Campbell Collaboration Social Welfare Coordinating Group

Title Registration Form

Please complete this form to begin the process of registering a review with the Campbell Collaboration Social Welfare group. When approved by the editorial board, the title and registration form will be posted in the Campbell Library (http://www.campbellcollaboration.org/Fralibrary2.html). Please be explicit about what you will and will not do. Use as much space in the form as you wish. Please return the completed form to awi@nokc.no.

1. Title of review (Suggested format: [intervention/s] for [outcome/s] in [problem/population] in [location/situation]. Example: behavioural therapy for reducing violence among adolescents in institutions)

Interventions to reduce distress in adult victims of sexual violence and rape

2. Background and objective of this review (Briefly describe the problem and the intervention.)

Estimates of the incidence and prevalence of rape and other forms of sexual assault vary depending on how terms are defined, what types of sexual assaults are included, the time frame during which the data are collected, sampling methods used, age and gender of the population studied, and the location of the sample (Acierno, Resnick & Kilpatrick, 1997). For instance, in a survey of 6,000 students from 32 colleges in the United States, 50% indicated having experienced some form of sexual violence since age 14 and 27.5% reported having been raped (Koss, Gidycz & Wisniewski, 1987). In a subsequent study with 2,700 college women, 15% reported rape and 12% reported attempted rape since age 14 (Koss & Dinero, 1989). Gross and colleagues (2006) reported that 27% of a sample of college women had experienced some form of unwanted sexual contact (ranging from kissing and petting to intercourse) since entering college. A population-based study of 1,769 women in Virginia discovered that the lifetime prevalence of sexual assault was 27.6% and the prevalence of rape was 17.8%. In survey of households in Los Angeles, the lifetime prevalence of sexual assault was 13.2% (16.7% for women and 9.4% for men; Burnham et al., 1988). A similar study in the Northeast, reported a lifetime prevalence of sexual assault of 7.3% for women and 1.3% for men (Norris, 1992). A national random digit dailing survey of women found that 12.7% reported a history of rape and 14.3% reported other forms of sexual assault (Resnick et al., 1993). While estimates vary, sexual assault affects a non-trivial percentage of the population.

Distress often occurs after a person has been exposed to serious trauma such as sexual assault. Resick (1983) for example found that victims of rape exhibited more depressive symptoms, more fear and anxiety, more problems with social and work adjustment, and more problems with sexual functioning than did a control group of non-victims. The increased prevalence of Post-Traumatic Stress Disorder (PTSD) in victims of rape is well documented. PTSD has been reported to affect between 9 and 15 percent of the general population and almost 50 percent of individuals who have been raped (Treadwell & Foa, 2004).

As the negative effects of sexual assault have become better recognized, there is increasing attention to the possibility that psychosocial interventions may reduce suffering and limit distress. There are now several treatments modalities available for victims of rape and sexual assault including: pharmacology; behavioural techniques such as flooding, systematic desensitization, eye movement desensitization and retraining (EMDR); cognitive behavioural

therapy; cognitive therapy; relaxation; rational-emotive therapy; group therapy; hypnosis; family/couple therapy; existential therapy; humanistic approaches; and psychodynamic therapy. Although a variety of interventions have been used in attempts to reduce distress following sexual assault, Stein, Ipser and Seedat's (2006) systematic review of pharmacotherapy for PTSD is the only systematic review to examine the reduction of distress for victims of rape. These reviewers concluded that while medication treatments can be effective in treating PTSD, there continues to be a need for more effective agents.

Within the psychotherapy literature, there have been several non-systematic reviews of treatment for rape and sexual assault (Falsetti, 1997; Foa, Rothbaum & Steketee, 1993; Foa & Rothbaum, 1998). Other reviews have examined the reduction of distress in populations experiencing symptomology of PTSD but these reviews were not specific to adult victims of rape and sexual assault. For example, Bisson (2006) completed a Cochrane Review of psychological treatments to reduce symptoms of post traumatic stress disorder (PTSD). There were no restrictions on the basis of severity of PTSD symptoms or type of traumatic event. As a result, the study populations included war veterans, female assault (mainly sexual assault) survivors, road traffic accident survivors, refugees and police officers, and mixed groups of individuals who had experienced a variety of traumatic events including road traffic accidents, assaults, bereavement and industrial accidents. Likewise, Sherman (1998) completed a meta-analysis of controlled and clinical trials of psychotherapeutic treatments for posttraumatic stress disorder (PTSD) and included samples of combat veterans from the Vietnam and Lebanon Wars, crime-related victims, and severe bereavement sufferers and victims of rape. Sherman examined cognitive, and psychodynamic treatments, in group and individual settings and found the overall impact of psychotherapy on PTSD and psychiatric symptomatology was significant ($d = .52$, $r = .25$).

Although these reviews suggest that there may be effective treatments for trauma and PTSD in general, there remains a substantial gap in the empirical evidence related to the effectiveness of various modalities to treat rape and other forms of sexual assault.

There is no clear consensus among therapists and researchers on the best way to treat victims of rape and sexual assault. In addition, most research has tested behavioural, cognitive or cognitive behavioral therapies. Therefore, the objective of this systematic review will be to complete an exhaustive and comprehensive search of controlled and clinical trials of psychotherapies for victims of rape and sexual assault, and to synthesize the studies based on outcomes related to distress and trauma.

3. Define the population (Who is included and who is excluded?)

The population for this review will include adults, 18 years of age and older, who have been victims of rape or sexual assault. The population will include both males and females.

Rape is a term that refers to forced or attempted sexual intercourse with a male or female, by an offender that may be of the same sex or a different sex from the victim. Sexual assault is usually defined to encompass rape; attempted rape; forced oral sex, anal sex, penetration with objects, touching of intimate parts; and other types of threats or coercion in which unwanted sexual contact is attempted or occurs between the victim and offender.

4. Intervention/s (What is given, by whom, and for how long? What are the comparison conditions?)

Interventions included in this review will be psychological or psychosocial in nature. Although we expect to find more controlled trials of cognitive behavioural therapy, a comprehensive search will be conducted to uncover all controlled investigations of effects of interventions to treat rape and sexual assault victims. These interventions will include: behavioural techniques such as flooding, systematic desensitization, eye movement desensitization (EMDR); cognitive behavioural therapy; cognitive therapy; relaxation; rational-emotive therapy; group therapy; hypnosis; family/couple therapy; existential therapy; humanistic approaches; and psychodynamic therapy. It is expected that most studies evaluating the effectiveness of these forms of treatment will be time-limited. Length of treatment will be included as a variable for analysis. Since the main objective of this review is to compare psychosocial interventions to reduce distress, interventions that are exclusively based on pharmacology will be excluded. Studies that compare psychosocial treatments to pharmacological treatment comparisons and studies that combine psychosocial treatments and pharmacological treatments will be considered.

5. Outcome/s (What are the intended effects of the intervention? Primary and secondary outcomes should all be mentioned.)

The primary outcome is a decrease in trauma symptoms (PTSD). Secondary outcomes are: deceased levels of depression, anxiety, and guilt; and increases in positive functioning (e.g., social support, peer relations, locus of control, self-efficacy).

A wide range of instruments and reporting measures have been used to measure these primary and secondary outcomes. These measures vary in quality and validity.
For this review, the minimum standards for the inclusion of data from outcome instruments will be 1) psychometric properties of the instrument have been described in the study sample or in other samples; 2) the instrument was completed by a clinician, an independent rater or self-report by the participant in the treatment.

The primary outcome will be assessed in terms of the independent rating of severity of traumatic stress symptoms using a standardised measure such as the Clinician Administered PTSD Symptom Scale (Blake 1995) and severity of self-reported traumatic stress symptoms using a standardized measure such as the Impact of Event Scale (Horowitz 1979).

Secondary outcome measures will include: 1) severity of depressive symptoms using scales such as the Beck Depression Inventory (Beck 1961); 2) severity of anxiety symptoms using scales such as the Spielberger State Trait Anxiety Inventory (Spielberger 1973).

In addition, analyses of outcomes will include any adverse negative affect of treatment (increased distress following treatment).

6. Methodology (What types of studies are included and excluded? Please describe eligible study designs, control/comparison groups, measures, and duration of follow-ups.)

Studies are eligible for the review if the allocation of study participants to experimental or control groups was by random allocation or parallel cohort design (i.e., groups are assessed at the same point in time). Studies will be divided based on sample allocation into 1) those that

did and did not use random assignment; 2) the quality of random assignment; 3) whether there were baseline differences between groups, and if so, 4) whether controls for baseline differences were used; and 5) differential attrition (i.e., drop-out rates will be recorded and examined for possible effects on both the treatment and comparison groups).

For studies that include follow-up times, these will be divided into 1 month, 3 months, 6 months, 9 months, 12 months and above 2 year follow-ups.

Double coding of these studies by team members will ensure that the studies meet the eligibility requirements according to the Campbell Collaboration's guidelines.

Reviewer/s

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Do you need support in any of these areas: methodology and causal inference, systematic searches, coding, statistics (meta-analysis)?

A reference group has been established at the Faculty of Social Work, University of Toronto which includes experts on rape, sexual assault and trauma. The reference group also includes authors of accepted Campbell Collaboration Titles, a systematic review specialist and a systematic review coordinator. Nonetheless, we welcome support from the Campbell Collaboration with respect to developing a systematic search strategy, translation of reports not written in English or French, and methodological and statistical consultation (particularly as advances in these areas are developed within the Campbell and Cochrane Collaborations).

Once the editorial board approves the registration of your title, you have six months to complete the protocol. If the protocol is not finished after six months, the review area is opened up for others. Queries should be addressed to awi@nokc.no