Realising recovery online:

a rapid review of online support interventions for survivors of sexual violence and abuse

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Summary

This rapid review of literature explores what is known about online support interventions designed to support recovery from childhood sexual abuse (CSA). Owing to the small number of studies that focus on children and young people (CYP), we expanded the scope of the review to include adults.

The review considers what type of interventions currently exist, the benefits and risks/harms associated with online support and how safety and risk can be managed.

To do this, we analysed 35 studies and best practice guidelines that described best practice recommendations and experiences of online support interventions. Using thematic analysis, we determined three over-arching themes across studies relating to

1) strengths and benefits of online support,

2) concerns and barriers and

3) managing safety.

Key messages

Types of interventions

We found 29 online support interventions across 30 studies.[1] These figures reflect that this area of study is under-researched. The studies identified in this review were predominantly situated in western contexts with a majority of white participants, while dedicated research into the experiences of minoritised groups was mostly missing, as well as studies that focused on the needs and considerations of CYP. Interventions identified included online support groups (n = 11), synchronous communication interventions (n = 10), web-based self-help (n = 5), web-based education interventions (n = 4), virtual environments (n = 2) and human-supported web-based therapy (n = 1). Studies into asynchronous communication or robotic simulation interventions were not identified.

Strengths and benefits

Across studies, we observed a range of benefits to survivors and services involved in the receipt or delivery of online support interventions for sexual violence and abuse. These benefits were related to contextual factors (e.g. service-level or practitioner, parent/carer benefits) and engagement, as well as improved wellbeing and help-seeking. Findings suggest that online support interventions can increase the reach of services and have benefits for practitioners (e.g. time-saving, cost-effective). Online delivery also helped to promote engagement from parents/carers in CYP's recovery. Survivors reported that they could build strong and trusting relationships online with practitioners and peers and that the anonymity provided within online spaces helped them to feel safe.

Survivors also demonstrated improved mental health and emotion regulation after accessing online support interventions. However, the evidence base is small, and future studies are urgently needed, particularly for CYP and minoritised groups. These positive outcomes may be related to the finding that online interventions helped survivors to make sense of their trauma narrative, normalise trauma symptomology and enhance coping mechanisms. Survivors reported that online support interventions helped to facilitate disclosure of sexual abuse and promoted help-seeking offline.

Concerns and barriers

We also identified a range of concerns and barriers that were involved in receiving and providing online support interventions for sexual violence and abuse. These were related to access and engagement (e.g. inequality of access, the impact of peers, confidence to work online and practitioner wellbeing) and suitability and safety (e.g. communication challenges, tailored interventions, ongoing abuse, privacy and safety of support from home). The findings highlighted that a key barrier to accessing support online is the inequality of resources (e.g. access to tech) and the varied technical ability of parents/carers to facilitate access. There is variation in the level of confidence and understanding among practitioners around how to deliver support online, and doing so from home can present challenges for safety, privacy and staff wellbeing. Survivors reported that the impact of peers, particularly within unmoderated peer forums, can also be a barrier to engagement and recovery.

[1] This figure is inclusive of peer-reviewed articles, theses and organisational research. Littleton and Grills (2019) performed a secondary analysis of a primary study (Littleton et al., 2016), which is also included in this review.

Findings demonstrate that online support interventions are not appropriate for all survivors of sexual violence and abuse, and interventions must be tailored to the individual needs of those accessing them. This is particularly important for survivors with complex needs or higher levels of trauma symptomology. For example, findings suggest that within online support interventions, non-verbal communication is challenging. Most importantly, ongoing abuse and lack of safety at home can hinder engagement with online support interventions and makes managing risk or processing trauma difficult. With this in mind, it was often recommended that online support interventions should be used to supplement and facilitate but not wholly replace face-to-face treatment options.

Managing safety

This section considers strategies identified within our analysis that demonstrate the evidence base around how safety has been managed within online support interventions for CSA. The analysis also includes key policy and best practice guidelines that were synthesised alongside individual study outcomes. These findings reflect three sub-themes that represent important aspects of receiving care for sexual violence and abuse online: preparation to enter service, continued assessment and communication, and promoting a sense of safety through co-production and agency.

The findings highlight that effective preparation for accessing support online is critical to managing the safety and ability of survivors to derive benefit from interventions. Continued assessment and communication about risk throughout online support interventions using in-built platform tools and offline resources can promote safety. Studies demonstrate that survivors are most likely to feel safe within online support interventions when they can remain in control of their own care needs, and this can be established through effective co-production.

Next steps and future directions for research

This review was conducted during the COVID-19 pandemic when research into online support interventions for sexual violence and abuse was emerging. Future research that accompanies the popularisation of telehealth should pursue dedicated or disaggregated findings inclusive of marginalised groups. Similarly, suitability should be explored across diverse experiences taking into account cognitive and technological abilities. To understand the efficacy of online support interventions, further research is needed around the support needs and considerations for CYP and into interventions involving asynchronous communication, artificial intelligence or collaborative creative resources not identified in this review. COVID-19 has necessitated the rapid adoption of online interventions by support services. As this provision continues, there is a clear need for organisations to produce guidance for support services to guide safe and effective delivery.

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1

Introduction

This report forms part of an exploratory research study undertaken by the Bluestar Project at the Green House designed to understand which aspects of online support are effective for children and young people (CYP) who have experienced child sexual abuse (CSA) and to develop best practice recommendations for the delivery of online support interventions. The research is funded by the UK Home Office CSA support services transformation fund, which is designed to assist the delivery of the Home Office's Tackling Sexual Abuse Strategy (*2020*).

1.1 Background

It is estimated that 15% of girls and 5% of boys will experience CSA before the age of 16 (*Karsna & Kelly, 2021*). Research suggests that early intervention diminishes the chances of adverse mental health outcomes post assault such as depression, anxiety, post-traumatic stress disorder (PTSD) and suicidal ideation/behaviour. However, CYP who have experienced sexual abuse face a number of barriers to accessing mental health support. There are few specialist CSA therapy services across the UK, and most have long waiting lists; the availability of support varies by local area and is often short-term. CYP are most likely to be offered face-to-face psychotherapy or creative therapies such as drama, dance and art (*Parkinson & Sullivan, 2019; Halliwell, Retter, Daw, & Hay, 2021*). At the beginning of the COVID-19 pandemic, many CSA therapy services were paused for the lack of a suitable platform that could facilitate safe, interactive and age-appropriate access to support. As the pandemic continued, CSA therapy services started to transition to therapeutic support online in varying ways to ensure that CYP had access to therapy. Online support interventions have the potential to expand the provision of mental health treatment options, increase the reach of services, reduce waiting times and provide a complementary approach to face-to-face services. However, little research exists that can guide practitioners regarding which aspects of online support interventions are effective in the delivery of therapeutic care for CYP who have experienced sexual violence and abuse. There is a clear and urgent need to synthesise and understand current evidence surrounding online support interventions for the safe and effective future delivery of these services.

1.2 Our rapid review

Our rapid review forms part of a suite of research reports generated by the Bluestar Project, which through its activities (i.e. rapid review, interviews with therapists and survey of CYP) aims to understand for whom online support interventions work and in what context they work best. The findings from this review will be considered alongside interviews with therapists and CYP's views to inform the development of best practice guidelines for the delivery of online support interventions for CSA. This rapid review aims to explore the existing evidence base in this area, addressing our main research question:

> What is known about online support interventions designed to support recovery from CSA?

Building on learning from an initial search of the literature (*Jan–Feb 2021*) and in co-production with our best practice advisory group, this research question was broken down into four sub-questions:

- What type of online support interventions exists for CSA?
- What are the benefits of online support interventions for CSA?
- What are the risks/harms associated with online support interventions for CSA?
- How are safety and risk managed within online delivery of support interventions for CSA?

1.3 Method

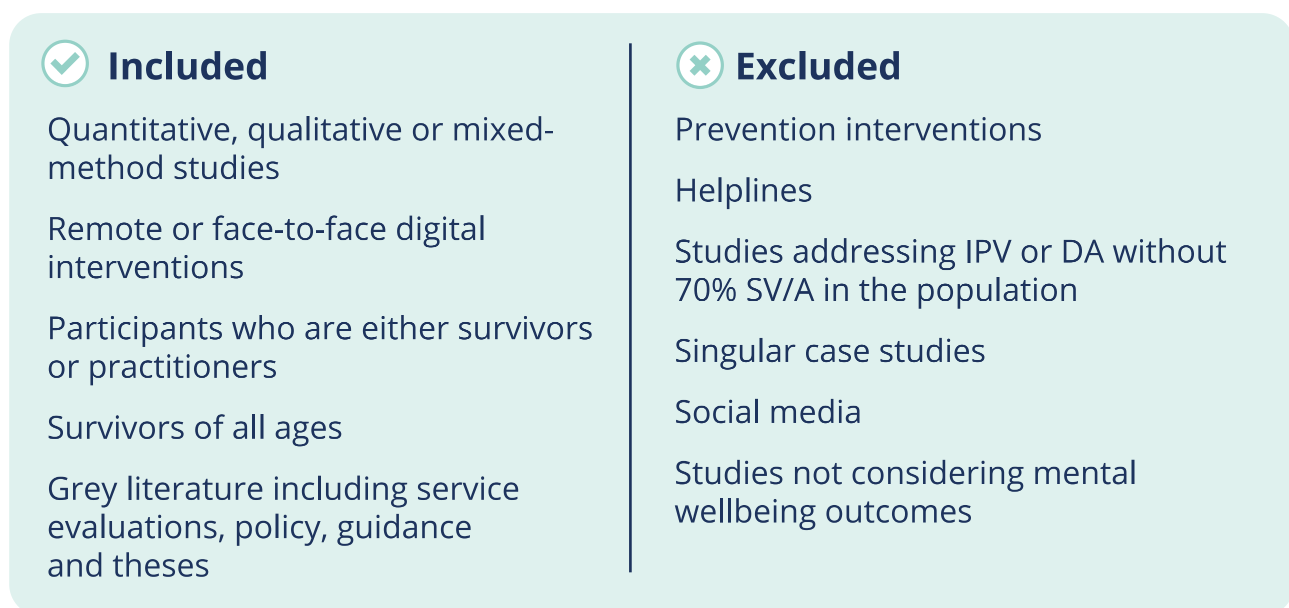
We chose a rapid review method because the research is state-commissioned, policy-focused and multi-method (Watt et al., 2008). Adopting this approach meant that the findings from the review could be used to resolve our research questions and inform policy decisions promptly whilst still upholding the key tenets of systematic research. The literature search was conducted between May and September 2021 and was restricted to English-language publications published from 2010 onwards. Literature had to address online support interventions designed to support the mental wellbeing of survivors of sexual violence and abuse. For the literature search, we used the following definitions:

> **Online support interventions** are therapy or wellbeing resources, tools and programs that are accessed remotely or brought into offline support spaces to aid psychological wellbeing

> **Sexual violence and abuse** is inclusive of survivors of all ages in this review and is defined as any instance or pattern of sexual activity or behaviour occurring in any setting where the victim did not or was unable to give consent, regardless of their relationship to the perpetrator. We chose to include survivors of all ages as our initial searches demonstrated a lack of existing literature specifically regarding CSA (see section 2.6). It is important to note that legislative definitions of sexual violence and abuse vary across jurisdictions and over time. Survivors of sexual violence and abuse in this review were self-identified.

Inclusion and exclusion criteria: The inclusion and exclusion criteria for the literature search can be found in Figure 1. The COVID-19 pandemic necessitated innovation in the online delivery of support interventions, and many services were quickly transitioned from face-to-face to online spaces. With this in mind, grey literature was included in this review in order to capture the most relevant and emergent evidence. Preliminary searches found an under-representation of sexual-violence-specific research, with existing evidence weighted towards studies in areas of intimate partner violence (IPV) or domestic abuse (DA). Within these studies, sexual violence and abuse were also underrepresented in participant populations. Thus, studies addressing IPV or DA without explicit reporting of sexual violence and abuse histories of at least 70% in participant populations were excluded.

Figure 1. Inclusion and exclusion criteria



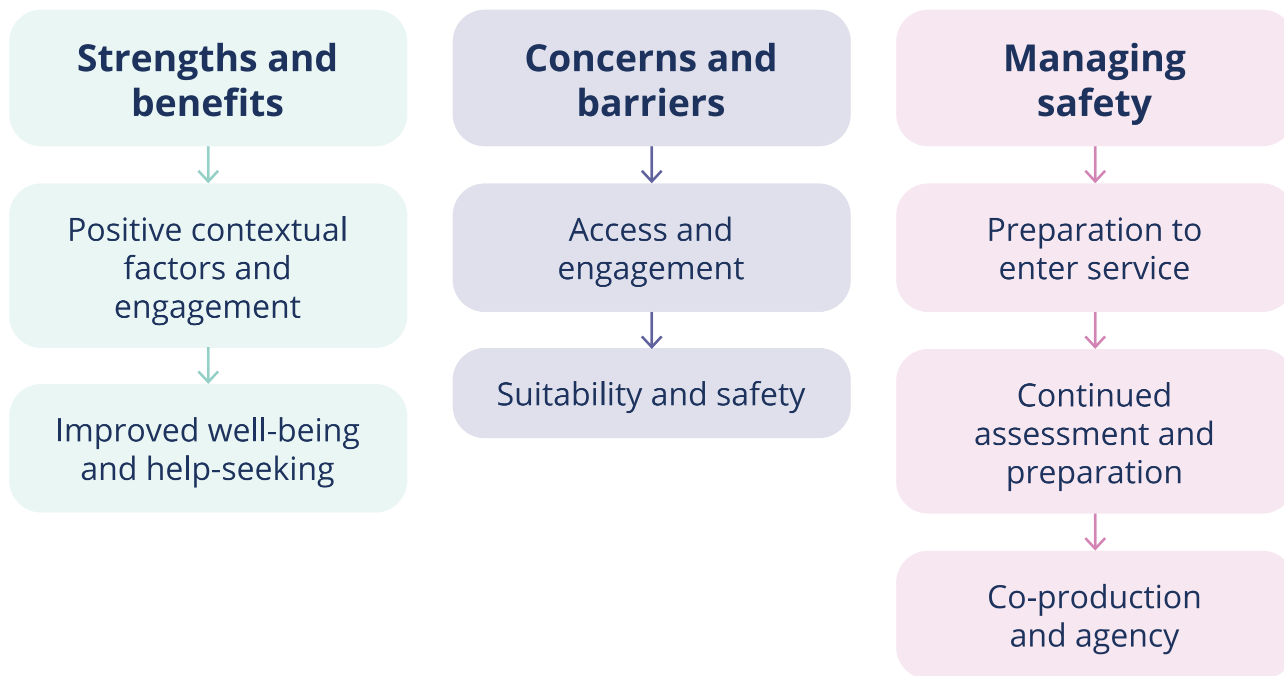
Search strategy: For peer-reviewed literature, a search strategy was built in consultation with a team of researchers that encompassed medical subject headings and free text words relevant to (A) sexual violence and abuse, (B) therapy and support and (C) online delivery.

Data synthesis: We synthesised data using a thematic methodology to identify themes that existed across studies (*Thomas, 2008*). The purpose of thematic analysis is to develop analytical themes through descriptive synthesis and find explanations relevant to review questions (*Ring, 2011*). We used NVivo (Version 12, Release 1.3) for this analysis.

Three researchers analysed the data. We derived our themes from the data following the iterative phases of our thematic analysis approach. Boyson led on familiarising herself with the data through repeated readings and noting initial ideas, generating initial codes through the double-coding of notable features of the data across the dataset and collating codes into potential themes that related to our research questions. Halliwell and Daw led on reviewing themes to check that they captured the essence of the coded extracts and the entire dataset and defining and naming themes. Due to time and

resource constraints, this review did not perform risk of bias assessment. The analysis demonstrated three key themes relating to 1) strengths and benefits of online support, 2) the risks and harms associated with online support and 3) managing safety. Each theme was split into sub-themes, as demonstrated in Figure 2.

Figure 2. Themes



1.4 Structure of this report

This rapid review of literature considers what is known about online support interventions designed to support recovery from sexual violence and abuse. We highlight findings about the efficacy of online support services, what works for whom and in what context. We also highlight gaps in the existing literature, identifying the need for future research. The findings of the report are split into three sections reflecting our review questions:

1. Results – this section describes the studies included in the review and the types of online support interventions evidenced in the literature.
2. Review findings – this section provides an overview of our synthesis of studies according to our three themes: strengths and benefits, concerns and barriers, and managing safety.
3. Conclusion and future directions for research – this section summarises our key findings, the limitations of this review and new areas for future research to explore.

2

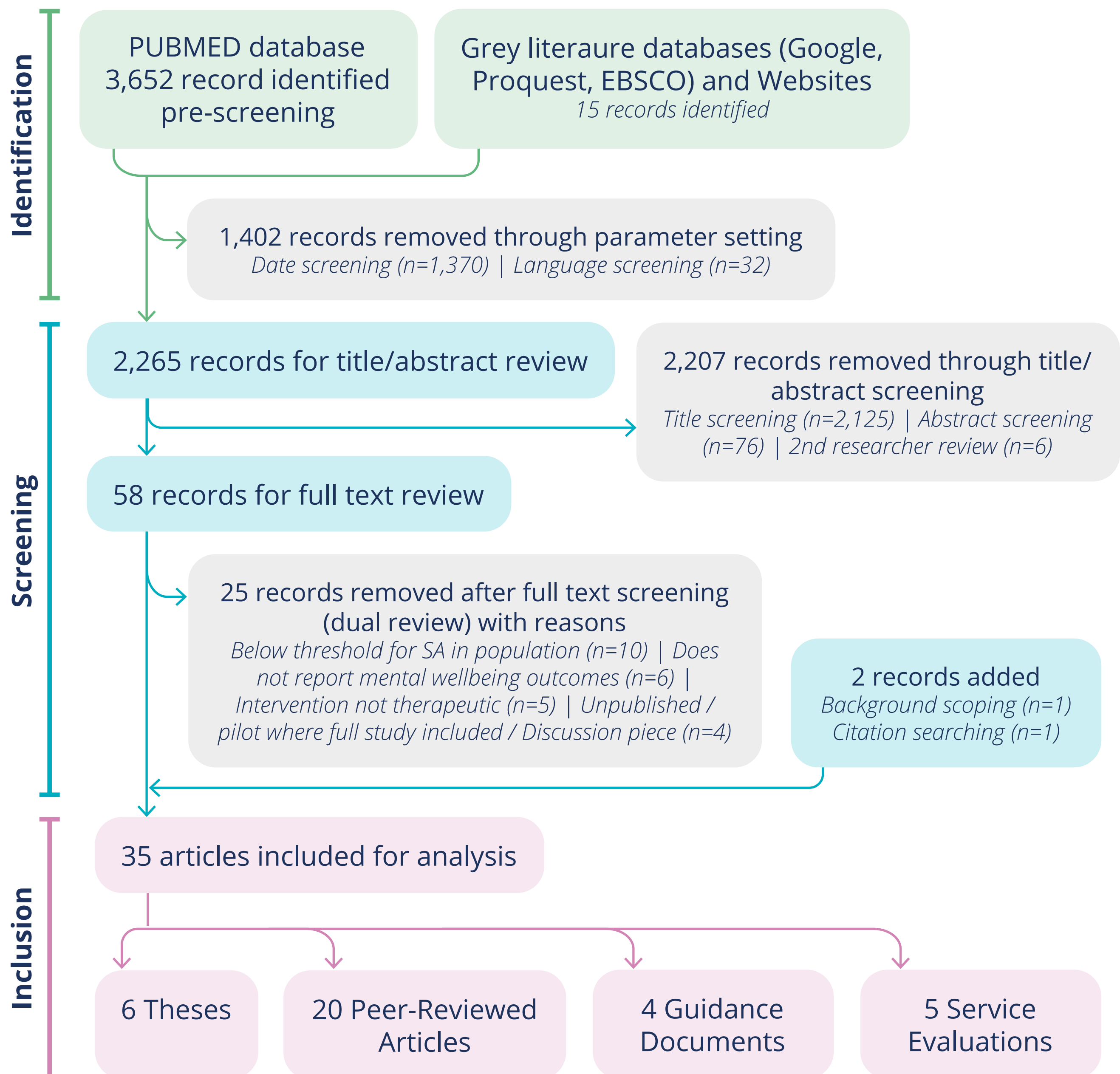
Results

2.1 Results of the search

With date and language filters applied, this search identified 2,250 peer-reviewed records. After rounds of screening, review and citation searching illustrated in Figure 3, the search yielded 20 peer-reviewed studies for analysis. The grey literature search included using thesis databases, search engines and searches of specific organisational and service websites identified in consultation with a team of researchers. The grey literature search yielded an additional 15 documents for analysis. These texts were then extracted into a table (see Appendix 1).

Alongside characteristics of study design, setting, participants and interventions studied, this table includes a summary of results, which underwent review by Retter. We included in our analysis a total number of 35 articles, of which 20 were peer-reviewed studies, 6 theses, 4 service evaluations and 5 guidance.

Figure 3. PRISMA Flow diagram



2.2 Description of studies

Of the 26 included studies (peer-reviewed and theses), the majority (n = 17) originated in the US, and the remainder were from Australia, the UK, South Korea, the Netherlands and Israel (in descending order of quantity). The studies were published between 2014 and 2021, of which seven (28%) were published in 2021, reflecting a growing interest in online support interventions as necessitated by the COVID-19 pandemic. All service evaluations (n = 5) were conducted in the UK and reported adaptations during pandemic restrictions since 2020. Statutory guidance on online support interventions for survivors of sexual violence and abuse was scarce, with just brief mentions in Australian statutory guidance identified globally. Other guidance included in this review (n = 4) were published institutionally or within academic journals (*e.g. Briere, Lanktree, & Escott, 2020*).

2.3 Study participants

Included studies – practitioners

All service evaluations (n = 5) and five studies involved research with therapists and support practitioners. While practitioner research was typically situated in a western context with a majority of white participants (n = 8), one national second-tier organisation, Imkaan (2020), explored the experience of racially minoritised survivors and practitioners in *The Impact of the Two Pandemics: VAWG and COVID-19 on Black and Minoritised Women and Girls*, and Tener et al. (*2020*) conducted a comparative analysis of practitioner interviews from Israel and the US.

Practitioners were largely based in therapeutic services (n = 306). Other support practitioners came from sexual health (n = 14) and child welfare services (n = 60).[2]

Included studies – survivors

Within our review, we found 24 studies/service evaluations related to survivors' experiences of accessing support. Survivors reported recent and historic experiences of sexual violence and abuse across childhood and adulthood. The most common institutional backgrounds of survivors were universities and the US military for those who survived military sexual trauma (MST). Most studies worked with female survivors exclusively; those that were mixed mostly had a majority of female participants, and two interventions supported male survivors and trans women exclusively.

Consistent with practitioner research, most studies were situated in a western context with a majority of white participants. An exception to this was Lee and Cha's (*2021*) controlled feasibility study of a virtual reality intervention for young female survivors in South Korea and the observational analysis of Noack-Lundberg et al. (*2020*) concerning online forums for racially minoritised trans women.

[2] Not all studies could provide exact participant figures; therefore these figures are approximate.

2.4 Description of interventions

During extraction, we used Warwick's (*2017*) *Types of Psychological Services Provided Online* (Table. 2) to map the interventions studied. A full description of the studies can be found in Appendix 1. We describe a summary of the studies included within our review according to this classification model:

Web-based self-help interventions (n = 5) often took shape as limited-session psycho-educative programmes with accompanying exercises adapted from traditional therapeutic approaches such as mindfulness or acceptance commitment therapy.

Web-based education interventions (n = 4) differed from self-help interventions in the sense that survivors did not follow a treatment programme, and the interventions could either be accessed at any time or were delivered at one time strategically along the recovery journey of the survivors. For example, Gilmore et al. (*2020*) and Miller, Cranston, Davis, Newman, and Resnick (*2015*) all evaluated 'brief video interventions' that were designed to explain typical reactions to sexual trauma and instruct on coping exercises and mechanisms. These interventions were delivered in clinical settings pre- and post-forensic examination and evaluated through measuring mental health symptoms and wellbeing longitudinally.

Virtual environment interventions (n = 2) identified in this review were delivered face to face with close guidance from a therapist/practitioner rather than being delivered remotely. The first of those identified was designed to be used between CYP survivors and their therapists to aid communication. Using synchronised tablets and characters in an application, CYP can toggle between clothed and unclothed characters and use icons to visually (as opposed to verbally) narrativise their experiences (*Endendijk, Tichelaar, Deen, & Deković, 2021*). The other, BraveMind, was employed for veteran survivors of MST undergoing prolonged exposure (PE) therapy as it virtually immerses clients in trauma-relevant environments such as deployment living conditions.

Synchronous communication, in addition to all service evaluations, was addressed in five studies (n = 10). Synchronous communication in this context describes real-time conversations where the deliverance of and response to messages are immediate. This was typically via video or audio-conferencing but can also be inclusive of text modalities. The circumstances surrounding the delivery of these synchronous interventions were often to overcome logistical or attitudinal barriers to in-person treatment and were most often delivered using videoconferencing to veteran survivors or CYP (in service evaluations) with a variety of therapeutic approaches.

Online support groups in this review (n = 7) can be broadly split between those that were service provided and moderated (n = 4) and those that grew in existing online forums such as Reddit with little or no moderation (n = 3). Anonymity is a key factor of online forums, and the space is used to share experiences and receive support and advice from peers.

Human-supported web-based therapy (n=1) was identified in two studies, one of which was a secondary analysis of an initial controlled trial of this intervention. *From Survivor to Thriver* is a therapist-facilitated online cognitive behavioural therapy (CBT) programme set over nine multi-media modules.

Therapist facilitation comes in the form of tailored written and video feedback to task completion (*Littleton, Grills, Kline, Schoemann, & Dodd, 2016; Littleton and Grills, 2019*).

We did not identify any studies within our inclusion criteria that explored robotic simulation (of a therapist/practitioner) or asynchronous communication (typically text communication where there is a time-delay between delivery and response), though one intervention utilised a holographic simulation of a survivor (*Lee & Cha, 2021*), and a 'human-supported web-based therapy' intervention included asynchronous feedback, though this was not its defining feature.

2.5 **Engagement with interventions**

Across studies, engagement with and continued attendance to online interventions varied, demonstrating a high level of heterogeneity. For example, Valentine et al. (*2020*) compared rates of completion of veterans with MST-related PTSD engaging in cognitive processing therapy (CPT) and PE via either remote videoconferencing or in person. They found that completion rates were 50% for in-person sessions and 32.3% for videoconferencing. Conversely, other studies reported low attrition rates (*Creech et al., 2021; Fiorillo, McLean, Pistorello, Hayes, & Follette, 2017*). A trial of a modular web-based self-help intervention for female veterans with MST-related PTSD reported that 95% of participants completed all intervention modules and were retained at two months following up (*Creech et al., 2021*).

Several factors led to withdrawal from interventions. Some participants dropped out due to additional life stressors such as family illness, bereavement or time constraints (*Johnson 2020; Fiorillo et al., 2017*). Some survivors were also not ready to disclose and process their trauma (*Lee & Cha, 2021; Johnson, 2020*). Difficulty with emotion regulation and PTSD symptomology during treatment was also a contributing factor (*Gilmore et al., 2020; Valentine et al., 2020*).

Factors that facilitated engagement included practitioners sending text reminders between sessions (*Gulati, Blayney, Jaffe, Kaysen, & Stappenbeck, 2021; Fiorillo et al., 2017*) or delivering the intervention in a condensed treatment plan (*Loucks et al., 2019; Valentine et al., 2020*). Preparation for online sessions was also a key component of maintaining engagement. Key components included assessment of previous treatments and expectations (*Valentine et al., 2020*), psychoeducation about the benefits of treatment (*Johnson, 2020; Valentine, 2020*), or peer support pre-treatment. Positive experiences of peer support during the intervention increased willingness to return (*Valentine et al., 2020*). More generally, ease of use was achieved through intuitive platform navigation (*Polks, 2021; Lee & Cha, 2021*) and simple, paced delivery (*Gulati et al., 2021; McElearney, Hyde-Dryden, Palmer, & Walters, 2021*). The use of multimedia and interactivity were found to engage survivors, to aid understanding (*Gulati et al., 2021*) and to be enjoyable (*Endendijk et al., 2021*). Survivors indicated that intervention content was most favourable when it was relatable, engaging, practical, non-judgemental and honest (*Gulati et al., 2021; Gilmore et al., 2019a; Montgomery, Seng, & Chang, 2021*).

2.6 **Limitations**

Several limitations affect the findings of this review. Firstly, the search for peer-reviewed literature was limited to one database (although this database does include searches across other platforms). This may have introduced publication bias and neglected potentially relevant publications. Only English-language articles were included, and the articles did not undergo a risk of bias assessment. However, due to a lack of available evidence and the policy focus of this research, this streamlined approach was determined to be the most pragmatic. Additionally, a complete lack of evidence surrounding CYP in this context required the expansion of our review to include survivors of all ages. Therefore, these findings may not be wholly applicable to CYP.

Secondly, we observed several limitations across the included studies that impact the validity and generalisability of this review's findings. In terms of methodology, some lacked randomisations or a 'pure' control group due to the ethical concerns of including survivors receiving no intervention (*Johnson, 2020; Lee & Cha, 2021; Loucks et al., 2019*). Others were limited in what data they collected, whether that be through reliance on self-reported measures (*Gulati et al., 2021; Johnson, 2020; Littleton & Grills, 2019*) or an inability to contact users at all because of guidelines around intruding into existing peer-support spaces (*Webber, 2014*).

During data collection, one study reported missing data due to tech issues (*Loucks et al., 2019*). Data can also be impacted by bias. As survivors participate in studies voluntarily, it is likely that they were likely motivated to participate due to treatment (*Fiorillo et al., 2017*). Similarly, participants may have exhibited social desirability, causing their responses to distort due to imagined ideas of what answers are valued most (*Endendijk et al., 2021*).

Social desirability has the potential to complicate the interpretation of findings. However, external research suggests this impact may be limited within the context of self-reported wellbeing measures (*Caputo, 2017*).

When reflecting on their participants, some studies were limited by small sample sizes (*Creech et al., 2021; Johnson, 2020; Lee & Cha, 2021, Valentine et al., 2020; Weiss, Azevedo, Webb, Gimeno, & Cloitre, 2018*), in some cases due to attrition (*Gilmore et al., 2019a; 2019b*). For others, participants lacked representation from sexually, racially or ethnically minoritised groups (*Gilmore et al., 2019a; Fiorillo et al., 2017; Gilmore et al., 2020; Gulati et al., 2021; Tener et al., 2021*). Diversity of perspective was also lacking in some studies in which the researchers only talked to clinicians and not clients (*Endendijk et al., 2021*) or because researchers only recruited undergraduate-aged survivors who were more computer literate and had access to more resources than other populations (*Johnson, 2020; Littleton et al., 2016*). As these underrepresented groups often face additional barriers to recovery, their inclusion is crucial to comprehensively assess the efficacy of an intervention.

Owing to these limitations, drawing firm resolutions to our research questions is difficult. However, to our knowledge, this review is the first to synthesise evidence in this area and has provided insight into an emergent area of research and found some evidence that explores the dynamic of benefit and risk in delivering online support interventions to survivors of sexual violence and abuse. This review was conducted during the COVID-19 pandemic when research into online support interventions was emergent. Future reviews will benefit from an expected growth and diversification of the evidence base and policy that will accompany the popularisation of telehealth (*Calkins, 2021*).

3

Review findings

3.1 Strengths and benefits of online support interventions.

This section provides an overview of our synthesis of studies relating to the strengths and benefits of delivering support interventions online to survivors of sexual abuse. It describes our findings according to two sub-themes: contextual factors and engagement, and improved wellbeing and help-seeking.

Sub-theme: Contextual factors and engagement

We identified a range of benefits to survivors and services involved in the receipt and provision of online support for sexual violence and abuse. These spoke to positive contextual factors (e.g. service-level or practitioner, parent/carer benefits) and engagement factors (e.g. advantages of anonymity, building safe relationships online).

FINDING 1: Online support interventions can increase the reach of services.

Survivors reported many benefits to accessing support interventions online. In some cases, they had been drawn to online support interventions because of a lack of access elsewhere. For some, available offline resources were perceived as not representative or inclusive since sexual violence and abuse are typically perceived through a heteronormative lens *(Noack-Lundberg et al., 2020; Gilmore et al., 2019a)*. For others, previous experiences of help-seeking had resulted in unhelpful or harmful responses from friends, family or professionals *(Gali, 2014; Noack-Lundberg et al., 2020)*, with one survivor saying

> 'I didn't cause my sexual assault. This is what I needed to hear from an objective professional, but lately it feels like he's [therapist] saying the opposite (106)' *(O'Neill, 2018, p. 52)*.

Engaging in online interventions remotely overcomes logistical barriers to support, whether they be scheduling commitments, reliance on caretakers, inaccessibility or a lack of provision in underserved communities *(Fiorillo et al., 2017; Tener et al., 2021; Valentine et al., 2020)*. Round-the-clock availability of some interventions fills a gap in the availability of offline services and offer choice surrounding when, how often and how much a user can engage *(Montgomery et al., 2021; Gali, 2014)*. Additionally, when in-person support causes financial burden, online interventions can be a relatively low-cost alternative *(Kamarudin, 2019)*.
When offered in clinical settings, online interventions have also been shown to be easily integrated alongside existing treatment programmes *(Creech et al., 2021)*.

FINDING 2: Online delivery had benefits for practitioners (e.g. time-saving, cost-effective) and promoted engagement from parents/carers in CYP's recovery.

Benefits of working online were also reported for practitioners and parents/carers. Practitioners shared that work satisfaction was enhanced by an emotionally supportive team, information and skill sharing, and feedback from clients that evidences the difference they are making to their wellbeing *(Polks, 2021; McElearney et al., 2021; Moore & Churchill, 2020)*. When working remotely, some practitioners reported that without the need for travel, they could be more productive *(Furber & Garrett, 2020; Moore & Churchill, 2020)*. Additionally, offering online support interventions to survivors facilitates the involvement of wider professionals, including interpreters, cultural consultants and disability support workers *(NSW Government Relations, 2020)*. For some parents/carers, the uptake of online delivery during the pandemic allowed them to become more engaged in the therapeutic process *(Moore & Churchill, 2020)*. When appropriate, online interventions were utilised to inform parents and other caregivers on how to best support their child and themselves *(Polk, 2021)*.

FINDING 3: Anonymity helps survivors to feel safe in online spaces.

Studies reported that survivors may fear and internalise stigma associated with attending face-to-face support; as such, online support interventions can offer more confidentiality and anonymity *(Fiorillo et al., 2017; Gilmore et al., 2019a)*. Feeling safe online when accessing support was an essential condition for some survivors' engagement *(Harms, 2017)*. A key design feature of online interventions for survivors is anonymity *(Kamarudin, 2019; O'Neill, 2018)*. Survivors felt that anonymity created a sense of privacy, which helped them to feel safe in sharing their experiences *(Noack-Lundberg et al., 2020)*. When interventions were service affiliated, anonymity allowed survivors to test responses from practitioners and build trust preceding more substantive support *(Spencer-Hughes, Syred, Allison, Holdsworth, & Baraitser, 2017)*.

FINDING 4: Survivors reported that they could build strong and trusting relationships online with practitioners and peers.

While some interventions involved no virtual or face-to-face interaction with others, those that did often found that these interactions were one of their most valued components. Therapists *(Littleton et al., 2016)*, moderators *(Harms, 2017)* and program staff *(Weiss et al., 2018)* were received as warm and sincere and enabled a safe online environment to offer support and facilitate amongst peers. The connection, trust and alliance that can be formed online was recognised in the feedback of this child returning to face-to-face sessions:

> 'I felt like we were closer on Teams than being six feet apart from each other in a room' *(McElearney et al., 2021, fig 2, p. 6)*.

Peer support online was similarly regarded. With their conversational format, online forums are centred around mutual support and provide the infrastructure from which survivors can share their experiences and develop a sense of community *(Harms, 2017; Gali, 2014; O'Neill, 2018; Otway, 2016)*. For survivors that feel isolated through a lack of offline support, online support spaces are essential to receiving social

support *(O'Neill, 2018; Otway, 2016)*. In their study of a forum for adult male survivors of child sexual abuse, Harms *(2017)* found that the more a user returned, the less isolated and more accepted they felt. For those that fear stigmatisation, online forums are somewhere they can belong. Beyond sharing their own experiences, users often offer emotional and practical support to others, validating others' experiences, expressing solidarity, offering coping strategies and sharing advice on disclosing and seeking justice offline *(Otway, 2016; Webber, 2014; O'Neill 2018)*. Spaces for altruism were valued and helped survivors learn how to be kinder to themselves: '95% of forum members surveyed agreed with the statements

> "I provide encouragement to other members" and "I feel accepted by other members of the group"'
> *(Harms, 2017, p. 54)*.

Sub-theme: Improved wellbeing and help-seeking

We identified a range of benefits across studies among survivors who had accessed online support in terms of improved health and wellbeing and increased disclosure and help-seeking offline.

FINDING 5: Survivors demonstrated improved mental health and emotion regulation after accessing online support services. However, this evidence base is small and future studies are urgently needed, particularly among CYP who have experienced sexual violence and abuse.

Across studies that used quantitative methods (n = 12),[3] the most common outcomes measured were PTSD (n = 11), depression (n = 5), and anxiety (n = 4). These were often related to contributing psychological factors, such as avoidance (n = 2) and emotional regulation (n = 2). Some studies also assessed alcohol use (n = 3) and participants' knowledge and skills around intervention content (n = 1).

Most studies reported significant improvements in outcome measures (n = 8) (See Appendix 1). For example, Littleton et al.'s *(2016)* efficacy evaluation of the therapist-facilitated CBT Program *From Survivor to Thriver* recorded clinically significant reductions in PTSD symptoms from pre-treatment to follow-up for 80% of survivors in their interactive programme and 70% of survivors in their psycho-educative programme. In a trial of a clinically situated brief video intervention, effect sizes were large for all measures (PTSD, depression, emotional regulation, social engagement) such that 87.5% of participants who exceeded diagnostic cut off for PTSD for pre-treatment scored below at post-treatment (*Weiss et al., 2018*).

Findings from studies using qualitative methods (n = 19)[3] similarly suggest the efficacy of online support interventions to improve mental wellbeing. Participants reported how the interventions informed them of coping strategies and made them feel supported in their recovery. For example, one participant in Harms' (2017) research into a moderated online forum described the intervention to be educational and helpful, reporting that

> 'Many of the conceptual tools are things I can latch onto, to give me a framework to help me recognize my emotions and behaviours, and apply that so as to feel more control over my life.'
> *(Participant #10, p. 59).*

[3] Some studies triangulated qualitative and quantitative methods. Therefore, the sum total of studies using quantitative and qualitative methods referenced here will not be equal to the total number of interventions (n=30).

In another instance, a participant from Gilmore et al.'s *(2019a)* study into a modular psycho-educative mobile application provided the following feedback in regard to the general coping skills module:

> '[Its] really something good to read and something that you can kind of read, kind of figure out how to control it and how to settle down and just kind of relax after going through something and you're not exactly sure how to cope with' *(p. 11)*.

Both quantitative and qualitative findings that relate to mental wellbeing outcomes must be considered within the limitations of the evidence base captured in this review, as discussed above (see section 2.6).

In some quantitative studies, positive outcome measures did not reach statistical significance, or no support was found from the outcome measures for the efficacy of the interventions. Johnson's *(2020)* evaluation of an online mindfulness-based stress reduction intervention found no support for reducing depressive or somatic symptoms, with some survivors still experiencing significant PTSD, depressive and somatic symptoms after the intervention. In an evaluation of a brief video intervention administered before sexual assault forensic examinations, there was no support for the effects of the intervention on PTSD compared to the relaxation control condition or treatment as usual *(Gilmore et al., 2019b)*.

Reports of no support or insignificant outcome measures for efficacy in these cases can be accounted for in part by small sample sizes. Gilmore *(2019b)* did not reach recruitment goals for their hard-to-reach population of recent survivors of sexual assault, and Johnson *(2020)* similarly experienced low recruitment and retention in their undergraduate student sample, perhaps due to the lack of availability or reluctance to disclose their sexual assault. Attrition as a contributory factor to insignificant results may have also impacted the efficacy trial of an online CBT programme (*Littleton et al., 2016*). Just 15.8% of participants completed the intervention, and there was no significant difference in outcome measures between the experimental and control group. Further research is needed on the influence of online delivery on completion of treatment, though Valentine et al. *(2020)* found in their study that participants who reported positive experiences with a practitioner or peers were less likely to drop out from the intervention (see section 2.5).

FINDING 6: Online support interventions helped survivors to make sense of their trauma narrative.

Online support interventions, particularly peer-led spaces, helped to facilitate survivors' reflection and narrativisation of their trauma. Using online forums allowed survivors to practice giving their account and structure a narrative they felt comfortable vocalising *(Gali, 2014)*. Survivors reported that having an online audience to bear witness to their experiences was validating without being overwhelming *(Otway, 2016)*. Offline digital resources such as the serious game *Vil Du?!* also help survivors construct a narrative of their trauma by offering alternative means of communication *(Endendijk et al., 2021)*. Through narrativisation, survivors redefined their relationship with victimisation:

> '[I] could be self-poised about sexual violence. I was able to look at myself as a sexual violence victim and survivor from the same point of view'
> *(Lee & Cha, 2021, p. 54)*.

FINDING 7: Online support interventions improved survivors' understanding of trauma, sexual violence and abuse and enhanced coping mechanisms through the normalisation of trauma symptomology.

Studies also demonstrated that online support interventions could empower survivors by challenging common myths around sexual violence and abuse. Reading the experiences of other survivors and interacting with practitioners validated experiences as non-consensual and encouraged a change in perception without self-blame *(Gali, 2014; Lee & Cha, 2021; Otway, 2016)*. For CYP, online resources facilitated psychoeducation around sexuality and self-protection *(Endendijk et al., 2021)*. Online support interventions also served to destigmatise survivors' responses to trauma *(O'Neill, 2018, Gilmore et al., 2019a)* before offering alternative coping strategies around distress tolerance and mindfulness. In this way, survivors felt empowered and hopeful for the future *(Gali, 2014)*. One participant said,

> 'It happened four years ago. Now, I am starting to take care of myself' *(Lee & Cha, 2021, p. 54)*.

FINDING 8: Online support interventions facilitated disclosure of sexual violence and abuse and promoted help-seeking offline.

The strength of online support interventions to facilitate disclosure was highlighted in several studies *(Gali, 2014; Harms, 2017; Kamarudin, 2019; Otway, 2016)*. Offering a platform to disclose sexual violence and abuse online is underpinned by an 'information-providing' approach that prioritises the need for survivors to feel safe, comfortable and unpressured when sharing their account and taking the first step in seeking help (Spencer-Hughes et al., 2017). Supportive environments in online forums act as a space for survivors to give accounts of their trauma and provide an audience to receive it *(Otway, 2016; O'Neill, 2018)*. The vulnerability of others in peer support spaces gives others courage to share:

> '… because of you I have strength … I see these people that are coming out with their stories and feel like I should do the same. Thank you, survivors. You are an inspiration' *(O'Neill, 2018, p. 54)*.

For survivors lacking offline support, online spaces are often the first place they gave an account of their trauma *(Gali, 2014)*. For one survivor concurrently engaging in face-to-face therapy, posting online acted as an interim step, learning 'that the world doesn't end if I tell' *(Gali, 2014, p. 19)*.

When used as a supplement to face-to-face support, online resources allow for a less confrontational, non-verbal form of communication to ease the difficulty of disclosing trauma:

> 'The shame and guilt […] were such large barriers to talk to me about what exactly happened. If I would not have had the tablets it would have been much more difficult' *(Endendjik et al., 2021, p. 8)*.

As disclosure is sometimes a first step in ensuring safety for a survivor, resources that facilitate it are valuable *(Endendjik et al., 2021; Gali, 2014)*.

A measure of effectiveness evidenced across the studies was the role of online interventions in facilitating offline disclosure and help-seeking *(Gali, 2014; Johnson, 2020; Kamarudin, 2019; Spencer-Hughes et al., 2017)*. Whether through self-guided psychoeducation and signposting,

advice from a practitioner or discussions with other survivors, online support interventions play an important role in helping survivors overcome attitudinal barriers to treatment. Interventions deemed beneficial by survivors built a sense of hope that in turn fosters a sense of worthiness of support, leading to a willingness to seek it out (*Harms, 2017*). For male survivors, who on average disclosed CSA trauma in their 40s and 50s, the outcome that 45% of them disclosed their CSA trauma to others because of their engagement with an online forum is hugely significant (*Harms, 2017*).

3.2 Concerns and barriers to online support interventions.

This section provides an overview of our synthesis of studies relating to the concerns and barriers of delivering support interventions online to survivors of sexual violence and abuse. It describes our findings according to two sub-themes: access and engagement, and suitability and safety

Sub-theme: Access and engagement
We identified a range of concerns and barriers that were involved in receiving and providing support for sexual violence and abuse online. These spoke to access and engagement issues for both survivors (e.g. inequality of access, impact of peers) and practitioners (e.g. confidence to work online, wellbeing).

FINDING 9: A key barrier to accessing online support interventions is inequality of resources (e.g. access to tech) and the varied technical ability of parents/carers to facilitate access.

Findings suggest that online delivery may not alleviate some of the barriers associated with face-to-face support. Where parents/carers are required to be informed and facilitate a CYP's support programme, survivors are reliant on their buy-in and commitment to the process *(Briere et al., 2020)*. Practitioners reported that some parents/carers struggled to maintain consistency, impeding their child's access to regular scheduled online support *(Moore & Churchill, 2020)*. Another major risk to the feasibility of online support is the unavailability or insufficiency of required resources. Studies repeatedly cited a 'digital divide' that has exacerbated inequality of access to treatment. Some survivors and their families had no/ insufficient devices, or they shared devices. Others did not have secure or adequate internet connections or lacked digital literacy *(Briere et al., 2020; Moore & Churchill, 2020)*. Funding was the most commonly cited cause of these issues, though in one instance, lack of access was due to religious restrictions *(Tener et al., 2021)*. At its best, lack of adequate tech causes disruption in sessions, and at its worst, can prevent survivors from accessing support completely. Thus, there is an urgent need to tackle digital inequality *(Canadian Institutes of Health Research [CIHR], 2021)*. But despite calls for state support *(Moore & Churchill, 2020)*, funding is sometimes left to services *(Briere et al., 2020)*. For smaller, more specialist services, digital inequality can present more significantly, and there is less funding to address it:

> ‘Between 40–60% of women in some services had no safe access to phones, no credit, and no access to the internet’ *(Imkaan, 2020, as cited in Imkaan, 2020)*.

With this in mind, it was often recommended that online support interventions should be used to supplement and facilitate but not wholly replace face-to-face treatment *(CIHR, 2021; Imkaan, 2020; Endendijk et al., 2021)*.

FINDING 10: The impact of peers can be detrimental to the recovery process.

The inclusion of peers in online support interventions also has its limitations. Though survivors draw value from peer-to-peer interactions, studies found some instances of misinformation. This misinformation tended to centre around assigning culpability for a survivor’s victimisation *(Otway, 2016)*. In these instances, though peers still assigned most blame to the perpetrator and seemed to have good intentions, they would sometimes express the vulnerability of the survivor as contributing to their victimisation:

> ‘P22B: You do not need to feel guilty…A lesson from this is to ‘Trust your gut more’’’ *(Otway, 2016, p. 70)*.

In other instances, posts seemed to be deliberately hurtful:

> ‘Ans R6: Are you reading what you wrote! You wanted that to happen. Come on, he knew he was getting some that night’ *(Webber, 2014, p. 373)*.

FINDING 11: There is variation in the level of confidence and understanding of how to deliver online support interventions for experiences of sexual violence and abuse.

Studies demonstrated mixed attitudes and levels of confidence among practitioners in delivering online support interventions. For example, in their assessment of serious games for CYP who have suffered sexual abuse, Endendijk et al. *(2021)* found to their surprise that practitioners deployed the resource for fewer reasons than anticipated. Additionally, they were alarmed by the number of suggestive utterances used by practitioners when using the resource with the clients.

To mitigate this risk, Endendijk et al. *(2021)* suggested that practitioners ask deliberately bogus questions to elicit some ‘no’ answers from their clients. To maximise the resource’s potential, they recommended comprehensive training to ensure that practitioners understand fully the interventions’ functionality and associated risks. Similar training resources were recommended more broadly for practitioners moving into online work *(Tener et al., 2021; Webber, 2014)*.

FINDING 12: Delivering online support interventions for CSA from home can be challenging for practitioners, and there is a need to ensure the wellbeing of staff working remotely.

Risks to practitioners and their families were considered when delivering support from home. The risk and consequences of vicarious trauma could be aggravated when working from home due to limited interactions with team members and additional stressors resulting from the COVID-19 pandemic. Aside from risks to client confidentiality, they may also navigate an additional risk to their family's wellbeing if the family intrudes on their work:

> 'I am working at home with a 6-year-old child, who kept wandering into my office making it difficult for me to have a conversation about child sexual abuse' *(Moore & Churchill, 2020, p. 22).*

For smaller, more specialist organisations, there was sometimes insufficient funding to offer clinical supervision or other accommodations, the effects of which could be long-term *(Imkaan, 2020)*. It is recommended that in the absence of logistically necessitated breaks in the workday, practitioners should schedule time to reflect and process sessions *(Furber & Garrett, 2020)*, though this was not always feasible due to demand.

Sub-theme: Suitability and safety

We also identified a range of concerns and barriers across studies among survivors who had accessed support interventions online relating to suitability (e.g. the need to tailor interventions, challenges with communication) and safety (e.g. ongoing abuse, privacy and the risk of processing trauma at home).

FINDING 13: Online support interventions are not appropriate for all survivors of sexual violence and abuse, and interventions must be tailored to the individual needs of survivors accessing them.

Across studies, survivors and practitioners reported some concerns with the delivery of online support interventions for sexual violence and abuse. Within the COVID-19 pandemic, a number of therapeutic support services transitioned their face-to-face services into online spaces. However, studies reported that some clients rejected online provisions and opted to wait for face-to-face support to return *(McElearney et al., 2021; Polks, 2021)*. One service reported that 20% of their clients had been put on hold, most commonly due to them opting to wait for face-to-face support *(Furber & Garrett, 2020)*.

Some studies found limited benefits when the intervention did not target survivors' primary trauma symptomologies or diagnoses or when their presentation was too complex *(Miller et al., 2015; Valentine et al., 2020)*. When survivors perceived the intervention as irrelevant to them, they were shown to be resistant to its content *(Gilmore et al., 2019b)*. Survivors reported on aspects of intervention content that they found dissatisfactory. For example, in some cases, self-guided interventions were considered to be too long or too difficult to understand and implement:

> 'Many believed these skills were "easier said than done", especially when experiencing intense emotions' *(Gulati et al., 2021, p. 5).*

Inversely, other survivors found the contents of some interventions to be too basic or childish *(Endendijk et al., 2021; Gulati et al., 2021)*. When online resources were used in face-to-face support to facilitate communication, practitioners found that older or more verbally communicative clients rendered digital

tools redundant *(Endendjik et al., 2021)*. Relatedly, some survivors felt patronised during the interventions, whether that be because they were too old for the content or because the content was framed in a way that assigned blame *(Endendjik et al., 2021)*. Others found some behavioural aspects of psychoeducation to be irrelevant if they did not already engage in these behaviours (e.g. substance misuse) *(Gulati et al., 2021).*

It is important to note that online support interventions for survivors of sexual violence and abuse should not be treated with a 'one-size-fits-all' approach, but rather, there is value in providing a blended/hybrid offering *(McElearney et al., 2021)*. Some studies found that their interventions worked better for certain sub-groups and less for others *(Miller et al., 2015; Gilmore et al., 2019b)*. For example, in Littleton et al.'s *(2016)* randomized control trial of a therapist facilitating an online cognitive behavioural program, the researchers concluded that the psycho-educational website was superior in reducing symptoms for survivors with low-to-moderate PTSD, while the interactive programme was better suited for survivors with more severe and complex symptoms.

FINDING 14: Non-verbal communication is challenging within online support interventions, particularly among survivors with complex needs.

Studies reported that some survivors appreciated the value of non-verbal communication in sessions, which was less perceptible online *(Polks, 2021; The Children's Society, 2021)*:

> "'Face to face … helps the person doing the session to see the signs. Some children may not speak up" – *Young Person' (The Children's Society, 2021, p. 27).*

Dependence on verbal communication further impacts clients with fewer language skills *(Moore & Churchill, 2020)*. In one instance, therapy began optimistically, but it was soon discovered that for the client, verbal communication fell short of capturing the range of their emotions *(Tener et al., 2021)*. Limited communication also hinders clients with more complex needs as practitioners do not have the required level of sensitivity to perceive these needs *(McElearney et al., 2021)*.

Though adaptive steps can be taken, parental interference also led to significant disruptions in communication for some practitioners and their clients:

> 'The child feels like they can't express themselves or they can't let loose because their parent is going to constantly correct them' *(Polk, 2021, p.56).*

Though these limitations were easier to deal with if practitioners had had face-to-face contact with their clients before online delivery, some practitioners found that as a result, their clients struggled to engage with sessions *(Moore & Churchill, 2020)*, which in turn challenged the therapeutic relationship. This concern was aggravated in faceless support interventions, where it was even easier to disengage with the process *(Spencer-Hughes et al., 2017)*.

FINDING 15: Ongoing abuse and lack of safety at home can hinder engagement with online support interventions and makes managing risk difficult.

Another major barrier to safety for online support interventions is the risk associated with a survivor's offline environment when engaging from home. When living with others, young people raised concerns around privacy from home and the risk of others over-hearing verbal communication *(McElearney et al., 2021)*. Headphones, while sometimes proposed as a remedy to privacy risks, only protect one end of the communication, and they introduce additional concerns for some trauma survivors who avoid anything that obstructs awareness of their immediate environment *(Briere et al., 2020)*.

Engaging from home may also endanger survivors through their increased proximity to harmful or complicit actors *(Imkaan, 2020)*. Moore and Churchill's *(2020)* report on the experiences of National Society for the Prevention of Cruelty to Children (NSPCC) staff during the pandemic found that lack of face-to-face contact made it more challenging to assess risk. Worryingly, some parents were also exploiting physical distancing restrictions to obstruct practitioners from accessing their homes to assess child wellbeing. Oftentimes in online interventions, clients and practitioners must rely on verbal or textual communication, which presents barriers in assessing risks, both regarding the client's distress level and the stability of their offline environment when speaking with parents/carers:

> '...the lack of visual non-verbal clues is making gathering evidence of concerns extremely difficult for statutory services. We may hear slurring or poor cohesion in conversations with parents but without actual physical sight that these parents are not fit to care, then we are powerless' *(Moore & Churchill, 2020, p.17)*.

This limited awareness can be exploited by abusive or complicit actors who can more easily deceive practitioners *(Moore & Churchill, 2020)*. When safeguarding concerns do arise in sessions, face-to-face services are better positioned to provide immediate protection due to the clients' physical presence in a support space *(Spencer-Hughes et al., 2017)*.

In the context of intimate partner violence, perpetrators were similarly exploiting distancing restrictions to isolate survivors, leaving them with no safe space to access support:

> 'The woman was in her bathroom whispering and running the water from the tap to try to drown out the sound of the conversation. I told the client that if she was worried that someone was coming or overhearing, they would pretend that it was a sales call...' *(Imkaan, 2020, p. 13)*.

As a result, there is an increased risk of survivors disengaging from support *(Imkaan, 2020)*.

FINDING 16: Engaging in trauma processing online and in household environments with limited privacy is a key barrier to engaging safely.

Some survivors expressed concerns about experiencing or anticipating discomfort processing trauma in their home environment, preferring the safety of a dedicated therapy space away from their day-to-day lives *(McElearney et al., 2021)*. Travelling affords survivors time to decompress, which is lost during engagement with online support interventions and replaced by the immediacy of family life after a potentially difficult session *(Tener et al., 2021)*. This risk is aggravated for survivors in crowded home environments who may not be able to achieve privacy at all *(Briere et al., 2020)*. Similarly, practitioners missed debriefing and reflecting with colleagues in the workplace and instead faced the additional stressors of COVID-19 for themselves and their clients from home, blurring the distinction between their professional and personal lives *(Moore & Churchill, 2020)*.

Additionally, some digital resources designed to facilitate communication and trauma processing increased the risk of distress *(Lee & Cha, 2021; Loucks et al., 2019)*. For veteran survivors engaging with PE for PTSD symptomologies, the use of virtual reality that visually and auditorily immersed them in the context of their trauma (e.g. overseas deployment, barracks) necessitated close monitoring of physiological and behavioural signs of distress. Endendijk et al. *(2021)* researched a serious game in which practitioners can work collaboratively with CYP through interacting with digital characters. Users simulate actions on characters who can be in various states of dress, with icons such as hands, mouths and genitals. Therapists who used the tool with survivors cited increased distress as the most common reason for stopping using or not using the resource.

3.3 Managing safety

This section considers strategies identified within our analysis that demonstrate how safety has been managed within online support interventions for CSA. The analysis also includes key policy and best practice guidelines that were synthesised alongside individual study outcomes. These findings reflect three sub-themes that represent important aspects of receiving care for sexual violence and abuse online: preparation to enter service, continued assessment and communication, and promoting a sense of safety through co-production and agency.

Sub-theme: Preparation to enter service

FINDING 17: Effective preparation for accessing support online is critical to managing safety and survivors' ability to derive benefit from interventions.

When working directly with a survivor, practitioners are recommended to complete an initial assessment of their clients' suitability for online support, considering diagnoses and current symptoms, cognitive and emotional development, and the safety of their offline environment *(American Telemedicine Association, 2020; Fiorillo et al., 2017; NSW government relations, 2020)*. It is also advantageous to involve and inform non-abusive parents/carers as much as possible during this stage to help ensure offline safety and confidentiality,

regardless of whether they are supervising sessions *(Briere et al., 2020; American Telemedicine Association, 2020)*. Integration within a wider system of support services is also essential for effective referrals and safeguarding protocols *(Spencer-Hughes et al., 2017)*. However, care must be taken when involving statutory authorities like police if the survivor has had negative experiences with institutional racism or other maltreatment. Therefore, it is vital that safety plans be discussed with survivors to ascertain who they regard as safe *(Briere et al., 2020)*.

Sub-theme: Continued assessment and communication

FINDING 18: Continued assessment and communication about risk throughout intervention delivery using built-in platform tools and offline resources can promote safety.

Across studies, a variety of online and offline tools have been utilised to enhance the safety of survivors, their families and practitioners involved in the delivery and receipt of online support interventions. Most often in self-guided intervention studies, participants were provided with 24/7 local and national crisis hotlines to be used in cases of suicidality and other safety concerns *(Fiorillo et al., 2017; Lee & Cha, 2021)*. One study also distributed contact details for offline treatment centres that could provide additional support *(Gilmore et al., 2019b)*. When working with a practitioner, platform features that promoted safety included time-out buttons that pause the content and move to a neutral screen when pressed by the survivor *(Endendijk et al., 2021)*. With regards to aesthetics, survivors reported that discreet layout and neutral colour choices allowed for more privacy, allowing them to get support in confidence if they had safety concerns in their offline environment *(Gilmore et al., 2019a)*.

Policies and best practice guidelines recommend that when offering videoconferencing support, practitioners should show their immediate environment to their clients. For those moving from face-to-face to videoconferencing therapy, placing familiar objects in view is advised for continuity *(Briere et al., 2020)*. When working with survivors, virtual backgrounds were dissuaded as clients could interpret them as deceptive and wonder what the practitioner is hiding. In the same vein, practitioners could also begin each session in a full-body view to assure the survivor that they are fully dressed. Relatedly, aesthetics of professionalism in the dress and background of the practitioner are conducive to a reliable and stable therapeutic environment, as opposed to casual wear, which could be perceived as loosened boundaries, or personal spaces like bedrooms, which could be triggering to some survivors.

During programmes of online support, guidance suggested that practitioners should regularly communicate with their clients at the start of each session about their immediate environment, including their physical location in case a safeguarding concern arises *(Briere at al., 2020)*. Check-ins are also advised whenever the survivor appears distressed, and there should be established methods of communication between sessions, if not with the therapist then with another service previously integrated into the safety plan. To facilitate safety when risk arises, practitioners can discuss discreet ways of raising concerns with their client, whether that be asking questions that are answerable with 'yes' or 'no', using text communication or establishing code words that could be different for different types of risk *(Briere at al., 2020)*. Additional support from practitioners could include assessing for motivation to return at the end of each session *(Valentine et al., 2020)* and integrating skills training on emotion regulation concurrent with treatment when appropriate *(Gilmore et al., 2020)*.

Sub-theme: Co-production and agency

FINDING 19: Survivors are most likely to feel safe within online support interventions when they can remain in control of their own care needs, and this can be established through effective co-production.

Online support interventions could facilitate a sense of perceived safety by creating an environment where survivors felt in control, and this was especially the case when users were anonymised *(Spencer-Hughes et al., 2017)*. Those who endorse a user-controlled approach attest that without support from the survivor, disclosures could likely be retracted:

> 'So, if they don't reveal it, they don't reveal it. I've always said in safeguarding, you can only do what you do on the information you're given and actually if you start digging around people might just go, poof and not be seen ever again' *(Spencer-Hughes et al., 2017, p. 5)*.

Discussing preferences with clients promotes a sense of control, which can facilitate perceived safety *(Briere et al., 2020)*.

Facilitators of safety in online support groups included sharing the space with other users who have attended regularly. Survivors reported that this promoted feelings of trust through continuity: they perceived the space as a community, rather than as a collection of strangers *(Harms, 2017)*. Moderated online support spaces operated under terms of use that prohibited inflammatory or malicious posts. It was commonplace for the moderator to monitor posts, uphold user safety by monitoring identifying information and remove messages and/or users when appropriate *(Gali, 2014)*. Respondents trusted moderators to execute this role effectively *(Harms, 2017)*. The efficacy of online support interventions is facilitated by survivor input in the design/development process *(Montgomery et al., 2020; McElearney et al., 2021)*. Through centring interventions around survivors' expertise, users can receive trauma-informed support in a peer-to-peer style *(Montgomery et al., 2020)*. For services that adapted to online delivery through the pandemic, a person-centred approach meant pacing the progress of the therapy programme to suit the needs of clients and their families *(McElearney et al., 2021)*.

4

Conclusions & directions for future research

4.1 Conclusion

This rapid review of literature explored what is known about online support interventions designed to support recovery from CSA. We included studies about adult interventions because there were so few studies focussed on the evaluation of CYP interventions. Across studies, we observed a range of benefits to survivors regarding the services involved in the receipt or delivery of online support interventions for sexual violence and abuse. The findings suggest that online support interventions can increase the reach of services and have benefits for practitioners (e.g. time-saving, cost-effective). Online delivery also helped to promote engagement from parents/carers in CYP's recovery. Survivors reported that they could build strong and trusting relationships online with practitioners and peers and that the anonymity provided within online spaces helped them to feel safe.

Survivors also demonstrated improved mental health and emotion regulation after accessing online support interventions. However, the evidence base is small, and future studies are urgently needed, particularly of CYP and minoritised groups. These positive outcomes may be related to the finding that online interventions help survivors to make sense of their trauma narrative, normalise trauma symptomology and enhance coping mechanisms. Survivors reported that online support interventions helped to facilitate the disclosure of sexual abuse and promoted help-seeking offline.

We also identified a range of concerns and barriers that were involved in receiving and providing care for sexual violence and abuse. The findings highlight that a key barrier to accessing support online is the inequality of resources (e.g. access to tech) and the varied technical ability of carers/parents to facilitate access. There is variation in the level of confidence and understanding among practitioners around how to deliver support online, and doing so from home can present challenges for safety, privacy and staff wellbeing. Survivors reported that the impact of peers, particularly within unmoderated peer forums, can also be a barrier to engagement and recovery.

The findings also demonstrate that online support interventions are not appropriate for all survivors of sexual violence and abuse, and interventions must be tailored to the individual needs of those accessing them. This is particularly important for survivors with complex needs or a higher level of trauma symptomology. For example, the findings suggest that within online support interventions, non-verbal communication is challenging. Most importantly, ongoing abuse and lack of safety at home can hinder engagement with online support interventions and makes managing risk or processing trauma difficult. With this in mind, it was often recommended that online support interventions should be used to supplement and facilitate, but not wholly replace face-to-face treatment options.

Given the concerns and barriers identified, the final part of our analysis focussed on identifying strategies for managing safety within online support interventions for sexual violence and abuse. These related to the importance of preparation to enter services, continued assessment and communication and promoting a sense of safety through co-production of services and establishing agency. The findings demonstrate that effective preparation for accessing support online is critical to managing safety and survivors' ability to derive benefit from interventions. Continued assessment and communication about risk throughout online intervention delivery using built-in platform tools and offline resources can promote safety. Studies demonstrate that survivors are most likely to feel safe within online support interventions when they can remain in control of their own care needs, and this can be established through effective co-production.

4.2 Directions for future research

The purpose of this rapid review was to synthesise and explore the current literature surrounding online support interventions for survivors of sexual violence and abuse. With these findings in mind, several considerations can be made for future research. First, there is a need to further illuminate and examine the nature of victimisation and help-seeking in minoritised and marginalised groups through dedicated studies and the disaggregation of data *(Noack-Lundberg et al., 2020; Imkaan, 2020)*.

Second, it is important to explore a diversity of experience as it relates to varying cognitive and technological abilities (Littleton et al., 2016), varying trauma histories and differential experiences of tech inequity, as these factors may impact suitability.

Third, in the development of this rapid review, we found a lack of evidence surrounding CYP. Therefore, further research is needed to explore unique considerations for this population when accessing and engaging with online support interventions. Accompanying this, research is also needed to examine the involvement and role of relevant stakeholders such as parents/carers and wider agencies in the delivery of these interventions.

Fifth, it is important to develop the evidence base to represent types of online support interventions not found in this review, specifically research that assesses the efficacy of interventions that use asynchronous communication, AI and collaborative creative resources.

Sixth, online support group research, though identified more commonly in this review, has often been limited by their inability to consult service users; future research would benefit from their insight *(Gali, 2014; Otway, 2016)*.

Lastly, future research should pursue greater validity and generalisability through larger sample sizes, control conditions and working within diverse cultural and policy contexts.

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Appendix 1. Extraction table of included studies

Peer reviewed studies

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	Creech, K., Pulverman, S., Shin, E., Roe, T., Tzilos Wernette, G., Orchowski, M., Kahler, W., Shea, T., & Zlotnick, C. (2021).	Non-randomised pilot trial Assessing acceptability, feasibility, and potential benefit.	n = 20. Female army veterans with sexual trauma history. Aged 25–63. 45% white, 55% racialised minority. United States.	Web-based self-help. Limited session, web based, personalised and interaction psychoeducation and goal setting. Delivered in a clinical setting. Consistent with motivational interviewing.	95% completion. Moderately high levels of satisfaction. Significant improvements in IPV risk two months post and PTSD four months post. Non-significant improvement in hazardous drinking.	Small sample size. No control group. Non-randomised trial design.
	Endendijk, J. J., Tichelaar, H. K., Deen M., Deković M. (2021)	Mixed method triangulation of survey and interview findings. Assessing usability.	n ≈ 23 surveyed. n =10 interviewed. Therapists that work with children with sexual abuse trauma history. *M*age of client 11.38. The Netherlands	Virtual environment. Non-verbal virtual environment communication game. Users control characters that can perform actions on each other. Delivered face to face in a therapy space. Alternative communication tool to narrativise trauma and discuss associating issues.	Used with clients for: - Trauma narration (60%) - Psychoeducation (30/26%) - Self-protection skills (13%) Can facilitate disclosure earlier. Most common reason not to use is when client shows high levels of negative emotions or signs of re-experiencing around CSA disclosure.	Clients were not directly surveyed or interviewed. Most therapists work for the same organisation. Therapists were not given instructional materials.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	Fiorillo, D., McLean, C., Pistorello, J., Hayes, S. C., & Follette, V. M. (2017)	Non-randomised pilot study. Assessing feasibility, acceptability and efficacy.	n = 25. Females with interpersonal trauma history. *M*age 39.12 76% white, 24% racialised minority. United States.	Web-based self-help. Limited session, web-based, psycho-educative programme with accompanying exercises. Delivered without personalisation. Adapted from acceptance and commitment therapy.	84% completion. High levels of satisfaction. 'Good' levels of usability. Statistically significant improvements in targeted outcomes (PTSD, depression, anxiety).	No control condition. Non-randomised trial design. Non-diverse sample leads to limited generalisability.
	Gilmore, A., Davidson, T., Leone, R., Wray, L., Oesterle, D., Hahn, C., Flanagan, J., Gill-Hopple, K., & Acierno, R. (2019a)	Mixed-method triangulation of survey and interview findings. Assessing usability.	n = 38 Adults with sexual trauma history (n = 13) *M*age 28.00 85% female 100% white Practitioners who work with adults with sexual trauma histories (n = 25) United States.	Web-based education intervention. Mobile application. Modular, psychoeducation intervention. Modules include 'Posttraumatic Stress and Depressive Symptoms', 'General Adaptive Coping Skills' and 'Physical Health'. Included signposting to offline assistance.	Helpful considering reported barriers to traditional support. Most helpful components include dispelling rape myths, information on further resources, techniques on emotional regulation and mindfulness. Suggestion to include intersectional factors in recovery.	Small sample size. Non-diverse sample limits insight. Researcher observation may have been inhibiting.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	Gilmore, A., Walsh, K., Frazier, P., Meredith, L., Ledray, L., Davis, J., Acierno, R., Ruggiero, K., Kilpatrick, D., Jaffe, A., & Resnick, H. (2019b)	Randomised clinical trial. Assessing efficacy.	n = 233. Females who have received post-sexual assault forensic examination. *M*age 27.43 40% white, 60% racialised minority. United States.	Web-based education intervention. Brief video intervention for post-rape stress (PPRS) designed to mitigate the development of PTSD and increase perceived present control. Delivered in a clinical setting. Control groups received an active control condition, 'Pleasant Imagery and Relaxation Instruction' (PIRI) or 'Treatment as Usual' (TAU).	No support for main effects of the PPRS video on PTSD symptoms compared to TAU. There were also no significant differences between PPRS and PIRI. Participants with SA history reported improved PTSD and PPC measures six months post compared to TAU.	Small sample size. Participants were provided with different information based on their assigned condition. Did not assess for gender or sexual minority status.
	Gilmore, A., Lopez, C., Muzzy, W., Brown, W. J., Grubaugh, A., Oesterle, D., & Acierno, R. (2020)	Secondary data analyses from an ongoing randomised clinical trial Assessing predictive factors of attrition.	n = 136 Female veterans with military sexual trauma history and PTSD symptomology. *M*age 43.40 27% white, 73% racialised minority. United States.	Synchronous communication. PE therapy Comparing delivery remotely via in-home video conferencing and in-person standard care. 12 sessions delivered over 12 weeks.	50% completion. Difficulties with emotional regulation were a significant predictor of drop-out from treatment. No difference in completion across delivery modalities (in-person vs video conferencing).	Used self-report measures of Emotional Regulation only. Did not include male or gender minority participants.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	Gulati, N. K., Blayney, J. A., Jaffe, A. E., Kaysen, D., & Stappenbeck, C. A. (2021)	Mixed-method intervention development pilot study Gathering feedback on design, relevance and helpfulness	n = 21. Heavy drinking female college students with rape (attempted/ completed) trauma histories. *M*age 20.71. 67% white, 33% racialised minority. United States.	Web-based self-help. Web-based, multi-media, modular self-help intervention. Content focussed on alcohol consumption and emotional regulation. Delivered remotely. Based on CBT and dialectical behaviour therapy.	Interventions were rated as helpful, easy and satisfying. Reported instances of judgemental language. Suggestions for personalisation and increased interactivity.	Small sample size. Data collection via open-ended survey limited elicitation.
	Lee, M. R. & Cha, C. (2021)	Randomised controlled pilot study Assessing feasibility and preliminary effects	n = 34 Females with sexual trauma history not currently receiving formal therapy. Aged 19–24 Race characteristics unreported. South Korea.	Web-based self-help. Tailored mobile virtual reality programme. Experimental group received 3D hologram to prompt reflective writing and mindfulness. Control group received audio prompt. 8 exercises delivered over four weeks.	63% completion in experimental group. 93% completion in control group. Both groups of participants experienced significant improvements in perceived support, suicidal ideation and negative impact from sexual violence measures. Qualitative findings report facilitation in universality and empowerment.	Small sample size. self-report measures only limited elicitation.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	Littleton, H., Grills, A. E., Kline, K. D., Schoemann, A. M., & Dodd, J. C. (2016)	Randomised control trial Assessing efficacy.	n = 87 Females with rape trauma history and related PTSD diagnosis. *M*age 22 41% white, 59% racialised minority. United States.	Human-supported web-based therapy. Online CBT programme. Experimental group received multi-media content, sequential modular delivery and asynchronous therapist feedback. Control group received link to psycho-educative website without multimedia content, sequential modular delivery or therapist facilitation.	15.8% completion rate. Both online interventions reported significant reductions in PTSD and depressive symptoms from pre- to post-treatment. No significant difference in outcome measures between the interventions. Experimental group reported strong working alliance with therapist.	Participants entered study with high levels of computer literacy and comfortability. Contact rates with withdrawn participants low.
	Littleton, H. & Grills, A. (2019)	Secondary analysis of a randomised control trial (See above). Assessing trauma-related conditions as treatment mechanisms.	See above	See above	Reductions in trauma related cognitions were strongly related to reductions in PTSD symptoms among the experimental group, but only weakly related to symptom reduction in the control group. Psycho-educative programme suited to low-to-moderate PTSD. Facilitated programme suited to more severe PTSD.	See above. Sole reliance on self-report assessments of coping and trauma-related cognitions.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	Loucks, L., Yasinski, C., Norrholm, S. D., Maples-Keller, J., Post, L., Zwiebach, L., Fiorillo, D., Goodlin, M., Jovanovic, T., Rizzo, A. A. & Rothbaum, B. O. (2019).	Open clinical trial. Assessing feasibility	n = 15 Veterans with military sexual trauma history. *M*age 46 74% female 33% white, 67% racialised minority United States.	Virtual environment. Virtual reality exposure therapy Visual and auditory immersion in trauma-related environments. Delivered across 6–12 sessions in a clinical setting with a therapist facilitation.	60% completion rate. 100% completion (n = 4) in intensive outpatient programme. Significant reduction in PTSD and depressive symptoms post treatment The majority of participants no longer met diagnostic criteria for PTSD at the three-month follow-up.	Small sample size. No control group. 2/3 drop out in waitlist pre-treatment.
	Miller, K. E., Cranston, C. C., Davis, J. L., Newman, E., & Resnick, H. (2015)	Randomised trial. Assessing efficacy.	n = 164 Females with recent sexual trauma experiences. *M*age 29 62% white, 38% racialised minority. United States.	Web-based education intervention. Brief video intervention. Provides psychoeducation and modelling. Delivered in a clinical setting at the time of a Sexual Assault Forensic Examination (SAFE). Control group received standard care.	15% did not receive intervention in the experimental group due to technical malfunctions. Experimental group reported statistically significantly lower scores in anxiety measures at two months post. Participants reporting no previous sexual assault history reported significantly fewer posttraumatic stress symptoms two weeks post.	Small sample size. Insufficient data to explore characteristic differences between participants who completed and withdrew.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	Montgomery, E., Seng, J. S., & Chang, Y. S. (2021)	Mixed-method intervention co-development study.	n = 37 Females with experience of or interest in pregnancy, childbirth or new motherhood and with child sexual trauma history. Aged 20–68 89% white, 11% racialised minority. United Kingdom.	Web-based education intervention. Modular, multimedia, psycho-educative and experience-sharing e-resource. Autonomous navigation.	Participants drew altruistic value from their involvement. Survivor co-production ensures expertise by experience and peer-to-peer communication style. Intervention content reported as honest, compassionate and helpful. Suggestions to be sensitive of language use and link to external organisations. Jurisdiction of linked organisations limited international generalisability.	Some participants withdrew from involvement.
	Noack-Lundberg, K., Liamputtong, P., Marjadi, B., Ussher, J., Perz, J., Schmied, V., Dune, T., & Brook, E. (2020)	Qualitative forum analysis	n = 420 (posters) Forum focus on trans women of colour. 67% self-reported women 6% self-reported men. Australia (intervention global potentiality)	Online support groups. Four unmoderated, publicly accessible online forums. Users can access anonymously. Asynchronous peer support.	Users motivated to access online forums because of the lack of suitable offline groups (typically either cis women or men). Some users experienced dissatisfaction with offline support. Concerns around the impact of sexual trauma on gender identity.	Inability to contact users impedes elicitation. International potentiality of the intervention precludes insight into support experiences in specific contexts.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	O'Neill, T. (2018)	Qualitative forum analysis	n = 7000 (users) Forum focused on SA survivors. User demographics not provided. Australia (intervention global potentiality)	Online support groups. One unmoderated, publicly accessible online forum. Users can access anonymously. Asynchronous peer support.	Users are motivated to access online forum for storytelling, advice and to find community. Some users experienced dissatisfaction with offline support Self-blame is dissuaded. Can form collective identity through mutual identification. Therapy sometimes not meeting all needs.	See above.
	Spencer-Hughes, V., Syred, J., Allison, A., Holdsworth, G., & Baraitser, P. (2017)	Exploratory study using interviews.	n = 14 Expert practitioners across sexual health services sector. No demographic characteristics provided. United Kingdom.	Not a direct assessment of an intervention(s). Interviews focused on safeguarding barriers and facilitators against child sexual exploitation in a range of online and offline sexual health services.	Broadly, safeguarding approaches lie on a spectrum two approaches between information providing and information gathering. Information providing services are a less pressured environment for CYP but risk disengagement. Online services must be integrated into a wider clinical system including local offline services.	Small sample size. Sample did not include users of the intervention. None of the sample worked directly with online services. Findings within a UK policy context limits generalisability.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	Tener, D., Marmor, A., Katz, C., Newman, A., Silovsky, J. F., Shields, J., & Taylor, E. (2021)	Cross-cultural comparative study	n = 60. Practitioners working with intra-familial child sexual abuse (IFCSA). *M*age 40.52. 74% female. United States and Israel.	Synchronous communication. Video conferencing or telephone remote support for IFCSA families. Therapeutic and child-welfare support. Adaptation in response to pandemic restrictions.	Reported shift in type of therapy and focus. Lack of preparedness. Engagement was impeded. Loss of privacy, especially for younger clients. Loss of distinction between clinic/home. Differential access to technology due to religious and cultural practices.	Self-selected participation in online interviews may have affected sample characteristics. Differential distribution of professional backgrounds across study locations.
	Valentine, L. M., Donofry, S. D., Broman, R. B., Smith, E. R., Rauch, S. A., & Sexton, M. B. (2020)	Control trial. Assessing completion and minimum adequate care rates.	n = 171 Veterans with military sexual trauma and associated diagnoses of PTSD. *M*age 44.4 74% female 69% white, 31% racialised minority. United States.	Synchronous communication. Remote video conferencing CPT and PE. 12 sessions delivered over 12 weeks. Delivered at home (10%) Delivered in a community-based outpatient setting (90%). Control group received in-person care.	Completion rates were 50% and 32.3% for in-person and Clinical Video Technology (CVT), respectively. MAC rates were 62.1% and 41.9% for in-person and CVT, respectively. Participants using CVT were more likely to withdraw	Low opt-in for home-based delivery. Lack of consideration into other variables that may be related to treatment completion.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Peer reviewed studies	Webber, R. (2014)	Qualitative online forum analysis.	n = 30 (posts) Posts concerned with sexual abuse between peers. Self-reported ages ranged between 13 and 21. Australia (intervention has global potentiality)	Online support group. Moderated, publicly accessible, online community where registered members can ask and answer questions on a wide range of topics. Questions and responses can be up and down voted. Responses from sexual assault counsellors and other members.	The answers provided by counsellors typically included a supportive comment, advice (personal, legal and medical), reflection or interpretation, resources and places to go for help. Other members' answers lacked consistency, often failing to provide appropriate advice, empathy and resources. They were sometimes emotionally harmful.	Inability to contact users impedes elicitation. International potentiality of the intervention precludes insight into support experiences in specific contexts.
	Weiss, B. J., Azevedo, K., Webb, K., Gimeno, J., & Cloitre, M. (2018	Pilot study. Assessing feasibility, acceptability and initial efficacy.	n = 10 Female veterans with military sexual trauma history and live in rural areas. *M*age 51.30 80% white, 20% racialised minority. United States.	Synchronous communication. Clinic-to-clinic video conferencing therapy. 8–10 sessions delivered over 8–10 weeks. Programme focused on teaching emotion management and interpersonal skills.	100% completion High satisfaction Symptoms of PTSD and depression were significantly reduced. Emotion regulation skills significantly improved Problems in social functioning approached a significant reduction.	Small sample size. No monitoring of adherence to session content.

Theses

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Theses	Galli, A. (2014)	Qualitative online forum analysis Master's thesis.	n ≈ 1000–2,500 (posts) Forum focused on sexual assault survivors. United States (intervention has global potentiality).	Online support group. Moderated, publicly available online forum. Users can access anonymously. Website includes links to external support organisations.	Users utilised the intervention to: - Share their experience, narrative their trauma. - Find a community. - To share and receive advice. Limitations of offline therapy discussed, offline help-seeking encouraged. Anonymity key attraction to the intervention.	Inability to contact users impedes elicitation. International potentiality of the intervention precludes insight into support experiences in specific contexts.
	Harms, J. (2017)	Mixed-method online forum analysis. Master's thesis.	n = 40 Adult males with child sexual abuse trauma history. No demographic information provided. United States (intervention has global potentiality)	Online support group. Moderated, online support group. 90-minute, text-based, synchronous communication. Users can access anonymously. Moderators ensure safety and facilitate discussion.	Support group participants felt less alone, more hopeful, and less angry. Psychoeducation, universality, mutual support and trust were present and helpful. The more sessions users attend, the greater the effects.	Only certain therapeutic factors of support groups assessed. Limited generalisability to different support groups.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Theses	Johnson, E. (2020)	Open clinical trial. Assessing efficacy. Doctoral thesis.	n = 18 Adults with sexual assault trauma history *M*age 20.80 89% female 67% white, 33% racialised minority. United states.	Web-based self-help. Self-guided, multi-media, online mindfulness training. Daily exercises delivered over eight weeks.	56% completion. Significant improvements in overall psychological distress, emotional avoidance, PTSD symptoms and mindfulness skills. Insignificant changes to depressive symptoms, somatic symptoms, alcohol use and quality of life. Some participants still experienced significant PTSD, depressive, and somatic symptoms following this intervention.	Small sample size. Student sample may have higher tech literacy and comfortability, limits generalisability. No control group.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Theses	Kamarudin, N. S. (2019)	Mixed-method online forum analysis. Doctoral thesis.	n = 1,921 Forum focused on rape survivors. No demographic information provided. United States (intervention has global potentiality)	Online support groups. Two unmoderated, publicly accessible online forums. Users can access anonymously. Support professionals informally participate.	Anonymity facilitated perceived safety and disclosure. Emotional support evidenced. Limitations of offline support discussed. When professionals participated, discussion content was more solutions focused.	Inability to contact users impedes elicitation. International potentiality of the intervention precludes insight into support experiences in specific contexts.
	Otway, L. J. (2016)	Qualitative online forum analysis Doctoral thesis.	n = 212 (posts) Forum focuses on females who have rape/sexual abuse history. No demographic information provided. United Kingdom (intervention has global potentiality)	Online support group. Moderated, publicly accessible online forum.	Users were found to: - Validate victim's status - Give and receive emotional support. - Encourage offline help-seeking. - Share experiences, narrative trauma. In some instances, blame was assigned to survivors as a means to give safety advice.	Inability to contact users impedes elicitation. International potentiality of the intervention precludes insight into support experiences in specific contexts.

Continued below

	Author(s) & Date	Study design	Sample & setting	Intervention	Results	Study Limitations
Theses	Polk, S. (2021)	Qualitative action research study. Doctoral thesis.	n = 6 Welfare and therapeutic professionals working with children with sexual abuse trauma history. 83% female No additional demographic characteristics provided. United States.	Synchronous communication. Trauma-focused CBT and play therapy. Delivered remotely via video conferencing. Delivered as an adaptation to the pandemic.	Lack of preparedness, difficult transition to remote online delivery. Shift in type of therapy in some instances. Instances of parental disruption. All agreed that a client can successfully receive TF-CBT and play therapy through telehealth.	Small sample size. All participants work in the same local area, limits generalisability

Service Evaluations

	Author(s) & Date	Setting	Intervention	Themes
Service Evaluations	Furber, L., & Garrett, E. (2020)	Regional therapy and advocacy service 'Imara' supports children and families with child sexual abuse trauma histories. Service evaluation of provision during the pandemic. United Kingdom.	Synchronous communication. Children's independent sexual violence advocacy service. Using video/audio conferencing.	Lack of preparedness. Client engagement more challenging with virtual support. Distributing resources helped engagement. Limited perceptibility of non-verbal communication. Concerns over client safety when accessing support from home. Practitioners experienced containment challenges.
	Imkaan (2020)	National umbrella women's organisation 'Imkaan' dedicated to addressing violence against Black and Minoritised women and girls. Mixed-method exploration of support for black and minoritised women with abuse trauma history during the pandemic. United Kingdom.	Synchronous communication. Remote welfare and therapeutic support. Using video/audio conferencing.	Aggregated VAWG statistics obfuscates intersectional mediators of structural inequality during the pandemic. Client engagement challenged through lack of safety at home. Existing digital inequity in by-and-for services reinforced due to disruptions from lack of sufficient tech and connectivity.

Continued below

	Author(s) & Date	Setting	Intervention	Themes
Service Evaluations	McElearney, A., Hyde-Dryden, G., Palmer, L., & Walters, H. (2021)	National charity NSPCC. Organisational learning from adapting service provision during the pandemic. United Kingdom.	Synchronous communication. Remote therapeutic support for children and families Using video/audio conferencing.	Positive experiences of delivering creative therapies online. Most staff confident in upskilling for virtual care. Some clients favoured their connection to therapist online due to in-person social distancing. Improved parent–child engagement. Remote delivery necessitated slower pace that suited clients. Complex assessments not suitable for online as online communication is mostly virtual/textual, Difficult to interpret distress Remotely. Some clients had difficulty accessing from home due to distractions/disruption or containment challenges.
	Moore, E., & Churchill, G. (2020)	National Charity NSPCC. Experiences of frontline staff working during the pandemic. United Kingdom.	National Charity NSPCC. Experiences of frontline staff working during the pandemic. United Kingdom.	Staff reported blurred boundaries between their home and work lives. Confidentiality concerns when working from home. Face-to-face staff support and debriefing was favoured to remote communication. Reported frustration around lack of face-to-face contact with children and families.

Continued below

	Author(s) & Date	Setting	Intervention	Themes
Service Evaluations	The Children's Society (2021)	National Charity 'The Children's society' Service evaluation inclusive of service provision during the pandemic. United Kingdom.	Synchronous communication. Remote welfare and therapeutic support for children and families. Using video/audio conferencing. Synchronous communication. Remote welfare and therapeutic support for CYP who are at risk of or are currently being, sexually or criminally exploited, and those that are repeatedly reported missing. Using video/audio conferencing.	Staff reported blurred boundaries between their home and work lives. Confidentiality concerns when working from home. Face-to-face staff support and debriefing was favoured to remote communication. Reported frustration around lack of face-to-face contact with children and families. Building relationships with clients is challenging online, especially when they had not met face to face previously. Creative therapies were adapted to online, distributing offline activities to complete synchronously. Client dissatisfaction with the limited perceptibility of non-verbal communication through remote delivery.

Guidance

Author(s) & Date	Description	Recommendations
American Telemedicine Association (2020)	Practice guidelines for telemental health with children and adolescents United States.	Therapy should be conducted in a neutral environment for the client. Practitioners should assess the suitability of parental involvement in sessions. Risk protocol for distress management and tech disruptions should be established.
Canadian Institute of Health Research (2021)	Recommendations from a lay summary of knowledge synthesis. Canada.	Virtual care is more effective as a supplement than as a replacement to in-person care. Concerns for clients with trauma symptoms include safety, privacy and loss of human connection. There is evidence for online support to reduce symptoms. There is an urgent need to address digital inequity.
New South Wales Government Relations (2020	State policy and practice guidance for health services responding to adult and child sexual assault. Australia.	New South Wales government recommends online counselling for adults who are not in a crisis state. Children, staff and parents must be educated on communication and safety protocols. Children should be consulted in the design of online support spaces. Telehealth can be used to improve accessibility of support.

Guidance

Continued below

	Author(s) & Date	Description	Recommendations
Guidance	Briere, J., Lanktree, C., & Escott, A. (2020)	Guidelines for teletherapy for trauma exposed youth. United States.	Ensuring safety requires continual assessment. Protocols should be agreed with clients around safety and distress management, including code words. Practitioners should present professionally in dress and background. Practitioners should offer full-body view to show full dress. Some visual continuity from face-to-face environment is recommended. Clients should receive therapy from a non-threatening environment. The use of virtual environments may be interpreted as deceptive.

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