Summary Review of effective support services for treating Mental Health needs of adult victims of sexual trauma

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Current provider landscape

The current specialist service in Thurrock aimed at supporting victims of sexual violence is the South Essex Rape & Incest Crisis Centre (SERICC). The stated aim of SERICC is to "raise awareness, prevent and reduce sexual violence through the provision of high quality specialist support services". This service has been approved by Rape Crisis England & Wales and meets National Service Standards. The offer of SERICC includes:

- An information and support line
- Independent Sexual Violence Advisors (ISVA)
- Specialist Sexual Violence Counsellors (for mental wellbeing needs relating to their sexual abuse)
- Advocacy Service
- Brighter Futures
- Young People's Sexual Violence Counselling Service

It is worth noting that SERICC's counsellors are not CBT-trained and therefore do not treat mental health conditions such as depression and anxiety.

Inclusion Thurrock is commissioned as the IAPT (Improving Access to Psychological Therapies) provider in Thurrock to provide treatment of common mental health conditions – including those of sexual violence survivors; although they refer patients to SERICC for other specialist therapeutic support specifically related to their sexual violence trauma.

Thurrock's Recovery College (also delivered by Inclusion/MIND) provides peer recovery and self-management support to those with poorer mental health; however this does not have a specialist remit for sexual violence survivors.

This review aims to consider the evidence base for best practice in regards to mental health treatment provision for adult sexual violence (both recent and historical) survivors and will feed into discussions about service development.

Treatment of PTSD for sexual violence survivors and adult survivors of child sexual abuse

A 2009 meta-analysis (Taylor & Harvey, 2009) examined the results of 15 studies on the outcomes of different types of psychotherapeutic approaches for sexual assault victims experiencing PTSD or rape trauma symptoms. Included studies used a variety of treatments including cognitive processing therapy (CPT) , cognitive restructuring (CR) , eye movement desensitization reprocessing (EMDR) , imagery

rehearsal therapy (IRT) , and prolonged exposure (PE) . Results were highly consistent, producing effect sizes of .91 and .90 respectively. (Effect sizes larger than .8 are generally considered large, and these particular effects mean that the probability of the psychotherapy treatment being superior to the control is approximately 74%). The authors observed a pattern of larger effect sizes for studies involving some aspect of cognitive behavioural therapy (CBT) . This supports the guidance of NICE as well as the American Psychological Association which both recommend CBT strongly for the treatment of PTSD. Effects were maintained 6-12 months after treatment; indicating that psychotherapy is an effective treatment method for adults who have been sexually assaulted.

A separate 2014 meta-analysis (Ehring, 2014) examined psychological treatments for PTSD in adult survivors of childhood abuse. The 16 included RCTs evaluated a variety of treatments including trauma-focused CBT, non-trauma focused CBT and EMDR. Results showed trauma focused treatments were found to be more effective than non-trauma focused, with the best evidence overall specifically for trauma-focused CBT, though trauma-focused EMDR also appears to be effective. The key to both of these therapies seems to be that they focus mainly on processing the memory of the trauma and its meaning. However both trauma-focused and non-trauma focused treatments performed better than no treatment as those receiving either treatment showed significant improvement in depression, anxiety and dissociation compared to no-treatment groups.

This conclusion is supported by a 2011 review (Kendall, 2011) which also concluded that abuse focused therapy such as CBT, EMDR and emotion-focused therapy was generally beneficial and yielded symptom improvement amongst CSA survivors, regardless of the specific therapeutic technique used.

Cognitive behavioural therapy (CBT): a psychological intervention where the person works collaboratively with the therapist to identify the effects of thoughts, beliefs and interpretations on current symptoms, feelings states and problems areas. They learn the skills to identity, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms or problems, and appropriate coping skills. Duration of treatment varies depending on the disorder and its severity but for people with depression it should be in the range of 16 to 20 sessions over 3 to 4 months; for people with Generalised Anxiety Disorder (GAD) it should usually consist of 12 to 15 weekly sessions (fewer if the person recovers sooner, more if clinically required), each lasting 1 hour.

Trauma-focused CBT: a type of CBT specifically developed for people with PTSD that focuses on memories of trauma and negative thoughts and behaviours associated with such memories. The structure and content of the intervention are based on CBT principles with an explicit focus on the traumatic event that led to the disorder. The intervention normally consists of 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session,

longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week).

Eye movement desensitisation and reprocessing (EMDR): a psychological intervention for PTSD. During EMDR, the person is asked to concentrate on an image connected to the traumatic event and the related negative emotions, sensations and thoughts, while paying attention to something else, usually the therapist's fingers moving from side to side in front of the person's eyes. After each set of eye movements (about 20 seconds), the person is encouraged to discuss the images and emotions they felt during the eye movements. The process is repeated with a focus on any difficult, persisting memories. Once the person feels less distressed about the image, they are asked to concentrate on it while having a positive thought relating to it. The treatment should normally be 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week).

Phase-based approach

There is emerging evidence that a phase-based approach comprising skills training and trauma-focused interventions is more effective than trauma-focused treatment alone for this complex group. So in practice, a survivor could be receiving more than one type of intervention at once, potentially from different organisations. Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy is designed to foster the development and strengthening of emotion regulation and interpersonal skills and promote resilience before addressing the trauma directly. A 2010 study (Cloitre, 2010) compared STAIR therapy to Immediate Trauma Focused (ITF) therapy and found that after 6 months the STAIR group was more likely to achieve sustained and full PTSD remission relative to the ITF (27% versus 0%). STAIR produced greater improvements in emotion regulation than ITF and greater improvements in interpersonal problems. STAIR was associated with fewer cases of PTSD worsening relative to ITF. However this was a single small study, so more research is needed to fully understand the benefits of phase-based therapy over standard trauma focused methods.

Treatment modality

Both the Taylor & Harvey (2009) and Ehring (2014) studies looked at whether individual or group sessions were more effective for treating PTSD in sexual violence survivors and CSA survivors respectively. Both studies found individual sessions to produce greater improvements in outcomes than group sessions.

In terms of length of treatment, the authors observed that hour-long sessions, sessions delivered twice per week, and treatment programmes lasting 10 or more

sessions were considered to be most effective. Semi-structured approaches including ‘homework’ were also favoured by effect sizes.

Statutory vs. Specialist Services for addressing wider mental wellbeing needs

A 2018 piece of qualitative research from the University of Suffolk (Bond, 2018) explored adult CSA survivors’ experience of support services overall – i.e. not just for their mental health needs. The research revealed that over 70% of survivors were more satisfied with the support offered by the specialist voluntary sector than statutory services both in regards to disclosure and treatment experience. The specialist services provided a more appropriate environment where survivors felt listened to, believed and respected for the first time.

Appropriate specialist support fostered trust and confidence in the service provided which facilitated greater treatment effects. The specialist provider differed from standard services in a number of important ways:

- Professionals had specialist training and many even had their own stories of trauma
- Shared experiences- true empathy rather than sympathy
- Addressing the cause, not just the symptoms
- Flexible, responsive, open-door provision tailored to individual needs
- No fixed time frames so survivors could take things at their own pace
- Service-user led instead of rigidly structured
- Long-term ‘safety-net’ support
- Access to other survivors

Summary

This review has found that most research around treatments and therapies for sexual violence victims revolves around the symptoms of PTSD. The evidence suggests that the most effective form of therapy for sexual violence-related PTSD is trauma-focused cognitive behavioural therapy or EMDR delivered on an individual basis for one hour sessions over at least ten sessions. Cognitive behavioural therapy and EMDR are the standard recommendations for survivors of sexual abuse by both NICE and the APA and are provided by Inclusion Thurrock.

However, while PTSD is a common and serious effect of sexual violence it is still only a symptom. Survivors who have experienced both statutory and specialist services expressed frustration with standard service focus on treating symptoms instead of addressing the trauma itself. Statutory services do not provide that same experience as specialist services to adequately support initial disclosure.

It is therefore concluded from the above research that whilst mental wellbeing needs relating to sexual violence trauma are best treated in a specialist sexual violence service setting, the treatment for sexual violence-related PTSD should be trauma-

focussed CBT or EMDR delivered on an individual basis (1 hour sessions) for at least ten sessions. There is some evidence that a phase/combined approach might be helpful, in that some sort of preparatory therapy (e.g. around interpersonal and assertiveness skills) before trauma-focused therapy begins.

References

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