EUROPEAN JOURNAL OF PSYCHOTRAUMATOLOGY
2025, VOL. 16, NO. 1, 2524892
https://doi.org/10.1080/20008066.2025.2524892

CLINICAL RESEARCH ARTICLE

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Painful, but necessary: a qualitative process evaluation on patient experiences with modified prolonged exposure as early intervention after rape (the EIR study)

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ABSTRACT

Background: Early trauma-focused cognitive behavioural therapy may help reduce post-traumatic stress symptoms in individuals recently exposed to sexual assault. In Norway, specialized Sexual Assault Centres (SACs) provide psychosocial support to survivors of sexual assault, yet the effectiveness of these services remains uncertain. The Early Intervention after Rape (EIR) study is a multisite randomized controlled trial evaluating the effectiveness of modified prolonged exposure therapy (mPE) compared to treatment as usual (TAU) in alleviating post-traumatic stress symptoms shortly after rape.
Objective: This qualitative study explores patients' experiences with participating in the EIR study and receiving mPE as early psychosocial intervention at three SACs in Norway.
Method: We interviewed 15 patients, 10 receiving mPE and five receiving TAU.
Results: Thematic analysis revealed that patients found participation in the EIR study beneficial and meaningful, and that it was facilitated by a respectful and a trauma-competent research team. Patients favoured psychosocial support that directly addressed the traumatic event over non-specific focus on everyday concerns and recommended integrating mPE into the SAC's psychosocial support services.
Conclusion: This study provides insights into the experiences of women receiving psychosocial support at SACs after recent sexual assault. It highlights clinical and practical challenges in implementing a novel intervention and conducting a multisite RCT, whilst at the same time identifying opportunities to enhance evidence-based support, ensuring alignment with survivors' preferences and recovery process.

Doloroso, pero necesario: una evaluación cualitativa del proceso sobre las experiencias de las pacientes con la exposición prolongada modificada como intervención temprana después de una violación (el estudio EIR)

Antecedentes: La terapia cognitivo-conductual temprana centrada en el trauma puede ayudar a reducir los síntomas de estrés postraumático en individuos recientemente expuestos a una agresión sexual. En Noruega, los centros especializados en agresiones sexuales (SACs, en siglas en inglés) proporcionan apoyo psicosocial a las sobrevivientes de agresiones sexuales, aunque la eficacia de estos servicios sigue siendo incierta. El estudio Intervención Temprana después de una Violación (Early Intervention after Rape, EIR, en siglas en inglés) es un ensayo controlado aleatorizado multicéntrico que evalúa la eficacia de la terapia de exposición prolongada modificada (mPE, en siglas en inglés) en comparación con el tratamiento habitual (TAU, en siglas en inglés) para aliviar los síntomas de estrés postraumático poco después de una violación.
Objetivo: Este estudio cualitativo explora las experiencias de las pacientes al participar en el estudio EIR y recibir la mPE como intervención psicosocial temprana en tres SACs de Noruega.
Método: Entrevistamos a 15 pacientes, 10 que recibieron mPE y cinco que recibieron TAU.
Resultados: El análisis temático reveló que las pacientes encontraron beneficiosa y significativa la participación en el estudio EIR, y que fue facilitada por un equipo de investigación respetuoso y competente en traumas. Las pacientes favorecieron el apoyo

KEYWORDS
Early intervention; rape; PTSD; prolonged exposure therapy; qualitative; sexual assault center

PALABRAS CLAVE
Evaluación del proceso; cualitativa; exposición prolongada modificada; intervención temprana; violación; TEPT; centro de agresiones sexuales; apoyo psicosocial

HIGHLIGHTS

- Modified Prolonged Exposure (mPE) is perceived as beneficial by recent rape survivors and is recommended for integration into support services at Sexual Assault Centres (SACs).
- Augmenting psychosocial support with trauma-focused interventions that facilitate safe disclosure may enhance outcome for survivors.
- Research involving recently sexually assaulted individuals is well-tolerated and provides valuable insights for improving intervention strategies.

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Supplemental data for this article can be accessed online at https://doi.org/10.1080/20008066.2025.2524892.

psicosocial que abordaba directamente el acontecimiento traumático frente al enfoque inespecífico en las preocupaciones cotidianas y recomendaron integrar la mPE en los servicios de apoyo psicosocial del SACs.
Conclusiones: Este estudio proporciona información sobre las experiencias de las mujeres que reciben apoyo psicosocial en los SACs tras una agresión sexual reciente. Pone de relieve los desafíos clínicos y prácticos que plantea la aplicación de una intervención novedosa y la realización de un ECA multicéntrico, al tiempo que identifica oportunidades para mejorar el apoyo basado en la evidencia, garantizando la alineación con las preferencias de las sobrevivientes y el proceso de recuperación.

1. Introduction

Research involving survivors of rape often raises concerns about the safety of participants and the potential for psychological harm due to emotional distress (Newman & Kaloupek, 2004). While research participation may evoke strong emotions, these are usually temporary and not harmful. Research indicates that survivors typically perceive participation as positive and meaningful, with many reporting a sense of personal satisfaction and increased self-esteem from contributing to research (Campbell et al., 2010; Jaffe et al., 2015; Nielsen et al., 2016). In a large-scale study by Short and colleagues (Short et al., 2024), 94-97% of the participants appreciated the experience despite reports of emotional distress. Most importantly, vulnerable groups, such as those with high levels of psychiatric symptoms had comparable experiences. These reports indicate that research involving survivors may be conducted safely and benefit the participants, which is promising for advancing intervention research through a broad representation of survivor voices.

Rape imposes significant health burdens and carries a high risk of developing post-traumatic stress disorder (PTSD) (Dworkin, 2020; Kessler et al., 2017; Rothbaum et al., 1992). A meta-analysis (Dworkin et al., 2023) found that 75% of sexually assaulted met PTSD criteria (except the duration criteria) after the first month, and further recovery after the initial three months levelled off. Combined with a high prevalence (~ 42% after 12 months), this highlights the need for evidence-based interventions to support the recovery process.

In Norway there are 23 specialized sexual assault centres (SACs) providing medical treatment, forensic examination, and psychosocial support. However, the psychosocial support lacks standardization due to vague guidelines (Helsedirektoratet, 2021), resulting in considerable variability in the type and quality of support offered across SACs.

The ongoing Early Intervention after Rape (EIR) study (Haugen et al., 2023; Haugen et al., 2024; Haugen et al., 2025) is a parallel two-arm clinical randomized trial examining the effectiveness of modified prolonged exposure (mPE) therapy as compared with treatment as usual (TAU). Women seeking assistance within seven days after rape are invited into the study, and eligible patients, according to the inclusion- and exclusion criteria, are randomized to either mPE + TAU or TAU.

The mPE intervention consists of up to five weekly sessions and is delivered in addition to the ordinary TAU services. The mPE is initiated within 14 days of the assault and includes psychoeducation on common reactions to trauma, explains how avoidance and unhelpful thoughts contribute to the maintenance of PTSD, and provides a rationale for how exposure therapy targets these maintaining factors. Two exposure techniques are used; gradual *in vivo* exposure to trauma-related feared situations, and imaginal exposure and trauma memory processing (Foa et al., 2020). Imaginal exposure and processing refer to a repeated, detailed, and aloud recounting of the traumatic event, followed by a reflection about the experience. PE is rooted in Emotional Processing Theory (Foa & Kozak, 1986), which suggests that PTSD symptoms persist when trauma memories are encoded with inaccurate and overly threatening associations, such as the belief that the world is entirely dangerous and others are completely untrustworthy. Repeated exposure to the memory, followed by thoughtful reflection, allows for the integration of corrective information. This leads to habituation that lower distress and PTSD symptoms.

The standard services, TAU, are not clearly defined and vary across centres. They may include medical and forensic examination, legal advice, pregnancy testing, prophylactic treatment for sexually transmitted diseases, and psychosocial support. The psychosocial support offered within TAU includes elements of emotional first aid and coping strategies aimed at helping individuals manage the psychological and emotional impact of sexual assault. The traumatic event is not in focus unless the patient initiates it. The content is rather tailored to the individual's needs. The overall impression is that TAU primarily emphasizes stabilization and support and is offered face-to-face or by telephone with no set limit on the number of sessions offered.

The main aim is to investigate whether mPE + TAU will prevent post-traumatic stress symptoms more

effectively than TAU alone. Additionally, we anticipate that the intervention will be safe and well-tolerated when initiated shortly after rape and delivered by trained SAC nurses and social workers. An overview of study procedures and outcomes has been published elsewhere (Haugen et al., 2023). As part of the EIR study, we conducted a qualitative process evaluation of the entire study protocol by interviewing therapists (Haugen et al., 2025) and patients about their experiences with participating in the EIR study. The objective of the present study was to supplement effectiveness analyses by incorporating the qualitative perspectives of the participating patients. This approach may offer nuanced insights into the delivery and impact of the intervention, thereby contributing to more robust evidence for scaling and adapting interventions.

2. Methods

2.1. Design

The study was a qualitative process evaluation embedded in an ongoing randomized controlled trial (the EIR study), as recommended by the UK Medical Research Council (Skivington et al., 2021a, 2021b).

2.2. Setting and participants

Using a convenience sampling strategy, participants were recruited from among those enrolled in the EIR study. Research assistants (RAs) identified and contacted eligible individuals at three SACs involved in the EIR study: Trondheim, Oslo, and Vestfold (the fourth SAC had not yet begun recruiting). Only participants actively enrolled in the EIR study (i.e. had not dropped out or declined further participation) were considered for inclusion.

To ensure a range of experiences with the EIR study, RAs aimed to recruit participants who were at different stages of study participation. This included individuals who had completed the first follow-up (6 weeks post-assault), the second follow-up (three months), or the third follow-up (6 months). At the time of recruitment, time since enrolment in the RCT ranged from 2 to 8 months (mean duration ~ 4 months).

Participants were informed about the qualitative interview study during their follow-up assessments. The interviewer later contacted those who expressed interest with further information about the study before consenting to participate. In addition to those currently undergoing follow-up assessments, some participants who had completed the six-month follow-up were contacted in order to capture longer-term experiences. All participants received gift cards in appreciation of their time and contributions. A total of 16 participants initially agreed to be contacted by the interviewer. One participant later withdrew due to time constraints. Ultimately, 15 participants completed interviews: 10 from the mPE group and five from the TAU group. Participants were recruited from the SAC in Trondheim ($n = 6$), Oslo ($n = 8$), and Vestfold ($n = 1$). All participants were female, aged between 17 and 34 years (mean age ~ 23 years). Educational backgrounds varied: three had completed primary school, six had finished high school, four held a bachelor's degree, and two had a master's degree.

2.3. Ethical statement

The trial was approved by the Regional Committee for Medical and Health Research Ethics (REK-Midt, #348496) on 16.12.21, and is conducted following guidelines for good clinical practice and by the principle of the Declaration of Helsinki. All EIR study participants were asked for informed consent, and additional consent was obtained for this qualitative study.

2.4. Data collection

Data were collected between May and December 2023 and the interviews lasted between 26 and 63 minutes (mean ~ 42 minutes). Four participants were interviewed face-to-face, two by telephone, and nine via video conference. A semi-structured interview guide (see Appendix) was developed to capture the variations in participants' experiences while ensuring coverage of the study's key areas of interest. The interview included 15 fixed but open-ended questions about participating in the EIR study. Moreover, five and two questions were specific for the participants in the mPE and the TAU group, respectively. Interviews were audiotaped, de-identified and transcribed verbatim with participants' consent. The interviews were conducted by one of the first authors (MK), who is an independent researcher and not part of the RCT.

2.5. Data analysis

Data was analysed using thematic analysis (TA) due to its suitability for identifying patterns of meaning and broad themes across textual data (Braun & Clarke, 2006; Braun & Clarke, 2022). TA was conducted from an experiential, realist perspective, using a data-driven, inductive approach. The first authors, TH and MK, approached the interview transcripts with openness and a reflexive stance, aiming to allow themes to emerge naturally while being mindful of how their prior experiences and assumptions might shape the analysis. The analysis was partly informed by process evaluation frameworks (Skivington et al.,

Table 1. Themes and sub-themes.

Theme	Description	Sub-theme
Participating in Research Following Recent Sexual Assault	Exploration of how patients perceive and experience participation in the EIR study. Understanding the burden on patients in terms of time commitment, cost	Recruitment and motivation Participants' experiences with the study procedures: - Collecting hair and saliva - Wearing actigraphy - Questionnaires - Interviews - Randomization Perceived benefit of research participation
Perspectives on Psychosocial Support	Exploration of the participants' experience with TAU and mPE, including satisfaction, engagement, and perceptions of the usefulness and relevance	TAU stories Perceived benefit of TAU Experiences with the new intervention, mPE: Imaginal exposure and processing *In vivo* exposure PE Coach Perceived benefit of mPE Patients' recommendations regarding implementation of mPE within SACs
Supportive Factors and Obstacles for Research Participation	Identify factors that hinder or help participation in the EIR study, and suggestions to enhance participation	A respectful and sensitive research approach Challenges with multiple contacts Clearer descriptions of the research process

2021a, 2021b), with interview questions focusing on barriers, facilitators, research participation experiences, and intervention quality. The six phases of a TA (Braun & Clarke, 2022) were applied: after a familiarization with the transcripts (step 1), the authors independently coded the data (step 2). Responses to questions about mPE and TAU, and research participation were categorized as positive, negative, or mixed. Similar codes were grouped into categories to identify candidate themes, which were refined through reflexive inquiry (step 3). Themes were reviewed collaboratively with the other authors to ensure relevance and consensus (steps 4 and 5). The final themes and sub-themes reflected the broader patterns in the data (step 6), as shown in Table 1.

3. Results

3.1. Participating in research following recent sexual assault

This theme explored the benefits and challenges that patients faced when participating in research shortly after a sexual assault. Specifically, it explored the burdens related to time commitment, cost, and emotional responses.

3.1.1. Recruitment and motivation

Participants were introduced to the EIR study through a written brochure after their acute consultation at the SACs, followed by a phone call from a research assistant who offered additional information and addressed questions.

Reactions to the recruitment process varied. While some were immediately open to joining the study, others hesitated due to feeling confused and overwhelmed in the aftermath of the sexual assault. For some, understanding the importance of early involvement helped shift initial reservations:

> It happened very suddenly, it was like: am I going to be a lab rat already? That was how I felt at first, but then I realized that I had to do it as early as possible for it to help. P7.

While not all participants read the brochure, they confirmed that the research assistant had provided verbal explanations that addressed their concerns and clarified the study's objectives.

Participants identified two main reasons for joining the study: personal benefits and a desire to help others in the same situation. These motivations were often intertwined, reflecting a balance between self-care and altruism. Eleven participants highlighted the potential for personal benefits, such as receiving better support, learning coping strategies, and managing troubling thoughts. Others were motivated by a desire to prevent the assault from impacting their future well-being negatively:

> Perhaps I sought help to clarify my thoughts, thinking it might help me. P15.

Some also viewed their participation as a way to transform negative experiences into something meaningful, believing their experiences could improve knowledge through research:

> It meant so much to know that my experiences had meaning beyond myself- it became part of something bigger. I felt like more than just a part of a terrible incident. P9.

Seven participants expressed a strong aspiration to help others, viewing their participation as a contribution to improving care for future survivors:

> I wanted to help other people by sharing my experience, so that the best treatment is found for those who are experiencing the same thing. P13.

3.1.2. Participants' experiences with the study procedures

The participants' experiences with the study procedures varied.

Collecting hair. Most participants found this straightforward, with 13 participants reporting no issues. However, one participant found it intrusive, and explained that her hair was something deeply personal, and that she did not want the sexual assault to have such an influence on her physical appearance. Two participants expressed surprise at the amount of hair collected, having anticipated only a few strands.

Collecting saliva samples. While 11 participants managed the saliva sampling process without major issues, others found it stressful due to the need for strict timing:

> These saliva tests are not unpleasant but a bit time-consuming. It's hard to remember to take them at the right time, but it is manageable. P13.

Strategies like setting alarms, using reminders, and preparing the equipment in advance helped participants comply to the sampling instructions. One participant shared a positive perspective, saying that the sampling served as a comforting reminder that a system was looking out for her. However, three participants found the process too complicated or stressful, and decided to discontinue:

> I made a decision that I can't waste energy on this. P3

Wearing actigraphy. Twelve participants experienced minimal issues with the accelerometers. However, some challenges were noted. Five participants experienced skin irritation, including itching from the adhesive, and two had to remove the devices due to developing rashes. Additionally, two participants reported that one of the two accelerometers occasionally fell off during use. The visibility of the devices was mentioned by seven participants, though it was generally not perceived as a problem. Most participants were comfortable discussing their involvement in the research when questioned by others:

> I haven't made any attempt to hide it; I just say that I'm part of a research project. P9.

One participant used creative explanations when asked about the devices:

> I just said it was an electronic monitoring device for criminals, then they stopped asking. P12.

Questionnaires. Most participants found the questionnaires straightforward to complete, though a few encountered challenges in scaling their responses accurately. Only one participant reported feelings of distress, as it required revisiting painful memories of the assault:

> I had to think about it. I tend to push the thoughts away, but now I had to relive it. P1.

Three participants expressed discomfort with questions about their sexual lives, describing them as overly personal. Additionally, two participants noted that some questions implicitly assumed that all respondents had a sexual partner, which excluded the experiences of those who did not.

Interviews. Thirteen participants described the clinician-administered interview about post-traumatic stress symptoms as unproblematic, with seven noting that the conversational format made answering questions easier compared to written responses. Several participants appreciated the approach of the student interviewers, describing them as caring and empathetic. However, one participant perceived the interviewer as lacking warmth, and another questioned their competence. While many participants found the interviews helpful, two found them emotionally challenging, suggesting the need for additional follow-up to manage distress:

> You feel like you're just telling how bad it's been, and there's nothing more to it. P6.

The telephone format was generally well-received, although two participants suggested that in-person interviews might have been more effective.

Randomization. Reactions to randomization varied, with preferences leaning towards the mPE group as more favourable. Nine participants expressed wanting to be allocated to mPE, compared to two preferring TAU. Two participants had no preferences, whereas three expressed disappointments upon being assigned to the TAU group:

> I wanted to end up in the other group (mPE). I crossed my fingers that I would, but I didn't. It was a bit sad. P9.

Conversely, one participant felt relieved to be in the TAU group, saying:

> I'm glad I didn't get the other one because it sounded scary … It was the exposure part; it sounded really scary. P7.

Four participants reported not understanding the difference between mPE and TAU. One participant who was allocated to TAU reflected:

> I didn't really understand the difference between the two. But looking back now, I think maybe exposure therapy would have worked better for me. P14.

Additionally, one participant misunderstood the concept of randomization, believing that those with more severe symptoms would be prioritized for mPE.

3.1.3. Perceived benefit of research participation

Many participants viewed their involvement in the research as a form of healing, while also appreciating the opportunity to contribute to research. For some, attending appointments and engaging in structured

tasks were seen as important steps towards regaining a sense of normalcy:

> I felt more productive because I couldn't work very much at the time. I felt like I was taking steps to improve my own health and possibly help others. It gave me a sense of accomplishment. P8.

However, the practical study demands were sometimes overwhelming, particularly for those managing co-occurring life challenges:

> I found it more demanding than I thought it would be … I struggle with work and everyday things, so going to the SAC and keeping track of the saliva samples at certain times, and when you can eat and drink, and filling out questionnaires, it's been challenging. P3.

Additionally, some study procedures inadvertently reminded participants of the rape, especially during follow-up testing:

> For me, it became a bit too much towards the end, when I felt like I had moved on. P6.

3.2. Perspectives on psychosocial support

This theme explored participants' experiences with the psychosocial support they received, including both TAU and mPE, focusing on their satisfaction, engagement, and perception of the support's usefulness and relevance.

3.2.1. TAU stories

Participants' experiences with TAU varied widely, reflecting the inherently flexible and varied application across SACs. One of the participants never attended a single session and explained that she wanted to forget about the sexual assault and tried to avoid being reminded of it. Another participant had regular sessions spanning 4–5 months. Regarding the content of TAU sessions, most said that the primary focus was on their overall well-being and daily activities, and that sessions often revolved around filing police reports or seeking legal advice. One participant noted that, despite attending multiple TAU sessions, the recent sexual assault was never addressed:

> We talked a lot. I just updated her on what was happening, and she gave me feedback … but I never talked about what happened that night. P14.

Given the wide variation in participants' experiences and perceptions of TAU, no distinct patterns emerged. Instead, we present two different examples (narratives) of TAU experiences.

Participant 5 had a mixed and reflective experience with TAU since her enrolment about three months before the interview. Initially uncertain about the purpose of the sessions, she attended them anyway and described her interactions with the therapist as pleasant:

> It was nice … talked a little about how I was feeling. It was okay, but I'm not sure how much I got out of it.

The sessions primarily focused on exploring her feelings and future plans, but P5 often felt they lacked therapeutic depth and clarity. Conversations sometimes felt more like recounting the past week's events than fostering meaningful progress:

> It became more of a story about what I had done and just saying out loud what I had done and how I felt … I was a bit unsure about how much I got out of it and how much it helped me.

Having attended two or three sessions and receiving test results over the phone, P5 remained uncertain about the sessions' purpose and effectiveness. She questioned the intent behind the interactions, noting they sometimes felt purposeless:

> It became a bit like now we're going to talk just for the sake of talking.

Eventually, P5 decided to contact the therapist only if needed, as she felt the sessions offered limited value:

> It ended with an option to make contact if needed. I didn't feel like I was getting much out of it anyway.

Despite her reservations, P5 appreciated the supportive framework of TAU and the reassurance of having access to care:

> It was nice to know there was a system that looked after me and that I had someone to talk to, absolutely.

She also appreciated the possibility of seeking help in the future, though she recognized a psychological barrier to doing so:

> There is a threshold for contacting them and asking for help, including to ask for a new appointment, but I know it is an option.

Participant 9 had a nuanced and evolving experience with TAU after four months participation in the EIR study, marked by both positive and negative aspects. Initially, she deeply appreciated the explicit validation offered by her therapist, especially the consistent reassurance that the sexual assault was not her fault. This emphasis on faultlessness and validation was particularly meaningful:

> It's so important to have someone who is clear about that.

However, as the sessions progressed and P9 began to express deeper emotions, challenges emerged. She felt her therapist misinterpreted her distress, focusing excessively on potential self-harm, which P9 found unwarranted and unhelpful:

> What I needed to talk about wasn't that I was going to go home and hurt myself … I needed to talk about my future and the uncertainty ahead.

This misalignment left her feeling misunderstood and detracted from addressing her primary concerns.

Efforts to continue therapy proved unsuccessful, as P9 found the therapist's approach increasingly unsuitable. For instance, when the therapist suggested revisiting the rape incident to explore what P9 could have done differently, she found this approach counterproductive and potentially harmful. P9 seem to have interpreted the suggestion as implying that she had made mistakes during the assault, which risked reinforcing self-blame, even if that was probably not the therapist's intention:

> I understand where you're going, but it's completely wrong for me. It will destroy me.

Ultimately, these negative experiences led P9 to discontinue her sessions entirely. She also hesitated to seek further help, feeling self-conscious about asking for resources:

> I feel like I'm being too demanding or taking resources from someone else.

3.2.2. Perceived benefit of TAU

The experiences of P5 and P9 highlight some of the variability of TAU. While all five participants in the TAU group appreciated the opportunity for support, validation, and care, their satisfaction with the sessions themselves differed. P5 found the sessions repetitive and was unsure about their therapeutic value. P9, initially positive, experienced a disconnection as the therapist shifted and maintained a focus on issues the patient considered irrelevant, leading her to discontinue the support. Otherwise, the participants valued the flexibility of TAU, and the opportunity to ask for more sessions if needed.

3.2.3. Experiences with mPE

Participants were encouraged to reflect on their experiences with the core components of mPE, including its rationale, imaginal exposure and processing, *in vivo* exposure, and the PE Coach mobile app.

Rationale. PE is rooted in Emotional Processing Theory, which suggests that PTSD symptoms persist when trauma memories are encoded with inaccurate associations (e.g. about the cause or consequences of the trauma) and avoided due to the associated distress that it evokes. Repeated exposure to trauma-related fear and the trauma memory, allows for thoughtful reflection and integration of corrective information. Over time, this leads to a reduction in distress and PTSD symptoms.

Most participants expressed an understanding of the purpose and rationale of mPE and how it could reduce trauma-related symptoms, as one participant expressed:

> It's just thoughts, it's not happening again. It's something that has happened. It's a thought, it doesn't come and take you, it's harmless. P4.

Imaginal exposure and processing. Imaginal exposure involves the intentional and repeated retelling of the traumatic event aloud and in detail, followed by a reflective discussion about the experience, called processing. The latter is a key component of PE, where therapist and patient work together to make sense of the traumatic memory, exploring new meaning, and promoting emotional learning.

All 10 participants found imaginal exposure and processing helpful, despite its initial emotional demands. Although uncomfortable and emotionally taxing in the beginning, most participants described it as becoming more manageable after subsequent sessions. As one participant explained:

> The first time was terrible. I've never had a conversation before where I had to recount what happened. I got really anxious. I went completely numb. My emotions were all over the place. Eventually, the second time, it was easier to talk about it. Talking about it has worked. P15.

Another participant echoed this sentiment, stating:

> At first, I found it very uncomfortable to attend those sessions, but I noticed after the first that it helped a lot. P2.

Several participants expressed that imaginal exposure helped them overcome the urge to avoid trauma memories and realize that thinking about the trauma is not dangerous. One participant explained:

> One would like to avoid thinking about it, that is what is most comfortable … You are forced to confront the event. Make the pieces fall into place, get an overview of what happened, how you feel about it and practice becoming less afraid of it. You should not be afraid of the memory. P8.

Engaging with the memory allowed participants to access and process aspects of the trauma that had been too difficult to deal with previously. One participant shared:

> Being forced to talk about it multiple times, not being allowed to ignore it, has made it easier for me to admit things, to say things out loud that I am ashamed of. P12.

Another participant echoed a similar experience:

> It's been awful talking about it, but it helped me to be able to speak up. About the guilt too. I have felt a lot of guilt about what happened, but now I have moved away from it. It was not my fault. P15.

One participant did not anticipate the emotions that the process elicited:

> It was uncomfortable in a different way than I had anticipated. I thought there would be more fear, or that you experience the same feelings as when it happened. What I remembered most now was that it was disgusting and shameful, and that feeling was very strong. P3.

Talking to a competent therapist about their experiences during imaginal exposure was described as a valuable part of mPE. For some, retelling the incident to the therapist provided a new understanding of themselves. One participant found the feedback and discussions with her therapist to be the most valuable part:

> I find it very exciting that she gives me feedback and that we process after each exposure. Such as "this time you went through everything very quickly and very superficially, but the second time you spent more time or was more personal, gave more details", or "you started to breathe very shallowly", or "you are not present" … Things that I don't see myself or *notice, that she sees. Then we discuss it together. I think that was the most valuable part of the exposure.* P11.

In vivo exposure. *In vivo* exposure involves confronting real-life situations, activities, or objects that the patient is avoiding because they remind her of the trauma. These situations are not objectively dangerous but may trigger distress because they are associated with the trauma. The rationale for gradual *in vivo* exposure is to reduce avoidance behaviour and to correct dysfunctional cognitions about feared situations.

Eight participants engaged in *in vivo* exposure for trauma-related fear and found it helpful:

> I listened to songs that reminded me of the incident and revisited the places where it happened. I'm glad I followed through on what we agreed upon. Getting past the hurdle, reclaiming those songs, and returning to those places. You're taking ownership of it. P13.

Two participants stated they did not avoid situations and therefore did not engage in *in vivo* exposure, and one explained that the situations she avoided were not safe to confront and therefore had to be adjusted.

PE Coach Mobile App. PE Coach is a free application for smartphones to support patients undergoing PE. The app provides psychoeducation information about PE and allows user to audio record therapy sessions directly onto their mobile. Patients are encouraged to listen to these recordings between sessions to reinforce learning.

While eight participants found the app user-friendly, two encountered technical difficulties, such as recordings missing. Listening to the recordings at home was described as particularly challenging, with many participants noting their tendency to avoid this step:

> I didn't do it as much as I probably should have. To do something uncomfortable when you don't have to … I only listened to it a few times. P8.

For those who followed through, the recordings offered a new perspective on their trauma:

> Listening to the recordings helped me as well, to hear myself speak about it in the present tense, it allowed me to recognize how small and scared I sounded, and to feel sympathy for myself. It reassured me that it really happened and that I didn't do anything wrong. It wasn't my fault. P12.

3.2.4 Perceived benefit of mPE

All 10 participants described mPE as beneficial, highlighting its positive impact despite the challenges it posed:

> Coming here and getting that therapy, it's helped me more than anything else. I'm not saying it's helped 100%, but it's helped me more than anything else. P10.

While the intervention was described as emotionally demanding, most participants felt that the benefits outweighed the temporary distress:

> It was very painful, but it was necessary. P12.

Many acknowledged that mPE required significant personal effort, emphasizing that it is not a quick fix but a process that involves hard work and active participation:

> There are drawbacks to every type of therapy, you must put in the work. It's not a pill that fixes everything while you go on with your life, it takes effort. No one else can do it for you. P11.

Several participants underscored the crucial role of support from the SAC throughout the process:

> I don't think I could go through it that well on my own as I have with all the help I've received. P2.

3.2.5 Patients' recommendations regarding implementation of mPE within SACs

All 10 participants in the mPE group recommended the intervention for others seeking help at SACs, highlighting its value as a structured and effective treatment:

> I believe mPE should be the standard treatment for everyone. P2.

However, three participants advocated for flexibility in its application, suggesting mPE could be one of several options offered, and recommended that services should be tailored, especially for those with complex representations:

> I absolutely believe mPE should be an option, but it must be a choice. If someone can't go through it, they should be offered an alternative. It also needs a clear explanation up front, what it involves, how challenging it can be, and that there are moments where you might feel worse before you feel better. For

> some, this can be the best solution, but I can easily see how, for others, it might be too much, too intense to handle. P11.

Some underscored the importance of individual tailoring. Participants valued both the structured approach in *in vivo* and imaginal exposure and processing to help them overcome trauma-related fears and process their trauma memories. Importantly, none expressed dissatisfaction, regrets, or discouraged the implementation of mPE.

3.3. Supportive factors and obstacles for research participation

This theme explored experiences with factors that either facilitated or hindered participation. Participants proposed several adjustments to improve the study experience and enhance the clarity and utility of their involvement.

3.3.1. A respectful and sensitive research approach

Participants appreciated the individualized and respectful approach of the research team, which contributed to a positive experience and encouraged continued engagement.

> I appreciated that you get a personal SMS from everyone involved. That you don't get a message like, "you have an appointment, blah blah" from some public number. That's important, it becomes more personal. P12.

Many described feeling validated and cared for throughout their involvement, rather than being regarded merely as subjects in an experiment:

> I don't feel like I'm part of an experiment. Everyone I've met has been very kind and supportive. I feel safe, seen, and well taken care of. P11.

Participants valued the sense of control they had over their involvement in the study. Knowing they could withdraw at any time, either partially or fully, contributed to their sense of safety and reassurance. They also highlighted the importance of clear communication, obtaining consent, and maintaining a calm, non-intrusive atmosphere during the research process:

> I appreciated that people are calm, that I'm not overwhelmed with information, that they ask for permission before doing things like cutting my hair and putting on activity devises. They give me time to do the questionnaires while I'm there, ask me if I need to drink, ask me how things are going, and generally acknowledging me being there. P12.

Scheduling multiple appointments on the same day reduced logistical burdens, particularly for those with long commutes or busy lives. Some also appreciated that travel expenses were covered, and that they were offered food and beverage when they had travelled long distances.

3.3.2. Challenges with multiple contacts

Participants interacted with several professionals, including physicians, nurses, social workers, research assistants and student interviewers. Many valued being met by a professional and caring team which understood their situation and the complexity of their needs:

> It was important to me that the people I met here responded appropriately to what I shared. That has had a huge impact on me—it means a lot. It's been a great experience to be surrounded by such caring people who understand my situation. P9.

However, some participants got confused by the large number of contacts and their respective roles:

> It can be difficult to remember who does what. If I have a question, I'm not always sure who to ask. I had to make a list with names and numbers to know who does what. P8.

3.3.3. Clearer descriptions of the research process

Some participants expressed a need for a more explicit description of the study's timeline and procedures. Ambiguity about what to expect led to confusion for some, potentially affecting their engagement. Some suggested that using visual timelines, checklists, or participant guides could help improve communication and clarify expectations.

4. Discussion

This present study is a qualitative process evaluation of the EIR study, which examines the effectiveness of mPE versus TAU on reducing post-traumatic stress symptoms after rape. Conducted at three SACs in Norway, the current study explored patients' experiences with research participation and the psychosocial support received. Findings suggest that while both mPE and TAU were generally well received, mPE was perceived as more structured and effective in alleviating trauma-related distress. Despite its emotional intensity, participants valued mPE's focus on confronting trauma-related fears, highlighting its potential as an early intervention for post-traumatic stress symptoms. Experiences with TAU varied, with some questioning its therapeutic purpose.

This study confirms that recently sexually assaulted women are willing and able to participate in research on acute trauma, aligning with prior findings on its tolerability and value (Campbell et al., 2010; Nielsen et al., 2016; Short et al., 2024). Participants were motivated by both self-care and altruism, suggesting recruitment should acknowledge these dual benefits. Follow-up calls from research staff facilitated

recruitment by clarifying procedures and alleviating concerns. Participants' experiences with study procedures highlighted the need to balance data collection with participant burden, suggesting that clearer instructions and opt-out options could improve adherence and experience. Structured tasks and coordinated appointments helped participants feel engaged and in control, with many finding the research process purposeful and reinforcing a sense of normalcy. However, some struggled with multiple study contacts, suggesting a need for clearer role delineation and visual aids.

Integrating research and clinical care seemed to enhance participants motivation. The research team's respectful, individualized approach fostered trust and safety and confirms the importance of autonomy and empowerment in research (Campbell et al., 2019; Substance Abuse and Mental Health Services Administration, 2014).

This study provides new insight into how women experience psychosocial support at SACs, an area with limited research. The effectiveness of SAC services in aiding recovery remains unclear. A 2012 evaluation (Eide et al., 2012) found substantial variations in psychosocial support at Norwegian SACs, and a recent NORCE report (Johnsen et al., 2024) showed that only half of the SACs offer psychosocial support. Duration of support varies, typically one to three sessions, sometimes only by phone. Standardized procedures and validated screening tools for psychological symptoms are rarely used. SACs without psychosocial support refer patients directly to nonprofit organizations, general practitioners, or mental health services.

The recent Official Norwegian Report (NOU) on rape (NOU, 2024:2, 2024) concludes that psychosocial support is inadequate, with many survivors denied specialist care. This reflects both resource limitations and the lack of a clear mandate for addressing the needs of a vulnerable population within the public services. Guidelines for specialist care services (Helsedirektoratet, 2015) dictates that individuals who have experienced a recent trauma should be supported in primary care, yet misalignment between policies, resources, and service delivery limits timely, targeted support to survivors of sexual assault. Strengthening these services is crucial to reducing long-term psychological distress and promoting recovery.

Participants' experiences highlighted a gap between mPE and TAU in terms of perceived relevance and effectiveness. TAU participants were more uncertain about its purpose and therapeutic value, leading to dissatisfaction and disengagement for some. TAU was seen as centered on general functioning rather than the trauma itself, with some describing it as 'talking for the sake of talking'. A contributing factor to this may be the lack of a clear therapeutic rationale in TAU. In contrast, mPE participants appeared more engaged and motivated, appreciating its structured, trauma-focused, and goal-oriented approach. The direct focus on trauma processing, combined with a safe and collaborative environment, helped them manage trauma-related distress more effectively.

While TAU therapists may occasionally initiate or respond to trauma-focused discussion, such efforts can be misinterpreted or experienced as unhelpful, particularly when they are not grounded in a clear therapeutic rationale or embedded in a coherent therapeutic approach. For instance, P9 perceived a therapist's suggestion to revisit the rape incident and reflect on what she could have done differently as implying blame. Although likely unintended, the comment risked reinforcing the participant's feelings of self-blame. To our knowledge, this misunderstanding was neither clarified nor explored further by the therapist, leaving the participant with lingering confusion about both the intervention and the therapist's intent.

Certain trauma-focused therapies, such as Imagery Rescripting and Reprocessing Therapy (IRRT) (Smucker, 2005), do involve exploring alternative endings to the traumatic event. However, like other trauma-focused approaches, they rely on explicit preparation and careful communication to be both effective and psychological safe. P9s experience highlights the risks involved when such methods are introduced without sufficient explanation or therapeutic scaffolding.

This case also underscores the importance of appropriate training in trauma-focused work. Therapists must be able to clearly communicate the purpose and process of interventions, while creating a safe and supportive environment that helps patients feel understood and contained.

When therapists in TAU setting choose to address trauma content, they must also be equipped to manage heightened emotional distress and simultaneously monitor for self-harm risk. In P9's case, the therapist's suggestion to revisit the trauma memory appeared to follow a conversation about concerns related to self-harm risk. However, P9 perceived these concerns as exaggerated and misplaced, but the abrupt shift from risk assessment to trauma exploration, without a meaningful transition or explanation, seemed disjointed and confusing. Such disconnects may strain the therapeutic alliance and diminish the perceived helpfulness of the intervention.

In contrast, participants in the mPE group consistently described feeling safe enough to take steps that exceeded their own expectations. They attributed this to the trust they had in their therapist's guidance and competence. The predictable structure of mPE, combined with a transparent rationale about the goals and methods of therapy, appeared to foster a sense of collaboration and safety that enabled participants to engage more fully in the therapeutic process.

TAU may offer benefits beyond what the EIR study captures, and the valuable competence and specific knowledge the SACs hold about this population must be preserved. To maximize their impact, validation and legal or practical advice should be integrated with other evidence-based interventions. This could enhance effectiveness in reducing post-traumatic stress sequelae. Given SACs' unique access to survivors in the immediate aftermath of rape, their role could be expanded with a clearer focus on mitigating its long-term effects.

International guidelines recommend trauma-focused cognitive behavioural therapies (CBT) over non-trauma-focused approaches for treating PTSD, including early prevention (National Institute for Health and Care Excellence, 2018). Trauma-focused interventions are more effective in addressing post-traumatic stress symptoms and may accelerate recovery for sexual assault survivors (Oosterbaan et al., 2019; Short et al., 2020). In contrast, generalized approaches may leave significant aspects of the trauma unexamined, perpetuating avoidance and unresolved trauma-related health issues. Sexual assault carries a higher risk for PTSD compared to other traumatic events (Dworkin, 2020), and may follow distinct recovery trajectories. Trauma-focused CBT addresses negative attributions and avoidance, which can impede natural recovery (Ehlers & Clark, 2000; Foa & Kozak, 1986). When trauma remains underexplored at the SAC, this represents a missed opportunity to attain healing and recovery. The experiences of ineffectiveness among TAU participants in our study may also affect future help-seeking behaviours.

Research on sexual assault disclosure suggests that how survivors share their experiences and how others respond can influence psychological outcomes (Scoglio et al., 2022). While negative reactions from others, such as blaming and shaming, are linked to psychopathology (Hakimi et al., 2018), the impact of positive reactions are less clear. Despite expectations that social support might protect against PTSD (Sylaska & Edwards, 2014; Ullman & Peter-Hagene, 2014), a recent meta-analysis (Dworkin et al., 2019) found no clear association. It suggests that the inherent PTSD risk factors after sexual assault outweighs the benefits of positive social reactions, implying positive social reactions alone may not be sufficient to prevent psychopathology. Although participants in this study valued the positive validation and reassurance, this may not be enough to prevent PTSD.

4.1. Strengths and Limitations

Concurrent process evaluations alongside randomized controlled trials provide valuable insight not captured by efficacy and effectiveness measures alone. Patient experiences with the EIR study offer critical information for improving future SAC implementation and research.

Fifteen informants provided a diverse range of experiences, though the low representation of TAU participants is a limitation. While this qualitative process evaluation was not designed to compare mPE and TAU efficacy, more input from TAU participants could offer additional perspectives. TAU's lack of clear operationalization within the SACs means that the interventions vary, so we asked open-ended questions rather than specific ones, which could have limited our understanding of TAU's full scope.

TAU is often used as a control group in trials of behavioural interventions, but our results highlighted challenges with its variability, which may impact internal validity (Gold et al., 2017; Watts et al., 2015). Some participants' disappointment with being assigned to TAU may imply less positive expectation of TAU being effective, potentially biasing the effect size estimates. This should be considered when interpreting the RCT outcomes.

The recruitment of participants from the three SACs was not random, which may have introduced biases. Non-random selection may have led to a sample with specific characteristics, motivations, or interests, potentially limiting the generalizability of findings. For example, patients who declined participation in the EIR study may have had reservations about mPE, resulting in a sample primarily composed of those with positive expectations of the intervention. Additionally, participants who dropped out of the EIR study could be less inclined to engage in this process evaluation, which may have led to the loss of important perspectives.

Using an independent interviewer mitigated potential biases, fostering open and honest exchange. The interviewer and first author (MK) had no prior involvement in the EIR study, which enhances the objectivity of the process. However, the inherent subjectivity in data analysis may introduce potential interpretive and confirmation biases. The other first author (TH) is both a member of the research project team and the PE expert in this context, which may predispose her to a biased data interpretation. To mitigate these biases, a critically self-reflective approach was employed (Malterud, 2001). Multiple coders and reviewers re-evaluated impressions and responses, helping to reduce potential biases and enhance the reliability of the findings.

4.2. Conclusion

This qualitative process evaluation provides valuable insights into women's experiences with psychosocial support at Norwegian SACs after a recent sexual assault. The study shows that mPE is well-received, while experiences with TAU are ambiguous and need further investigation. Overall, this analysis

supports the feasibility and acceptability of integrating early trauma-focused intervention into standard care.

4.3. Implications

Research involving recently sexually assaulted individuals requires careful considerations yet excluding them leaves critical gaps in our understanding and knowledge. This study reveals participants experiences, perceived barriers and facilitators, and suggestions for improvement, which should guide future studies. Implementing trauma-focused intervention like mPE in SACs could improve care for rape survivors, and if proven effective, mPE could be safely integrated it into SAC's psychosocial support services.

Acknowledgements

We would like to thank all patients who participated in this study.

Author contributions

All authors read and approved the final manuscript.

Disclosure statement

No potential conflicts of interest were reported by the authors.

Funding

This work was funded by the Research Council of Norway (project #320637), the Department of Clinical and Molecular Medicine, the Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology (NTNU), and from the Department of Obstetrics and Gynaecology, St. Olavs hospital, Trondheim University Hospital.

Data availability statement

Interview transcripts are not available. On reasonable request, coding and theme tables are shared.

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