Review Manuscript

Complex Trauma Survivors' Experiences of Services and Support for Mental Health: A Qualitative Thematic Synthesis

TRAUMA, VIOLENCE, & ABUSE
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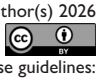

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Abstract

In exploring survivors' experiences of the wide range of services across settings that they sought for mental health support, this review synthesises experiences, facilitators and barriers encountered to help-seeking in adult survivors of complex trauma. We searched multiple databases including Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PsycINFO, EMBASE, Applied Social Sciences Index, Web of Science, and PROQUEST. In total, 23,129 records were retrieved and screened, out of which 108 records were eligible for inclusion. Following a narrative synthesis, seven themes representing facilitators and barriers to seeking help were identified at individual, organisational and societal levels: internal and external stigma, peer support, staff attitude, service flexibility, therapeutic relationship, skills and training. Our synthesis resulted in a conceptual model with three interconnected overarching themes: feeling safe, embarking on a journey, and achieving connectedness, all of which contribute to the development of post-traumatic self. Offering a comprehensive understanding of the obstacles involved in seeking support for complex trauma is essential. A large number of studies highlighted a need for greater public awareness to reduce stigma, trauma-informed training for staff in statutory and non-statutory settings, peer support, funding and better links between services to offer a more holistic approach. Political and practical interventions could help improve accessing support, hence further research to redress this balance is therefore warranted.

Keywords

complex trauma/abuse/violence, childhood abuse, intimate partner violence, mental health support

Introduction

A large body of research has demonstrated a link between complex trauma and mental health (Mauritz et al., 2013; Shevlin et al., 2008). Complex trauma can be defined as resulting from experiencing prolonged and repeated, and often interpersonal, trauma from which escape was impossible or difficult (Coventry et al., 2020; Herman, 1992). Examples include childhood sexual abuse, intimate partner abuse, war, bullying, racism, and forced displacement, but this list is not exhaustive (Sweeney et al., 2018). Many survivors experience multiple, overlapping forms of trauma, violence, and abuse at different points in their lives. Complex trauma can have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and spiritual well-being (Huang et al., 2014).

Global research, policy, and practice are increasingly focusing on the role of trauma in the aetiology of mental health problems, to the extent that it is now argued that trauma is a major public health issue (Sara & Lappin, 2017)

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with marked consequences for society (Trautmann et al., 2016). For example, extensive research has established that child abuse and neglect are significant causal factors for psychosis (Dillon et al., 2014; Shevlin et al., 2008) whilst a dose-dependent relationship has been identified between severity, frequency and range of adverse experiences and later mental health difficulties (Dillon et al., 2014). Systematic reviews identify that many people who meet diagnostic criteria for post-traumatic stress disorder (PTSD) or complex PTSD (CPTSD; World Health Organization, 2019) also have mental health diagnoses, most commonly emotionally unstable personality disorder (particularly in women), psychosis, major depression, anxiety, and harmful alcohol and drug use (Coventry et al., 2020; de Aquino Ferreira et al., 2018).

Amongst people who are referred to mental health services, a high proportion have experienced complex traumatic events, and these rates are higher than in the general population (Frans et al., 2005; Mauritz et al., 2013). Black, Asian, and minority ethnic groups are simultaneously more likely to experience trauma (Hatch & Dohrenwend, 2007), are persistently overrepresented in acute mental health care (Halvorsrud et al., 2018), and receive the most negative and adversarial responses (such as compulsory treatment) which are known to cause iatrogenic harm (Mohan et al., 2006; Morgan et al., 2004). Contrary to these findings, research evidence indicates a large disparity between lifetime exposure to trauma and formal diagnosis or identification of a trauma history among mental health service users: studies report exposure to trauma in excess of 80% and diagnosis of PTSD or CPTSD between 5% and 20% (Cusack et al., 2004; Hyland et al., 2021). A high proportion of people accessing mental health services do not have their trauma history assessed or recognised in formulation and planning and are likely to receive inappropriate or ineffective support as a result. Some individuals do not see their distress and need for support as mental health problems but as the impacts of complex trauma. They may prefer to use non-statutory services for practical and mental health support where they are aware of and able to access this, such as peer-led groups for domestic abuse survivors or charitable organisations for refugees.

Herman (1992) called for services and providers to view complex trauma as an *adaptive* response to unbearable experiences. This strengths-based understanding of complex trauma centres the role of relationships and connection in healing and recovery. It also prioritises emotional and physical safety when working with survivors of trauma, including, importantly, listening to and learning from survivors (Elliott et al., 2005; Sweeney & Taggart, 2018).

Prior reviews on trauma survivors' experiences and perceptions of mental health support tend to focus on users in receipt of specialist mental health services. These include reviews of strategies to implement trauma-informed approaches in youth inpatient psychiatric settings (Bryson et al., 2017), acute inpatient settings (Muskett, 2014; Wilson et al., 2017), emergency medicine (Brown et al., 2022), primary care (Lewis et al., 2023), and community mental health care (Trevillion et al., 2014). This delineation risks negating the experience of a large proportion of complex trauma survivors who might not have access to and/or chosen not to use mental health services. Many trauma survivors, despite struggling with mental health problems, are known to be reluctant to seek mental health treatment (Bell et al., 2019); and for those who reached out for treatment, a wide range of barriers are reported (Kantor & Straus, 2017).

No prior reviews have explored survivors' experiences of the wide range of services across settings that they sought out for mental health support. These services include non-statutory/charitable organisations, some of which are led by campaigners with lived experience of surviving trauma (e.g. rape crisis services, domestic abuse shelters and peer-led services). As such, we conducted a comprehensive systematic review to explore complex trauma survivors' experiences – healing and harmful – of services and support for mental health. We explored survivors' experiences, facilitators and barriers they encountered in seeking support for their mental health needs. Our review used Herman's (1992) definition and understanding of complex trauma and thus focused beyond diagnostic labels and service remits in terms of populations and exposure.

Methods

Lived Experience Involvement

Our review team comprised clinical academics alongside academics and researchers with experiential expertise. This diversity informed the interpretation of findings by combining lived experience with clinical and methodological expertise, and reflexive discussions were used throughout analysis to critically examine how these positionalities shaped interpretation and to balance insider and outsider perspectives. In addition, we sought input from a Lived Experience Advisory Group (LEAG) consisting of four female trauma survivors from diverse cultural backgrounds with lived experiences relevant to our topic. Throughout the review lifecycle, we held four workshops with the LEAG to input into (a) devising and finalising the protocol, (b) make sense of, and (c) refine our preliminary synthesised results, and (d) devise and work on dissemination strategies. The workshops were run according to the trauma-informed intersectional patient and public involvement in research guidance (Shimmin et al., 2017). LEAG members made active and unique contributions to the review and are authors of the review.

Search Strategy

Our review followed PRISMA reporting guidelines (Page et al., 2021). We prospectively registered the review protocol

on PROSPERO (CRD42023398011; Peeren et al., 2023). A systematic search was undertaken across databases including Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PsycINFO, EMBASE, Applied Social Sciences Index, and Web of Science. In addition to dissertation and theses which were published, we sought expert advice to find grey literature (information not controlled by commercial publication such as internal reports) including consulting members of our LEAG and the wider review teams including experts for the topic. We hence screened 96 established mental health and/or survivor-support organisations' websites for relevant reports (e.g. Barnardos, Mind, Nuffield Foundation, WHO). Lastly, we conducted forward citation tracking (using PubMed) and backward citation tracking (through reference list screening) on all included studies.

We developed our search strategy with reference to other reviews looking at similar topics (including Brown et al., 2022; Havig, 2008; Kantor & Straus, 2017; Stige et al., 2022; Trevillion et al., 2014). Our search strategy included MeSH terms and synonyms for the three key domains of our review question: complex trauma ((complex/complic*/child*/developme*/domestic/intim*) adj2 (trauma*/abuse/event/advers*)); AND experiences of survivors (experience*/qualitative/perspect*/); AND support for mental health ((mental health/psychol*/emotional*) adj2 (service*/program*/support*)). We limited our search to papers published in English and those with the full-text available. The review was limited to English-language publications due to resource constraints and to ensure accurate appraisal and synthesis of the available evidence, whilst acknowledging the potential for language bias. See Supplemental Material for full search strategies used in various databases.

Study Inclusion

This systematic review explored trauma survivors' experiences of seeking, accessing, and using services and support for mental health, and scoped facilitators and barriers through their perspectives. To achieve our aim to include comprehensive research literature covering a wide range of support used by survivors, we included any services and support for mental health, including statutory or non-statutory services, delivered in any settings (including but not limited to residential, drop-in, community, or university-based). We also included studies exploring specialist pathways such as perinatal services, which often run across both primary and secondary care. In terms of study participants, we included adults aged 18 or over who have experienced complex trauma at any point in their life. We have chosen this population for various reasons, including the relative stability in developmental differences and also the fact that adults could generally be perceived to have more autonomy in help-seeking behaviours. In this review, inclusion was based on the type of exposure of complex trauma as aforementioned, including self-definition, rather than diagnostic categories. This is partly because trauma is still poorly recognised and responded to in the healthcare system, but more importantly because survivors can be harmed and (re)traumatised by the mental health system's reliance on diagnosis (Sweeney & Taggart, 2018). Included studies were required to report primary qualitative data collected from survivors. We included mixed-methods studies. which had qualitative components and where qualitative data specific to survivors could be extracted from the studies. In studies including participants other than survivors, such as staff members or family carers, only those with data pertaining to survivors that could be extracted separately were included in the review.

Study Screening and Selection

Titles and abstracts of studies were downloaded from databases in RIS format. The RIS files were then imported directly into Cadima (Kohl et al., 2018) with duplicates removed. Title and abstract screening against the eligibility criteria were conducted using Cadima, by six reviewers (CR, SP, VA, MN, LA, and JS). Full-text papers were downloaded and screened by CR, VA, MN, LA, JS, and AL. A random sample of 40% of all abstracts and full texts were independently screened by two researchers who were blinded to each other's decisions. Any disagreements were resolved by review and discussion with other team members for consensus.

Three reviewers (CR, SD, and JH) extracted comprehensive data from each of the included studies, including study design features, participant's socio-demographic characteristics (including housing, finance, relationship status, education, and work), types of trauma exposure, providers and funding behind the service/support sought or used. Extracted data were recorded onto a piloted extraction form run on MS Excel; the wider team members independently checked data extraction and discussed ambiguity to ascertain quality. In the case of disagreements, the full team conferred and all discussions were logged.

Quality Assessment

All included studies were appraised for methodological quality by two reviewers (AL and JS) independently, using the Joanna Briggs Institute's Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015). The tool consists of 10 criteria and includes items such as congruity between the research methodology and the research question, and whether participants, and their voices, are adequately represented. Each checklist item were rated "Yes," "No," "Unsure," or "Not applicable."

Furthermore, we added three additional items from a study quality checklist to assess quality pertaining to the inclusiveness of research with trauma survivors (Hermaszewska et al., 2022). These items were chosen in

consultation with our LEAG members, including: (a) Have issues relating to intersectionality been considered? (b) Have the authors made every effort to ensure fair and equal opportunity of participation, and (c) Have survivors been involved in the research beyond being participants?

Synthesis Approach

To synthesise the huge volume of qualitative evidence, we undertook a narrative synthesis (Popay et al., 2006) to draw out barriers and facilitators to seeking mental health support experienced by survivors of complex trauma. Four reviewers (CR, JH, SD, and JS) worked independently and collaboratively, using an adapted method of Rapid Research, Evaluation and Appraisal Lab (San Juan et al., 2022), to support the narrative synthesis. Firstly, we undertook inductive coding using the results and discussion of 50 papers independently. Secondly, we came together to compare and discuss coding before coming to consensus in the coding, and the development of descriptive themes. These were used to generate "overarching" themes and individual/service/society-level factors and the framework encompassing such themes. Thirdly, we worked independently again to pilot and validate the framework on 15 papers to ensure all data were captured and grounded with quotations reported by the studies. We held regular team discussion and reflection along the synthesis process. Furthermore, we presented our framework of themes to the LEAG for feedback and revised it to ensure that the overarching themes subsumed all relevant concepts, and the themes were not overlapping, but worked well to synthesise findings into a coherent piece of work

Results

The systematic review focused on primary qualitative research on survivors of complex trauma and their experiences of seeking help. There were 23,129 records found during the initial search. Of these, 4,896 records were removed as they were identified as duplicates, meaning 18,233 records were screened. Relevant grey literature was also identified during the search and 31 reports were retrieved during initial screening. However, as these reports did not meet our inclusion criteria, they were all excluded. Following the screening of all titles and abstracts against the eligibility criteria, 510 full-text papers were assessed. At the final stage of screening 108 studies were included in the review. All studies included were published in English and peer-reviewed. The search process and results are presented in Figure 1 PRISMA flowchart. Direct quotations are indicated by quotation marks or, for larger excerpts, by indentation and italics.

Included Study Characteristics

The review included 108 papers representing 108 unique study datasets (see Table 1 for a summary of included studies; we refer to the included studies using the study numbers presented in Table 1 hereafter). Across the studies, the number of participants totalled 2,114; including 1,702 women, 312 men, and 104 for whom the gender was not reported. A wide age range was represented, from 18 to 90 years old.

The majority of the studies were undertaken in North America ($k=50$) and Europe ($k=33$). The remainder were undertaken in Asia ($k=12$), Australasia ($k=7$), Africa ($k=4$), and South America ($k=1$). One paper reported a study conducted across continents, in Australasia and Europe. Respondents in the studies came from a wide range of regions, ethnic groups, countries, and religions; however we are unable to report these in many cases, as most studies did not report socio-demographic details of participants.

Data were collected largely using semi-structured interviews ($k=93$), with six articles using focus groups and five using a combination of both. Two studies used open-ended questionnaires, one used photovoice techniques and for one paper, data were collected using medical records that reported communications between asylum seekers and clinicians (86). Studies were published from 1996 to 2023, with the number of papers per year spanning from 1 (e.g. 1996, 2008) to 13 (2021).

Many papers did not report a specific diagnosis ($k=93$) and of those that did, PTSD ($k=4$) and substance use disorder ($k=4$) were most often reported. Other unique diagnoses included psychosis ($k=1$) and symptoms of dissociation ($k=1$). In addition to these papers, two were from participants with a variety of mental health diagnoses and three included participants with both physical and mental health diagnoses.

Childhood adversity (including childhood sexual abuse) featured in 23 articles; intimate partner violence in 50 studies and sexual violence (including rape) in 16. Nine articles studied different types of traumas including human-inflicted trauma, elderly abuse, the Holocaust, forced migration and asylum-seeking, and interpersonal trauma and eight articles looked at multiple types of traumas (e.g. physical and sexual violence). Finally, in two cases, the type of trauma was not reported.

The large majority of papers used thematic analysis ($k=51$), content analysis ($k=12$) or a phenomenological approach ($k=21$). Six studies used grounded theory and four performed a narrative analysis. In one case, a mixed-methods analysis was used and in six cases other approaches were used (i.e. discourse analysis, dimensional analysis, explicitly survivor-generated analytical account, Miles et al. (2014) data display analysis, Moustakas (1994) approach, and I-Poems (Gilligan et al., 2003). Finally, in four cases, the authors did not report a specific analytical approach to their investigations and in a further three papers, the approach was labelled as qualitative without any detail.

Outcome of Quality Appraisal

JBI and additional research inclusion quality assessment revealed variation across the 108 included studies, as shown by Figure 2.

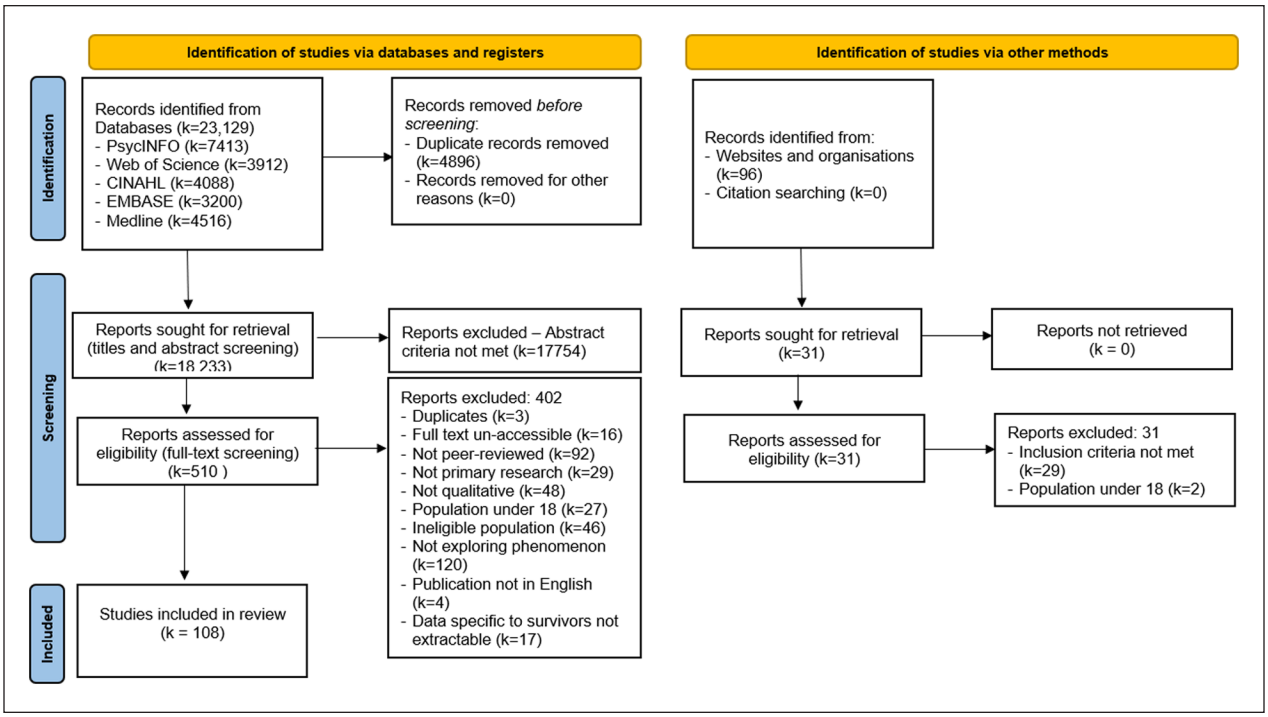

Figure 1. PRISMA flowchart.
PRISMA = Preferred Reporting Items for Systematic reviews and Meta-Analyses; PsycINFO = abstracting and indexing database covering the behavioural and social sciences Web of Science; CINAHL = Cumulative Index to Nursing and Allied Health Literature, a database primarily focused on nursing and allied health disciplines; EMBASE = Excerpta Medica database, a comprehensive biomedical and pharmacological database; Medline = NLM bibliographic database that contains references to journal articles in life sciences, with a concentration on biomedicine; *k* = the number of studies; NLM = National Library of Medicine's.

Overall, congruity between methodology, research objectives and data collection and analysis (criteria 1–4), was high, with positive ratings of ranging from 61% to 87% of studies (see Figure 2). The remaining studies were largely rated as "unsure" on criteria 1 to 4 owing to insufficient information, with a small number rated negatively due to use of comparatively less bona-fide qualitative methods, such as free text entry on surveys or qualitative data collection added on to an otherwise quantitative study. In terms of congruity between methodology and interpretation of results (criterion 5), there was wide variation in study quality. Fewer than 20% of studies reported mechanisms such as member-checking or validation techniques to aid interpretation of results; just over 20% reported no clear details on this domain; over 60% of studies were rated negatively due to methodological considerations of the interpretive approach taken (e.g. treating brief survey response as qualitative data). Study quality with respect to cultural or theoretical location (criterion 6) and researcher reflexivity (criterion 7) was similar: nearly 70% of studies scored negatively; clear statements locating the researcher culturally or theoretically and explicitly exploring how researchers shaped the research respectively was only evident in about 15% of included studies. Studies tended to score well on recruiting participants representative of the specified population (criterion 8), with fewer than 20% of studies rated as unclear and very few rated negatively. Across the studies, the quality of ethics consideration (criterion 9) was generally good. Eighty-three per cent of studies included explicit statements reporting ethics approval and ethics consideration; though no evidence of explicit ethics considerations was found in 7% of studies and the remainder were rated as unclear. Conclusions drawn based on analysis and interpretation (criterion 10) were rated positively in over 85% of studies.

The additional areas of quality assessment added by the research team, focusing on research inclusiveness, fared less well. Discussions of intersectionality in the analysis and interpretation of results (criterion 11) were absent (32%) or unclearly reported (41%) in the majority of studies. For the remaining 26% of studies, participant characteristics, including financial circumstances and ethnic-socio-demographic data were reported, though authors did not necessarily reflect on intersectionality in the findings and discussion. Across studies, reporting of measures to promote fair and equal participation for those who were underserved due to language, or any other reasons (criterion 12) was either unclear (43% of studies) or absent (44%); the remaining 13% of studies were rated positively. Only a handful of studies (4%) had good participant involvement (criterion 13), which we defined as actively involving participants in the design and conduct of the study or data analysis to ground the analysis and conclusions in participants' experiences.

Table 1. Methodological Characteristics of Included Studies.

Study no.	First author (year)[a]	Country	*N*	% of women	Trauma type	Services accessed	Data
1	Aguillard (2022)	USA	33	100	IPV	NR	Interview
2	Anderson (2000)	USA	27	93	CA	Support groups	Interview
3	Arias (2013)	USA	10	100	CA	Previous therapy	Interview
4	Bacchus (2003)	UK	16	100	IPV	NR	Interview
5	Bahrami (2015)	Iran	18	100	IPV	NR	Interview & FG
6	Birdi (2022)	UK	10	100	Sexual	NR	Interview
7	Blakey (2017)	USA	26	100	Other	Medical detox	Interview
8	Boterhoven de Haan (2021)	Australia	44	73	Sexual	EMDR or ImRs	Interview
9	Bradbury-Jones (2017)	UK	10	100	IPV	Referral for safety	Interview
10	Braganza (2022)	Canada	33	100	IPV	Spiritual support	FG
11	Braun (2021)	USA	7	100	Sexual	Mindful yoga therapy	Interview
12	Buchbinder (2016)	Israel	12	100	IPV	NR	Interview
13	Burke Draucker (1999)	USA	33	100	Sexual	NR	Interview
14	Choi (2021)	South Korea	12	100	Sexual	Drop-in discussions	Interview
15	Chouliara (2011)	UK	44	100	CA	Talking therapies	Interview
16	Crandall (2005)	USA	9	100	IPV	Counselling	Interview
17	Creighton (2019)	Canada	11	100	CA	Photovoice	Interview
18	Das (2013)	US	20	100	Sexual	Formal counselling	Focus group
19	Davis (2010)	Australia	9	100	IPV	NR	Photovoice
20	De Piñar-Prats (2022)	Spain	53	100	IPV	NR	Interview
21	Dichter (2021)	USA	68	NR	IPV	Advocate service	Interview
22	Dickins (2022)	USA	22	100	NR	Primary care	Interview
23	Faulkner (2020)	UK	7	57	Multiple	Psychotherapy	Interview
24	Gerber (2017)	USA	50	48	Other	Community gardening	Interview
25	Ghafournia (2021)	Australia	14	100	IPV	(In)formal assistance	Interview
26	Gill (1999)	Canada	10	0	CA	NR	Interview
27	Gillum (2009)	USA	14	100	IPV	NR	Interview
28	Goldstein (2020)	USA	40	68	CA	Motivational interview	Interview
29	Hathaway (2002)	USA	49	100	IPV	DV programme	Interview
30	Hogan (2021)	UK	26	0	IPV	DV services	FG
31	Hovey (2011)	Canada	58	0	CA	NR	Interview
32	Huey (2013)	USA	60	100	Multiple	Shelter	Interview
33	Kantor (2022)	Austria	46	28	CA	NR	Interview
34	Kelly (2006)	USA	17	100	IPV	NR	Interview
35	Lafferty (2013)	Ireland	9	NR	Other	Elder abuse support	Interview
36	Larsen (2012)	Germany	6	100	IPV	Medical examination	Interview
37	Lewis (2015)	USA	6	100	IPV	NR	Interview
38	Logan (2005)	USA	30	100	Sexual	NR	Interview
39	Loke (2012)	Hong Kong	9	100	IPV	Unspecified treatment	Interview

(continued)

Table 1. (continued)

Study no.	First author (year)[a]	Country	*N*	% of women	Trauma type	Services accessed	Data
40	Lowe (2014)	UK	9	56	Multiple	Trauma-focused CBT	Interview
41	Lutz (2003)	USA	12	100	IPV	Prenatal care	Interview
42	Machado (2017)	Portugal	10	0	IPV	IPV specialist services	Interview
43	Maier (2011)	Switzerland	13	39	Other	Medical-psychosocial	Interview
44	McCauley (1998)	USA	21	100	IPV	NR	Interview
45	McCleod (2010)	USA	5	100	IPV	NR	Interview
46	McGarry (2010)	UK	16	100	IPV	NR	Interview
47	McGregor (2006)	New Zealand	20	100	CA	Previous therapy	Interview
48	Moore (2017)	UK	22	90	CA	NR	Interview
49	Mukamana (2008)	Rwanda	7	100	Sexual	NR	Interviews and FG
50	Mumey (2020)	US	6	100	Sexual	Support groups	FG
51	Myers (2019)	South Africa	20	100	Multiple	TI-intervention	Interview and FG
52	Nair (2021)	India	30	100	Sexual	Rehabilitation	Interview
53	Newton (1996)	UK	14	100	CA	NR	Interview
54	Nichols (2018)	USA	27	100	IPV	Mental health services	Interview
55	O'Brien (2007)	Australia	14	100	CA	NR	Interview
56	Ormon (2013)	Sweden	9	100	Multiple	Psychiatric care	Interview
57	Oswald (2010)	USA	24	100	IPV	NR	Interview
58	Page (2021)	USA	49	100	IPV	Support group	Interview
59	Park (2020)	South Korea	20	70	IPV	NR	Interview
60	Parker (2007)	Canada	7	100	IPV	WRAP	Interview
61	Parry (2017)	UK	7	100	NR	NHS inpatient	Interview
62	Peleg (2012)	Israel	17	47	Other	Testimony Theatre	Interview
63	Phanichrat (2010)	UK	7	57	CA	NR	Interview
64	Phillips (2004)	Canada	7	100	CA	NR	Interview
65	Phillips (2021)	USA	40	100	IPV	Wide range	Focus group
66	Pratt-Eriksson (2014)	Sweden	12	100	IPV	Refuge	Interview
67	Purket (2020)	Canada	25	64	CA	Emergency care	Interview
68	Rajaram (2018)	USA	22	100	Sexual	NR	Interview
69	Reina (2015)	USA	10	100	IPV	Sexual assault agency	Interview
70	Renner (2020)	Germany	20	20	Other	NR	Interview
71	Sall (2022)	USA	19	100	Sexual	NR	Interview
72	Salter (2014)	Australia	31	81	CA	Rehab, counselling	Interview
73	Schwarz (2020)	USA	25	100	IPV	EMDR	Interview
74	Schwarz (2021)	USA	21	100	IPV	EMDR	Interview
75	Shamai (2006)	Israel	11	81	Other	Previous therapy	Interview
76	Sigurdardottir (2016)	Iceland	10	100	CA	Wellness-Programme	Interview

(continued)

Table 1. (continued)

Study no.	First author (year)[a]	Country	*N*	% of women	Trauma type	Services accessed	Data
77	Simpson (2014)	USA	16	100	IPV	None	Interview
78	Smith (2001)	USA	7	100	Sexual	NR	Interview
79	Smith-Marek (2018)	USA	8	100	Sexual	TI yoga	Interview
80	Sorrentino (2020)	US	50	100	IPV	Psychotherapy	Interview
81	Stevens (2018)	UK	5	100	IPV	Yoga	Interview
82	Stewart (2023)	UK	19	100	IPV	NR	Interview
83	Stige (2013)	Norway	13	100	Multiple	Stabilisation group	Interview
84	Stige (2017)	Norway	13	100	Other	Stabilisation group	Interview
85	Stige (2020)	Norway	11	73	CA	NR	Interview
86	Sundvall (2018)	Sweden	18	100	Other	MH emergency service	Medical notes
87	Teram (2006)	Canada	95	NR	CA	NR	Interview and FG
88	Thurston (2016)	China	13	100	IPV	PAR	Interview
89	Tong (2017)	Australia	8	88	Multiple	DM and education	Interview
90	Tower (2006)	Australia	9	100	IPV	NR	Interview
91	Tsang (2021)	China	10	0	IPV	NR	Interview
92	Vala Jonsdottir (2020)	Iceland	9	100	CA	NR	Interview
93	Villiardos (2023)	UK	4	0	CA	Counselling/therapy	FG
94	Vincent (2013)	UK	7	43	Multiple	TFCBT	Interview
95	Wachter (2021)	USA	35	100	IPV	Resettlement agency	Interview
96	Wade Taylor (2018)	USA	9	0	CA	TFCBT, sexual health	Interview
97	Walker (2020)	UK	7	100	Sexual	Forensic advocacy	Interview
98	Walker-Williams (2017)	South Africa	10	100	CA	Strengths-based group	Interview
99	Wallin Lundell (2017)	Sweden	8	100	IPV	Hospital care	Interview
100	Walstrom (2013)	USA	18	100	Sexual	Support groups	Interview
101	Wester (2007)	Netherlands	12	100	IPV	Shelter	Interview
102	Wild (2022)	Australia	28	100	IPV	NR	Interview
103	Wood (2020)	USA	25	100	IPV	Housing	Interview
104	Zafar (2022)	UK	21	100	IPV	NR	Interview
105	Zink (2004)	USA	38	100	IPV	NR	Interview
106	Zonp (2021)	Turkey	17	100	IPV	NR	Interview
107	Zust (2006)	USA	10	100	IPV	INSIGHT	Interview
108	Zverina (2011)	Canada	14	0	IPV	Group therapy	Interview and FG

Note. *N* = number of participants; % of women = proportion of female participants; FG = focus group; CA = childhood abuse; CBT = cognitive behavioural therapy; EMDR = eye movement desensitisation reprocessing; DV = domestic violence; INSIGHT = group cognitive therapy programme; ImRs = Image Rescripting; IPV = intimate partner violence; NHS = National Health Service; NR = not reported; WRAP = Women Recovering from Abuse Programme; PTSD = post-traumatic stress disorder; TI = trauma-informed; PAR = participatory action research; TFCBT = trauma-focused cognitive behavioural therapy.
[a]See Supplemental Material for citation details.

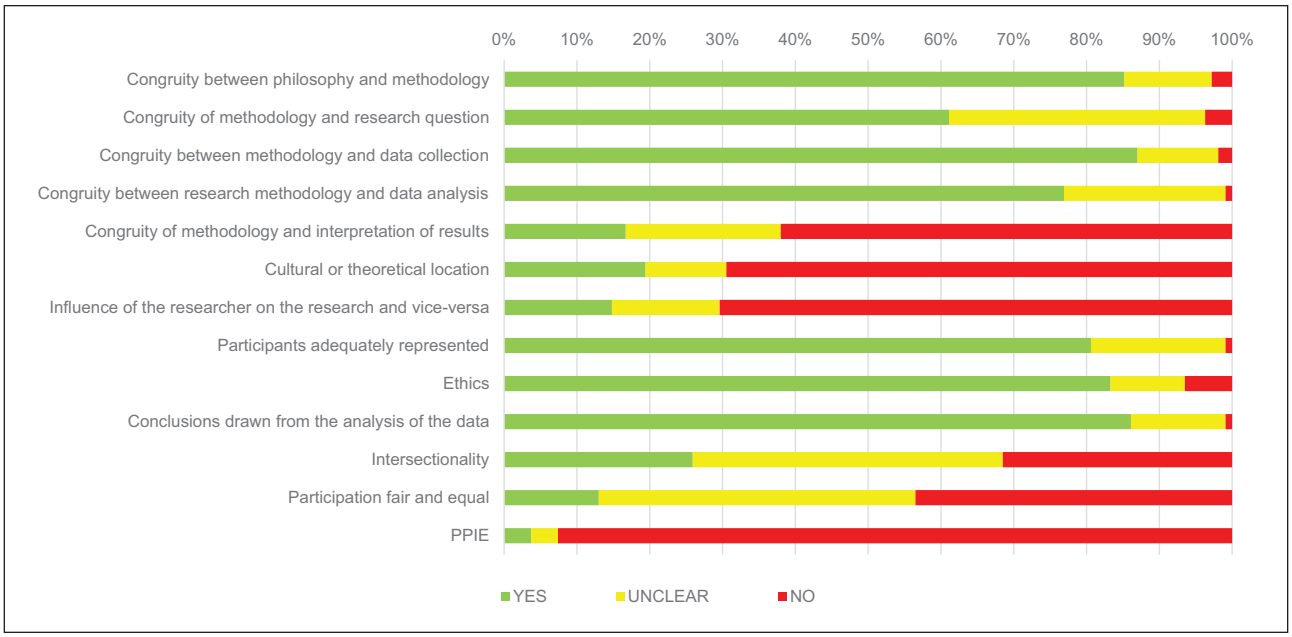

Figure 2. Overview of quality appraisal.

The references for Table 1 can be found in the Supplemental Material.

Themes and Overarching Themes

Through the synthesis, we identified seven themes that act as both facilitators and barriers to seeking help and engaging with services. We identified that these themes can be described as operating on three intertwined levels – individual/micro (internal stigma), organisational/meso (staff attitude, skills and training, therapeutic relationship, treatment flexibility), and community/macro (external stigma), with peer support spanning all three levels (see Table 2 for a summary). These factors feed into the overarching themes that will be presented further in this paper.

Individual Level

Internalised Stigma. In the case of the role of internalised or self-directed stigma, only negative experiences were reported, as can be expected.

In noting that survivors often delay or hesitate to seek out help or use services for mental health support, participants shared that they felt that they were damaged goods and that they did not feel that they belonged within society and their communities (26). The concept of self-blame and shame was prevalent (39), with survivors of trauma reporting that they were in some way unworthy of help (22, 42, 38) or warranted the abuse (18, 10, 40, 81, 91, 88).

> "My mind just tells me that I'm a bad person and I don't deserve help, because that's what my mum used to say to me, I was evil. Obviously at the time it was to stop me from telling anybody, but all these years later it's still there quite strong." (81)

In the same vein, some took on a victim role (43) and felt that their identity was defined by this status (62). In a study concerning male survivors of intimate partner violence (IPV), the participants reported having the belief that men should be strong and that they were therefore weak in some way, but meanwhile also did not deserve help (87).

> "Men are tough. Men are macho. Men don't need [help]. All we have to do is to get over it! Get over it—be a man!" (87)

Survivors were often embarrassed (35) or uncomfortable (29) sharing their experiences or seeking help and felt that there were no words powerful enough (49). Some stated that they had not told their partner or family the full details of their childhood abuse (48) and that they lived with intense shame (70, 46).

Organisational Level

Staff Attitudes. Some participants reported staff helping them to feel like a person and treating them like a human being after the dehumanisation of the abuse (35, 61). Sometimes all they felt the need for was to simply be listened to without being judged (102, 55) and for the professionals to explicitly acknowledge the abuse (57, 23, 51).

> "I felt free [to talk], there was no-one who was judging me, telling me how wrong I was, or saying, 'you are doing such bad things,' and judging my past." (51)

Table 2. Summary of Themes as Barriers and Facilitators.

Theme	Facilitator	Barrier
Internal stigma	Not applicable	Participants felt they lacked a sense of belonging. They believed their experiences made them somehow different and felt stigmatised in their own eyes.
Staff attitude	Survivors found staff's compassion validating. It helped reframe their reactions to trauma, allowed them to feel believed, valued, not alone, and worthy of help.	In a large number of cases, no discussion or assistance was offered following disclosure and staff did not believe or validate the trauma.
Skills and training	Some medical professionals (especially GPs) were very proactive and well informed when it came to referring survivors to statutory and non-statutory services, encouraging disclosure and helping to manage the situation.	A distinct lack of knowledge or awareness of trauma services amongst professionals can delay or prevent accessing help.
Therapeutic relationship	Understanding and validating traumatic experiences are key ingredients of a positive therapeutic relationship, especially when survivors feel believed, respected and supported on an emotional level.	Survivors reported feeling that the treatment providers did not listen, were patronising and engaged in victim blaming as well as telling the client how they should think and feel.
Treatment flexibility	Holistic services that provided financial, legal, spiritual and practical support such as, shelter, childcare or food, alongside access to psychological therapy.	The question of accessibility was at the forefront of treatment flexibility whether that be financial, logistical, or practical. However, cultural and linguistic barriers exist. In addition, some services had a rigid remit.
External stigma	Not applicable	Abused women felt condemned by friends, family and the community and relationships were frayed or broken.
Peer support	Mostly positive experiences by survivors, who amongst peers did not feel alone with others who get it and who respect each other without judgement.	Some participants reported that they did not develop emotionally supportive relationships outside the confines of the group.

Services that were welcoming and calm could foster a sense of belonging (52, 103, 97). Support came from myriad formal sources such as midwives or emergency department staff and their assistance led to survivors reaching out for help (92, 104, 15). Some survivors felt that the attitude of the staff led to them gathering awareness and knowledge of abusive relationships (5).

> "I went to a consultant. I don't know; I didn't feel I could do anything that time. He told me that I deserved more than this life. This left a great influence on me. I came to my senses and tried to change my life and value myself." (5)

In comparison, impersonal, cold and indifferent responses from staff were commonly experienced among survivors and described by some as cruel (38, 34). Clinicians were often seen as only interested in the physical manifestations or the psychiatric comorbidities of trauma rather than the traumatic experience itself (18, 4). Some participants reported avoiding help-seeking because of bureaucracy and authoritarian reactions (69, 48, 99, 66, 71), such as threats of deportation.

In a large number of cases, no discussion or assistance was offered following disclosure (21, 37, 36, 82, 41, 9, 14) or led only to unhelpful labelling rather than attempting to understand the unique experiences of the survivors (61). Adult survivors who had experiences of relational and emotional difficulties did not feel that the staff members' attitudes were helpful (85). Survivors reported finding that some staff failed to validate, and sometimes minimised, survivors' experiences (61, 105) or gave inappropriate responses (45, 65, 53). As reported by one researcher:

> "R told her therapist she was thinking of killing herself and the therapist replied that she didn't have the guts.'" (53)

Male survivors in particular were faced with disbelief and were both overtly and covertly told by medical and social care professionals that they could not be victims and were also treated as though they were the aggressor (42, 26, 30).

In many other situations, survivors found that the clinicians whom they saw at the emergency room or crisis service experienced the shared powerlessness and helplessness. Such was also the case in asylum applications (86), or when there was a language barrier (16).

Therapeutic Relationships. Understanding and validating traumatic experiences were key to positive therapeutic relationships (18, 85), especially when survivors felt believed, respected and supported emotionally (97, 6, 89). Being listened to and accepted promoted feeling safe in a successful

therapeutic relationship (65, 15, 29, 28). A non-judgemental approach towards survivors was appreciated by them (30, 15, 8) and mutual trust, was also crucial (50, 31). The therapeutic relationship was even described as positively life-changing (1).

Some survivors explained that positive therapeutic relationships could be helped by clinicians explicitly setting boundaries and explaining formal therapeutic processes from the very beginning (47, 50). A professional relationship that had clearly defined boundaries, but yet flexibility around access to the therapist/support helped survivors not only to share their experiences but also to make sense of them whilst meeting their needs (61, 2).

> "I think that from day one she and I just had a connection. Even to this day I could pick up the phone and call her I don't know what it was. It's like we just connected, and it was more than just counsellor." (37)

Culturally specific therapy made survivors feel more welcome and ensured the creation of positive therapeutic relationships (37). For some immigrants who sought to re-settle in an asylum after losing their family network back home through war or persecution, they perceived the health and social professionals taking on the role of family (95).

> "The caseworker, he's the one who received me the first time when I came here. We don't know anybody else here. He's like my mom and my dad. So, if I have a problem, I have to go to him." (95)

Conversely, relationships with staff were sometimes described as uncaring. Survivors reported feeling that treatment providers did not listen, were patronising and engaged in victim blaming as well as telling the client how they should think and feel (53) or that there was no relationship at all (7, 82, 101, 90).

There could be a level of distrust between service providers and survivors. In one case, the client reported that the information he gave his therapist, and which was placed in his file, was used against him by care workers (33).

> "Everything I was telling him was documented in my file, right? And then everybody knew what we were saying! And this was used against me by the care workers." (33)

Skills and Training. Professionals' advocacy skills were particularly appreciated by survivors and described as being therapeutic (80), be it in navigating the criminal justice system (97, 25), providing academic support to students who had experienced abuse (71) or helping survivors access health services (18).

Some clinicians focused on a need to diagnose and treat a mental disorder before addressing or asking about the trauma (18) or paid more attention to the physical manifestations of the trauma, treating injuries such as genital mutilation (44, 39). Medical professionals (especially GPs) were sometimes very proactive and well informed (104, 4, 9, 65, 105, 81).

Multiple cultural and language barriers to seeking help and receiving appropriate support were identified. For example, using an interpreter could lead to the nuances of clinical communication being missed (86); and provision of interpretation or translation on its own offered no guarantee for culturally appropriate practice/care (16). Further, male-centric vocabulary could be used by professionals to ensure that men were also recognised as survivors (30, 87).

> "Male victims of child abuse need as much care and concern and validation as female victims of child abuse." (87)

For some survivors, there was a clear absence of formal or informal networks of potential support (46). There was also evidence that a distinct lack of knowledge or awareness of trauma services amongst professionals delayed and prevented access to support (21, 70, 61, 48, 38).

> "And I don't think, even my own GP, I mean I had to talk to my GP when I was going to the redress thing because of the psychiatric report, and I don't think they had a clue. I mean I don't think they have the foggiest what I was talking about." (48)

Service Flexibility. The question of accessibility was at the forefront of this theme whether that be financial, logistical, or practical. Financially, the cost of treatment was often a barrier to accessing support (50), including in cases where the abusive partner controlled the finances (1). Logistical considerations also arose such as a lack of flexibility around attending support. In two studies survivors flagged the potential option of taking part in an intensive programme as an inpatient or the existence of a hotline to address logistical challenges (18, 33). Practical considerations were also significant, such as a curfew at a shelter preventing a participant from gaining employment (103) and the provision of necessary items to those fleeing abuse and therefore meeting their basic needs (68). In some cases, the waiting time for domestic violence services was judged to be too long (54), and survivors frequently faced cultural and linguistic barriers (16).

In the case of medication, one study showed that a holistic approach to well-being led to a reduction or even cessation of prescription drugs (11) whereas other providers prescribed medication without psychological treatment (44).

> "We really need this; they keep pushing pills on us . . . Yoga is more of a lifestyle; it made us stop thinking about all . . . all the issues that we're here for. It puts you in a better state of mind, more focused, kinder to people, to yourself, to your whole body. . . knowing that you can be calm and peaceful and . . . I guess Zen is the best word . . . I felt calmer with the yoga than I ever did with [anti-anxiety] pills." (11)

Gender was an important consideration for both men and women. Men requested tailored IPV services as they felt that

they were in the minority when seeking support (30) whilst women highlighted the importance of single-sex settings in order to feel safe (72).

Being able to individualise treatment was raised as most important, with survivors explicitly asking to share, with the staff/assessors, control of the pace, the act of withholding/sharing information, the practical aspects of leaving an abuser (23, 80, 27, 5) as well as requesting ongoing support (55). Several survivors felt that they needed to have the option of addressing the original problems rather than the later-arising impacts (53, 8, 22).

> "They don't . . . too much judge you. . . . They don't give you no limited time and say well, you got 2 weeks to leave him or you know, you can't come here no more. They don't kind of do that. They let you take your time because they know it's a time thing." (27)

Finally, many survivors wanted to be supported to fulfil their social and occupational needs and gain independence (69, 40) and to have the choice whether to engage with services or not (21).

Community and Service Level

External Stigma. External stigma is defined as negative and blaming responses to trauma on a systemic and societal level. Many parents, especially mothers, were afraid of the authorities and specifically having their children removed from their care (44, 34, 82). Undocumented immigrants also feared involvement from the criminal justice system (69). A fear of authorities was a common barrier of seeking help (21, 34) and there could be a feeling that victims can only trust themselves (75).

> "They [health-care providers] get you in trouble. . . As soon as a woman is in domestic violence they all assume the kid is in danger. . .so you get scared sometimes and you don't talk." (34)

The relationship between religion and external stigma was common and prevalent across different faiths (e.g. Muslim, Christian) and was acknowledged as a barrier to seeking help either by keeping the abuse secret (10) or by supporting a culture of intolerance around factors such as sexual orientation (77). Under-reporting of trauma was common in some minority ethnic communities in which survivors also experience increased negative attitudes towards seeking professional support (18, 12, 16). The issue of gender role expectations often interacted with the external stigma displayed towards survivors of IPV, often casting them as gendered stereotypes (30, 31, 87). These situations were exacerbated at the intersection between gender and culture; for instance, Chinese male gender roles were described as being dominant, and inconsistent with their victim status (91).

> "I think there is a great deal more stigma for men to talk about sexual abuse. I recognize culturally for women to talk about sexual abuse was a risk of them appearing to others as being damaged goods and so on; but for men I think it was different and greater because it gets mixed up in all kinds of issues as gender identity . . . . and so on and so forth." (87)

Many participants were afraid of being stigmatised by friends and family members but also society in general (33, 35, 86, 25). A lack of awareness led to non-disclosure, especially when the trauma was sexual (97, 68, 49, 17).

> "It's easier to—if you think that something's going on at your neighbour's house, we'll all just be quiet. Close your eyes to it, even though you know. Like people don't speak up. People don't stand up for each other. . . I mean, people have a blind eye, or they don't do anything." (68).

Trauma victims who had tried to seek help and been turned away or dismissed from informal and formal support were less likely to make that step again, describing the frustration of not being heard (21, 67, 57, 99). We also found evidence of minimisation, where victims were made to think that their experiences were not as bad as they thought (55, 71).

Familial pressure to conceal the abuse, especially when the abuser is a member of the family or community, contributed to a culture of non-disclosure (4, 95, 38). Conversely, if the parents had initially disapproved of the relationships, survivors were prevented from leaving their abusive partners due to not wishing to admit that their parents had judged the situation correctly (45). Victims sometimes experienced negative consequences triggered by their disclosure, including being blamed or shunned (59, 102).

Community/Organisational/Individual Level

Peer Support. A common theme transcending levels of help-seeking was the role of survivor-led support services, peer support or survivor-led support groups. Participants often described that through peer support, they experienced not being alone (73, 15, 52), being with other people who "get it" (20, 63, 60, 98, 36, 32) and being treated without judgement (65).

> "There is one thing about this group that I enjoy so much, it's that here I can be absolutely me. If I want to cry, I cry, nobody thinks I'm silly. If I want to laugh, I can laugh. If I want to fail, I can be a failure. I can feel, I can feel like I'm here. I'm here." (98)

Survivors felt that they were truly understood by their peers (85), which in turn validated their own experiences (2) and led to them making sense of what had happened to them (50). There was a sense of connection when sharing with a group of people who have similar experiences (58) and of comfort, support and closeness (14, 62, 49).

> "Coming here it helps us that we can talk to each other and be like we're not gonna judge you because we've been through that and it's just helping each other like you can do it." (58)

Peer-led organisations offered a safe space for survivors at crisis point which allowed not just an escape from

Table 3. Overarching Themes with Sub-Themes Leading to Post-Traumatic Life.

Overarching themes and sub-themes	Summary
Feeling safe	
Disclosure and seeking support	Having a sense of control and being acknowledged as the experts of their own experiences led some participants to feel able to open up about their situations.
Meeting needs	The characteristics of the service were important be that practical, cultural or just providing a safe space and the presence of welcome, patient and nurturing staff.
Making a journey	
Coming to terms	The explicit acknowledgement of trauma was life-changing and survivors who experienced compassionate validation began to feel believed and worthy of therapy.
Time	Therapy is a long and complex process. The lost years must also be addressed and dealt with.
Achieving connectedness	
Integrated within self	A strong feeling of empowerment accompanied a sense of connection and coming to terms with their situation and the optimism of being able to envisage future possibilities.
Connection with others	The power of peer support enables both empathy and the sharing of experiences which led to acceptance of the traumatic events especially when the peers were members of the same cultural community.
Communication with trustworthy services	Services provided by professionals who have themselves experienced trauma was particularly helpful and peer support was seen to be of great value.

isolation (30, 107, 11) but also a level of disclosure that would not be possible with professionals or figures of authority (68). The sense of connection with others also improved people's sense of coping (100), self-confidence and sense of empowerment (32, 25, 2). Practical support and information provided by communities could be equally helpful (24, 48, 18, 78, 10). It was especially appreciated when the staff were themselves survivors (1, 27).

For both men and women, peer support was also seen as effective when it was gender specific (30, 37), and there was also a desire to be with other survivors from one's culture (67).

> "There was a lot of crying went on, a lot of revelations and a lot of crying. And in our recovery programme we all cried together. And I think that's good because men rarely cry, do they?" (30)

However, not all experiences of peer support were positive. Some participants reported that they did not develop emotionally supportive relationships outside the confines of the group (51).

Overarching Themes

The seven themes reported above describe the barriers and facilitators that survivors reported experiencing when seeking help and support from mental health services. The three overarching themes are reported below – feeling safe, achieving connectedness, and making a journey – and offer an explanation of the process towards the survivor's post-traumatic self. The seven factors detailed previously feed into these three overarching themes at three levels – individual, organisation and community. Table 3 summarises the overarching themes and their sub-themes. We believe all three themes need to co-exist for any possibility of realising a post-traumatic self. Specifically, safety is identified as a crucial prerequisite for connectedness to be established. Likewise, the journey towards the post-traumatic self can only start with these two other overarching themes in place. Figure 3 proposes a model that links these barriers, facilitators and processes.

Feeling Safe. This theme reflects the steps necessary to feel safe and therefore being able to disclose trauma, seek support and meet physical and psychological needs.

Disclosure and Seeking Support. When it came to feeling safe, empathetic (18, 40, 56, 44) and non-judgemental (40, 19) approaches to trauma survivors were particularly important. A sense of belonging was fostered by creating a community, both of peers (30, 100, 63) and professionals (10, 62, 70), and a sense of connection (37, 58).

There were instances where survivors felt that they were the subject of gossip and a lack of confidentiality within services (77, 39) which led to them not feeling that they were in a safe space or that they didn't belong (26). In addition to this, participants felt out of control if they didn't initiate the contact with services, but the abuse was discovered by social workers through other pathways (35).

In some situations, survivors felt that the services took a parental role (95, 49) or reminded them of being in their home country or some forms of shelter (24) which could be

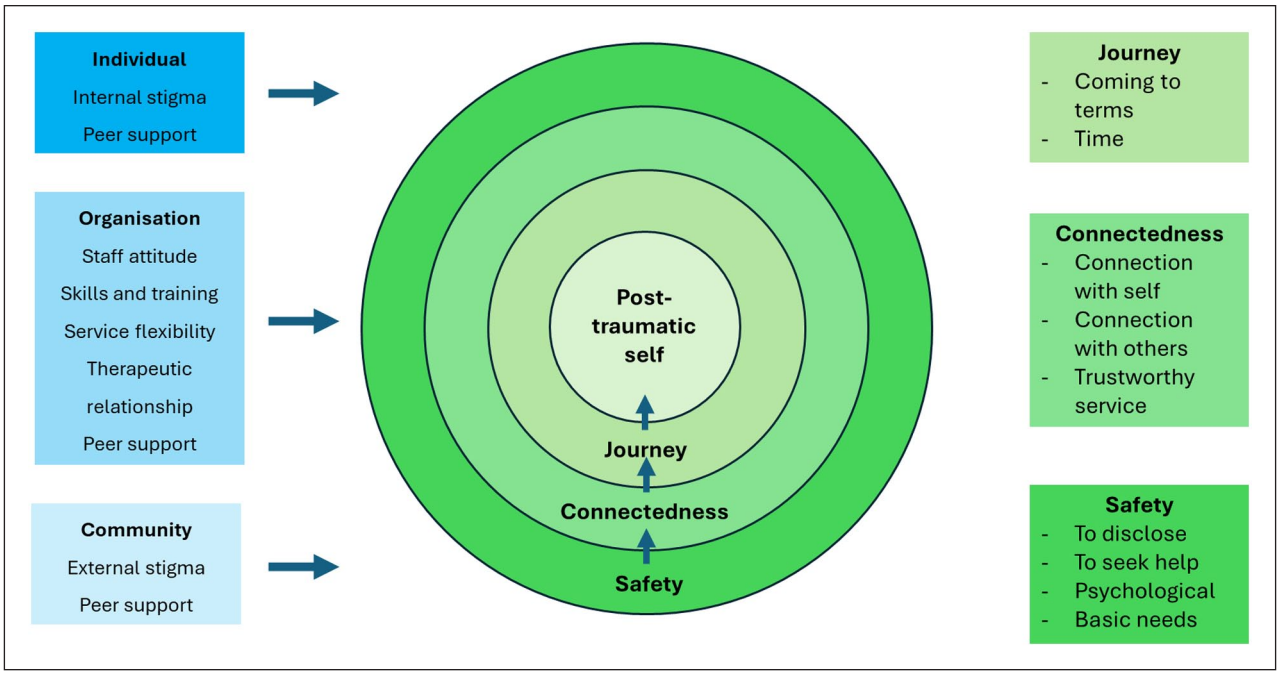

Figure 3. A model of facilitators, barriers, and process of accessing support for mental health among complex trauma survivors.

a welcomed relief. Consequently, a sense of safety led to some participants feeling able to open up about their situations (104, 6, 55, 28).

Meeting Needs. In addition to this, continuity of care (90, 34) and positive relationships with staff (61, 78) encouraged survivors to seek help. Being assured of both physical security (99, 79, 45) and confidentiality (65, 48, 4) had an impact on survivors seeking support.

> "That was the first time I had openly discussed with anyone about what had gone on in my childhood, and I think I just connected to her because I feel like she was the first person to validate my feelings so openly, too." (18)

The characteristics of the service were important, be they practical (68, 94, 16, 911, 101), cultural (27) or just providing a safe space (74) and a calm welcome (103, 97) with patient, nurturing staff (81, 97, 41).

Making a Journey. This theme reflects the voyage taken by survivors whilst both coming to terms and reflecting on the long and difficult journey with the post-traumatic self.

Time. For some survivors, although psychotherapy had a positive effect on processing the trauma experience and its impact, it was necessary to acknowledge that therapy is a long and complex process and that its difficulty must not be understated (104). The lost years must also be addressed and dealt with (46, 65).

> "I haven't come to the end of my journey in terms of dealing with what happened to me, but I'm a lot further forward than I would have been, had I not been able to get outside support. It's taken a long time for me to recognise and understand that my mission in life is to be the best version of me." (104)

Coming to Terms. In order to take a step closer to accepting what had happened, survivors felt they needed to recognise and normalise the effects of the abuse (47, 80). Coming to terms with a traumatic experience involved both accepting and understanding the subsequent negative emotions (74, 87, 96, 8). Some survivors learnt to question negative thinking (40) and find healthier ways to cope with the trauma, instilling confidence and optimism, without necessarily having to give up previous coping strategies (75, 52, 51).

> "She gave me understanding . . . she said . . . 'You've been through this and it's fair enough that you feel like that.' . . . She was the only one (mental health professional) that said . . . 'It's OK that you feel . . . that way because of the things that have happened to you.'" (47)

Achieving Connectedness. Through our synthesis, it became clear that a feeling of connectedness was needed in order to move towards post-traumatic life, both within self and others, as well as being able to connect with trustworthy services. Connectedness was particularly influenced by internalised and external stigma.

Connected Within Self. Processing the experience allowed individuals to express themselves more effectively and contributed to safer and more successful conflict management (80). Being able to connect with one's trauma experience and all the negative impacts it had inflicted led to a desire to change or take control of their situation (50, 31), and

acknowledged their own need for support/therapy (23, 54, 87, 51, 92).

Connection with Others. Once again, the power of peer support was discussed, enabling both empathy and the sharing of experiences which led to learning to live with the traumatic events they had experienced (18, 98), especially when the peers were members of the same cultural community (24, 49). Peers took the role of family (58) and had a dual role of fellow help-seeker and support provider (14).

> "Most of us that's in the shelter have the same problems. So, might as well talk about it with them. We [are] like a little family." (32)

Formal and social support that was impartial helped survivors to gain a broader understanding of their experiences (97, 36).

> "As I went through the five stages of grief from denial to acceptance, they did the same. Of course, situations were different, however, their emotions and thoughts were just a replication of mine." (14)

Trustworthy Services and Staff. Services provided by staff who have themselves experienced trauma were considered to be particularly helpful (98, 13, 27). Survivors who experienced compassionate validation from service staff began to feel believed and in turn, build trusting relationships for therapy (23, 54, 87, 51, 92). Open lines of honest communication supported the development of trust (40, 90, 34) and reduced isolation (80, 14).

> "The good part [about] telling [my case manager] was just, you know, someone else knows about it. It's like, I've been hiding something and letting it out feels just, good." (89)

There was a strong concern about disclosure and whether the survivor will be believed or not (18, 65, 36, 26, 34, 101, 71). Even when survivors were able to access services, continuity of care was poor (4, 68). For many survivors, in response to often untrustworthy people/services, choosing not to trust or engage with services or staff was an act to protect themselves from experiencing further trauma.

> "I think many women have the problem of reporting the men or dealing with [the abuse] or seeking helping for themselves because of [not having visible injuries], because they are just afraid that they won't be taken seriously." (36)

Post-Traumatic Self. Survivors who experienced feeling safe, achieving connectedness and going on a journey are able to construct a post-traumatic life. This involved compassion with self and does not necessarily mean post-traumatic growth, which implies an active process of self-development, but can just be the experience of acceptance. The post-traumatic self-nurtures optimism and hope, and a sense of agency, where the survivor feels in charge of their own life.

Compassion. The process of understanding one's own strengths and rediscovering oneself was addressed across different studies (85, 35, 107). Acknowledging the trauma and its impact was necessary in coming to terms with the trauma that survivors have experienced and critical to the integration of the whole self (28, 81, 78). Supporting survivors to improve their mental health could remarkably improve their physical health and may lead to greater compassion to self and others. They felt connected and were more aware of their own needs, and being able to address them.

> "I've been doing, for the last three years, a lot of work on myself, both mentally and physically trying to take care of my body and trying to take care of my stress, working on [the aftermath of] my abuse." (31)

Hope and Optimism. A strong feeling of empowerment accompanied a sense of connection and coming to terms with their situation and the optimism of being able to envisage future possibilities (94, 5, 19). Some participants spoke of the importance of hope in healing (23, 37, 71). In this vein, many women felt encouraged to build new relationships with self and others, through the journey (83, 11).

> "I think with all of those problems and experiences you always have two ways either to lose everything and to lose yourself or to improve and develop skills and your brain and yourself first of all and I think I was put by [therapist] in the second way, so that I can really you know create a better person, not the same, even, but a better person." (94)

Agency. Agency describes a sense of responsibility for one's actions and decisions and an awareness of the consequences of these choices. Survivors appreciated taking control of their own life and having an opportunity to give back (18, 10). There were also practical themes, such as returning to work and having financial independence, feeling safe, and living healthily (51, 76, 106, 9). However, the overarching theme was that of reinvention and gaining agency (93, 40, 76, 75, 8).

> "I currently work with survivors myself, so there's that, I'm going to go to school for social work. It's made me a more empathetic person; it's made me somebody who wants to help others." (18)

Survivors reported that they no longer felt invisible and had new control over their lives (74, 64). They had an increased sense of optimism and were able to look towards the future with increased resilience (104, 20, 32). They were more assertive, had higher levels of self-efficacy (24, 100) and were able to advocate for themselves (74, 24). Some

Table 4. Summary of Critical Findings.

- Seven underlying factors contributed as barriers and facilitators to help-seeking: internalised stigma, staff attitude, skills and training, therapeutic relationships, treatment flexibility, external stigma, and peer support.
- Some staff showed limited knowledge of trauma-focused care.
- There is a high level of internalised and external stigma.
- Survivors require not only mental health support but also practical help and holistic care.
- Survivors need to feel safe and achieve connectedness within self and with others in order to reach a post-traumatic self.

survivors found their own journey inspired them to advocate for others and take on leadership roles (10). Empowerment was another element of post-traumatic self that was discussed, and the ability of survivors to live their dreams (12, 58, 107).

> "I learned to open up and express myself, to feel safe and to be myself, since I was under his control. Now, I can say what I'm thinking, express myself, and say what's wrong or right." (58)

Discussion

This systematic review explored the barriers and facilitators to complex trauma survivors' accessing services and support for mental health. Seven factors that contribute to the ease or difficulty of accessing services were described. Further to this, we identified three overarching themes that support the realisation of post-traumatic self. Table 4 summarises the critical findings of the review.

Survivors reported high levels of stigma, both internal and external. Equally, staff attitude and skills and training were both mentioned as being key to accessing support. It is clear that awareness campaigns amongst the general public, especially in areas with high levels of social deprivation, are necessary in order to tackle the outdated and incorrect views that surround complex trauma. Equally, clinicians, especially GPs, emergency room practitioners and psychiatrists, need to receive up-to-date training in both identifying and supporting people who either experience or have experienced complex trauma. This is also the case for social workers, particularly those based in children's services, and immigration services.

Whilst we recognise the practical difficulties involved, there is a desperate need for fluid and seamless communication and partnership between services, especially in the case of statutory care. Funding should be for the individual and provide a holistic approach recognising the nature of a long and protracted journey of healing from complex trauma. For example, a survivor with co-occurring substance misuse issues and CPTSD may only be able to access one service at a time. The movement between layers of support – such as ensuring that a survivor being offered trauma-informed counselling also has somewhere safe to stay – could ensure that the treatment provided is as effective and humane as possible.

Peer support is highly appreciated by survivors, whether formalised or non-formalised. Survivors particularly reported wanting to connect with peers around spirituality, culture or who had experienced the same type of trauma for the benefits of mutualised support. It is therefore crucial that services, statutory or non-statutory, should involve some type of peer support, including employing survivors or supporting survivor-led organisations. Previous research highlights the role of economic empowerment interventions (Keith et al., 2023), something that would particularly be useful in cases of IPV with control and coercion, or in forced migrants who do not have the financial resources for help-seeking.

We observed that the issues of gender and culture are central to several barriers to help-seeking. Regardless of the gender of the survivor, gender norms are often used to dismiss, shame, or silence them. In the case of male survivors of IPV, gender norms can be over-stereotyped to portray them as the perpetrator in the relationship. Gender-specific interventions are appreciated, especially peer support, where fellow male survivors could work to make sense of their experiences with other men. However, women also described needing same-sex services in order to feel comfortable enough to disclose their abuse, especially in the case of IPV and childhood sexual abuse. Survivors from minority ethnic backgrounds reported experiencing external stigma from other members of their communities, especially in religious settings. Although research exists comparing different ethnic groups' experiences of help seeking, further research would allow us to develop a more nuanced understanding of the intersections that impact help-seeking. These findings highlight the need for systemic change in order to avoid the barriers posed by gender- and cultural-focused stigma as well as other intersecting issues such as forced migrant status and poverty.

The vast majority of studies concerned female survivors as compared to men; women are more likely to experience IPV and sexual violence (Hatch & Dohrenwend, 2007). Further, we speculate that often survivors fly under the radar and that the stigma attached to gender roles and racial/ethnicity background prevents them from seeking help at all. It is therefore very important to improve the detection of complex trauma in (mental) health service users, especially amongst GPs and emergency room clinicians. For male survivors, research (Ellis et al., 2020) has highlighted the need to develop non-statutory services, such as peer support groups as extremely helpful in supporting them to acknowledge and disclose trauma, leading to male survivors accessing formal treatment.

Across many studies, migrant survivors faced additional barriers to accessing services. There can be a fear of seeking

Table 5. Implications for Practice, Policy and Research.

Practice	Policy	Research
Staff in both statutory and non-statutory services should receive survivor-led training in trauma-informed care.	Cultural and gender appropriate services should be funded.	Investigate differences in help-seeking amongst culturally diverse populations.
Connections between mental health, social and rehabilitation services needs improvement.	Public awareness campaigns aiming to reduce stigma of complex trauma.	Attempt to include and understand trauma survivors who do not seek help.
Peer support should be available across statutory and non-statutory services and not just a tokenistic add-on.	Funding should not only be available for services with strict criteria but should aim for holistic treatment.	Include survivors in research.
Structures need to be in place to connect survivors to appropriate services, ensuring both mental health and practical support post-disclosure.		Intersectionality should be addressed in further research.
Services and professionals need to recognise survivors need time and flexible, long-term and person-centred care.		

help due to their immigration status, afraid that if they were caught, then they would be deported. Even among those who were legally in the country, cultural practices and the presence of tight-knit communities often prevented help-seeking due to external stigma. The layer of intersectionality experienced by migrant women who do not have socio-economic independence is extremely important to bear in mind, increasing the risk of exposure to ongoing trauma.

When reflecting on the literature synthesised in this review, it became clear that the commonly reported narratives of trauma survivors lacking trust in others or failing to engage with services, being a major challenge for service providers was not echoed by our findings. Instead, our review focusing on survivors' perspectives points out that services need to demonstrate that they are trustworthy by believing or trusting the survivors. Placing the burden of trust on survivor's shoulders, only leads to further victimising of those who have experienced trauma (Alyce, 2023).

Our model suggests that for survivors to realise their post-traumatic self it is necessary to feel safe, achieve connectedness and to have taken a journey. Often the literature did not detail the whole process and instead concentrated on post-traumatic growth which implies some degree of advancement from the old self which may not be realistic or desirable for all survivors. This idea of a post-traumatic life suggests an ongoing, more often than not bi-directional, process that the survivor embodies to construct a holistic sense of acceptance or coming to terms with what happened, feeling alright within self and having agency of one's own journey as much as destiny. This builds upon Herman's (1998) model of stages of trauma recovery, in particular the final stage of reconnection and integration, with the emergence of a new sense of self.

Strengths and Limitations

Our study was of high methodological quality with an extensive search of the international literature concerning the help-seeking experiences of survivors of complex trauma. We used a double-screening process on a proportion of all search results and forwards and backwards citation tracking. The data-extraction process was rigorous and dynamic, with our coding framework evolving over time, based on both our findings but also the feedback of the LEAG. The involvement of the LEAG at all stages of the data collection and analysis is a further strength of this study. In addition to this, we had a multidisciplinary team, including those with clinical-academic and academic backgrounds, as well as survivor-researchers. The data synthesis was therefore a co-productive process, including experts in qualitative research methods and those with lived experience.

As we only included studies published in English, we may have a skewed understanding of survivors' experiences. Equally, due to the international nature of this qualitative synthesis, it is inappropriate to compare the barriers and facilitators experienced by different levels of services. Whilst in Europe statutory services can be free or low cost at the point of access, in the USA these services can be extremely expensive and therefore exclusionary. Meanwhile, the extent of and access to voluntary services may vary widely.

Most of the studies were led by researchers or professionals working in the field; our LEAG speculated that these may have tinted the interpretation of survivors perception of services, positively. The quality assessment of the studies highlights the low quality of reflexivity and authors' positionality.

Our synthesis highlighted the critical need to further develop research, policy and practice, as summarised in Table 5.

Summary

Survivors of complex trauma experience significant barriers to accessing support, primarily due to external or internalised stigma and unsuitable or exclusionary services. The major findings of our study show that whilst there are myriad barriers to seeking help, there are also numerous facilitators in statutory or non statutory settings, which supported survivors to seek help and experience feeling safe, connected and validated. A large number of studies showed that there was a general misunderstanding of trauma in the general population but also a lack of knowledge of trauma-focused approaches within both statutory and non-statutory services. This systematic review shows that, negative factors exacerbated disempowerment whereas positive factors can lead to a journey towards a post-traumatic life. Political and practical interventions and further research to redress this balance are therefore warranted.

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Supplemental Material

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