, M., Dugal, C., Hebert, M., & Godbout, N. (2020). Is my sex life ok? The mediating role of sexual anxiety in the association between childhood sexual abuse and sexual coercion against women [Empirical Study; Quantitative Study]. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, *29*(6), 717-733. https://doi.org/https://dx.doi.org/10.1080/10538712.2020.1774697

Gola, H., Engler, H., Schauer, M., Adenauer, H., Riether, C., Kolassa, S., Elbert, T., & Kolassa, I.-T. (2012). Victims of rape show increased cortisol responses to trauma reminders: A study in individuals with war- and torture-related PTSD [Empirical Study; Quantitative Study]. *Psychoneuroendocrinology*, *37*(2), 213-220. https://doi.org/https://dx.doi.org/10.1016/j.psyneuen.2011.06.005

Gomez, F., Kilpela, L. S., Middlemass, K. M., & Becker, C. B. (2021). Sexual trauma uniquely associated with eating disorders: A replication study [Empirical Study; Experimental Replication; Quantitative Study]. *Psychological Trauma: Theory, Research, Practice, and Policy*, *13*(2), 202-205. https://doi.org/https://dx.doi.org/10.1037/tra0000586

Gorman, K. (2013). *Clinical Models of Treatment for Trauma Experiences and Symptoms specific to Sexual Abuse and Sexual Assault - Initial Review of Existing Literature (2005-2012)*. https://aasas-media-library.s3.us-west-2.amazonaws.com/AASAS/wp-content/uploads/2015/08/Clinical-Models-of-Treatment-for-Trauma-Experiences-and-Symptoms-specific-to-Sexual-Abuse-and-Sexual-Assault-2013.pdf

Grant Thornton. (2022). *The importance of the consumer to the Northern Ireland economy*. T. C. C. f. N. Ireland. https://niopa.qub.ac.uk/bitstream/NIOPA/15837/1/Importance%20of%20the%20consumer%20to%20the%20NI%20economy.pdf

Gray, M. J., Hassija, C. M., Jaconis, M., Barrett, C., Zheng, P., Steinmetz, S., & James, T. (2015). Provision of evidence-based therapies to rural survivors of domestic violence and sexual assault via telehealth: Treatment outcomes and clinical training benefits. *Training and Education in Professional Psychology*, *9*(3), 235.

Gregory, A., Johnson, E., Feder, G., Campbell, J., Konya, J., & Perôt, C. (2022). Perceptions of peer support for victim-survivors of sexual violence and abuse: An exploratory study with key stakeholders. *Journal of Interpersonal Violence*, *37*(15-16), NP14036-NP14065.

Grey, C. N. B., Woodfine, L., Davies, A. R., & Azam, S. (2019). Childhood adversity in those with lived experiences of homelessness in Wales: a cross-sectional study [Conference Abstract]. *The Lancet*, *394(Supplement 2)*, S45. https://doi.org/https://dx.doi.org/10.1016/S0140-6736%2819%2932842-9

Harvey, S., Mitchell, M., Keeble, J., McNaughton Nicholls, C., & Rahim, N. (2014). Barriers faced by lesbian, gay, bisexual and transgender people in accessing domestic abuse, stalking and harassment, and sexual violence services. *Welsh Government*.

Hébert, M., & Bergeron, M. (2007). Efficacy of a group intervention for adult women survivors of sexual abuse. *Journal of Child Sexual Abuse*, *16*(4), 37-61.

Hembree, E. (2008). Prolonged exposure therapy for post traumatic stress disorder following sexual assault. *Prolonged Exposure Therapy for Post Traumatic Stress Disorder Following Sexual Assault Nov 6, 2008, np*, np. https://queens.ezp1.qub.ac.uk/login?url=http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=psye&AN=649352010-001

Hembree, E. A., Rauch, S. A., & Foa, E. B. (2003). Beyond the manual: The insider's guide to prolonged exposure therapy for PTSD. *Cognitive and Behavioral Practice*, *10*(1), 22-30.

Hetrick, S. E., Purcell, R., Garner, B., & Parslow, R. (2010). Combined pharmacotherapy and psychological therapies for post traumatic stress disorder (PTSD) [Meta-Analysis Review Systematic Review]. *Cochrane Database of Systematic Reviews*(7), CD007316.

Ho, G. W. K., Karatzias, T., Vallieres, F., Bondjers, K., Shevlin, M., Cloitre, M., Ben-Ezra, M., Bisson, J. I., Roberts, N. P., Astill Wright, L., & Hyland, P. (2021). Complex PTSD symptoms mediate the association between childhood trauma and physical health

problems. *Journal of Psychosomatic Research*, *142 (no pagination)*, Article 110358. https://doi.org/https://dx.doi.org/10.1016/j.jpsychores.2021.110358

Hogbeck, I., & Moller, A. (2021). Female sexual function six months after sexual assault: Post-traumatic stress disorder strongest risk factor for impaired function. *Journal of Sex & Marital Therapy*, No Pagination Specified. https://doi.org/https://dx.doi.org/10.1080/0092623X.2021.1958964

Hogg, B., Valiente-Gómez, A., Redolar-Ripoll, D., Gardoki-Souto, I., Fontana-McNally, M., Lupo, W., Jiménez, E., Madre, M., Blanco-Presas, L., & Reinares, M. (2022). High incidence of PTSD diagnosis and trauma-related symptoms in a trauma exposed bipolar I and II sample. *Frontiers in Psychiatry*, *13*, 931374.

Home Office (2017). The role of the independent sexual violence adviser: Essential elements. London: Home Office.

Horvath, M., Rose, H., Dalton, T., & Massey, K. (2021). Independent Sexual Violence Advisers in England, Wales and Northern Ireland. A study of impacts, effects, coping mechanisms and effective support systems for people working as ISVAs and ISVA Managers. London: Middlesex University.

Houston, J., Murphy, J., Shevlin, M., & Adamson, G. (2011). Cannabis use and psychosis: Re-visiting the role of childhood trauma [Empirical Study; Interview; Quantitative Study]. *Psychological Medicine*, *41*(11), 2339-2348. https://doi.org/https://dx.doi.org/10.1017/S0033291711000559

Humphreys, K. L., Sauder, C. L., Martin, E. K., & Marx, B. P. (2010). Tonic immobility in childhood sexual abuse survivors and its relationship to posttraumatic stress symptomatology [Empirical Study; Quantitative Study]. *Journal of Interpersonal Violence*, *25*(2), 358-373. https://doi.org/https://dx.doi.org/10.1177/0886260509334412

Husain, M., Moosa, K., & Khan, K. (2016). The relationship between previous trauma and alcohol and substance misuse in women [Conference Abstract]. *European Psychiatry*, *33(SUPPL.)*, S301. https://doi.org/https://dx.doi.org/10.1016/j.eurpsy.2016.01.1027

Hyland, P., Elklit, A., Vallieres, F., Shevlin, M., Murphy, J., Garvert, D. W., & Cloitre, M. (2017). An Assessment of the Construct Validity of the ICD-11 Proposal for Complex Posttraumatic Stress Disorder [Article]. *Psychological Trauma-Theory Research Practice and Policy*, *9*(1), 1-9. https://doi.org/10.1037/tra0000114

Hyland, P., Vallières, F., Cloitre, M., Ben-Ezra, M., Karatzias, T., Olff, M., Murphy, J., & Shevlin, M. (2021). Trauma, PTSD, and complex PTSD in the Republic of Ireland: prevalence, service use, comorbidity, and risk factors. *Social Psychiatry and Psychiatric Epidemiology*, *56*, 649-658.

Ilgen, M. A., Burnette, M. L., Conner, K. R., Czyz, E., Murray, R., & Chermack, S. (2010). The association between violence and lifetime suicidal thoughts and behaviors in individuals treated for substance use disorders [Empirical Study; Quantitative Study]. *Addictive behaviors*, *35*(2), 111-115. https://doi.org/https://dx.doi.org/10.1016/j.addbeh.2009.09.010

Jackson, L., Power, K., Mitchell, K., Duncan, K., Graham, L., & Wilson, K. (2023). Understanding female survivors of interpersonal trauma and their experience of the 'Survive & Thrive'course. *Group Analysis*, 05333164221150408.

Jacob, L., Thoumie, P., Haro, J. M., & Koyanagi, A. (2020). The relationship of childhood sexual and physical abuse with adulthood disability. *Annals of Physical and Rehabilitation Medicine*, *63(4)*, 332-339. https://doi.org/https://dx.doi.org/10.1016/j.rehab.2019.06.005

Johnson, S. D., Cottler, L. B., Ben Abdallah, A., & O'Leary, C. C. (2011). History of sexual trauma and recent HIV-risk behaviors of community-recruited substance using women [Empirical Study; Quantitative Study]. *AIDS and behavior*, *15*(1), 172-178. https://doi.org/https://dx.doi.org/10.1007/s10461-010-9752-6

Kalaf, J., Coutinho, E. S. F., Vilete, L. M. P., Luz, M. P., Berger, W., Mendlowicz, M., Volchan, E., Andreoli, S. B., Quintana, M. I., de Jesus Mari, J., & Figueira, I. (2017). Sexual trauma is more strongly associated with tonic immobility than other types of trauma-A population based study [Empirical Study; Quantitative Study]. *Journal of Affective Disorders*, *215*, 71-76. https://doi.org/https://dx.doi.org/10.1016/j.jad.2017.03.009

Kamiya, Y., Timonen, V., & Kenny, R. A. (2016). The impact of childhood sexual abuse on the mental and physical health, and healthcare utilization of older adults. *International Psychogeriatrics*, *28*(3), 415-422. https://doi.org/https://dx.doi.org/10.1017/S1041610215001672

Karatzias, T., Cloitre, M., Maercker, A., Kazlauskas, E., Shevlin, M., Hyland, P., Bisson, J. I., Roberts, N. P., & Brewin, C. R. (2017). PTSD and Complex PTSD: ICD-11 updates on concept and measurement in the UK, USA, Germany and Lithuania. *European journal of psychotraumatology*, *8*(sup7), 1418103.

Karatzias, T., Ferguson, S., Gullone, A., & Cosgrove, K. (2016). Group psychotherapy for female adult survivors of interpersonal psychological trauma: a preliminary study in Scotland [Multicenter Study]. *Journal of Mental Health*, *25*(6), 512-519.

Karatzias, T., Howard, R., Power, K., Socherel, F., Heath, C., & Livingstone, A. (2017). Organic vs. functional neurological disorders: The role of childhood psychological trauma. *Child Abuse & Neglect*, *63*, 1-6. https://doi.org/https://dx.doi.org/10.1016/j.chiabu.2016.11.011

Kendall-Tackett, K., Cong, Z., & Hale, T. W. (2013). Depression, sleep quality, and maternal well-being in postpartum women with a history of sexual assault: a comparison of breastfeeding, mixed-feeding, and formula-feeding mothers. *Breastfeeding Medicine: The Official Journal of the Academy of Breastfeeding Medicine*, *8*(1), 16-22. https://doi.org/https://dx.doi.org/10.1089/bfm.2012.0024

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, *52*, 1048-1060.

Kim, S.-Y., Chung, Y.-K., Kim, B. S., Lee, S. J., Yoon, J.-K., & An, Y.-S. (2012). Resting cerebral glucose metabolism and perfusion patterns in women with posttraumatic stress disorder related to sexual assault [Brain Imaging; Empirical Study; Quantitative Study].

Psychiatry Research: Neuroimaging, *201*(3), 214-217. https://doi.org/https://dx.doi.org/10.1016/j.pscychresns.2011.08.007

Koch, S. C., Riege, R. F., Tisborn, K., Biondo, J., Martin, L., & Beelmann, A. (2019). Effects of dance movement therapy and dance on health-related psychological outcomes. A meta-analysis update. *Frontiers in Psychology*, *10*, 1806.

Konya, J., Perôt, C., Pitt, K., Johnson, E., Gregory, A., Brown, E., Feder, G., & Campbell, J. (2020). Peer-led groups for survivors of sexual abuse and assault: A systematic review. *Journal of Mental Health*, 1-13.

Korkmaz, B., & Soygut, G. (2023). The psychotherapeutic change process in women who have been sexually assaulted: An examination of the schema therapy model. *Counselling and Psychotherapy Research*, *23*(2), 359-377.

Krakow, B., Hollifield, M., Schrader, R., Koss, M., Tandberg, D., Lauriello, J., McBride, L., Warner, T. D., Cheng, D., Edmond, T., & Kellner, R. (2000). A controlled study of imagery rehearsal for chronic nightmares in sexual assault survivors with PTSD: A preliminary report. *Journal of Traumatic Stress*, *13(4)*, 589-609.

Krakow, B., & Zadra, A. (2010). Imagery rehearsal therapy: principles and practice. *Sleep Medicine Clinics*, *5*(2), 289-298.

Kronenberg, G., Schoner, J., Levitanus, M., Balderrama, A. V. A., Geran, R., Laumeier, I., Schlattmann, P., Nelson, C. P., Endres, M., & Gertz, K. (2021). The importance of previous lifetime trauma in stroke-induced PTSD symptoms and mental health outcomes [Article]. *Journal of Psychiatric Research*, *136*, 589-594. https://doi.org/10.1016/j.jpsychires.2020.10.033

Lagdon, S., Owczarek, M., McCartan, C., Anyadike-Danes, N., Shevlin, M., & Jordan, J.-A. (2023). *Every voice matters! Violence against women in Northern Ireland*.

Lahey, B. B. (2009). Public health significance of neuroticism. *American Psychologist*, *64*(4), 241.

Lalor, K., & McElvaney, R. (2010). Child sexual abuse, links to later sexual exploitation/high-risk sexual behavior, and prevention/treatment programs [Literature Review]. *Trauma, Violence, & Abuse*, *11*(4), 159-177. https://doi.org/https://dx.doi.org/10.1177/1524838010378299

Lange, B. C. L., Condon, E. M., & Gardner, F. (2020). A mixed methods investigation of the association between child sexual abuse and subsequent maternal parenting [Research Support, Non-U.S. Gov't]. *Child Abuse & Neglect*, *103*, 104389. https://doi.org/https://dx.doi.org/10.1016/j.chiabu.2020.104389

Lasky, G. B., & Riva, M. T. (2006). Confidentiality and privileged communication in group psychotherapy. *International journal of group psychotherapy*, *56*(4), 455-476.

Lee, J., Dhauna, J., Silvers, J. A., Houston, M. H., & Barnert, E. S. (2022). Therapeutic Dance for the Healing of Sexual Trauma: A Systematic Review. *Trauma, violence & abuse*, 15248380221086898.

Lely, J., Smid, G.E., Jongedijk, R.A., Knipscheer, J.W., & Kelber, R.J. (2019). The effectiveness of narrative exposure therapy: a review, meta-analysis and meta-regression analysis.

European Journal of Psychotraumatology, 10, 1550344. https://doi.org/10.1080/20008198.2018.1550344

Leroux, J., Johnston, N., Brown, A. A., Mihic, A., DuBois, D., & Trudell, A. (2022). Delivery of Distance Counselling to Survivors of Sexual Violence: A Scoping Review of Promising and Best Practices [Systematic Review Research Support, Non-U.S. Gov't]. *Inquiry*, *59*, 469580221097427.

LimeCulture (2023). *Guidance for professionals working with people with Learning Disabilities who have experienced sexual violence and abuse.* Hale: LimeCulture. Available at: https://limeculture.co.uk/wp-content/uploads/2022/02/Guidance-for-professionals-working-with-people-with-Learning-Disabilities.pdf

LimeCulture (2023). *Working the victims and survivors from Gypsy, Roma and Traveller Communities*. Hale: LimeCulture. Available at: https://limeculture.co.uk/wp-content/uploads/2022/03/Working-with-victims-and-survivors-from-Gypsy-Roma-and-Traveller-Communities.pdf

Linde, D. S., Bakiewicz, A., Normann, A. K., Hansen, N. B., Lundh, A., & Rasch, V. (2020). Intimate Partner Violence and Electronic Health Interventions: Systematic Review and Meta-Analysis of Randomized Trials [Meta-Analysis Systematic Review]. *Journal of Medical Internet Research*, *22*(12), e22361.

Littleton, H., Abrahams, N., Bergman, M., Berliner, L., Blaustein, M., Cohen, J., Dworkin, E., Krahe, B., Pereda, N., & Peterson, Z. (2018). Sexual assault, sexual abuse, and harassment: understanding the mental health impact and providing care for survivors: an International Society for Traumatic Stress Studies briefing paper. *International Society for Traumatic Stress Studies*.

Liu, H., Petukhova, M. V., Sampson, N. A., Aguilar-Gaxiola, S., Alonso, J., Andrade, L. H., Bromet, E. J., De Girolamo, G., Haro, J. M., & Hinkov, H. (2017). Association of DSM-IV posttraumatic stress disorder with traumatic experience type and history in the World Health Organization World Mental Health Surveys. *JAMA psychiatry*, *74*(3), 270-281.

Liu, X.-h., Xie, X.-h., Wang, K.-y., & Cui, H. (2014). Efficacy and acceptability of atypical antipsychotics for the treatment of post-traumatic stress disorder: a meta-analysis of randomized, double-blind, placebo-controlled clinical trials. *Psychiatry Research*, *219*(3), 543-549.

Lomax, J., & Meyrick, J. (2022). Systematic review: Effectiveness of psychosocial interventions on wellbeing outcomes for adolescent or adult victim/survivors of recent rape or sexual assault. *Journal of health psychology*, *27*(2), 305-331.

Longden, E., House, A. O., & Waterman, M. G. (2016). Associations between nonauditory hallucinations, dissociation, and childhood adversity in first-episode psychosis [Empirical Study; Quantitative Study]. *Journal of Trauma & Dissociation*, *17*(5), 545-560. https://doi.org/https://dx.doi.org/10.1080/15299732.2016.1155193

Lovell, A., Majeed-Ariss, R., & White, C. (2021). Repeat attenders are disproportionately vulnerable: An exploration of revictimisation at Saint Mary's Sexual Assault Referral Centre [Observational Study]. *Journal of Forensic & Legal Medicine*, *80*, 102158. https://doi.org/https://dx.doi.org/10.1016/j.jflm.2021.102158

Loya, R. M. (2015). Rape as an economic crime: The impact of sexual violence on survivors' employment and economic well-being [Empirical Study; Interview; Qualitative Study]. *Journal of Interpersonal Violence*, *30*(16), 2793-2813. https://doi.org/https://dx.doi.org/10.1177/0886260514554291

Maher, J., Spivakovsky, C., McCulloch, J., McGowan, J., Beavis, K., Lea, M., Cadwallader, J., & Sands, T. (2018). *Women, disability and violence: Barriers to accessing justice. Key findings and future directions (Research to policy and practice, 02/2018)*.

Malhotra, A., & Baker, J. (2019). *Group therapy*. Treasure Island (FL): StatPearls Publishing.

Marshall, M., Shannon, C., Meenagh, C., Mc Corry, N., & Mulholland, C. (2018). The association between childhood trauma, parental bonding and depressive symptoms and interpersonal functioning in depression and bipolar disorder. *Irish Journal of Psychological Medicine*, *35(1)*, 23-32. https://doi.org/https://dx.doi.org/10.1017/ipm.2016.43

Matheson, S. L., Shepherd, A. M., Pinchbeck, R. M., Laurens, K. R., & Carr, V. J. (2013). Childhood adversity in schizophrenia: a systematic meta-analysis [Review]. *Psychological Medicine*, *43*(2), 225-238. https://doi.org/10.1017/s0033291712000785

McCartan, C., Davidson, G., Bradley, L., Greer, K., Knifton, L., Mulholland, A., Webb, P., & White, C. (2023). 'Lifts your spirits, lifts your mind': A co-produced mixed-methods exploration of the benefits of green and blue spaces for mental wellbeing. *Health Expectations*.

McCracken, N. (2023). *Sexual violence and abuse helpline calls increase in Northern Ireland*. BBC. Retrieved 8th July from https://www.bbc.co.uk/news/uk-northern-ireland-64264109

McEwen, C. (2018). *A guide to evaluating interventions related to violence against women* (ANROWS Insights, 03/2018, Issue.

McNair, S. M., & Boisvert, L. (2021). Prevalence of adult female genital trauma after acute sexual assault: The need for a universal definition of genital trauma [Empirical Study; Longitudinal Study; Retrospective Study; Quantitative Study]. *Journal of forensic nursing*, *17*(3), 140-145. https://doi.org/https://dx.doi.org/10.1097/JFN.0000000000000325

McQuillan, K., Hyland, P., & Vallieres, F. (2022). Prevalence, correlates, and the mitigation of ICD-11 CPTSD among homeless adults: The role of self-compassion. *Child Abuse and Neglect*, *127 (no pagination)*, Article 105569. https://doi.org/https://dx.doi.org/10.1016/j.chiabu.2022.105569

Meichenbaum, D., & Deffenbacher, J. (1988). Stress inoculation training. *The Counseling Psychologist*, *16*, 69-90.

Melton, H., Meader, N., Dale, H., Wright, K., Jones-Diette, J., Temple, M., Shah, I., Lovell, K., McMillan, D., Churchill, R., Barbui, C., Gilbody, S., & Coventry, P. (2020). Interventions for adults with a history of complex traumatic events: the INCiTE mixed-methods systematic review [Review]. *Health Technology Assessment*, *24*(43), 1-+. https://doi.org/10.3310/hta24430

Micali, N., Martini, M. G., Thomas, J. J., Eddy, K. T., Kothari, R., Russell, E., Bulik, C. M., & Treasure, J. (2017). Lifetime and 12-month prevalence of eating disorders amongst

women in mid-life: a population-based study of diagnoses and risk factors. *BMC Medicine*, *15*(1), 12. https://doi.org/https://dx.doi.org/10.1186/s12916-016-0766-4

Mieseler, V., & Myers, C. (2013). Practical steps to get from trauma aware to trauma informed while creating a healthy, safe, and secure environment for children. *Jefferson City Missouri Coalition for Community Behavioral Healthcare Retrieved from httpsmocmhcorgdocumentsThursday20OctoberMieselerMyers20Trauma20Informed20CarePRACTIC AL20STEPS20TO20GET20FROM20TRAUMA20AWARE20TOpdf*.

Miles-Johnson, T. (2013). LGBTI variations in crime reporting: How sexual identity influences decisions to call the cops. *Sage open*, *3*(2), 2158244013490707.

Millegan, J., Milburn, E. K., LeardMann, C. A., Street, A. E., Williams, D., Trone, D. W., & Crum-Cianflone, N. F. (2015). Recent sexual trauma and adverse health and occupational outcomes among U.S. Service women [Empirical Study; Followup Study; Longitudinal Study; Prospective Study; Quantitative Study]. *Journal of Traumatic Stress*, *28*(4), 298-306. https://doi.org/https://dx.doi.org/10.1002/jts.22028

Moulton, S. J., Newman, E., Power, K., Swanson, V., & Day, K. (2015). Childhood trauma and eating psychopathology: a mediating role for dissociation and emotion dysregulation? *Child Abuse & Neglect*, *39*, 167-174. https://doi.org/https://dx.doi.org/10.1016/j.chiabu.2014.07.003

Muehsam, D., Lutgendorf, S., Mills, P. J., Rickhi, B., Chevalier, G., Bat, N., Chopra, D., & Gurfein, B. (2017). The embodied mind: a review on functional genomic and neurological correlates of mind-body therapies. *Neuroscience & Biobehavioral Reviews*, *73*, 165-181.

Munro, M. L., Foster Rietz, M., & Seng, J. S. (2012). Comprehensive care and pregnancy: The unmet care needs of pregnant women with a history of rape [Empirical Study; Followup Study; Longitudinal Study; Prospective Study; Interview; Quantitative Study]. *Issues in Mental Health Nursing*, *33*(12), 882-896. https://doi.org/https://dx.doi.org/10.3109/01612840.2012.731136

Murphy, J., Houston, J. E., Shevlin, M., & Adamson, G. (2013). Childhood sexual trauma, cannabis use and psychosis: Statistically controlling for pre-trauma psychosis and psychopathology [Empirical Study; Interview; Quantitative Study]. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, *48*(6), 853-861. https://doi.org/https://dx.doi.org/10.1007/s00127-012-0592-8

Ng, I. S., Cheung, K. C., & Chou, K. L. (2013). Correlates of eating disorder in middle-aged and older adults: evidence from 2007 British National Psychiatric Morbidity Survey [Research Support, Non-U.S. Gov't]. *Journal of Aging & Health*, *25*(7), 1106-1120. https://doi.org/https://dx.doi.org/10.1177/0898264313494798

Nguyen, T., Hauck, Y. L., Pedruzzi, R. A., Frayne, J., Rock, D., & Dragovic, M. (2017). Sexual health and sexual trauma in women with severe mental illness: An exploratory survey of Western Australian community mental health services [Empirical Study; Quantitative Study]. *Health Care for Women International*, *38*(7), 705-714. https://doi.org/https://dx.doi.org/10.1080/07399332.2017.1313845

NICE. (2018). *NICE Guideline: Post-traumatic stress disorder*. NICE. Retrieved 7th July from www.nice.org.uk/guidance/ng116

Niemeyer, H., Lorbeer, N., Mohr, J., Baer, E., & Knaevelsrud, C. (2022). Evidence-based individual psychotherapy for complex posttraumatic stress disorder and at-risk groups for complex traumatization: A meta-review. *Journal of Affective Disorders*, *299*, 610-619.

Nothling, J., Abrahams, N., Toikumo, S., Suderman, M., Mhlongo, S., Lombard, C., Seedat, S., & Hemmings, S. M. J. (2021). Genome-wide differentially methylated genes associated with posttraumatic stress disorder and longitudinal change in methylation in rape survivors [Article]. *Translational Psychiatry*, *11*(1), 21, Article 594. https://doi.org/10.1038/s41398-021-01608-z

NSW Health Education Centre Against Violence. (2013a). *Recovering from Adult Sexual Assault: Navigating the Journey*.

NSW Health Education Centre Against Violence. (2013b). *Sharing the Un-Shareable: A Resource for Women on Recovering from Child Sexual Abuse*.

NSW Health Education Centre Against Violence. (2013c). *When a man is raped: A survival guide Information for men who have been raped, their parents, partner's, spouses and friends*.

NSW Health Education Centre Against Violence. (2013d). *Who can a man tell? Information for men who were sexually assaulted as children, their parents, spouses and friends*.

NSW Ministry of Health. (2019). *Integrated Prevention and Response to Violence, Abuse and Neglect. NSW Health Violence, Abuse and Neglect Redesign Program*.

O'Neill, T., Maguire, A., & Shevlin, M. (2021). Sexual trauma in childhood and adulthood as predictors of psychotic-like experiences: The mediating role of dissociation [Empirical Study; Quantitative Study]. *Child Abuse Review*, *30*(5), 431-443. https://doi.org/https://dx.doi.org/10.1002/car.2705

Office for National Statistics. (2020). Nature of sexual assault by rape or penetration, England and Wales: year ending March 2020. In.

ONS. (2023). *Sexual offences in England and Wales overview: year ending March 2022*.

Oosterbaan, V., Covers, M. L., Bicanic, I. A., Huntjens, R. J., & de Jongh, A. (2019). Do early interventions prevent PTSD? A systematic review and meta-analysis of the safety and efficacy of early interventions after sexual assault. *European journal of psychotraumatology*, *10*(1), 1682932.

Oram, S., Khondoker, M., Abas, M., Broadbent, M., & Howard, L. M. (2015). Characteristics of trafficked adults and children with severe mental illness: a historical cohort study [Research Support, Non-U.S. Gov't]. *The Lancet. Psychiatry*, *2*(12), 1084-1091. https://doi.org/https://dx.doi.org/10.1016/S2215-0366(15)00290-4

Oshodi, Y., Macharia, M., Lachman, A., & Seedat, S. (2020). Immediate and long-term mental health outcomes in adolescent female rape survivors [Empirical Study; Followup Study; Longitudinal Study; Prospective Study; Quantitative Study]. *Journal of Interpersonal Violence*, *35*(1-2), 252-267. https://doi.org/https://dx.doi.org/10.1177/0886260516682522

Ottisova, L., Hemmings, S., Howard, L. M., Zimmerman, C., & Oram, S. (2016). Prevalence and risk of violence and the mental, physical and sexual health problems associated with

human trafficking: an updated systematic review [Article]. *Epidemiology and Psychiatric Sciences*, *25*(4), 317-341. https://doi.org/10.1017/s2045796016000135

Parcesepe, A. M., Martin, S. L., Pollock, M. D., & Garcia-Moreno, C. (2015). The effectiveness of mental health interventions for adult female survivors of sexual assault: A systematic review. *Aggression and Violent Behavior*, *Part A. 25*, 15-25.

Pinciotti, C. M., Luehrs, R., Horvath, G., Orchowski, L. M., & Badour, C. L. (2023). Disclosure of traumatic details and obsessive-compulsive contamination symptoms in sexual assault survivors. *Psychological Trauma: Theory, Research, Practice, and Policy*.

Plant, M., Plant, M., & Miller, P. (2005). Childhood and adult sexual abuse: relationships with 'addictive' or 'problem' behaviours and health [Research Support, Non-U.S. Gov't]. *Journal of Addictive Diseases*, *24*(1), 25-38.

Plummer, S.-B., & Findley, P. A. (2012). Women with disabilities' experience with physical and sexual abuse: Review of the literature and implications for the field. *Trauma, Violence, & Abuse*, *13*(1), 15-29.

Potter, S., Howard, R., Murphy, S., & Moynihan, M. M. (2018). Long-term impacts of college sexual assaults on women survivors' educational and career attainments [Empirical Study; Quantitative Study]. *Journal of American College Health*, *66*(6), 496-507. https://doi.org/https://dx.doi.org/10.1080/07448481.2018.1440574

QCDFVR. (2022). *Trauma-informed Responses to Sexual Assault. Research to Practice Paper*.

Quadara, A. (2015). *Implementing trauma-informed systems of care in health settings: The WITH study. State of knowledge paper*. Australia's National Research Organisation for Women's Safety.

Rabinovitz, S., Goldman, K., Rosca, P., Barda, J., & Levine, S. Z. (2019). The role of substance use and adult sexual assault severity in the course of schizophrenia: An epidemiological catchment study of sexual assault victims [Empirical Study; Quantitative Study]. *Schizophrenia Research*, *208*, 406-413. https://doi.org/https://dx.doi.org/10.1016/j.schres.2019.01.008

Rachman, S. (2004). Fear of contamination. *Behaviour Research and Therapy*, *42*(11), 1227-1255.

Rape Crisis England & Wales. (2023). *What is sexual violence?* Retrieved 17th July from https://rapecrisis.org.uk/get-informed/about-sexual-violence/what-is-sexual-violence/#:~:text=This%20is%20defined%20in%20English%20and%20Welsh%20law%20as%20sexual,forced%20to%20perform%20sexual%20acts.

Rauch, S. A., Kim, H. M., Powell, C., Tuerk, P. W., Simon, N. M., Acierno, R., Allard, C. B., Norman, S. B., Venners, M. R., & Rothbaum, B. O. (2019). Efficacy of prolonged exposure therapy, sertraline hydrochloride, and their combination among combat veterans with posttraumatic stress disorder: a randomized clinical trial. *JAMA psychiatry*, *76*(2), 117-126.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, *60(5)*, 748-756.

Resick, P. A., Williams, L. F., Suvak, M. K., Monson, C. M., & Gradus, J. L. (2012). Long-term outcomes of cognitive–behavioral treatments for posttraumatic stress disorder among female rape survivors. *Journal of consulting and clinical psychology*, *80*(2), 201.

Reyes-Rodriguez, M. L., Von Holle, A., Ulman, T. F., Thornton, L. M., Klump, K. L., Brandt, H., Crawford, S., Fichter, M. M., Halmi, K. A., Huber, T., Johnson, C., Jones, I., Kaplan, A. S., Mitchell, J. E., Strober, M., Treasure, J., Woodside, D. B., Berrettini, W. H., Kaye, W. H., & Bulik, C. M. (2011). Posttraumatic Stress Disorder in Anorexia Nervosa [Article]. *Psychosomatic Medicine*, *73*(6), 491-497. https://doi.org/10.1097/PSY.0b013e31822232bb

Roberts, R., O'Connor, T., Dunn, J., & Golding, J. (2004). The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring [Research Support, Non-U.S. Gov't]. *Child Abuse & Neglect*, *28*(5), 525-545.

Rogers, N. T., Power, C., & Pinto Pereira, S. M. (2021). Child maltreatment, early life socioeconomic disadvantage and all-cause mortality in mid-adulthood: Findings from a prospective British birth cohort. *BMJ Open*, *11(9) (no pagination)*, Article e050914. https://doi.org/https://dx.doi.org/10.1136/bmjopen-2021-050914

Rothbaum, B. O., Foa, E. B., Riggs, D. S., Murdock, T., & Walsh, W. (1992). A prospective examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress*, *5*, 455-475.

Rouse, A., Jenkinson, E., & Warner, C. (2023). The use of "art" as a resource in recovery from the impact of sexual abuse in childhood: A qualitative systematic review. *Arts & Health*, *15*(1), 86-109.

Russell, P. L., & Davis, C. (2007). Twenty-five years of empirical research on treatment following sexual assault. *Best Practices in Mental Health*, *3*(2), 21-37.

Russin, S. E., & Stein, C. H. (2022). The aftermath of trauma and abuse and the impact on family: A narrative literature review [Literature Review]. *Trauma, Violence, & Abuse*, *23*(4), 1288-1301. https://doi.org/https://dx.doi.org/10.1177/1524838021995990

Sarasua, B., Zubizarreta, I., De Corral, P., & Echeburúa, E. (2013). Tratamiento psicológico de mujeres adultas víctimas de abuso sexual en la infancia: resultados a largo plazo. *Anales de Psicología/Annals of Psychology*, *29*(1), 29-37.

Scarce, M. (2008). *Male on male rape: The hidden toll of stigma and shame*. Basic Books.

Schafer, I., & Fisher, H. L. (2011). Childhood trauma and posttraumatic stress disorder in patients with psychosis: clinical challenges and emerging treatments [Article]. *Current Opinion in Psychiatry*, *24*(6), 514-518. https://doi.org/10.1097/YCO.0b013e32834b56c8

Schafer, I., Gromus, L., Atabaki, A., Pawils, S., Verthein, U., Reimer, J., Schulte, B., & Martens, M. (2014). Are experiences of sexual violence related to special needs in patients with substance use disorders? A study in opioid-dependent patients [Empirical Study; Interview; Quantitative Study]. *Addictive behaviors*, *39*(12), 1691-1694. https://doi.org/https://dx.doi.org/10.1016/j.addbeh.2014.07.008

Schouten, K. A., de Niet, G. J., Knipscheer, J. W., Kleber, R. J., & Hutschemaekers, G. J. (2015). The effectiveness of art therapy in the treatment of traumatized adults: A systematic review on art therapy and trauma. *Trauma, Violence, & Abuse*, *16*(2), 220-228.

Seidler, G. H., & Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study. *Psychological Medicine*, *36*(11), 1515-1522.

Senior, R., Barnes, J., Emberson, J. R., & Golding, J. (2005). Early experiences and their relationship to maternal eating disorder symptoms, both lifetime and during pregnancy [Multicenter Study Research Support, Non-U.S. Gov't]. *British Journal of Psychiatry*, *187*, 268-273.

Sepeng, N. V., & Makhado, L. (2019). Psychological management intervention guidelines for rape survivors with post-traumatic stress disorder (PTSD): A brief exploratory systematic literature review. *Journal of Psychology in Africa*, *29*(2), 135-140. https://doi.org/10.1080/14330237.2019.1594631

Serrata, J. V., Rodriguez, R., Castro, J. E., & Hernandez-Martinez, M. (2020). Well-being of Latina survivors of intimate partner violence and sexual assault receiving trauma-informed and culturally-specific services. *Journal of family violence*, *35*(2), 169-180.

Sexual Offences Act, (2003).

Shapiro, F. (2014). The role of eye movement desensitization and reprocessing (EMDR) therapy in medicine: addressing the psychological and physical symptoms stemming from adverse life experiences. *The Permanente Journal*, *18*(1), 71.

Short, N. A., Morabito, D. M., & Gilmore, A. K. (2020). Secondary prevention for posttraumatic stress and related symptoms among women whohave experienced a recent sexual assault: A systematic review and meta-analysis [Meta-Analysis Research Support, N.I.H., Extramural Systematic Review]. *Depression & Anxiety*, *37*(10), 1047-1059.

Silk, K. (2023). *Formal support needs of adult victim-survivors of sexual violence: A literature review* (Ministry of Justice Analytical Series, Issue. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1131349/formal-support-needs-of-adult-victim-survivors-of-sexual-violence-literature-review.pdf

Silk, K., Larsen, C., & Finnemore, H. (2023). *Formal support needs of adult sexual violence victim-survivors: survey findings report* (Ministry of Justice Analytical Series, Issue. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1131292/formal-support-needs-of-adult-victim-survivors-of-sexual-violence-survey-findings-report.pdf

Sinai, C., Hirvikoski, T., Nordstrom, A.-L., Nordstrom, P., Nilsonne, A., Wilczek, A., Asberg, M., & Jokinen, J. (2014). Hypothalamic pituitary thyroid axis and exposure to interpersonal violence in childhood among women with borderline personality disorder [Empirical Study; Interview; Quantitative Study]. *European Journal of Psychotraumatology Vol 5 2014, ArtID 23911*, *5*. https://doi.org/https://dx.doi.org/10.3402/ejpt.v5.23911

Smith-Marek, E. N., Baptist, J., Lasley, C., & Cless, J. D. (2018). "I Don't Like Being That Hyperaware of My Body": Women Survivors of Sexual Violence and Their Experience of Exercise [Research Support, Non-U.S. Gov't]. *Qualitative Health Research*, *28*(11), 1692-1707.

Soares, A. G., Howe, L. D., Heron, J., Hammerton, G., Rich-Edwards, J., Magnus, M. C., Halligan, S. L., & Fraser, A. (2022). How does childhood maltreatment influence cardiovascular disease? A sequential causal mediation analysis. *International Journal of Epidemiology*, *51(2)*, 555-566. https://doi.org/https://dx.doi.org/10.1093/ije/dyab085

Sousa-Gomes, V., Abreu, B., Moreira, D., Del Campo, A., Moreira, D. S., & Favero, M. (2022). Psychological intervention and treatment programs for adult victims of child sexual abuse: A systematic review. *Psychological trauma : theory, research, practice and policy.*, *27*.

Spohn, R., Wright, E. M., & Peterson, J. C. (2017). Rape and mental health outcomes among women: Examining the moderating effects of "healthy" fear levels [Empirical Study; Experimental Replication; Interview; Quantitative Study]. *Violence against women*, *23*(9), 1055-1075. https://doi.org/https://dx.doi.org/10.1177/1077801216655625

Stafford, J., Chung, W. T., Sommerlad, A., Kirkbride, J. B., & Howard, R. (2022). Psychiatric disorders and risk of subsequent dementia: Systematic review and meta-analysis of longitudinal studies [Review]. *International Journal of Geriatric Psychiatry*, *37*(5), 22. https://doi.org/10.1002/gps.5711

Stansfeld, S. A., Clark, C., Smuk, M., Power, C., Davidson, T., & Rodgers, B. (2017). Childhood adversity and midlife suicidal ideation [Research Support, Non-U.S. Gov't]. *Psychological Medicine*, *47*(2), 327-340. https://doi.org/https://dx.doi.org/10.1017/S0033291716002336

Stefanidou, T., Hughes, E., Kester, K., Edmondson, A., Majeed-Ariss, R., Smith, C., Ariss, S., Brooker, C., Gilchrist, G., Kendal, S., Lucock, M., Maxted, F., Perot, C., Shallcross, R., Trevillion, K., & Lloyd-Evans, B. (2020). The identification and treatment of mental health and substance misuse problems in sexual assault services: A systematic review [Research Support, Non-U.S. Gov't

Systematic Review]. *PLoS ONE [Electronic Resource]*, *15*(4), e0231260. https://doi.org/https://dx.doi.org/10.1371/journal.pone.0231260

Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical Behavior Therapy for Posttraumatic Stress Disorder Related to Childhood Sexual Abuse: A Pilot Study of an Intensive Residential Treatment Program. *Journal of Traumatic Stress*, *24*(1), 102-106. https://doi.org/10.1002/jts.20617

Steine, I.M., Harvey, A.G., Krystal, J.H., Milde, A.M.,..., Pallesen, S. (2011). Sleep disturbances in sexual abuse systems: A systematic review. *Sleep Medicine Reviews, 16, 15-25.*

Streater, O. K. N. (2022). Truth, justice and bodily accountability: dance movement therapy as an innovative trauma treatment modality. *Body, Movement and Dance in Psychotherapy*, *17(1)*, 34-53.

Swaine, A. (2023). Resurfacing gender: a typology of conflict-related violence against women for the Northern Ireland Troubles. *Violence Against Women*, 29(6-7), 1391-1418.

Taylor, J. E., & Harvey, S. T. (2009). Effects of psychotherapy with people who have been sexually assaulted: A meta-analysis. *Aggression and Violent Behavior*, *14(5)*, 273-285.

TeBockhorst, S. F., O'Halloran, M. S., & Nyline, B. N. (2015). Tonic immobility among survivors of sexual assault [Empirical Study; Quantitative Study]. *Psychological Trauma: Theory, Research, Practice, and Policy*, *7*(2), 171-178. https://doi.org/https://dx.doi.org/10.1037/a0037953

Tran, K., Moulton, K., Santesso, N., & Rabb, D. (2016). Cognitive processing therapy for post-traumatic stress disorder: A systematic review and meta-analysis.

Turgumbayev, M., Shopabayev, B., Dzhansarayeva, R., Izbassova, A., & Beaver, K. (2023). An examination of associations between sexual assault and health problems, depression or suicidal ideation in a large nationally representative cohort of male and female 20-30-year-olds. *Criminal Behaviour and Mental Health*, No Pagination Specified. https://doi.org/https://dx.doi.org/10.1002/cbm.2280

Twinley, R. (2017). Woman-to-woman rape and sexual assault, and its impact upon the occupation of work: Victim/survivors' life roles of worker or student as disruptive and preservative. *Work*, *56*(4), 505-517. https://doi.org/https://dx.doi.org/10.3233/WOR-172529

Ullman, S. E., O'Callaghan, E., Shepp, V., & Harris, C. (2020). Reasons for and experiences of sexual assault nondisclosure in a diverse community sample. *Journal of family violence*, *35*, 839-851.

Ulrich, R. S. (1991). Effects of interior design on wellness: theory and recent scientific research. Journal of Health Care Interior Design: Proceedings from the... Symposium on Health Care Interior Design. Symposium on Health Care Interior Design,

Ulrich, R. S., Bogren, L., Gardiner, S. K., & Lundin, S. (2018). Psychiatric ward design can reduce aggressive behavior. *Journal of Environmental Psychology*, *57*, 53-66.

UK Psychological Trauma Society (2020). *Guideline for the treatment and planningn of services for complex post-traumatic stress disorder in adults*. UKPTS. Available at: *https://ukpts.org/wp-content/uploads/2018/03/guidance_11_2920929231.pdf*

Vallieres, F., Gilmore, B., Nolan, A., Maguire, P., Bondjers, K., McBride, O., Murphy, J., Shevlin, M., Karatzias, T., & Hyland, P. (2022). Sexual Violence and Its Associated Psychosocial Effects in Ireland. *Journal of Interpersonal Violence*, *37(11-12)*, NP9066-NP9088. https://doi.org/https://dx.doi.org/10.1177/0886260520978193

Van der Kolk, B. A., Spinazzola, J., Blaustein, M. E., Hopper, J. W., Hopper, E. K., Korn, D. L., & Simpson, W. B. (2007). A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance. *Journal of Clinical Psychiatry*, *68*(1), 37.

Vechiu, C., & Zimmermann, M. (2019). The effectiveness of psychoeducation and brief treatments in the aftermath of sexual assault. *Handbook of sexual assault and sexual assault prevention*, 501-513.

Ventimiglia, I., & Seedat, S. (2019). Current evidence on urbanicity and the impact of neighbourhoods on anxiety and stress-related disorders. *Current Opinion in Psychiatry*, *32*(3), 248-253.

Vickerman, K. A., & Margolin, G. (2009). Rape treatment outcome research: Empirical findings and state of the literature. *Clinical Psychology Review*, *29(5)*, 431-448.

Vieweger, M. (2019). *Women Rape Survivors Narratives of Psychological Support and Counselling Experiences* Faculty of Humanities].

Volker, C. A. (1997). *Treatment of sexual assault survivors utilizing cognitive therapy and art therapy*. California Institute of Integral Studies.

Wang, T. Y., Wei, H. T., Liou, Y. J., Su, T. P., Bai, Y. M., Tsai, S. J., Yang, A. C., Chen, T. J., Tsai, C. F., & Chen, M. H. (2016). Risk for developing dementia among patients with posttraumatic stress disorder: A nationwide longitudinal study [Article]. *Journal of Affective Disorders*, *205*, 306-310. https://doi.org/10.1016/j.jad.2016.08.013

Werbeloff, N., Thygesen, J. H., Hayes, J., Viding, E., & Osborn, D. (2020). The association between childhood sexual abuse and outcomes in patients with severe mental illness [Conference Abstract]. *Schizophrenia Bulletin*, *46(Supplement 1)*, S184.

Werbeloff, N., Thygesen, J. H., Hayes, J. F., Viding, E. M., Johnson, S., & Osborn, D. P. J. (2021). Childhood sexual abuse in patients with severe mental Illness: Demographic, clinical and functional correlates [Article]. *Acta Psychiatrica Scandinavica*, *143*(6), 495-502. https://doi.org/10.1111/acps.13302

Wessely, S., Bryant, R. A., Greenberg, N., Earnshaw, M., Sharpley, J., & Hughes, J. H. (2008). Does psychoeducation help prevent post traumatic psychological distress? *Psychiatry: Interpersonal and Biological Processes*, *71*(4), 287-302.

Westmarland, N., & Alderson, S. (2013). The health, mental health, and well-being benefits of rape crisis counseling. *Journal of Interpersonal Violence*, *28*(17), 3265-3282.

Whitley, R., & Drake, R. E. (2010). Recovery: a dimensional approach. *Psychiatric Services*, *61*(12), 1248-1250.

Williams, J. R., Girdler, S., Williams, W., & Cromeens, M. G. (2021). The effects of co-occurring interpersonal trauma and gender on opioid use and misuse [Empirical Study; Quantitative Study]. *Journal of Interpersonal Violence*, *36*(23-24), NP13185-NP13205. https://doi.org/https://dx.doi.org/10.1177/0886260519900309

Wolgensinger, L. (2022). Cognitive behavioral group therapy for anxiety: recent developments. *Dialogues in Clinical Neuroscience*.

Woodward, M. J., Eddinger, J., Henschel, A. V., Dodson, T. S., Tran, H. N., & Beck, J. G. (2015). Social support, posttraumatic cognitions, and PTSD: The influence of family, friends, and a close other in an interpersonal and non-interpersonal trauma group. *Journal of Anxiety Disorders*, *35*, 60-67.

Yates, K., Lang, U., Peters, E. M., Wigman, J. T., Boyda, D., McNicholas, F., Cannon, M., Alderson-Day, B., Bloomfield, M., Ramsay, H., & Kelleher, I. (2022). Hallucinations as a risk marker for suicidal behaviour in individuals with a history of sexual assault: A general population study with instant replication. *Psychological Medicine*, No Pagination Specified. https://doi.org/https://dx.doi.org/10.1017/S0033291722001532