Adult experiences of rape disclosures in nursing practice: A phenomenological study

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Adult Experiences of rape disclosures in nursing practice: A phenomenological study

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Abstract

Background

Sexual assault is a form of sexual violence, it is a deeply violating experience for the survivor resulting in both immediate and long-term health implications. Research demonstrates experiencing sexual assault leads to serious public health concerns of epidemic proportions yet the number of people seeking support from healthcare remains low, despite 1 in 3 experiencing some form of sexual violence. Nurses roles are continually evolving, leading to increased responsibility, this means nurses are significantly more likely to receive disclosures and/or support those that have experienced sexual assault. A review of the literature indicates there is limited evidence exploring both experiences of survivors disclosing to nurses, and experiences of the nurses receiving these disclosures.

Aim

The aim of this research is to address this gap in knowledge and gain an understand of the experiences of sexual assault disclosure to nurses, through the perspectives of both survivors and nurses.

Methodology and Methods

Conceptually, a phenomenological approach was used to carry out this research exploring the lived experience. Descriptive phenomenological methods were sought to capture the descriptions for both sets of participants. Applying a convenience and then purposeful sampling strategy resulted in seventeen participants taking part in this study (9 survivors and 8 nurses) using non-dyadic interviews. Data were analysed using the descriptive phenomenological psychological method.

Findings

The findings resulted in themes across all participants generating an example of overlapping intersubjective experience. The structures that encapsulate the essence of their experience divide into three phenomenological concepts: authenticity, empathy and embodiment. Survivors struggled to face their authentic self, often putting in coping mechanisms before addressing their experiences of sexual assault with nurses. Whilst both sets of participants experienced empathy they were often not aligned, for example, survivors were searching for empathy at the same time the nurse turned away from their empathetic response to carry out the responsibilities of the role. Facing the authentic self and the empathetic engagement result in an experience that embodied both sets of participants.

Theoretical insight from this study demonstrated nurses must be trauma informed in their care and practice, only then will they be able to fully support survivors of sexual assault. Both sets of participants' experiences are entrenched with underlying rape myth and victim blaming assumptions resulting in a bias that impacts communication, by being trauma informed the nurse can recognise the barriers these assumptions contribute to disclosure. Alongside these findings, healthcare services need to explore why a large proportion of survivors choose not to seek support. Only in addressing these barriers will people feel confident in seeking healthcare support following experiences of sexual assault.

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"One in three. Look to your left, look to your right. I am still broken but I am still here" "All I know is that somewhere, sometime, somehow, something has to change"

(Suzie Miller)

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas, and contributions from the work of others. Any ethical clearance for the research presented in this commentary has been approved. Approval has been sought and granted through the Researcher's submission to Northumbria University's Ethics Online System / external committee Faculty of Health and Life Sciences on 11.2.16

I declare that the Word Count of this Thesis is 84,720

Name: *Claire L. Dosdale*

Date: 3.10.22

Chapter 1: Introduction

1.1 Introduction to chapter

This chapter will introduce the reader to the background context underpinning this study. Whilst the research element of this thesis focuses on experiences of rape, this chapter will explore the context of rape and disclosure from a wider sexual violence (SV) perspective.

1.2 Background to thesis

Rape is a form of SV that substantially violates the human rights of the individual experiencing it. It is a deeply violating and painful experience for the survivor with both immediate and long-term health implications. These include (but are not limited to): physical, sexual, mental, and reproductive health problems, and social and economic costs resulting from inability to work and lack of participation in social activities, which can include difficulties caring for themselves, their children and families (World Health Organisation [WHO], 2021). In the United Kingdom (UK) alone, it is estimated that the consequences of rape and other sexual offences cost the economy approximately £12.2bn per year (Home Office [HO], 2019). It is the single biggest contributor to death, disease and disabilities in women between the ages of 18-44 (WHO, 2008). As such, SV is an increasingly serious public health concern of epidemic proportions and must be at the fore of nurses' considerations when supporting all patients.

From a personal perspective, the impetus behind this study comes from a career working in sexual health as a specialist nurse. For many years, I would hear disclosures of SV from survivors that had both positive and negative experiences of disclosure to healthcare professionals. Sadly, the majority were negative. Throughout this time, I observed colleagues who were nervous about receiving disclosures of SV for many reasons and, because of my interest in supporting survivors, I quickly became the nurse to whom all SV survivors in the department were sent. There was no education or training around the topic within the region in which I worked, and much of what I learnt was experiential and led by survivors and my own reading. Whilst searching for literature, it became apparent that, unless a forensic and/or medical approach was required, there was little research exploring the experiences of and ways to support survivors of SV in a healthcare setting within the UK. During the past 20 years, there has been a marked increase in those reporting experiencing all types of SV (HO, 2022; WHO, 2021). It is essential, therefore, that we begin to understand survivors' experiences and whether their needs are being met, from a nursing (and healthcare) perspective. It is also essential that we gain an understanding of nurses' experiences of receiving these disclosures, to ensure that their needs are being met too.

1.3 What is sexual violence

SV is a general term used to describe the process of manipulating or forcing another individual into an unwanted sexual act(s) or activity(ies) without their consent (Rape Crisis, 2022a). Any behaviour of a sexual nature that takes place without consent, and/or produces distress for the person experiencing it, is considered to be SV or abuse. It must be noted that consent may be impeded by ability to exercise choice in the following examples: age, illness, disability, mental capacity, fear and/or alcohol or other drug use. SV includes (but is not limited to) rape (as well as attempted rape), unwanted sexual touching, sexual harassment, child sexual abuse, sexual exploitation (adults and children), female genital mutilation, taking or sharing sexual images or videos without consent, forced marriage, trafficking of people for the purpose of exploitation, and conflict-related sexual violence. Whilst SV is not discriminatory of age, sex, religion, race, social status, or class, it is a gender-based violence, with women being significantly more at risk than men. Therefore, the topic is often situated within a wider context of gender-based violence against women (Borumandnia *et al.,* 2020).

Research, confusingly, uses a variety of terms interchangeably to describe the range of types of SV, often referring to one type by three or four different terms. For example, SV, sexual assault, rape and sexual victimisation are all used as descriptive terms of an 'non-consensual sexual act'. The Crime Survey for England and Wales (CSEW, 2021) uses the term sexual assault to describe all types of sexual offences recorded by their survey. However, the police use the term sexual assault to record one type of sexual offence, that being the touching of a person without their consent, which is the legal definition (Sexual Offences Act, 2003). Due to the magnitude of the various acts that are defined as SV, and for clarity, sexual assault (SA) will be used throughout this thesis as an overarching term (unless otherwise stated) to cover the following three definitions: rape, sexual assault and sexual assault by penetration, all classified as serious violent sexual crimes (HO, 2022) and are the types of SV that is the focus of this study.

1.4 People who have experienced sexual assault – terms used

One of the most sensitive discussions regarding terminology within the field of SV is how writers/researchers refer to people who have experienced SA. The four terms used interchangeably throughout the research literature explored for this thesis were: victim, survivor, victim-survivor, and complainant. Victim was the term used most frequently. Complainant is used in some research that focuses specifically on those that have reported the SA to the police, so they therefore are a complainant of SA in the legal sense. Due to the vast numbers of those who do not report their experience to the police, the term complainant will not be used in this thesis.

The term survivor increasingly seems to be the adjective used, due to the association with strength, recovery, empowerment, and the experience of having moved on from the rape (Holstien and Miller, 1990; Thompson, 2000; Parker and Mahlstedt, 2010). It could be argued, however, that this implies that a person has somewhat recovered from their assault (Hovath and Brown, 2022), which may not be the case and could impact individuals seeking support due to the perceived meaning of the term.

Thompson's (2000) research demonstrated an association of perceptions of weakness, powerless and vulnerability for women who have experienced rape when the term rape victim was used. However, in the literal sense, victim as a person harmed by criminal acts is an accurate description; the term emphasising the enormity of the experience. Hockett and Saucier (2015) carried out a systematic literature review to explore the two most commonly used terms (victims and survivor) in order to establish the implications for theory, research and recovery. In general, they found that literature exploring rape victims focused on negative outcomes, whilst the rape survivor literature emphasised positive outcomes. Patterson and Campbell (2010) used the term survivor throughout their research to refer to women who had been raped, except when referring to the rape itself and social victimization (victim blaming and rape myth adherence). Then, they used the term victim. Guerette and Caron (2007) use both terms throughout their research stating *"in choosing how to classify herself, a woman has the power to choose how to label a very disempowering experience*" (p.47). Conversely, a SA survivor is both a victim of a crime and a survivor of that crime. Therefore the term victim-survivor is often used in current discourse.

The discussion above clearly indicates that there are times when one term is appropriate, times when the other is more acceptable, and times when neither term is appropriate. Many of those who have experienced SV see themself as both survivor and victim, and neither, at different periods of their post-SV experience. For consistency, the term survivor will be used throughout this thesis.

For clarity, it is also important to define what is meant by disclosure. Disclosure is the act of giving people new (or secret) information and/or making something known to another person that they may not have been aware of (Cambridge Academic Dictionary, 2022). This information-giving process can be in many formats, including verbal and written. Disclosure can be both intentional and unintentional.

1.5 Statistics

Statistics on SA are difficult to ascertain. This is due to a range of factors which include: under reporting, lack of adequate recording of incidences when they are disclosed, attrition

rates of cases, disbelieving attitudes, cross-cultural beliefs of what SA is, and exclusion of large pockets of the population in most studies or data collection methods (specifically, older people and those identified with vulnerabilities). Consequently, it is impossible to accurately measure the prevalence of SA amongst the population. As a result, statistics surrounding SA are acknowledged to be vastly underestimated and, as such, should be interpreted with caution. Increased recording of these statistics is becoming more common and, whilst this has begun to give a greater insight of the scale of all types of SV globally, far more people experience incidences of SV than will ever report it, with some estimations being at 83% not reporting worldwide (Ceelen *et al.,* 2019: HO, 2022).

In the UK, it is estimated 4.9 million women and 989,000 men have experienced some form of SA since the age of 16 (Office for National Statistics [ONS], 2018). Rape Crisis (2022a) suggest a more accurate number is 1:5 women and 1:10 men. Worldwide, however, it is estimated that 1:3 women have experienced SA across their lifetime, a number that has remained static for the past decade (WHO, 2021). Also, male statistics are even more difficult to ascertain. Survivorsuk.org (2021) suggest that an estimated 12,000 men are raped in the UK every year, and more than 70,000 are sexually abused or assaulted. SA experience in men is difficult to estimate due to under-reporting. Gender norms, combined with cultural and religious taboos and a lack of male-focused services, all contribute to under-reporting. In the UK, 98.5% of rapists were identified as men; again, emphasising the gender-based notion of this crime (ONS, 2021). These high rates of prevalence and low rates of reporting result in poor understanding and widespread acceptance of rape myths that, ultimately, lead to low detection of abuse and missed opportunities to support survivors (Alshammari, McGarry and Higginbottom, 2018).

The CSEW works alongside the HO to determine an approximation of those having experienced SA on behalf of the ONS. They consider reports made to police and their large, nationally-representative sample surveys of the population in England and Wales (the CSEW), whereby data is collected from households using computer-assisted interviewing alongside paper-based questioning. For the crime types and population it covers, the CSEW can often provide a more accurate reflection of the extent of crimes than police recorded statistics because it includes crimes not reported to, or recorded by, the police. However, SV and intimate crime questions are categorised as sensitive in nature and, because of this, the CSEW has historically requested that only people aged between 16-59yrs complete this sealed part of the survey. Whilst this approach has changed very recently by the expansion of the upper age limit from 59yrs to 74yrs, it is argued that it still provides an inaccurate representation of the magnitude of these crimes; people over 74 are important contributors to the survivor pool and should have been acknowledged as such. It also fails to acknowledge gaps in the data collected. For example, it is questionable whether an

individual would disclose an assault if there were other people (potentially the assailant) in the house whilst the form is being completed. Twenty years ago, Walby and Myhill (2001) noted that the UK were behind the rest of the world in terms of how they record and research rates of SA, and this discussion demonstrates that little has changed.

Statistics indicate that the number of sexual offences reported in the UK had increased dramatically in the past 18 years, with 18,400 incidences reported in 2012/13 compared with 194,683 in 2020/21 (HO, 2022). Reasons for the upward trend are multi-factorial, but are largely associated with a greater willingness in survivors to come forward following high profile reports of sexual assaults and current/historic sex abuse cases being increasingly prominent in popular culture and media. These include the momentum of the #MeToo & #TimesUp movements, following the continuous assaults, rapes and murders against women in the UK and worldwide. This has built clearer knowledge about SA and consent, alongside increasing awareness of reporting avenues. Additionally, the increased focus on high profile cases and their subsequent inquiries have caused the police to review and improve their recording practice, which could also contribute to the increased statistics (Lovell *et al.,* 2021). That said, it is estimated 83% of survivors in the UK will not disclose their experience to the police (HO, 2022), and previous research by Brooker and Durmaz (2015) indicates a staggering 95% of survivors may not disclose the experience to professionals, indicating the statistic of this crime is the tip of the iceberg.

Most research finds that disclosure will often be to a friend or family member (Dunn, Vail-Smith and Knight, 1999; Fisher *et al.,* 2003; Ahrens *et al.,* 2007; Ullman 2010; Ullman and Peter-Hagene 2014). Golding *et al.,* (1989) and Koss *et al.,* (1988) found similar results in their retrospective studies; that approximately two thirds of complainants tell someone at some point, but do not always seek professional support. This demonstrates that in over 30 years this trend has not improved. It is safe to suggest, therefore, that statistics surrounding SA are significantly underestimated.

The COVID-19 pandemic has contributed to increasing challenging times for some of those experiencing SV (Dosdale and Skarparis, 2021). Many people were at home with their abusers, and access to services to disclose or seek guidance was removed or limited. As communities around the world have faced extraordinary uncertainty and followed government guidance to stay at home and/or reduce contact with friends and family, adults and children were placed at heightened risk of domestic violence, intimate partner violence, child abuse, and other forms of sexual and gender-based violence. However, it should also be acknowledged that lockdown may have also provided a protective reprieve for some of those experiencing, or who were at risk of, SV from someone they do not live with (for

example, a non-cohabiting partner or someone in a position of power), or due to travel restrictions and particularly in cases of female genital mutilation (FGM), sexual trafficking or forced marriage, whereby travel to undertake this form of SV is essential. As COVID restrictions came to an end, risks begin to rise.

1.6 SA disclosures to nurses

As the number of reported incidents of SA increases, so does the likelihood of nurses experiencing disclosure within the healthcare setting and/or caring for an individual who may have experienced SA but is yet to disclose. Nurses' roles are continually evolving, leading to an increase in responsibility (particularly with advanced clinical management), and this means that nurses are significantly more likely to receive and support disclosures of SA. Nurses are educated and trained to have the ability to recognise signs and symptoms of illness, disease and deterioration, and to respond with increased focus on improving health outcomes. For example, 1:16 people in the UK have diabetes and 1:8 women will have heart disease, and there are clear national frameworks for the management of these conditions. The 1:5 women who are known to have experienced SA far outweighs the prevalence for some other health issues, yet there is no national guidance or frameworks concerning how to support them. Therefore, it is essential to gain an understanding of how survivors of SA are currently responded to and supported, in order to encourage disclosures in a healthcare setting. Disclosures or indicators of SA could be identified within any area of health and social care where a therapeutic relationship has been established or built, whether in an acute or community setting. When considering the number of potential survivors identified above, the implications of disclosure on health and wellbeing, from both the survivor's perspective and for health and social services, are considerable.

SV associated post-traumatic stress (PTS) is a significant public health concern due to the substantial ongoing health implications for the survivor. These include (but are not limited to): anxiety, stress, fear, nervousness, social isolation, flashbacks, sleeping difficulties, drug/alcohol reliance, low self-esteem, increased cancer risks, self-harm and suicide. Understanding what happens before, during and after disclosure within a healthcare setting to nurses may provide greater insight on the support received and subsequent impact on recovery, alongside the needs of nurses receiving these disclosures.

UK policy drivers (Department of Health [DoH], 2001; DoH, 2012; DoH, 2013; HO, 2010; Crown Prosecution Service [CPS], 2019; Health Scotland, 2019;) have specified that HCPs must encourage disclosures of SV to both improve the emotional support for survivors at the earliest possible stage, and to aid in increasing conviction rates for perpetrators of SV. However, evidence suggests that survivors' negative experiences of these initial disclosures

in the healthcare setting continue to have a detrimental impact on their health and wellbeing (Campbell, 2008; Ahrens, 2007; McTavish *et al.,* 2019). Furthermore, evidence also indicates that once a survivor has made an initial disclosure of SV, the response of the person disclosed to is fundamental in reducing the psychological sequelae and the incidence of PTS (Home Office, 2010; Ahrens, Cabral and Abeling, 2009; Starzynski *et al.,* 2005; Ullman, 1999; Starzynski *et al.,* 2007). Westmarland, Anderson and Kirkham (2012) acknowledge this, and propose that therapeutic interventions (if received as early as possible following the experience) can prevent the onset of chronic PTS. It is therefore of the upmost importance that nurses get this right. Since nurses account for the largest proportion of professionals working with the National Health Service ([NHS]; Kings Trust, 2022), it is essential that we gain an understanding of whether they are getting it right from both the perspective of the survivor and the nurse.

1.7 Research aims

Within the UK, there is an absence of literature exploring the nature of the survivor's experience disclosing to nurses, and there also remains a lack of research into how nurses manage (support) initial SA disclosures, with much of any SA disclosure (from both the professional and service user experience) research coming from the United States (US) with a focus on criminology and psychology. Whilst this research continues to be relevant to the field and offers some transferability, the international contextual differences make generalisability difficult. Although a body of international research has explored the experiences of SA survivors disclosing the incident to informal (friends, family, partners etc.) and formal (police, counsellors, clergy etc.) support providers (see chapter 2 for research), little is known regarding disclosure to nurses. With increasing prevalence of SA, and an emphasis on encouragement to facilitate disclosures, comes the need for better understanding of this experience.

This research aims to explore the experience of SA disclosure to nurses, from the perspective of both the nurse and survivors. The foundation of this study is that whilst the forensic evidence is highly important to convict an assailant and aid recovery for the survivor, if the initial disclosure of SA within the healthcare setting is not managed with sensitivity, skill and knowledge, the case will rarely get as far as the survivor reaching a Sexual Assault Referral Centre (SARC). In turn, this will have a detrimental influence on the possibility that forensic samples are carried out, which may be an essential component to the CPS moving forward with court proceedings against a perpetrator. Ultimately, the psychological and physical wellbeing of the survivor must be paramount to the practitioner, which may mean non-police reporting disclosure. As identified above, the consequence of SA is a serious concern to the public's health, which poses a high cost on society both in

regard to the individual and the financial implications of long-term recovery and social support from the National Health Service (NHS). Nurses have a responsibility to get it right, yet while the physical and forensic care given is of upmost importance it is equally essential to be aware of how to respond to and support a disclosure. Understanding current experiences is vital in determining whether SA disclosure is being supported consistently and to a high standard in nursing practice.

1.7.1 Overview of research

This research explores the experience of disclosures of SA in adults aged 18 years or over. There is a wider range of literature that specifically focuses on child sex abuse. The gap identified in this study to explore is within the adult population.

1.7.2 Research question and aims of study

Having provided context for this research, my research question comprises two elements:

- What is the experience of survivors of sexual assault in making disclosures regarding their assault to nurses?
- What is the experience of nurses receiving disclosures of sexual assault?

The intended aims are to:

- Explore individual experiences of sexual assault disclosure to nurses within the UK.
- Explore individual experiences of receiving sexual assault disclosures in UK nursing practice.
- Develop an insight into sexual assault disclosures in a healthcare setting.
- Offer an original research contribution in understanding experiences of sexual assault disclosures in nursing practice.

1.7.3 Research approach and design

The methodological approach taken in this study is explored in more depth in chapter 3, but in order to give the reader an indication a brief overview will be given here.

This research is designed with an ontological assumption that the phenomenon being studied is complex and each participants' world is impacted by their background and history. To explore this, a descriptive phenomenological approach is used within a somewhat interpretivist paradigm; this holds that reality is not fixed, it is constructed by individuals in their social environment (Polit, Beck, and Hungler, 2004). Phenomenology is the study of the lived experience from consciousness in the world that is subjective and constructed by an individual (Husserl, 1970). Phenomenology as a research method has grown from its

philosophical beginnings (Husserl, 1970; Giorgi, 2009), and provides a conceptual framework to explore the lived experience. The emphasis on deep understanding of human experience is the focus of the phenomenological approach used in this study. The major distinction between Husserl's phenomenology and the other phenomenological epistemologies is the nature of how the understanding of experience is processed. Husserl's descriptive phenomenology believes the researcher can set aside their own assumptions and gain a deeper understanding of the specific phenomenon being explored. This research topic and specific context of nursing has already been identified as not having a place in contemporary discourse. Therefore, is important to me as a researcher that my voice does not overshadow that of the participants' descriptions of their experience. That said, I am aware there are times when I will not be able to separate myself from this, specifically when discussing the findings in relation to application within nursing practice (chapter 7). The process of descriptive phenomenology and how I navigate my way around this approach will be explored in chapter 3 (methodology) and 4 (application of methods).

1.8 Structure of the thesis

Chapter 1 has provided an introduction and overview of the topic of focus for this thesis. It gives a rationale, both from an experiential and evidence-based perspective, of the gap in research that this study will contribute to.

Chapter 2 presents a comprehensive review of relevant literature that contributes to the current knowledge surrounding SA disclosure in adults. Due to the lack of research solely focused on nursing practice, this literature review incorporates a wide scope in that it explores SA disclosure in general. The chapter establishes the gap in literature which the research questions aim to address.

Chapter 3 clarifies the methodological approach taken within this research. It makes explicit the beliefs and assumptions influencing the research design from the perspective of my personal world view. It rationalises the use of descriptive phenomenology and aims to give the reader insight into how this approach is best matched to addressing the research questions.

Chapter 4 provides a rigorous analysis of why descriptive phenomenology was chosen over the other approaches and goes on to demonstrate how this research method was applied to the study via ethics, sampling, data collection, data analysis and trustworthiness. It includes the ethical considerations, alongside the challenges of undertaking sensitive research.

Chapters 5 and 6 presents the findings from the survivors (chapter 5) and the nurses (chapter 6). Each respective theme is broken into sub-themes and characterizes the participants' experience of both giving disclosures (survivors) and receiving them (nurses). The findings are supported by participant quotes and are conceptualised in a phenomenological framework.

Chapter 7 explores how the findings have answered the research question. It provides an in-depth discussion of the findings presented in the previous chapter. It explores the originality of the study in relation to nursing practice and concludes by considering the limitations of the research, whilst also identifying areas that may need further exploration. Overall, the focus of this chapter is to discuss what the key findings mean for both the survivor and for nursing practice moving forward.

1.9 Chapter summary

This chapter has provided an overview of both the rationale for conducting this study and what the reader can expect throughout the remainder of the thesis. It has provided background context in relation to both professional and personal rationale for this study. SA disclosure is not situated very well in nursing research, and this chapter has demonstrated a gap in that research. The following chapter presents a more thorough review of the relevant literature in order to comprehensively address this gap in knowledge.

Chapter 2: Literature review

2.1 Introduction to chapter

The previous chapter outlined the supporting rationale and situated SA disclosure within the context of nursing. This chapter will provide a comprehensive review of the relevant literature already published regarding SA disclosure.

The literature review indicates a gap in the literature that the research questions aim to answer. It also develops an understanding of what is known about SA disclosure in nursing practice.

2.2 Search strategy

Understanding the theoretical context that relates specifically to the topic is essential to the foundations of this study; therefore, before exploring the literature it is key to demonstrate transparency to describe how that literature was identified.

In descriptive phenomenological studies, it is suggested that the literature review should be undertaken after the data analysis, so as not to influence the findings (Tordres and Holloway, 2004). However, there are two reasons why this is impractical for this doctoral study: 1) The literature review contributes to the disclosure context and the rationale. Without undertaking this, there is no clear evidence of the gap that the study is trying to fill. 2) Whilst undertaking research methods, the phenomenological reduction is an essential element of the process, as it allows the researcher to bracket their existing judgments, preconceptions, and biases to gain a clearer understanding of the participants' life world. This also applies to the literature read and reviewed.

Nevertheless, it is also important that the literature review is undertaken in line with my phenomenological philosophical stance, as a phenomenological researcher. Todres and Holloway (2004) describe the phenomenological literature review as the first stage in their process of empirical phenomenological research as a scientific practice, and they entitle this as *"articulating an experiential phenomenon for interest"* (pg. 84). They go on to suggest that understandings about an area of interest intimately inform our life world; things that are part of us as researchers and guide us round a topic. I have identified what motivated my interest in this study within the introduction chapter, therefore laying my judgements and predispositions bare.

It is clear that what motivates our enquiries is part of the natural world of everyday situations, experiences and contexts in which we participate, and without these there would be no desire to carry out the research. However, this is not enough. There needs to be a solid foundation on which these rationales can grow and from which research questions can be formulated. Therefore, the literature review from a phenomenological perspective involves not only the critical exploration of current literature surrounding the topic, but exploration of

the researcher's interests (see section 1.2 for researchers interests) that led to the investigation of the topic. This is how the literature review takes place and begins to determine a conceptual understanding of the wholeness of the phenomenon that is informed by our human embeddedness and participation in experiential life. A literature review placed in a phenomenological study should specifically serve to:

> *"locate the topic and the subject matter in a general way that can connect to everyday human concerns and directions" (Todres and Holloway 2004, p. 84).*

The purpose of this literature review is to critically explore the primary research literature surrounding SA disclosure made to nurses, and to increase understanding of the factors affecting disclosure from the perspective of the survivor and the nurse. Due to the lack of literature surrounding this specific phenomenon, search strategies were widened to include all types of disclosures of SA, with the hope of gaining further understanding of disclosure in general, thus aiming to identify the gap in research.

To carry out the literature review, the search strategy included the use of the following academic databases: CINAHL, PubMed, Science Direct, and Web of Science. These were all chosen due to their collective gathering of nursing and allied health journals. Electronic searches were undertaken from dates 2010 to 2022 (due to the limited literature found, this was extended to 2000) using the following key words:

- "Sexual assault disclosure in healthcare"
- "Rape disclosure in healthcare"
- "Sexual assault disclosure management in healthcare"
- "Rape disclosure management in healthcare"
- "Nurses management of sexual assault disclosures"
- "Nurses management of rape disclosures"
- "Disclosing rape to nurses"
- "Disclosing sexual assault to nurses"
- "Experience of nurses receiving sexual assault disclosures"
- "Experience of nurses receiving rape disclosures"

This study focused on experiences of adults, and all papers with a child focus were omitted from the search. Therefore, the key words were searched for with the quotations for a focused specific search, alongside the advanced addition of an extra row adding 'NOT CHILD*'. The search was expanded to literature outside of the UK in order to maximise the literature opportunities. Zero articles were identified using this tight search term at the time. However, nine articles were identified via the databases' SmartText and journals (2) with

an adolescent focus were also included if the research defined the ages inclusive of upwards of 18. However, due to the limited literature found, the search terms were widened using the same databases and search inclusion/exclusion criteria strategy to:

- “Sexual assault disclosure management”
- “Rape disclosure management”
- “Management of rape”
- “Management of sexual assault”
- “Sexual assault management”
- “Supporting survivors of sexual assault”
- “Supporting survivors of rape”
- “Rape management”

Twenty eight articles were identified using the criteria outlined above, with the removal of replicated articles from the initial search. Naturally, when I reviewed the articles, further research was highlighted that had not shown up in the literature search (snowballing technique). These papers were reviewed and used if appropriate and meeting the inclusion/exclusion criteria. No grey literature was identified by the data basis’s during these searches.

Overall, 54 papers were identified as appropriate contributions to this literature review. Alongside these research papers, I included seminal texts regarding SA disclosure that were highlighted in papers but did not fall into the search category. It is important to acknowledge that the papers included in this literature review are overwhelmingly research papers. That is not to say that grey literature does not have a place in this thesis, indeed it fully contributes to the supporting evidence in the introduction chapter as to why this topic is an important area to study, specifically around the wider notion of sexual violence. It is understood that grey literature exists by wider professional, charitable organisation and government publications, however, much of this grey literature is focused on: violence against woman and girls (VAWG), Interpersonal Violence, intimate partner violence, sexual violence disclosure in mental health inpatient environment, and statistics around sexual offences (examples of these can be found in appendix 1). It was felt that whilst this type of important literature provides a foundation of understanding and exploration around a wider focus of sexual violence, it is does not specifically focus on adult disclosures of SA or rape, therefore, it was felt that the inclusion of such studies would detract from, and overshadow, the limited peer reviewed literature available.

2.3 Literature themes identified

The review of the literature indicated that, within the UK, there is a limited body of research exploring SA disclosure within a general healthcare setting. Those few studies published

are mainly focused on the psychological aftermath of SA on the survivor or the medical approach to undertaking forensic examinations following disclosure. There is an absence of published research into supporting disclosures of SA (specifically) in healthcare outside the arena of child sex abuse and domestic abuse. However, a wider body exists from the United States (USA) and Australia.

A wide range of methodological approaches has been used by researchers to explore this field; however, quantitative research tends to be the methodological approach used most often (see table 1 for methodological breakdown). This is not unusual to see in a topic of this (sensitive) nature; an anonymous survey may be perceived to be appealing to those who may not have disclosed or talked about their experience previously.

Qualitative	Quantitative	Mixed Methods
18	36	5

Table 1: Literature review methodology breakdown

Whilst there is limited research on actual disclosure of SA in the adult healthcare setting, wider disclosure findings have been included in the literature review at this stage to maximise the understanding of research surrounding this topic and to establish this research's place within the literature, this includes literature from disclosures to other professionals and social support (i.e family and friends). What we need to understand to improve services is what facilitates a good experience for disclosure of SA, what are the barriers and how we can learn from them. Research findings about disclosure in formal settings (to police, healthcare staff, clergy, mental health staff) and informal settings (to friends, partners, family, work colleagues, outside of healthcare) have a great deal of transferability that practitioners can learn from.

The majority of studies focused recruitment on areas that would allow for ethnic diversity (however, most studies found predominantly white participant percentages), low-income neighbourhood areas with high rates of crime, and college students, which does not provide a diverse sample for generalisability, or transferability. Due to the increased focus on college campus SA and harassment, a participant trend throughout this literature review was observed; college students made up a large proportion of study participants. Not only do the students provide a participant pool that may be easier to access for researchers, but their lived experiences also provides a great contribution to the heightened focus of on-campus violence against women. It is acknowledged also that this age group are at more risk of experiencing SA than the wider population, and men must not be overlooked. Studies were consistent with high under reporting of SA to healthcare (and formal) professionals, although it could be argued that the rates in these studies were high due to the cost

implications of accessing healthcare, especially in the United States of America (USA) where most of the studies were undertaken. It could also be suggested that participants who were unable to access healthcare after their experiences may have used their participation in the study as an avenue to formally disclose in the hope of accessing support or counselling. Thus, this might therefore not be representative of an expanded community but instead represents a large proportion of people experiencing SA. Studies tended to be focused in large urban areas, and a wider national, rural and/or international representation might highlight differing experiences. The research comprising this literature review are studies which largely involved the participation of women, with only a small number exploring men's experience. It would be insightful to explore whether male, non-binary and transgender disclosure have the same psychological outcomes, all while acknowledging that these groups have reportedly lower rates of disclosing (HO, 2019).

The three overarching themes (with subsequent sub-theses) were extrapolated from the literature:

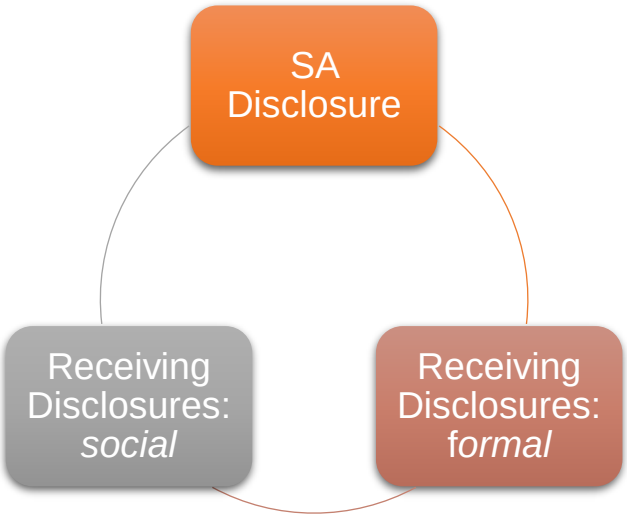


Figure 1: Literature review themes

The following sub-themes were identified:

Theme one – Sexual Assault Disclosures
- I. Barriers to disclosure
- II. Impact of disclosure on survivors and recipients

Theme two – Receiving disclosures: *formal support*
- I. Barriers to disclosure
- II. Survivors' experiences of disclosing to a healthcare professional
- III. Impact on recipient

Theme three – Receiving disclosures: *social support*
- I. Positive and negative experiences of disclosure
- II. Impact of disclosure on recipient

Themes one explores disclosure in general, this identified the nuances between formal and informal disclosure, this then necessitated the flowing two themes being divided and explored in 'formal' and 'social support' format. That said, pocketing research into one theme is complex. Many research studies have multiple outcomes that direct the disclosure of SA experiences. Therefore, whilst the three themes have been used, some articles do straddle the whole experience of SA disclosure and contribute to all three themes. These articles can be found listed in themes in Appendix 2.

2.4 Theme one: Sexual assault disclosures

Disclosure of SA refers to telling (or writing to) another person(s) about that experience. SA is a traumatic life event and, whilst disclosing trauma has long been associated with positive effects (Pennebaker, 1997), the application of this to sexual trauma has often led to inconsistent findings (Ullman, Foynes and Tang, 2010). SA disclosures have increased risks to the survivors that are highly complex, specifically when considering 90% of survivors know their perpetrator and the personal nature of the assault. Consequently, it often results in implications for the survivor's life and family following the disclosure. Ullman (2011) undertook a systematic analysis of research that focused on considering if disclosure of SA was ultimately helpful to survivors. Whilst the paper concurred that disclosure of trauma is useful from the perspective of seeking tangible support, from a SA perspective more exploration of the positive and negative implications of disclosing the trauma is required, as this is solely dependent on the response of the recipient. This review highlights that no matter whether the recipient is a formal or informal support provider, education, training and prevention programmes are essential to avoid negative reactions and facilitate supportive disclosures.

Of those that experience SA, it is suggested that approximately 5-34% will disclose the SA to a formal source, and approximately 60-80% will disclose to an informal source (Starzynski and Ullman, 2014; Orchowski and Gidycz, 2015). Due to the taboo nature of SA and the high number of those who will not disclose, it is difficult to get a solid indication of the true statistics; statistics differ depending on how the research is carried out (e.g., lifestyle questionnaires by ONS, surveys that are based on community recruitment, participants from college campuses, mental health support services, specialist sexual assault centres). However, research consistently identifies that there is a large gap between disclosing to informal support providers and formal support providers. Therefore, to bring those numbers closer together it is important to understand the nature of all SA disclosure, and gain insight into why formal services are not always prioritised by survivors when it comes to disclosing. It is also clear from these statistics that most people will have told a social support about their assault prior to a formal source, therefore, understanding these experiences will allow

for a better awareness of the survivors' experiences of disclosure pre disclosing to the nurse.

2.4.1 Barriers to disclosure

Since the 1970s, researchers and feminist activists have been increasingly exploring the dynamics that keep survivors from speaking about their SA. Feminist literature argues that the active function of powerlessness is a main reason for women not disclosing, and that silencing women serves to reinforce powerlessness (Brownmiller, 1976; MacKinnon, 1994, Koss, 1985; Abby, McAuslan and Ross, 1998). It could be suggested that, as a societal concept, this applies to formal sources where disclosure may determine a wider range of repercussions, meaning silencing is caused by many factors (fear of blame, shame and more which will be explored throughout this chapter). Accessing healthcare often results in a power imbalance; feeling unsupported in disclosing may silence survivors to refrain from further disclosure or, potentially, reporting their assault to the authorities. That said, we know that most survivors will tell at least one person from their social support about the assault, which indicates that they may feel less silenced in this relationship.

SA is an experience that is loaded in societal misconceptions, often based on rape myths and victim-blaming assumptions. The impact of these hinder disclosure. Rape myths and victim-blaming assumptions have been identified as directly correlating with disclosure. Rape myths can be defined as stereotyped or false beliefs about rape, rape victims and rapists (Burt, 1980). Rape myths influence and reinforce (from a societal perspective) what is, and is not, sexual violence, as well as who are, and who are not, deemed credible victims of rape. This has implications for victims, offenders, and societal assumptions in the way survivors of SA are (or are not) supported following disclosure. Lonsway and Fitzgerald (1994) describe this as attitudes and beliefs that are generally untrue but are widely and persistently believed.

Rape myths contribute enormously to victim-blaming behaviours (this includes both the survivors and recipients' responses to SA experiences), and this places the blame of the assault on the survivor. Victim blaming can be defined as someone implying or treating a person who has experienced SA as if it was a result of something they did or said, instead of placing the responsibility where it belongs: on the person who harmed them. A range of rape myths can be found in Appendix 3, however examples of these can include:

- "What did you expect going out dressed like that?"
- "Why didn't they / I fight back?"
- "You / I shouldn't have gone home with them."
- "Why did they / I get so drunk?"

- “Why didn’t you / I tell anyone at the time?”
- “But you don’t have any marks on you / It wasn’t violent”
- “It’s your partner and you’re supposed to have sex with them”

(Rape Crisis, 2022b)

Ullman and Filipas (2001) suggest that women do not always report rape because they often perceive that they are at fault themselves. For example, this may be because their circumstances do not reflect the societal stereotype of violence SA by a stranger. This is in line with rape myth and victim-blaming assumptions. Starzynski *et al.,* (2005) suggest that as a society we have a preconceived, socially-constructed definition that rape is violent, that those being attacked will fight back, and that it is anonymous and life threatening. However, it is frequently the opposite: the attacker often being a romantic partner, family member, friend, or acquaintance. The survivor often freezes, so not to anger their attacker further, and, more often, the actual rape is not life threatening (McCabe and Wauchope, 2005). Williams (1984) suggested that being blamed for the assault was the main reason why women were hesitant to disclose non-stereotypical SAs (i.e. not stranger rapes), which account for approximately 90% of SAs. Whilst it is appreciated that Williams’ work is 40 years old, it is still a finding that has been demonstrated consistently since (Ahrens, 2006; Clay-Warner and McMahon-Howard, 2009; Sigurvinsdottir and Ullman, 2015; Ullman, Lorenz and O’Callaghan, 2018).

Lack of acknowledgement of the experience as SA is another barrier to disclosure. Koss (1988) was one of the first to research the meaning given to SA among women, and her study found that 70% of the participants who described having unwanted sex did not believe they had been raped. This was coined as ‘hidden rape’. Starzynski *et al.,* (2005) found hidden SA was still common and proposed that underreporting of SA has the unintended effect of reinforcing society’s view of what constitutes SA (Lanthier, Du Mont and Mason, 2018). Koss’s (1988) research found widespread recognition of unacknowledged rape. Unacknowledged rape occurs when the survivor does not deem the assault as rape, but instead gives it a gentler label, such as ‘miscommunication’ (Littleton and Breitkopf, 2006), and thus ultimately hides or turns away from their experience. Ullman and Filipas (2001) suggest that survivors feel they have a greater legitimacy with stranger SA and that having physical injuries provides validation of experience, therefore aiding them to seek formal support, a finding that is still proven time after time (Ahrens, Cabral and Abeling, 2009; Ahrens, Stansell and Jenninigs, 2010; Dunleavy and Slowik, 2012; Starzynskil and Ullman, 2014; McQueen *et al.,* 2021). Ahrens, Stansell and Jenning’s (2010) study into the disclosure of 103 survivors of SA found that those with ‘classic’ SA scenarios were more likely to report, thus confirming the literature that stereotypical assumptions of what

constitutes SA may affect disclosure. Their research examined the impact of disclosure on subsequent recovery and, whilst their findings were consistent with previous studies in that they found non-disclosures reported higher levels of depression and PTS, this did not extend to physical health outcomes, contradicting previous studies (Greenberg, Wortman and Stone, 1996; Pennebaker and King, 1999). However, Ahrens, Stansell and Jenning (2010) did recognise that those who disclosed and received a negative reaction had higher levels of depression and PTS, and on-going physical health problems. This suggests that negative social reactions may negate the positive effects of the disclosure for some survivors, strengthening the need for professionals to be adequately prepared to support disclosures. This research also demonstrates that if negative reactions lead to higher levels of depression and PTS, considering what we know about how PTS impacts the public's overall health, the subsequent implications of these PTS symptoms will directly, and negatively, impact physical health.

It has long been reported that men are less likely to disclose SA than women, and those numbers are not changing (Isley, 1998; Sable *et al.,* 2006; Allen, Ridgeway and Swan, 2015; Walfield, 2018). Those who do disclose, are more likely to disclose historic child sex abuse than an experience of SA in adulthood (Graham, 2006; Javid, 2017). There are multiple barriers to men disclosing SA that are cloaked in rape myths and victim-blaming assumptions, including (but not limited to): men cannot be raped; real men can defend themselves; women cannot sexually assault men; male rape only happens in prisons; men who are raped by other men are homosexual; if a man gets an erection he must have wanted it; gay and bisexual men deserve to be raped because they are immoral / promiscuous (Sable *et al.,* 2006; Turchik and Edwards, 2012). Allen, Ridgeway and Swan (2015) found that male survivors' barriers were focused on shame, guilt and embarrassment, not wanting friends or family to know, and services being aimed predominantly at females who have experienced SA. More recently, Walfield's (2018) research undertook a validated male rape myth scale (MRMS) approach to explore 1,220 participants in order to measure male rape myth adherence. 55% of participants were male, which is a good range when considering the overwhelmingly female participant group numbers in most papers exploring SV in general (Isley, 1998; Sable *et al.,* 2006; Allen, Ridgeway and Swan, 2015). Walfield's (2018) study indicated that most individuals adhere to male rape myths to some degree, demonstrating that male rape is also a hidden crime due to these beliefs. Thus, social norms of male rape should be challenged, for example via societal approaches to sex and relationship education and consent classes focused on male and female experiences of SA.

Diversity is also acknowledged as playing a role in disclosure barriers (Washington, 2001; Tillman *et al.,* 2010; Lindquist *et al.,* 2016; Hakimi *et al.,* 2018). Several cultural barriers

have been identified including distrust and avoidance of police, legal and medical and social organisations (Lindquist *et al.,* 2016), and family shame (Huong, 2012). However, there is limited research of individuals from a minoritised ethnic background to generate any generalisability in findings. There is a small body of research from the United States (USA) that has examined the experiences of disclosure from historically black colleges and universities (HBCUs) (Fisher *et al.,* 2003; Krebs *et al.,* 2011; Lindquist *et al.,* 2016). The findings from these studies all identify that black women are less likely to report a SA than white women. However, overall, the barriers to reporting were similar across all cultural differences for the last 30 years: such as fear of not being believed, the use of drugs and alcohol prior to the assault, and lack of certainty that the experience was rape (Koss, *et al.,* 1988; Hakimi *et al.,* 2018), with the consistent main addition being distrust in public officials (Washington, 2001; Hakimi *et al.,* 2018). The reduction in disclosure linked to distrust in public officials is a constant that has not changed in over 20 years. Consequently, in Lindquist *et al's.,* (2016) study of 3,951 HBCU women's experience of SA disclosure, a major finding was the need for anonymous reporting or non-face-to-face mechanisms that would ensure confidentiality and reduce pressure of face-to-face discussions which might increase feelings of shame and / or embarrassment. Considering the current global COVID-19 pandemic and the mechanisms that had to be put into place, such as self-isolation and social distancing, it would be useful to explore whether this enhanced or hindered disclosure on a larger scale. It is recognised that a large proportion of previous studies were undertaken with college students as participants. Whilst it is understood that the average ages of college students (18-24) fall in the categories of those more likely to experience SA (HO, 2022), it is also identified that the overwhelming body of literature in disclosure comes from this background of men and women accessing a college education, which is not a wide sample of a diverse population.

Jacques-Tiura *et al.,* (2010) explored experiences of SA in both African American (52%) and Caucasian women (67%), accessing 272 participants who were currently not engaged in education. The research took a qualitative approach in their use of face-to-face interviews, which is novel in research exploring SA in such large numbers. Their study found 96% disclosed to at least one informal support provider, and only 24% to formal providers, higher than identified with previous data (Ahrens, Cabral and Abeling, 2009). African American women described receiving more negative responses to their disclosure and higher levels of PTS (Jacques-Tiura *et al.,* 2010). It is positively acknowledged that qualitative interviews with this volume of participants leads to exciting lived experience data that has a transferability of insight. Hekimi *et al's.,* (2018) more recent study was consistent with these findings, demonstrating that high negative reactions to black women's disclosure resulted in higher levels of PTS than in white females, specifically around their finding of a main barrier being 'black women are strong and just need to get on with it'. This was also

consistent with Washington's (2001) study 20 years ago. Again, this demonstrates that attitudes and perceptions are not changing, and this is directly causing barriers to women from diverse backgrounds in accessing ongoing help and support.

Huong (2012) explored the social support of rape in kin groups in Vietnam and found that disclosure is often bound to complexities of family honour and shame. In her study she found women's rape narratives are often pulled apart by other women in the community, with a focus on what the outcome would be for the perpetrator and his family. These type of beliefs and behaviours have been, and continue to be, mirrored in many marginalised patriarchal communities throughout the world (Heise, 1993; Hetu, 2020). Du Mont *et al.,* (2017) sampled 948 Canadian women, with 116 identifying as indigenous, focusing on the use of and satisfaction with specialised healthcare services in relation to SA. The study did not, however, explore disclosure specifically, therefore leaving a gap in our knowledge of this group of survivors and their experiences or barriers to disclosure.

The small body of research described above identifies a gap in the literature examining SA disclosure. Those survivors from more ethnically diverse backgrounds (for example, Asian, Latinas, indigenous or travelling communities), who do not / cannot access education, and those who fall outside of college / university age range (typically over 25yr olds), are being left behind when it comes to understanding disclosure experiences. Only by undertaking research with more diverse participant groups will there be a fuller understanding of the cultural and societal barriers of SA disclosure. It is also recognised that a large proportion of data from marginalised communities comes from the USA; therefore, there are transferability considerations. In the UK, currently, healthcare is free at the point of access and beyond, whilst the USA healthcare system is payable, and has insurance-level constraints for many people. In the UK and the USA there is also an increasing mistrust in formal support providers, such as the police, particularly from gender and racial perspectives (Johnson, Devereux and Wagner, 2022). These factors may deter people from accessing healthcare and other services, thus reducing the desire or opportunity for those disclosing to formal sources. Postmus' (2015) paper highlighted this view, indicating that research surrounding sexual assault screening and reporting among different racial groups is imperative.

In a study by Lea, Hunt and Shaw (2011), 6% of SA cases were found to have been survivors of an older age group (over 65 years); they go on to suggest that this number is significantly underestimated and will gradually increase alongside an ever-ageing population. Nevertheless, only a small body of research explores this age group in relation to the topic. Bows and Westmarland's (2016) freedom of information (FOI) research from 45 UK police forces found that from 87,230 cases of reported rape and sexual assault by

penetration, 0.75% of survivors were recorded as being 60+ years, which are lower rates compared with previous research (Lea, Hunt and Shaw, 2011; Ball and Fowler, 2008; Jeary 2005). The ONS UK lifestyle survey have recently increased their age limit (for people to complete) from 59 years to 74 years. Omitting people aged older than 74 from statistical analysis provides an inaccurate picture regarding SA in the UK and, in turn, minimises SA prevalence in this age group. Much of the prevention guidance is also aimed at younger people, again dismissing the potential of providing tangible support to older people and, potentially, impacting the number of survivors willing to report to formal sources. Not recognising older adults on government surveys and information contributes to an assumption that their assault will not be taken seriously. Walby and Allen (2004) suggest that that there may be confusion regarding the nature of SA perpetrated by partners.

Bows and Westmarland (2016) go on to suggest that, by omitting this age group, the government are surrendering to rape myth stereotypes in their approach to collecting data. They clearly state that bracketing SA survivors as young implies that older people are asexual and fuels the ageist approach of sex being a taboo subject in society. It could be argued that this taboo makes it more difficult for a practitioner to approach the topic with this group of service users, potentially missing opportunities to support survivors. Lea, Hunt and Shaw (2011) further support this by suggesting family, friends and professionals may miss the signs of SA in older adults due to society's stereotyping.

In a meta-analysis examining rape myth acceptance, Suarez and Gadalla (2010) found that rape myths are strongly associated with all types of prejudicial beliefs (such as racism, homophobia, sexism, ageism). It is clear from the literature described above that these barriers are not easing and are significantly impacting SA disclosure, demonstrating a need for education provided around SA/SV (to the public and organisations supporting survivors) to address the intersectionality of oppressive belief systems.

2.4.2 Impact of disclosure on survivors and recipient

Social and formal reactions contribute to whether, and how, survivors blame themselves for the SA (Ullman and Najdowski, 2011). Sigurvinsdottir and Ullman (2015) explored social reactions in relation to post disclosure self-blame and problem drinking in survivors. They found that negative reactions to SA disclosure reinforced any self-blame survivors might have had, and can lead to problem drinking. Blame is typically one of the most harmful reactions that survivors will experience when disclosing SA. Therefore, the concepts of self-blame must be understood by healthcare professionals supporting survivors. Vidal and Petrak (2007) found that participants in their study emphasised the role shame played in exacerbating PTS. Shame is consistent with self-blame and victim-blaming attitudes. However, their descriptive survey comprised 25 participants only and, whilst their findings

can inform practice and contribute to the disclosure debate, it would benefit from being replicated with a larger cohort of individuals to determine a wider generalisability.

In their study, Ahrens *et al.,* (2007) found overall negative social reactions towards SA disclosures are more common from formal support providers than from informal support providers. Previous to this research, few studies had attempted to explore this by measuring specific social reactions towards SA disclosures (Filipas and Ullman, 2001; Ullman, 1996). The studies show similar results. Ullmans' (1996) findings correspond with Ahrens *et al*., (2007) in that they both found the most common reaction from police and healthcare professionals was to blame the survivor. However, in Filipas and Ullman's (2001) study, blame was also a common reaction from family members. This study was replicated by Ahrens, Cabral and Abeling (2009), who found blame was still the most common reaction from family members. The purpose of Ahren, Cabral and Abeling's (2009) research was to test the hypothesis from Filipas and Ullman's (2001) study that suggested SA survivors may be interpreting the same reaction differently, depending on the identity of the support provider. Findings provided an inconsistent idea about how survivors interpreted blame responses from the recipient. For example, Ahrens, Cabral and Abeling (2009) found that whilst blame and doubting reactions from family members and partners are hurtful, the same reactions from counsellors and healthcare professionals were viewed as having a positive impact. This is because the survivor is interpreting the blame reaction as a lesson in enabling them to identify what factors may have contributed to the assault (e.g. clothing worn, alcohol or drug use, flirtatious behaviour), and develop understanding as a way of protecting themselves from future assaults. This finding has not been replicated in more recent studies whereby survivors identified blame from formal providers as negative experiences (Dunleavy and Slowik, 2012; Starzynskil and Ullman, 2014; McQueen *et al.,* 2021).

There is little evidence exploring survivors' decision to disclose further following an initial negative experience of disclosure. Dworkin and Allen (2018) explored this with a relatively small sample (54 participants), and found that negative responses were not associated with the cessation of disclosures. However, survivors indicated that they were less likely to continue to disclose if they were met with rape-myth assumptions, such as blame. It is clear from the literature that rape myths and victim-blaming assumptions largely contribute to SA disclosure implications and have done so for many years.

A growing body of research has explored the impact of SA disclosure on both the formal and informal recipients of SA disclosures (Christiansan, Bak and Elklit, 2012; Paul *et al.,* 2014; Kirkner *et al.,* 2018). We know from this body of research that most survivors will tell

someone about their assault, with the majority of these being friends and then family members. Much of the research found for this review explored college students' experiences of receiving disclosures. Therefore, it is understandable why friends are often the first person to disclose to, as many women are away from home and family for the first time, thus their friends often become their main source of support (Starzynki *et al.,* 2005), and the need for this support, in often unfamiliar surroundings, should not be underestimated.

Not only can informal recipients provide psychological support, but they can also provide support in encouraging survivors to seek formal aid, whether by reporting the assault or seeking psychological support. As such, this increases the likelihood of formal services being accessed and, in turn, increasing positive psychological outcomes. Disclosure recipients from a social support perspective are in a unique position; not only can they provide immediate support to their loved ones, but they can also aid in facilitating formal disclosure. 41.5% of participants in Paul ***et al's.,*** (2013) study indicated that they had received disclosures of SA, with 69% encouraging formal disclosure. Because of the increased number of friends and/or family being recipients, it is acknowledged that the scope of SA may impact far beyond the survivor. This is because the disclosure not only increases the incident of secondary victimisation to the survivors, but also impacts on the recipient in terms of vicarious trauma as a result of receiving a disclosure. Paul ***et al's.,*** (2014) study found that survivors often sought out recipients that had experienced SA, had mental health issues, and suffered from substance abuse. This could be because survivors perceived them as a low-risk recipients in that they were more likely to be believed by someone who had previously experienced trauma. This study only focused on recipients of disclosure and encouragement of formal reporting. It would be beneficial to repeat this study with an added focus on response, whether the recipient had experienced SA, if the recipient's own personal experience with formal disclosure impacted their advice to report, and how the disclosure then affected reflection of their own experiences.

Secondary victimisation is often referred to when victims of a crime suffer further harm as a direct result of how individuals deal with the victim, in the wider case of criminal law. When considering survivors of SA, secondary victimisation is a term more frequently used to describe behaviours and attitudes of formal support services that engage in victim blaming and insensitive behaviours which traumatise survivors further (Campbell, 2008). It is often used when describing survivors' experiences of court proceedings (McGlynn and Westmarland, 2019). That said, it is clear from the literature that a large proportion of survivors' experiences with disclosure is bound with experiences of blame, judgements and victim-blaming attitudes, therefore leaving them open to being re-traumatised whilst reliving

their trauma during disclosure, and then beyond. The experience of reliving the SA or being met with dismissive attitude can be so triggering to survivors that it is often referred to as 'the second rape' (Campbell and Raja, 1999).

It should be acknowledged in any education and training provided to aid individuals in supporting survivors of SA that, as a recipient of SA disclosure (whether informal or formal), there are psychological risks as the recipient listens to the experiences of trauma, and potentially re-lives their own past traumas. When considering the SA statistics and gendered ratio of staff in healthcare organisations, it is highly likely that a large proportion of healthcare workers have experienced their own traumas (SA or otherwise), and receiving disclosure can be triggering to these memories. Whilst there is a small body of research exploring the experiences of individuals receiving disclosures in an informal setting, there is little qualitative exploration, or large quantitative studies, of the impact on the recipient (Branch and Richards, 2013; Grandgenett *et al.,* 2022), or specifically into nurses receiving disclosures. No research found so far has explored the impact initial SA disclosures have on the wellbeing of nursing staff.

2.5 Theme two: Sexual assault disclosures - formal support providers

Literature exploring nurses' experience of receiving disclosures of SA is scant and, of those available, most focus on mental health practitioners. Existing literature specifically exploring HCPs as recipients of SA disclosures tends to focus on the subsequent impact of the disclosure on the survivor's recovery. However, this focus provided limited knowledge of their experiences of the actual disclosure. Most research exploring experience of SA disclosure tends to examine formal support providers as whole. This includes a range of professionals, including healthcare workers, clergy, police, psychological support service staff.

2.5.1 Barriers to disclosure

In a 2009 study, Patterson, Greeson and Campbell (2009) explored the experiences of 29 women who did not report their SA to formal support providers. Their goal was to determine why formal help seeking had not taken place. They found that women identified multiple reasons for not accessing any support (feelings of self-blame, shame and anticipated rejection) that, ultimately, made them not want to share their experience. Self-blame and shame were related to the rape myths associated with stereotypical (stranger, violence) and non-stereotypical (offender known and non-violence) rape experiences. Alongside this was the belief that they were self-protecting themselves from harm (not being believed, feeling vulnerable, being probed with questions that would re-live the trauma and not wanting to be

touched). This research is insightful as it emphasises the need to understand why survivors do not come forward to disclose and how we can ensure their experience is removed of these barriers. However, it is recognised that this paper is dated and focused on the USA where access to healthcare comes at a financial cost. These financial implications in accessing healthcare may be a contribution to disclosure barriers, however within the UK, where healthcare is free to access, it is a minimal barrier (unless considering private health and psychological healthcare). Therefore, it would be beneficial to replicate Patterson, Greeson and Campbell's (2009) research in the UK to provide contextual guidance in improving practice to make services more accessible to survivors.

It is acknowledged that men have additional barriers to disclosing when compared with women, as discussed in theme one above. Allen, Ridgeway and Sawn (2015) explored college students' beliefs regarding help seeking for male and female SA survivors. They found shame, guilt and/or embarrassment, fear of retaliation and fear of not being believed as the top barriers (for both men and women) to reporting the incident to campus support services or security. Additionally, men identified 'not wanting to be perceived as gay' as a top barrier, supporting the discussion regarding social stigma regarding male SA survivors. The overall findings indicated that participants suggested disclosure would not be as helpful for men as for women, leading to questions surrounding gender differences in the disclosure of SA (Allen, Ridgeway and Sawn, 2015). However, the research was not conducted with survivors who had an actual experience of disclosure, and thus the experience was hypothetically put to participants and often, when faced with a real-life experience, action can differ tremendously. That said, given the statistics of male SA, it is possible that a number of the participants may have experienced some form of SA but were not asked to disclose this as part of the study. This question regarding experience would have added an interesting element to the research.

Rape myths, beliefs and victim-blaming attitudes are just as prevalent now as 40 years ago, despite growing awareness of sexual violence and development of support services. However, this discourse is largely framed in women's issues or women's services, and it could be argued that a preventative programme focusing on (self-)prevention for women, and consent classes for men, do not help to reduce the gender stereotypes. Of course, it is clear that women are more at risk of SA than men. However, services must be aware that often the psychological support for men disclosing SA may be different than women, therefore highlighting a gap in service provision and awareness.

Another identified barrier of disclosure in the formal setting was lack of screening for assault experiences. Williston and Lafreniere (2013) carried out a study exploring healthcare

providers' experiences of enquiring about intimate partner violence (IPV). Due to the close links of IPV and SA it could be argued that this has clear transferability for this topic. A general consistency among family and nurse practitioners highlighted that asking about abuse had the potential to take them deep into a conversation that could be fraught with risk to both patients and themselves (Williston and Lafreniere, 2013). This is consistent with previous research (Millikien *et al.,* 2016; Banyard *et al.,* 2010; Christiansan, Bak and Elklit, 2012), demonstrating a need for recipient support following disclosures.

With the recorded prevalence of SA being at its highest (HO, 2022), healthcare professionals are likely to care for survivors of SA daily (WHO, 2013). Research identifies that more than 50% of SA survivors will go on to develop psychological disorders (including PTSD), with a large proportion being more likely to report physical symptoms, including chronic pain and health conditions, resulting from negative health behaviours such as increase alcohol and drug intake, smoking and eating disorders (Waigandt *et al.,* 1990; Golding, 1994; Kessler *et al.,* 1995). Littleton, Berenson and Breitkopf (2007) found that only 32% of women reported being screened by a healthcare professional regarding SA, with 52% reporting that a healthcare professional had never screened them or provided any sort of information regarding SA. This lack of screening is supported with McLindon and Harms' (2011) finding that 95% of nurses from a mental health unit believed SA should not be explored so as not to increase risk of trauma. Interestingly, fewer than 6% of women reported that they would find being screened for a sexual assault history to be bothersome or upsetting, and more than 95% of women who received any of the types of information about sexual assault from a healthcare professional reported that this information was potentially helpful (Littleton, Berenson and Breitkopf, 2007). The research highlights that woman are not offended to be asked about their SA history, contrary to healthcare professionals' perceived barriers. This research, even though dated, opens a bigger discussion into perceived barriers to screening for SA in clinical practice. Ultimately, the outcome from Littleton, Berenson and Breitkopf's (2007) research is that healthcare professionals discussing sexual assault with their patients is a conversation which most individuals are unlikely to find overly distressing or unhelpful, and can benefit from. It can also be added that this benefit is not only personal, but will also give the individual a sense of awareness of services available when receiving disclosure of SA; itself a cause of distress as highlighted by both Mallikien *et al.,* (2016) and Banyard *et al.,* (2010). That said, the response and support given to survivors of SA must be received in a positive way to provide positive outcomes.

The reason a child does not disclose episodes of SA is different from the reason an adult does not disclose (Bagley and King, 1990: Hollies 1990; Wilson 1994); yet, much education

provided to professionals surrounding SA (and SV) is focused on child safeguarding. Washington (2001) suggests that adults are selective in who they tell about their experience. This is influenced by a deep-rooted fear of being re-victimised and the potential of being ostracised, specifically when the assailant is known by family and friends. When considering that 90% of survivors know their attacker, this makes disclosure even more difficult. Of those who do disclose to healthcare providers, research suggests that they often receive inappropriate responses to their disclosure (Baker, Campbell and Straatman 2012; Lanthier, Du Mont and Mason, 2018).

Berry and Rutledge (2016) explored the factors that influenced women disclosing SA to healthcare professionals in primary care and found that women desired to be screened for SA since this gave them permission to disclose. This therefore demonstrates the importance of screening for SA, rather than making case-by-case decisions, based on symptoms which trigger nurses to ask, which is the norm is most healthcare settings in the UK (looking for indicators). This is consistent with Littleton, Berenson and Breitkopf's (2007) finding that women are not offended to be asked about experiences of SA. Research findings throughout the past 25 years are consistent with low screening rates for SA. Friedman *et al.,* (1992) found 6% of 164 patients who attended private and public primary care settings (in the US) had been asked if they had experienced SA by physicians. Littleton, Berenson and Breitkopf (2007) highlighted a higher proportion, with 37% of 945 women having been asked, specifically, about sexual assault experiences. Meanwhile, Berry and Rutledge (2016) uncovered in their paper most participants (female) had never been screened for SA (71.3% 102/165) by any healthcare provider they had accessed. Worryingly, this evidence suggests that never more than one third of people are screened for SA in healthcare practice, therefore potentially reducing signposting opportunities and subsequent access to support services and, in turn, increasing the likelihood of non-disclosure PTS. Approximately, 75% of women in Berry and Rutledge's study (2016) expressed an intention to disclose only if asked, and 71.3% (of 102 women) indicated that they had never been screened for SA. Again, this highlights the need for healthcare professionals to screen for SA using a direct inquiry to their approach.

Lee *et al.,* (2019) examined interprofessional education regarding a simulated event in undertaking sexual assault interview skills with medical students and nurses They found that 63% had previously had no education or training around SA, which demonstrates an understanding of why it may not be at the fore of consultations. However, this research was focused on those training within a military college and SA training is part of a yearly mandatory programme. Therefore, it could be argued that in civilian healthcare the percentage of those with no previous education or training regarding supporting survivors

of SA could be even higher, since it is not a mandatory subject within any nurse education provision outside the military. Lee *et al's.,* (2019) small-scale study identified an interesting finding that would benefit from further investigation in the wider context of UK healthcare: following the use of simulation in supporting survivors of SV, confidence in SV assessment and support giving increased for both sets of participants. This may then improve the confidence of healthcare professionals to enable screening to become more acceptable to their practice.

2.5.2 Survivors' experiences of disclosing to a healthcare professional

Vandenberghe *et al.,* (2018) undertook a survey exploring healthcare providers' knowledge and experiences towards SV in general, alongside the hospital's general policy of providing care for survivors of SV. Once the survey was completed, participants were invited to extend on some of their answers with a qualitative interview. Healthcare staff indicated that they had insufficient knowledge regarding the prevalence of SV. However, over half felt happy exploring experiences of SV when they suspected it within their consultations. This study was undertaken in Belgium where health services and health provider education are structured differently to the UK, therefore transferability is difficult to assess. A range of clinical areas contributed to their study (emergency room, gynaecology, psychiatry, urology, paediatrics and sexual assault centres), and the lack of knowledge surrounding the prevalence may have been from those areas less likely to support survivors on a regular basis. Of those that did support survivors, it was identified that their wellbeing and coping mechanisms (in relation to trauma disclosures) could affect the quality of care provided. This is a finding that has been identified in previous research (Schauben and Frasier 1995; Dunn, Vail-Smith and Knight,1999; Branch and Richards, 2013; Raunick *et al.,* 2015).

Du Mont *et al.,* (2017) examined the experiences of women using sexual assault and domestic abuse centres in Canada. This study offers limited data to contribute to this literature review as participants specifically went to the centres to disclose to healthcare providers who were specially educated and trained. However, the findings add value when looking at the women's experiences of disclosing to nurses. As with earlier research, Du Mont *et al.,* (2017) found that often intimate partner's assaults were more violent than stranger attacks, thereby diminishing the rape myths often adhered to regarding stranger rapes ('real rapes') being more violent (Möller *et al.,* 2012). This finding is important since those with violent experiences of SA are more likely to access health services (Möller *et al.,* 2012; Logan, Cole and Capilo, 2007). However, those who experience SA within intimate relationships, are less likely to report their assaults. Nurses need to be aware of this in assessing risks whilst undertaking health assessments/histories. These survivors could be

lost due to rape myths minimising the likelihood of the nurse asking more detailed questions about their health/intimate injuries (Möller *et al.,* 2012; Murphy *et al.,* 2011). Du Mont ***et al's***. (2017) study collected data from those centres attached to acute hospitals; therefore, giving no clear indication of survivors who present in primary care, a gap in research that would benefit from being explored further.

Ranjbar and Speers (2013) explored the experience of 27 females' post-SA disclosure health service encounters in the UK. This research focused on encounters that may have facilitated, or impeded, their recovery process. Their findings suggest that, in relation to health services, participants overwhelmingly reported negative experiences, citing inexperience in dealing with survivors of SA, disrespectful or inconsiderate treatment, and HCPs adhering to myths and stereotypes surrounding SA. The research does not state at which point in the service user's recovery these experiences occurred, although it does support the rationale for a clearer understanding of stages of experience and the need to tackle the rape myth assumptions in practice. Ranjbar and Speers' (2013) findings are consistent with those from research examining informal support providers' disclosure experiences (see next theme in this section).

McLindon and Harms (2011) explored the experience of mental health nurses receiving disclosures of historical SA. Due to the statistics suggesting 40% of women with severe mental health illness have a history of SA (Khalifeh *et al.,* 2015), it could be assumed that SA should be an item high on their assessment agenda. Ashmore, Spangaro and McNamara (2015) indicate that when disclosures of SA are made by those with mental illness, they are often not made in plausible terms, and it can be difficult to determine whether allegations are delusional episodes or not. As a result, they are therefore often minimised. They go on to suggest, the minimisation of disclosures increases the likelihood of traumatic and aggressive reactions to negative responses from recipients (Ashmore, Spangaro and McNamara, 2015). McLindon and Harms (2011) found that over 95% of nursing participants believed patients should not be asked initially or further (should the service-user have mentioned it) about sexual trauma, identifying increased risk of psychological distress as a reason to avoid the topic. Half of the sample expressed that they felt under confident in responding to disclosures. This is concerning considering the estimated levels of women with severe mental illness who have suffered rape or attempted rape as an adult discussed earlier (Khalifeh *et al.,* 2015). It could be argued that the individual is likely to seek psychological help due to the symptoms associated with that event (e.g. depression, anxiety, increased substance abuse, sexually transmitted infections). Thus, not addressing it would be of no advantage and, in some cases, detrimental to the survivor's ongoing health needs. It could also be suggested that not

exploring this event at a time of crisis diminishes both the experience and the impact that experience has on the service user. Individuals should feel supported, and staff must emphasise the importance and safety of being able to disclose (Humphreys and Thiara, 2003). McLindon and Harms (2011) also found 73% of mental health staff highlighted that they had received no training or education in at least the last 10 years to enable them to confidently manage and discuss disclosures, with 60% stating that they used personal experience to guide their professional practice.

Those survivors who have increased alcohol usage following SA are more likely to disclose their experiences to formal health support services (Ullman *et al.,* 2008). This could be linked to their more consistent use of health services, specifically surrounding their mental health, when considering PTS implications. However, there are studies that find that due to mental health concerns and alcohol use, staff are more likely to adhere to rape-myth assumptions and not take disclosures seriously (Ashmore, Spangaro and Mcnamara, 2015). This lack of support is mirrored by problem drinkers' social support mechanisms, thus highlighting that those with alcohol issues have decreased social and formal support, increasing the impact of their PTS which, in turn, results in worse health outcomes (Ullman *et al.,* 2007; Ullman *et al.,* 2008; Jasin, 2012).

When considering recovery for substance abuse, Hunter, Robison and Jasin's (2012) study of an in-house drug and alcohol residential treatment centre found that over 50% had disclosed their experiences of SA to other residents. The authors describe this peer support as a beneficial aspect of an in-house recovery programme, and link it to promoting trauma recovery. However, it should also be acknowledged (as noted previously), that disclosure can trigger the recipients' experiences of trauma. Therefore, staff who work in a recovery environment not only need to be aware of potentially responding to multiple PTS impacts of disclosure, but also need to be aware of the impact of secondary trauma for those already in recovery. It could also be argued that if this setting is being used as a positive example of informal support to women who are in recovery from substance abuse and have experienced SA, then these women need education and training in responding to disclosures in their programme, along with subsequent psychological support.

The topic of specialist knowledge to support disclosure is a one that was evidenced in Kirknew, Lorenz and Ullmans 2012 study: Fifty-four percent of survivors who participated in the research stated that they would advise other survivors to talk to someone specifically trained to support people who have experienced trauma. This is a strong reflection when considering the low number that report to formal support providers. The study participants also identified survivors should consider telling a friend or family member who had also

experienced trauma. It is clear from these results that survivors value the support of those who have knowledge of the impact of trauma. Whilst this study is important in exploring the survivor's view of support for disclosures of SA, it is also recognised that a retrospective study allows survivors to have reflected on their experience. This can be positive since they may look back and have a clearer idea of their needs at this time. However, at this stage of their recovery they may also have different needs, and this might also influence their recollection. That said, research investigating survivor-informed responses is an exciting development in the disclosure discourse.

Berry and Rutledge (2016) found that positive and helpful attitudes of the healthcare professional, together with increased comfort and trusting level, was indicated as important for disclosure. Again, this is consistent with previous and current research discussed in this review. It is acknowledged, however, that their study was completed with predominantly white women (86%), and therefore not generalisable to a wider diverse population.

Whilst Berry and Routledge's (2016) study found permission-giving encouraged disclosures to healthcare providers, previous research attributed this to validation (Ullman, 1996; Dunleavy and Slowik, 2012). These studies indicated that validation and acknowledgement was strongly attributed to positive experience, as this gives the survivors a sense of being believed by the recipient. Similarly, not being believed is strongly linked with negative experiences of disclosure. Showing compassion and providing an empathetic response is seen as providing positive emotional support in five studies (Ahrens, Cabral and Abeling, 2009; Ahrens, Stansell and Jenninigs, 2010; Dunleavy and Slowik, 2012; Starzynskil and Ullman, 2014; McQueen *et al.,* 2021). This included telling survivors that they were not to blame for the assault.

Starzynski and Ullman (2014) specifically examined survivors' health-seeking experiences and found a subsample of 365 women who had disclosed their experience of SA to a mental health practitioner. Their perceptions of the helpfulness of mental health professionals follows the trend of research outcomes highlighted thus far: positive outcomes are associated with empathy, emotional support and tangible aid, while negative outcomes are linked to victim blaming. Whilst Starzynski and Ullman's (2014) study gives an insight into disclosure in the mental health setting, it would be beneficial to have more depth to the findings transferable to other fields. This is because it is uncertain where the specific positive and negative experiences focus towards, since there were two questions in the survey that contributed to these results: whether or not women found mental health professionals helpful (yes/no) and how satisfied they were with those mental health practitioners they disclosed to (5 point Likert-type scale).

Consistently, the most common finding throughout the range of research literature discussed above is that blame is the single most contributing factor to negative experiences of disclosure. Blame is often attributed to the adherence of rape myths that result in victim-blaming approaches, as explored in the previous theme. Ullman and Townsend (2007) found that rape myths resulting in blame attributed to the survivors often caused barriers in their interactions with a range of healthcare services. This finding has been consistent in other studies on disclosure to formal support providers (Ahrens, Cabral and Abeling, 2009; Ahrens, Stansell and Jennings, 2010; Dunleavy and Slowik, 2012; Starzynskil and Ullman, 2014; McQueen *et al.,* 2021). In the UK, no research has investigated healthcare professionals' adherence (or otherwise) to rape and sexual harassment myths and victim-blaming attitudes. Other negative experiences reported by survivors include HCPs' behaviour, such as minimising or dismissing responses (Ahrens, Stansell, and Jennings, 2010; McQueen, 2021) and displaying a cold and detached approach to the support (Ahrens, Cabral and Abeling, 2009).

Henninger *et al.,* (2019) examined the satisfaction experiences of SA survivors within the criminal justice system in the USA. Whilst this research clearly has limitations when aligned to this study, there is one aspect of the research that has transferability. They examined survivors' perceived interactions along their disclosure journey (to nurses, police, lawyers, and the wider criminal justice system) with regards to four elements: being treated with respect, clearly explaining procedures, being believed, and demonstrating cultural sensitivity. Those with positive experiences highly rated all except clearly explaining procedures. This demonstrates that the importance of being believed and being treated in a sensitive and non-judgemental way is more important, and leads to a more positive experience than the practical aspects of the interaction. Similarly, McQueen *et al.,* (2021) conducted research exploring the experiences of 23 SA survivors with self-reported health impacts of not being believed, focusing on their experiences with police. They found descriptions of broken expectations, loss of trust, secondary victimisation and a loss of self that resulted in wider PTS implications (McQueen *et al.,* 2021). Again, whilst drawn from a small sample and not healthcare focused, this adds to the literature which demonstrates that avoiding blame and providing non-judgemental support is essential to positive disclosure experience. However, this does not seem to be happening in practice with respect to formal support providers.

2.5.3 Impact on recipient

A theme found in this body of research concerns both informal and formal support providers receiving disclosures, and then subsequently using their own personal experiences of SA

to give advice and guidance (McLindon and Harms, 2011; Branch and Richards; 2013). This therefore brings up memories of the recipient's own experiences with SA and is associated with re-triggering PTS.

Twenty years ago, Jancey, Meuleners and Phillips (2001) identified that supporting survivors of SA can lead to staff burn out. Their Australian study focused on healthcare professionals who supported survivors of SA in a wide range of clinical settings (emergency department, women's health centres, sexual assault referral centres and aboriginal medical services). They found that the experience of supporting survivors of SA was deemed emotionally demanding and often resulted in vicarious trauma, and their participants suggested that improved support from debriefing and structured staff supervision would be helpful. Supporting survivors of SA is an area of practice that is often unacknowledged in relation to staff support. It is argued that this is due to the lack of understanding around the support required for survivors who disclose, and therefore the impact on the staff is often overlooked (Schauben and Frasier, 1995; Jancey, Meuleners and Phillips, 2011). A number of considerations are looked at within Jancey, Meuleners and Phillips' (2011) research and its place in current practice. Although it is small in sample size (27), this provides a richness of data with transferability into practice that should not be overlooked, and the nature of the roles of those health worker indicates that they will be exposed to disclosures of SA more frequently than nurses working in other areas. Therefore, their burn out levels may be higher than the wider healthcare population, demonstrating the importance of clinical supervision as a way of support.

The impact of SA disclosure on recipients is clearly an area of research that would be beneficial to explore further in order to ensure that appropriate support can be provided for those receiving the disclosures at the most opportune point. Prior research concerning vicarious trauma experienced by formal support providers demonstrates that female counsellors who have a high workload of SA survivors on their caseload are at an increased risk of feelings of disrupted beliefs, in particular beliefs about goodness in others shaping their view of society and, ultimately, impacting their psychological wellbeing (Schauben and Frasier 1995). These findings reflect the work of both Dunn, Vail-Smith and Knight (1999) and Branch and Richards (2013), further solidifying the place for the research being carried out for this thesis. Ahrens and Campbell (2000) found that survivors expressed positive experiences when disclosing to friends who had a personal history of SA. There is no research concerning whether formal support providers disclosing their own experiences of SA impacts survivors' experience. In this instance, professional boundaries and HCPs comfort with sharing needs to be evaluated and considered.

2.6 Theme three: Sexual assault disclosures - social support providers

As set out above, empirical research has repeatedly examined the reactions survivors received from both formal and informal support providers; it is, however, weighted on the informal support provider response. This theme explores the support provided from informal support to gain an understanding of social reactions, how (and if) they differ from formal responses and if they have an impact on formal disclosures.

2.6.1 Positive and negative experiences of disclosure

Research exploring social support reactions to SA disclosure demonstrates that poorer health outcomes are attributed to social reactions to SA (Campbell *et al.,* 2001: Ullman and Filipas, 2001; Ahrens, 2006; Orchowski and Gidycz, 2015; Dworkin *et al.,* 2018; Dworkin, Brill and Ullman, 2019).

Positive social reactions to SA disclosure may include providing emotional and practical support. Conversely, negative social reactions may include blame, control, and distracting the survivor from the experience, as well as showing egocentric reactions (Ullman 2000; Orchowski, United and Gidycz, 2013) that might include disclosing and focusing on their own experiences of SA. However, whilst there is some consistency in the response to recipients' reactions (i.e. blame = negative experience), there are also responses that can be deemed as both positive and negative. This includes, for example, some survivors finding recipients taking control as a negative response (Campbell *et al.,* 2001), whereas others might find this helpful (Ullman and Filipas, 2001).

Sit and Schuller (2018) found that the least helpful response from informal providers was telling the survivors they could not have prevented the assault, and they were not to blame for the assault. This contradicts findings by Kirkner, Lorenz and Ullman (2021). Since approximately 90% of complainants of SA know their assailant (HO, 2022), it could be suggested that a negative reaction from social support is associated with recipient denial. This may arise because friends and family could be unsupportive when they know, and have a personal relationship with, the assailant and do not want to believe a person who has earned their trust could perform such a crime. Ahrens, Cabral and Abeling (2009) found that when the reaction from social support was anger, it had a positive response from the complainant since it made them feel protected. Ullman's (1996) paper found negative social reactions were related to poorer recovery and reduced psychological wellbeing, going on to suggest that as disclosure is more commonly directed to social support rather than professional support, reactions may be particularly influential with regard to SA complainant

recovery. This is supported by other research (Ullman *et al.,* 2007; Ullman, 2010; Frazier *et al.,* 2011; Peter-Hagene and Ullman, 2013; Orchowski, United and Gidycz, 2013).

Research demonstrates that one of the key factors in positive recovery from SA is the experience of perceived control (Peter-Hagene and Ullman, 2013). SA can lead to decreased perceptions of personal safety, feelings of vulnerability and lower perceived control (Janoff-Bulman, 1992). Peter-Hagene and Ullman (2013) found with their sample of 1,863 women that, when informal providers facilitated SA survivors to regain a perceived sense of control throughout and after their disclosure, the survivors had notably less PTS symptoms. This is important when considering formal support as ensuring that this skill is taught should help survivors who do disclose to feel empowered; thus providing helpful short- and long-term positive recovery outcomes.

Better health outcomes are attributed to positive responses to disclosure, these positive responses result in the survivors' experiencing perceived control after the assault and are often linked to lower rates of PTS and less problematic drinking reports (Orchowski, United and Gidycz, 2013; Ullman and Peter-Hagene, 2014). Further consideration is required however as both of these studies advertised for participants in and around particular communities, meaning there may be an impact of not accessing a cross sample of the SA survivor population. However, it does provide a wider sample than those focusing on college students for participation. Additionally, those survivors who are in recovery after having a positive experience of disclosure may be more likely to participate in a survey than those who may yet have to come to terms with (sought help for) their assault, or who have had a negative experience of disclosure and, therefore, do not want to re-live the experience. Alternatively, it could also be argued that those survivors who have had negative experiences may be more likely to participate in order to feel that they are influencing a change in the process for others. Clearly, there is a need not only to prepare professionals to support disclosures of SA, but also to educate and inform the public about what support is available.

Although reactions from informal recipients are generally rated as more positive than formal support providers, informal recipients of disclosure can engage in high levels of overtly negative reactions such as blaming, doubting, and patronizing behaviours. The social contextualization of SA and rape culture has an impact on the recipient's response. Mallikien *et al.,* (2016) suggest recipients' perceptions of blame and responsibilities regarding SA will contribute to why they may respond negatively to the disclosure. We know from discussions above that one of the most important elements of disclosure management is handing back control to the survivor; giving advice and support to help them make informed choices, whether that is to seek formal support or not. However, it is not

always easy for recipients to accept a survivor's decline of care. When individuals are put in a position of helping others in traumatic or stressful situations, perceptions of indecision or unwanted assistance can be frustrating to the recipient and can therefore negatively affect the aid given. For example, this could arise from a survivor deciding not to take advice from a friend, family member or partner to report the assault or access support services. This, in turn, can lead to feelings of helplessness, uncertainty, or frustration for the recipient, manifesting in negative behaviour and therefore adding strain to the relationship. This could be misinterpreted by the survivor as the recipient displaying blame-culture tendencies.

Kirkner, Lorenz and Ullman's (2021) article explored a gap in the research: survivor and social support providers' recommendations for receiving and responding to disclosures, based on their experiences. Their quantitative survey of 1,862 women, followed by qualitative interviews with 45 women, found that when survivors reflected on their experience, they wanted their social recipients to know they had a desire for an empathetic and positive response, without being smothered or shown pity. In addition, the main response they wanted from the recipient of their disclosure was anti-blaming support. Anti-blaming attitudes were aligned with positive disclosure experiences. This advice is in line with previous research regarding what can cause barriers to disclosure and negative experiences (Ullman 2000; Orchowski, United and Gidycz, 2013; Allen, Ridgeway and Sawn, 2015; Sit and Schuller 2018).

2.6.2 Impact of disclosure on recipients

Dunn, Vail-Smith and Knight (1999) carried out quantitative research with over 828 college students. They found that the participants' (whom were recipients of disclosure) level of detail regarding the survivors' experience indicate that survivors typically disclose more information regarding the details of the assault than the mere mention of an assault taking place, at times graphic details. SA on university (college) campuses is a significant problem which has been steadily increasing over the past 20 years globally (Sundaram, 2018). Banyard *et al.,* (2010) estimate that throughout college, 1:3 women and 1:5 men will have a friend disclose and look for support following an experience of SA, demonstrating consistency in SA statistics over time (Dunn, Vail-Smith and Knight, 1999), but also indicating a large proportion of college students being exposed to disclosures of SA.

This pattern is supported by Ahrens and Aldana (2012), who found that survivors choose to whom they will discuss the experience in more detail: with friends, then a little less with family, with significantly less details being expressed to intimate partners. The Dunn, Vail-Smith and Knight (1999) findings highlight that a heightened awareness of the impact on the recipients is needed to further understand, provide support and reduce the risk of

recipient trauma. Banyard *et al's.,* study (2010) acknowledged this, finding that those recipients with a history of previous SA experienced higher levels of emotional distress after being disclosed to by a friend.

Christiansan, Bak and Elklit (2012) found that 77% of recipients of SA disclosure reported some form of personal distress. Kirkner *et al.,* (2018) found similarly higher levels. This was higher than Banyard's (2010) previous study, which found that 48% of responses indicated that participants felt anger and distress related to the disclosure. Thus, this demonstrates an upward trend in the impact of SA disclosure on social support providers.

Milliken *et al.,* (2016) explored recipients' experiences of SA disclosure, with a focus on changes in the relationship with the victim following disclosure. Eighty-five participants were recruited to the study, with 58% of those expressing a personal history with SA. However, some of Miliken *et al.'s.,* (2016) findings were different from Barnyard *et al.*'s., (2010). Miliken *et al.,* (2016) indicate that participants in their study, with a history of SA, expressed no notably greater emotional distress than those without a history of SA. Conversely, Ullman, Lorenz and O'Callaghen's (2018) paper identified that recipients of SA disclosures develop long-lasting negative effects of receiving disclosures which, ultimately, limited their full participation in life events and socialisation. These behaviour changes included: adding security measures to their life, changes in drinking habits and hypervigilance that related to behaviour changes. This is consistent with previous research (Branch and Richards, 2013), and appears to directly mirror the experiences of survivors following disclosure (Ahrens and Campbell, 2000). This further supports the need for acknowledging that recipients of disclosure need support too.

Ullman, Lorenz and O'Callaghan's (2018) study explored the experiences of both the survivor and their direct social support provider (45 dyadic pairs). However, it should be noted that the relationship between the two was clearly ongoing and may have impacted their memory and/or feelings toward the experience of disclosure, thus impacting the research findings. Those disclosure experiences where the relationship had broken down after disclosure may have provided recipients with other thoughts on how the disclosure affected their lives. Ullman, Lorenz and O'Callaghan's (2018) study identifies survivors changing their behaviour, which suggests adherence to rape-myth assumptions by altering daily actions. This further perpetuates to recipients of disclosures that women only get raped in certain contexts and under certain circumstances, thus facilitating an ongoing reliance on prevention strategies that inadvertently comply to rape culture. Future research would benefit from replicating Ullman, Lorenz and O'Callaghan's (2018) study from a formal support provider perspective. This would gauge experience and highlight insight to improve

care and support for both survivors and formal support providers, specifically from a primary care perspective where there may be a consistent and on-going therapeutic relationship.

Miliken's (2016) research further explores the response of the recipient as key in the potential breakdown of the relationship with the survivor. Unsurprisingly, a positive response from the recipient aligns with a closeness of the friendship and a negative response being a precursor in the relationship breakdown. This study adds to the body of research supporting the belief that informal recipients often feel distressed when trying to support survivors. However, Miliken's study does not explore the long-term implications on the relationship.

Although the recipient of the disclosure provides obvious support for the survivor, Ahrens and Aldana (2012) suggest that this shared experience will impact on their on-going relationship, with the most common outcome being that the relationship will grow closer. However, Ahrens and Aldana (2012) explored the relationship from the perspective of the survivor and, therefore, do not provide an insight into the impact on the recipient. There seems to be mixed findings with regards to ongoing relationship patterns. Whilst Ahrens and Aldana's (2012) findings are consistent with other studies (Ahrens and Campbell, 2000; Banyard *et al.,* 2010), there is also a body of research that contradicts their findings, although this was published earlier when understandings of SA and rape might not have been as strong. For example, Crenshaw (1978) found that between 50% and 80% of relationships broke down following an experience of rape, further adding to psychological trauma.

Breakdown of relationships following SA disclosure is more prevalent with intimate partners (Burgess and Holstrom, 1979; Connop and Petrak, 2004); however, the literature is dated and limited. Burgess and Holstrom (1979) identified two distinct patterns of response associated with male partners of SA survivors. The first was those who identified themselves as modern and saw the assault as an act of violence, identifying their partner as a victim. The second group conceptualized the assault as a sexual act and identified themselves as traditional. These views identified men attributing a level of blame with the survivor, thus seeing himself as a victim of infidelity, aligning with victim-blaming attitudes. Connop and Petrak (2004) found similar results. They explored the impact of SA on heterosexual couples within the UK. They interviewed six men whose partners had been sexually assaulted within the past 12 years with findings suggestive of men feeling burdened by their role in supporting their partner. Putting their partner's feelings before their own often meant that men did not receive support for their own distress; this took its toll and, following the assault, 5:6 of the relationships broke down, with the sixth expressing

doubts for the future of his relationship. Cannop and Petrak (2004) make it clear that the emotional support of intimate partners is exceptionally important, highlighting the impact of SA extending further than the survivor. Whilst Cannop and Petrak's (2004) research contributes the richness of these participants' experience to the discourse, it is acknowledged this is a small-scale study (6 participants). Wider research would no doubt contribute to this field and, in turn, build upon improving services for survivors and their partners.

One area of disclosure that has received little attention until recently is experiences of workplace disclosure, which links to Holland *et al.*'s., (2018) concept of compelled disclosure. Compelled disclosure refers to instances where individuals feel that they do not have a choice regarding disclosing their experiences; for example, taking time off work, getting upset in front of people, being unable to perform their duties to the standard expected, taking time off work for court proceedings, or avoidance of perpetrator. Lorenz and O'Callaghan (2022) found that survivors (28 particpants) who were compelled to disclose at work experienced both negative (5) and positive (4) responses to their disclosure. However, the implications of being unsupported in the workplace environment added further detrimental implications of disclosure. These included anxiety surrounding attending the workplace, fear of being judged and pressures of people knowing, all of which could lead to taking time off work or to look for new employment. This is consistent with previous research in which positive responses have positive impacts and negative responses have negative impacts on wellbeing (Campbell *et al.,* 2001: Ullman and Filipas, 2001; Ahrens, 2006; Orchowski and Gidycz, 2015; Dworkin *et al.*, 2017; Dworkin, Brill and Ullman, 2019).

Lorenz and O'Callaghan's (2022) study sample was relatively small, with just six participants as a sub-sample from a larger study. Participants were drawn from a larger mixed methods study (414 survey / 28 participants in follow up interviews), six of whom discussed experiences of workplace disclosures as part of their post-disclosure experience. However, additional survivors did discuss the impact of the assault on their workplace productivity, but not disclosure experience (Lorenz and O'Callaghan, 2022). This aspect of the study has given insight into an area of disclosure that is yet to be fully explored and highlights the needs for further research. It also highlights that, as the NHS is one of the largest workforces in the UK, SA disclosure by colleagues to colleagues is a strong possibility.

Research studies providing specific experiences of SA disclosure to healthcare professionals (and specifically nurses working within the adult field) in the UK are

challenging to find. Yet, we know that individuals (particularly women) who have experienced SA report poorer health outcomes and access healthcare services more frequently than those who have not been sexually assaulted. Therefore, a gap in research is clearly identified.

2.7 Summary of chapter and literature gaps

This literature review has demonstrated that, within the UK, there is an absence of literature exploring the barriers, rationale, and nature of the survivor's experience of disclosing SA to nurses (especially from an in-depth qualitative research perspective). There also remains a lack of research into how nurses support survivors through their SA disclosures, with much of SA disclosure research coming from the United States with a focus on criminology, sociology, and psychology. Whilst this research continues to be relevant to the field, it must be noted that the international contextual differences and lack of healthcare focus make transferability difficult. Another factor that should be highlighted is the cohort of participants. Much of the current literature is focused on college students, their experience of disclosure and the experiences of fellow students as recipients. Arguably, this is due to the availability of students to researchers. Whilst this cohort of participants are statistically those that are at a higher risk of SA, this leaves a gap of those who are older and those not accessing higher education.

Demonstrated in this chapter is a body of research that has been undertaken to explore the experiences of SA survivors disclosing the incident to informal (friends, family, partners, etc.) and formal (police, counsellors, clergy, etc.) support providers. However, little is known regarding disclosure to healthcare professionals, specifically general adult field nurses who do not work in a mental health service. With increasing rates of SA nationally and an emphasis being put on encouraging and facilitating disclosures within healthcare (see introduction chapter), there is a need for professionals to be more prepared to receive disclosures and then to offer appropriate help. The research explored in this review dates back over the 30 years, and this is because it is a topic that does not receive regular consistent publications. However, it has been demonstrated throughout the research explored that the patterns of disclosure are consist over time. It is also clear from the research explored and the nature of the topic that to understand disclosure you need to explore experience. However, quantitative approaches to examining this topic with interviews as follow up are preferred methods of examining SA disclosure experience, which could be seen as a superficial approach to exploring experience. Therefore, this field would benefit from further qualitative studies that are specifically designed to capture the participants' lived experiences.

This literature review confirms that negative responses to SA disclosure equate to poorer health outcomes, and that this causal relationship has not changed in 30 years. It also highlights the need to conduct research from a contemporary nursing practice perspective in order to gain a deeper understanding of SA disclosure to nurses. This is essential if we want to encourage disclosure, improve the responses survivors receive and, in turn, aid their recovery / health outcomes following SA. By identifying, exploring and understanding SA experience, the nurse can support and signpost survivors to timely and appropriate help; connecting survivors to relevant services will thus help to reduce the impact of both the psychological and physical distress of SA.

The review of the literature has highlighted gaps in knowledge that, if addressed, would improve experiences of SA disclosure, both for the survivor and the nurse, and this thesis aims to do that. To capture some of these gaps and remain open to other aspects of experience, the following research questions and aims to explore were developed as:

- What is the experience of survivors of sexual assault in making disclosures regarding their assault to nurses?
- What is the experience of nurses receiving disclosures of sexual assault?

The intended aims are to:

- Explore individual experiences of sexual assault disclosure to nurses within the UK.
- Explore individual experiences of receiving sexual assault disclosures in UK nursing practice.
- Develop an insight into sexual assault disclosures in a healthcare setting.
- To offer an original research contribution in understanding experiences sexual assault disclosures in nursing practice.

My research aims to address this gap in the existing knowledge regarding disclosure of SA. The following chapter explores the philosophical principles and methodological approach chosen to address these aims.

Chapter 3: Methodology

3.1 Introduction to the chapter

Chapters 1 and 2 have established both a personal interest and a professional rationale for undertaking this research, alongside a comprehensive review of empirical literature. The literature review informed an understanding of disclosure of SA both in general and specifically to healthcare professionals. This has led to an identification of a gap in research, which this study aims to address.

This methodology chapter considers and identifies the relevant philosophical and theoretical tenets, discusses the research methodology and provides an overview of the key philosophical and theoretical framework that underpins this thesis, phenomenology. Methodology and methods are often defined in confusing ways within the research literature. Therefore, it is important to differentiate from the outset to clarify how this chapter will address only the methodology. Methodology is defined as the philosophical framework that must be identified by the researcher to demonstrate the approaches used to carry out the study. Methods refer to the specific research techniques used to carry out the study to gather, analyse and present the research data. Phenomenology has already been identified as the chosen philosophical framework that has shaped this study (see chapter 1: 1.7.3), and this chapter focuses on clarifying this philosophical and methodological approach. It will demonstrate how phenomenology shapes this thinking (rationalising its use). The descriptive phenomenological approach chosen to execute the research, the specific research methods used, and application of these, will be explored in Chapter 4.

3.2 Phenomenological language

At this point, as we delve further into phenomenology, is it a good time to define some of the language used that is specific to the approach.

The lived experience	Phenomenology is the study of the lived experience, and the lived experience can often be used an umbrella term in research for experience. The lived experience from a phenomenological perspective can be described as the very structures of human experience and consciousness, from those that experience it (events, situations, episodes). They are often experiences that are immediate, situated and daily, which are often lived without thinking about or paying attention to. Phenomenology stresses that only those that have experienced phenomena can

	communicate them to the outside world (Husserl, 1970). Therefore, it provides an understanding of an experience directly from those who have lived it.
Consciousness	Consciousness indicates the inseparable connectedness of the human being to the world, which means that all thinking (imaging, perceiving, remembering, etc.) is always thinking about something, and that the same is true for actions (Van Manen, 2002). This object that we are conscious towards can be real, imaginary, or conceptual (Koch, 1996). Husserl viewed the *essence* of the phenomenon as the relationship of the subject to the object (Husserl, 1970).
Essence	Whilst Husserl (1970) initially referred to the *essence* of a phenomenon as something precise, he later accepted that this was perhaps not always as specific as he believed (Husserl, 1982), going on to define two types of essence: - formal essence *(has a formal essence that separates it from something else, e.g. a pair of New Balance trainers cannot be a pair of Nike trainers, but they are both trainers and may be made from the same material or same colour, and therefore are similar).* - material essence *(substantive matter of facts, e.g. the object is yellow, it is hot, it is long/short, it is outside/inside, it has a handle, etc.)* Phenomenology seeks to identify or better understand the essence of a particular phenomenon. Giorgi (2009) says that although the phenomenologist would seek the most universal essence, what is really sought is the structure of the concrete experiences (Giorgi 2009). Essence is found by carrying out *imaginative variation*, to get to the core of experience to build these structures of understanding.
The natural attitude	The natural attitude is a link to the lifeworld. It is pregiven acceptance and understanding of the world and what it means. It is often referred to as our normal state of being in the world. Husserl (1970) believed that understanding the difference was key to comprehending our understanding of the world. It was Dilthey, however, who philosophised regarding the nature of our

	understanding and identified the problems we may face when scientifically studying ourselves (Rickman Ed, 2015). Dilthey went on to conceptualise how humans are already embroiled within the life we are trying to understand, as we are already grounded in experience due to our pre-existing life (Rickman Ed, 2015). Husserl defined this as the natural attitude. Husserl (1970) described the natural attitude as the standpoint of an individual's everyday life.
Intentionality	The experience of perception, thought, memory, imagination, and emotion, involve what Husserl (1970) called intentionality. This is one's directed awareness or consciousness of an object or event.
Imaginative variation	Imaginative variation is a process used to reveal possible meanings through employing imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from different perspectives and different positions (Husserl, 1960). This allows the research to locate the essential structure of the experience. The aim is to discover the underlying and precipitating factors that contribute to the experiences (Moustakas, 1994). Imaginative variation complements eidetic reduction and must be undertaken in the phenomenological attitude. The former eliminates the irrelevant, while the latter expands the scope of inspection to discover the veiled and the hidden. For example, researcher: *"you said it made you feel cold, could explain what you mean by that?", "you said you saw the nurse but they had no identification visible, can you describe the person you saw and how you came to the conclusion they were a nurse?"*
The lifeworld	The philosophical grounding of phenomenology is clear when one considers its focus on the lifeworld and the human, rather than the natural, sciences. Gathering everyday experiences, describing them, and reflecting on them is what Husserl called the lifeworld (Husserl ,1965). The lifeworld includes everything that is experienceable. Both descriptive and interpretive approaches to phenomenology attempt to investigate the lived experience (Husserlian) of the lifeworld (Heideggerian). These terms are very similar.

Phenomenological attitude and phenomenological reduction (Also referred to as: epoche / bracketing)	The concept of phenomenological attitude is derived from Husserl's philosophical stance that means all personal, cultural or experimental beliefs or assumptions should be put to the side (Husserl, 1970). This process allows researchers to attempt to see things for the first time, through fresh eyes as it were. This is essential to the data collection aspect of this research. Husserl (1960) describes entering the phenomenological reduction as changing one's consciousness (awareness) from the natural attitude to the philosophical attitude. Again, we go 'back to the things themselves' (Husserl, 2001 pg. 168). The phenomenological attitude is when a researcher's natural attitude towards the world is bracketed through reduction. In descriptive phenomenological inquiry, when embracing phenomenological attitude, researchers engage into the world of description by suspending personal and professional prejudices and biases about a phenomenon (Todres and Holloway, 2005). Bracketing is part of this process for researchers when undertaking data analysis, as they endeavour to allow themselves to be present in the data without prejudice, doubt or belief. It is argued by Husserl (1970) that the adoption of the phenomenological attitude should be taken and that what the participant describes should be accepted without value judgement. Giorgi (2009) advises that speculations must be avoided as the researcher looks at the data presented and makes no assumptions. He argues that the results are more secure and will allow for capturing the meaning of experience from the participant's perspective. Adopting the phenomenological attitude and bracketing can bring a certain discipline and rigour that realises fresh insights beyond the preconceptions of the researcher. Descriptive phenomenologists bracket, or suspend, prior knowledge and beliefs about a particular phenomenon. Husserl did not necessarily believe that the researcher could ignore previous knowledge, either of the experience itself or of the literature on it (Husserl, 1965). Bracketing has therefore been assumed by

	descriptive phenomenologists to be about suspending any particular views which results in having a more open-minded approach to other's experiences than the researcher imposing their own understanding or interpretation on the experiences (Langdridge, 2008; Giorgi, 2009).
Embodiment	Merleau-Ponty (2012) describes the human body as an expressive space which substantially contributes to the significance of personal actions. The body is a medium for perception of the world, physically and psychologically. Finlay (2011) describes the notion of embodiment and how the body is inextricably linked with how we live our lives in the world, as another fundamental facet of phenomenology. This suggests that phenomenological researchers link together the mind and the body, rather than divide them. What is meant here is that we use our bodies consistently in everyday life as we communicate, learn, eat and feel and so on. Finlay (2011) terms the body a vehicle for experiencing all, as we live our lives in the world. We are part of the world and the world is made up of us all.
Dasein	Dasein is *being-there*. The concept of Dasein was introduced by Heidegger (1962) as a way of describing *being-there* in the world. However, it is also from the perspective of always being projected towards the future as a being that is concretely submerged in the practical affairs of the everyday world.

Table 2: Phenomenological language

3.3 Philosophy and phenomenology

Values, beliefs, and feelings about the world and how we understand them, are subjective to everyone. Creswell (2013) suggests that we all bring certain beliefs and philosophical assumptions to our lives, and consequently our research, whether we are aware of this or not. Therefore, when planning a research project, it is essential to reflect on our own personal philosophies and beliefs about how knowledge is discovered, as this may contribute to choosing the methodological approach for the study. However, the final decision must be based on the methodological approach that best meets the research aims. Research needs to be relevant, credible and contribute to developing new knowledge. Therefore, this personal stance needs to be transparent from the outset of any research undertaken. This allows the researcher to articulate their awareness of how they impact the research design and for the reader to understand that approach from the beginning of the study. How knowledge is acquired, forms of knowledge and how knowledge is

communicated, are all important issues that must be considered whilst undertaking research (Holloway 1997).

Phenomenology is a philosophical movement with a theoretical lens that provides explanations of our lived experiences in the world (Husserl, 1970). Phenomenology was introduced by Edmund Husserl at the very beginning of the 20th century (Husserl, 1970), and is deep rooted in the philosophical works of Kant, Hegel and Mach (Moran, 2000; Guignon, 2006). However, Husserl has become known as the pioneer of phenomenology due to a desire to convert philosophy into a science (Guignon, 2006; Husserl, 1970). Husserl believed that the key to separating science from philosophy was to direct attention toward meanings that connect our experience of objects (Husserl, 1970); objects being emotions, feelings, physical items, and time, for example. Phenomenological principles assert that scientific investigation is valid when the information gained comes about through rich description that allows for understanding of the essences of experience (Moustakas, 1994), and is thus the study of how people experience and perceive things in the world. Therefore, it is a fully inclusive conceptual framework adapted to provide research approaches that provides a consistent philosophical structure for the researcher.

The fundamental premise of phenomenology is that the most basic human truths are accessible only through intersubjectivity, and that the experiencer is integral to the description (Husserl, 1970) of that experience. This is the essential reason for conducting this study within a phenomenological framework, as I am aware that the very people living the experience are key to our understanding of SA disclosure to nurses. Therefore their interpretation and descriptions of that lived experience will situate not only myself, but the reader of this study in their world.

Phenomenology describes the common meaning of a lived experience from several individuals. Moustakas (1994) states this description consists of what they experienced and how they experienced it. As previously stated, phenomenology is based on a philosophy that is widely recognised as a major style of philosophical inquiry (Idhe, 1986) and a one that expects to understand humans and their being in the world (Merleau-Ponty, 2012). It focuses on researching a person's experience of an object, the relationships between people, and the world in which they inhabit: the interface of thoughts and feelings both conscious and unconscious (intersubjectivity). The premise of the phenomenological approach is that human experience can be understood in terms of its essence, rather than in the terms of causal explanations. In Husserl's (1970) view, understanding the essence of an experience means is paying attention to the thing itself.

Phenomenology allows researchers to explore the norms and values that represent groups situated contextually by their social and cultural backgrounds (Schutz and Luckmann, 1973). Through discourse, we are then able to capture the relationships, significances and (personal and professional) subjectivities, which are fundamental elements of the process of understanding their world. Tilley (2004) argues that this is a strength of phenomenology, unlike empiricist or positivist approaches, as it allows for the subjectivity of how a person experiences the world to be described. While this description is a redescription by the person experiencing the phenomena, the findings can facilitate insights and new understandings of how the person experiences phenomena. Tilley (2004) goes on to suggest that phenomenology is a way to describe the objects of consciousness in the manner in which they are presented to consciousness. This, in addition to the appealing qualities of the approach discussed so far and below, argues for the strength and appropriateness of phenomenology as the selected methodology for this study.

It has been suggested that there are three philosophical assumptions that need to be taken into consideration when undertaking qualitative research: ontology, epistemology, and methodology (Creswell, 2013). According to Creswell (2013) ontology is the claim researchers make regarding knowledge, epistemology is how individuals arrive at that knowledge and methodology is the process and procedures used to study it. Carter and Little (2007) suggest it is epistemology, methodology and methods that should support the structure for the planning and application of qualitative research. Crotty (1998) recognized this and omits ontology from his description of the theoretical perspective when considering the research process. He claims ontology and epistemology are mutually dependent and when exploring the construction of meaning, conceptually, it is essential to explore the construction of a meaningful reality.

3.3.1 Ontology and epistemology

Ontological assumptions are associated with the nature of social realities (Buriro, Ednut and Khatoon, 2020); specifically, the relationship between the world and our human interpretations and practices. Ontology determines whether we think reality exists entirely separate from human practices and understanding (realism), or whether we think reality cannot be separated from human practices (relativism) so knowledge will always reflect our subjective experiences and perspectives (Braun and Clarke, 2013). Braun and Clarke (2013) go on to argue that this is a continuum, and there are many variations between the two positions. Crotty (1998) suggests:

> *"all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between*

human beings and their world and developed and transmitted within an essentially social context" (p. 42).

This holds that the way humans respond to the social environment is based on their own perceptions and experiences, and this significantly affects future actions and interactions (Heidegger, 1962; Guba & Lincoln, 1994). My research is designed with an ontological assumption that the phenomenon being studied is complex, and this study acknowledges that, for each participant, their world is impacted by their background and history. This research embraces the notion that there are multiple realities experienced when disclosing, or receiving a disclosure of, sexual assault. This, and the intersubjective nature of those experiences, are reflected in the findings chapter. These ontological assumptions of relativism aided my understanding of the lived experiences and worldview of the participants to align the constructivist and interpretive epistemological learning within this study. There may be a sense of contradiction here with proclaiming both approaches whilst asserting to be undertaking this research within a descriptive phenomenological framework. This will be further clarified as epistemology and phenomenology is looked at in more detail.

Epistemological assumptions are concerned with the emergence of knowledge. Both Schwandt (2001) and Carter and Little (2007) describe epistemology as the study of the nature of knowledge, and the justification of knowledge, and this can be characterised in various ways that shape the direction of the research. The positivist approach utilises traditional scientific methods to gain knowledge and does not do this from gaining insight into individual experiences and perspectives (Creswell, 2013). Rather it seeks to study social observations that can be measured outside of human practices (realism); therefore, this research will not take a positivist approach.

Both the epistemological stance and the theoretical considerations aim to understand and explain human and social reality via an inductive approach. The methodology chosen for this research represents an inductive approach where data is gathered from the lifeworld experiences of the participants. Gray (2009) suggests that when it comes to methodology, researchers either take an inductive or deductive approach in addressing research questions. The inductive approach involves the collection of new data, which is then analysed in order to explore patterns or relationships between variables, resulting in new theory. Indicative reasoning by its nature is focused on a more open-ended and exploratory approach, in line with a relativist ontology.

There has been considerable debate about the need to interpret or describe accounts of the lived experience to fully understand them (Langdridge, 2007). Pringle *et al.,* (2011) argue against description, and suggests that it is not possible to fully understand and

describe a phenomenon without interpreting its meaning along the way. I would argue an understanding of the philosophy that grounds phenomenology is essential to be able to carry this out and be aware of when and where interpretation is used. For example, participants interpret their experience, researchers reduce it (phenomenologically) in order to continue the description, and then, as we explore these findings and link to practice/current discourse, a level of interpretation is given. Descriptive phenomenology does not renounce all interpretation, but instead suggests that when an experience is being explored this experience should be as pure as possible from the person having experienced it. Novice nurse researchers should endeavour to understand phenomenology as both a philosophy and research method. This is vitally important because in-depth understanding of phenomenology ensures that the most appropriate method is chosen to implement a study and generate knowledge for nursing practice. That said, whilst the distinction between Husserlian or Heideggerian routes is an important choice for application of research methods, the underpinning phenomenological philosophy remains constant across all concepts, for example, empathy, temporality, embodiment, *being-in-the-world*/*Dasein/ the natural attitude*.

3.3.2 Constructivism / interpretivism and symbolic interactionism

This section will not only explore the place of constructivism, interpretivism and symbolic interactionism in this study, it will also touch on the debate concerning whether to underpin lifeworld research with a descriptive or interpretivist approach.

Husserl (1970) broke with the positivist, natural science epistemological approach, stating that it misinterprets ideas as facts. He asserted that the positivist approach creates a dichotomy between science and understanding the everyday world and subjective experiences in that world which, ultimately, leads to a dehumanisation of society rather than contributing to the benefits of science. Ferguson (2006) suggested that this subjective thought has cast constant doubt on the elements of certainty that have come to be expected from scientific research. That is not to say that phenomenological research is unscientific: Husserl conceived phenomenology as an approach concerned with the clear understanding of the nature of reality (1970). In this sense it could be ascertained that Husserl's phenomenology provides a means towards understanding rather than absolute truth about human experience. This is in contrast with the interpretive approach and often lies in the main critique of Husserl's work. Husserl never acknowledged himself as an interpretivist and has been described as a radical empiricalist and positivist by those who worked with him and studied his work (Heidegger, 1962; Merleau-Ponty, 2012). That said, Husserl's main concern was that of meaning, as things are meaningful only in the context of the lifeworld. This search for meaning in the lived experience is acknowledged by Husserl as another reality, and that there is not one truth/reality as we all experience objects

(experiences) based on our worldview. However, he determined that structures of experiences based on descriptions from the person who is living the experience is as close to their absolute knowledge as you can get (Husserl, 1970). This view in itself is accepting of interpretivism's place in descriptive phenomenology. Ferguson (2006) states that the core of phenomenology, therefore, represents a philosophical approach (with its own logic and compartments that predate most anti-positivist epistemological thought), a method of investigation and a conceptual framework for structuring and organising qualitative data, that keeps the experience(r) at the core and the researcher at an arm's length.

With the interpretive approach, the relationship between the researcher and participant is crucial because subjective evidence (knowledge emerging from each participant) can be influenced by the part the researcher plays in the interview and/or data analysis. Many interpretive methods put this relationship as central from the outset (for example, hermeneutics, IPA, grounded theory). Whilst the premise of phenomenology is vital in gaining an inside view of the lived experience, descriptive phenomenology implies that attempts to distance oneself in *certain aspects* of the research process are needed if the knowledge is to be revealed from the participants' descriptions (Husserl, 1990).

A constructivist epistemology similarly stresses that there is no external truth or knowledge to be discovered, but instead reality is constructed in the minds of participants as a result of interacting with the world. Therefore, although there may be similarities and things we have in common, each individual's reality will be subjective, or different. Crotty (2003) suggests that while phenomenology has roots in constructivism, it is placed in an interpretivist theoretical perspective. However, Mackenzie and Knipe (2006) assert that both the interpretivist and constructivist paradigm is generated from the philosophy of Husserl's phenomenology, which precedes these epistemological stances, and therefore has a foot in both. Husserl (1970) believed that description, rather than explanation, is the best means of identifying what constitutes human behaviour (experience). Therefore, within both the constructivist and interpretive approach, a researcher tries to seek the meanings, which are rooted in everyday incidences. Cohen and Manion (1994) agree and imply a similarity between the two. Therefore both approaches allow for an understanding of the world of human experience, and both approaches emphasise that the reality of the world is socially constructed. The interpretivist/constructivist approach relies upon the participants' views of the situation being studied, and recognises the impact on the research of their own background and experiences. Constructivists do not generally begin with a theory, rather they generate or inductively develop a pattern of meanings (or theory) throughout the research process. Whilst this research mostly aligns with a constructivist approach, there are elements of interpretivism. Researchers are often asked to situate themselves in one theoretical camp or the other. Whilst interpretivism aims to understand the world,

constructivism wants to change the world (Gadamar, 2004), and arguably one cannot happen without the other. We cannot make tangible changes to the world without first understanding it and, for that, there is a need to interpret experience. When a participant talks about a phenomenon, they first interpret their experience in order to articulate that experience. Researchers then reduce that interpretation and construct the descriptions into meaning as we carry on to describe it, from a phenomenological perspective. Eventually, a level of interpretivism is added as the researcher links these descriptions to current discourse.

With the descriptive phenomenological approach, Husserl (1970) and Giorgi (2009) make clear that the researcher is not a collaborator in experience, rather a vehicle to describe and decipher meaning. So, whilst my aim is to explore experience and acknowledge multiple realities, I will follow this approach. I see myself as a descriptive phenomenologist. I situate myself in phenomenology with an openness to discover new knowledge and a recognition of the unknown. As a descriptive phenomenologist, I acknowledge my presuppositions and set them aside (this concept explored further in this chapter) to better understand the lived experience as shared by the participants of this study.

The purpose of constructivism and interpretivism is understanding the meaning of social phenomena; it allows for a pragmatic methodology to explore human experience. Experiences are often tacit and grounded in symbolic meaning, which is constantly modified as interactions are part of human experience. Crotty (2013) suggests, therefore, that we must take into account historical, cultural and established individual interpretations of the world. Because of this, multiple realities exist within the context of research participants; no two people have the exact experience due to their past interactions in the world. As a researcher, it is these multiple realities (experiences) I wish to undercover. The importance of giving meaning to subjective experiences and perceptions is paramount in striving to know the world. In this case that is the world as interpreted by individuals as a result of their interactions and encounters with others (May, 2011). As we try to uncover experience and generate new knowledge, we find that experience is often grounded in symbolic meaning. We see society as the product of everyday interactions, and these interactions allow us to gain an understanding of how individuals interact with one another to navigate and solidify their experiences in the world. Blumer (1969) refers to this process as symbolic interactionism; a theoretical perspective which focuses on the social aspects of human action. The underlying principles of symbolic interactionism are based on three key principles: meaning, language and thinking. Humans act towards objects on the basis of the meaning that the object has for them personally. The meaning attached to such objects arises from social interaction with fellow humans, and this meaning is modified and interpreted by the human dealing with the object as it is encountered (Blumer, 1969). From

a phenomenological perspective, these objects can be emotions, material objects, time, bodies and feelings (Husserl, 1970; Husserl, 1990; Heidegger, 1962; Merleau-Ponty, 2012). Through a process of symbolic interaction, individuals constantly analyse the symbolic meaning of the environment around them and the actions of others, resulting in subjective interpretations which evolve into new insights and interpretations (Bryman, 2008). Therefore, this theoretical perspective compliments and aligns itself well with the underpinning philosophical principles of phenomenology in this study. For example, for many years it has been suggested that the mind and body are distinct and are to be treated as such (separate specialist physiological and psychological/psychiatry focus in medicine and nurse education programmes in the UK provided separately for each field of nursing: adult, mental health, learning difficulties and child, for example). However, Merleau-Ponty (2012) argued that mind and body interact causally with one another, impacting and contributing to experience. This has been developed further, more recently, by Toombs' (1992) phenomenological work on embodiment. This is further touched upon in the findings chapter.

3.3.3 Axiology

Axiological assumptions reflect the researcher's value base, which Creswell (2013) describes as an essential characteristic of qualitative or quantitative research. This must be made explicitly clear in descriptive phenomenology due to the nature of the researcher making transparent any bias or assumptions they may have regarding their research. Creswell (2013) claims that the researcher must position themselves, and this requires the researcher to be transparent about any biases, actively declaring any influences that they may have regarding their research. Having acknowledged in chapter one that I bring my personal and professional values to this research study, I am aware that my previous role as a specialist sexual health nurse supporting survivors of sexual violence gives me a level of bias in the way I think about disclosure of SA. Following Husserl's (1970) descriptive phenomenology enables the researcher to set aside their own assumptions (importantly, that does not mean forgetting about them or removing them) in order to gain a deeper understanding of the specific phenomenon being explored. Husserl (1970) refers to this as bracketing (see Table 2). The process of bracketing (or not) is the main controversial debate when reading phenomenological literature. Descriptive phenomenologists (Husserl, 1970; Merleau-Ponty, 2012; Toombs, 1992; Giorgi, 2009) aim to reveal the general meaning structures of a phenomenon. Finlay (2009) suggests that researchers can do this by staying as close as possible to the complexity and richness of the data that is given by the participants, and that researchers should limit themselves to only making assertions that are facilitated by adopting a phenomenological attitude. This means taking an open and non-judgemental stance which puts aside pre-existing ideas and assumptions. Meaning of

experience comes from the individual source and is not presumed, assumed or assigned to (or by) the researcher. The central focus of phenomenological research is to map and explore the meaning of an aspect of human experience. Phenomenology as a qualitative research approach focuses on the subject of human experiences and the study of social issues, and therefore is best suited to the inter-subjective nature of this research (Creswell, 2009). The purpose of various types of qualitative research involves description and interpretation of human experience in ways that will promote understanding, provide insight and uncover existing beliefs. It has already been established that within this research topic there is a clear need to do all three.

3.4 Research methodology: clarifying the approach

As previously identified, a phenomenological approach will be used as the qualitative research methodology to facilitate this study. Following an exploration of other approaches this was a decision not taken lightly and, at first, I found phenomenology to be a complex and difficult philosophical approach to navigate through. However, the essence of the approach is to explore experience, the 'whatness' (Finlay, 2011), and this is what was needed for a topic with little previous research. That said, other qualitative methods were considered, such as narrative inquiry. Narrative inquiry has similarities with phenomenology in that it seeks to explore participants' stories and personal accounts of an experience (Cresswell and Poth, 2018). However, in narrative inquiry the researcher and the participant work together to co-construct these meanings, and this clearly requires some interpretation on the part of the researcher, alongside an on-going relationship with the participant (Pinnegar & Daynes, 2007). Cresswell and Poth (2018) describe narrative inquiry as the focus of one or two individuals, delving deep into the experience by gathering a range of data through the collection of stories and experiences. This results in stories that are co-created by the researcher and participant from a collaborative perspective. Central to the principles of narrative inquiry is the premise that the researcher must interpret meanings from participants' accounts (Cresswell and Poth, 2018). It was important to me that meaning is developed from pure descriptions of experience, rather than analysis of identities or stories. Also, due to the sensitive nature of this research, it became clear that once the interview is completed, so is the relationship with the participant. Continuing the relationship to re-explore would potentially increase the risk of emotional trauma, and it was my aim to keep this risk to a minimum. Because of this, co-creational focus narrative inquiry was ruled out.

Whilst narrative studies focused on individual stories, the intent of grounded theory is to move beyond the stories and description to generate a theory, in the hope to explain practice (Corbin and Strauss, 2007). Grounded theory is also an inductive approach that is

concerned with people in the world, and the way in which they live (Glaser and Strauss, 1967). It is contextual and iterative in that it requires the researcher to examine and re-examine the world of the participant from their perspective (Charmaz, 2014). Is it my aim to describe experience rather than construct or develop theory, therefore grounded theory was not chosen as a suitable method for this research. This topic is under researched in this field, therefore I feel there needs to be an understanding of the descriptive experiences of those that make and receive SA disclosures in the healthcare setting. There is also a need to understand the structures of those descriptions before we start to consider how we then generate theories or frameworks.

This research requires a methodology to explicitly describe a phenomenon that is not easily defined or lacks understanding. Therefore, a phenomenological approach was best fitted to this study. Phenomenology is well suited to describe phenomena that is not well understood or difficult to rationalise, as it allows researchers to make explicit the meanings we attach to our human experiences (Husserl, 1970). Descriptive phenomenology has its foundations in the philosophical stance that the everyday human world should be the basis of science and knowledge. Husserl's (1970) view was that, by exploring the lived experience, one could get to the essence of a phenomenon, by going to the things themselves through descriptions of the ways things appear. The main principle of descriptive phenomenology is that explanation should not be imposed before the phenomenon is understood. Phenomenology as a research method clarifies the meanings of phenomena experienced by individuals through the analysis of their descriptions (Drew, 2004). It offers explanation of the chosen phenomenon, and illustrates the voice of people experiencing a particular phenomenon (Streubert and Carpenter, 1995).

Husserl and Heidegger were philosophers not researchers, and therefore successors have had to interpret (often through translation by third parties) what their philosophies could mean in researching the lived experience. The variations in approaches to phenomenology have evolved over time because of the philosophical beliefs of researchers, and because of the contexts within which they were explored (Giorgi, 2009; 2010). However, they all had their focus on the identification and study of phenomena. Despite the various adaptations of phenomenology, there are two major approaches used widely within phenomenological nursing research (Cronin, Coughlan and Smith, 2015): descriptive (Husserlian) and interpretive (Hermeneutics) phenomenology. The key distinction between the two approaches is the nature of how the understanding of a phenomenon is processed. As mentioned above, Husserl's phenomenology is referred to as descriptive phenomenology due to the belief that one can attempt to set aside their own personal assumptions to derive understanding or description of a phenomenon (Husserl, 1970). Heidegger's approach,

whilst also focusing on the lived experience, utilises that researcher's background in interpreting the lived experience from first contact with participants (Heidegger, 1962).

Phenomenology is used in several professional practices, such as psychology (Wertz, 2005; Todres, 2007; Giorgi, 2009), nursing (Rose *et al.,* 1995; Lawler, 1998; Todres and Galvin, 2006; McConnell-Henry *et al.,* 2009), and education (van Manen, 1990). However, literature indicates a proportion of nursing researchers will often refer to phenomenological research with no distinction made between approaches, instead using the term as an umbrella for both (Balls, 2009; Crotty, 1998; Paley, 2008). Paley (2008) goes a step further and suggests phenomenology used in nursing research tends to be sought from second-hand sources; he comes to this conclusion by stating that, whilst Husserl often is referenced in nursing literature, the lack of direct quotes indicates second-hand knowledge, demonstrating a lack of true understanding of phenomenology. Other phenomenological writers, for example Dowling (2007) and Skea (2016), have contributed to the discourse that nursing is not utilising the full potential of phenomenology, instead considering the approach as a qualitative research method and overlooking the essential concept that phenomenology is ultimately grounded in philosophy. However, others suggest that it is both the philosophical AND methodological roots that are key to understanding phenomenology (Todres and Wheeler, 2001; Todres and Galvin, 2006; Langdridge, 2008; Gallagher and Zahavi, 2008). Giorgi (2000) replied to Crotty's critique suggesting that he had biased views about phenomenology and, when compared with Husserl's original writings, these seem to be based on misinterpretations. Furthermore, Giorgi (2000) argued that Crotty did not make a distinction between scientific and philosophical phenomenology. He concluded that if researchers practised what Husserl suggested, they would be practising philosophy and not scientific inquiry. Therefore, Crotty's arguments regarding phenomenology cannot apply in the case of research studies. A demonstration of philosophical understanding is essential to the application of phenomenology to research, therefore the distinction between the approaches and underpinning theoretical concepts is essential for transparency of the research process.

3.4.1 Husserlian phenomenology

Husserl (1970) developed his view of the world through the identification of the essence of phenomena. Husserlian phenomenology is the focus on description of the experience in order to get at its essence or essential structure (Husserl, 1970; Husserl, 1960; Husserl, 1990). Thus, to understand or know a phenomenon we must be able to describe it with as much detail as possible. Husserl developed descriptive phenomenology to answer the question 'what do we know as persons?' (Husserl, 1970). He argued that those undertaking phenomenology should suspend all suppositions, is related to consciousness, and is based

solely on the individual's experience (Husserl, 1970). In the view of Husserlian phenomenology, the mind (human consciousness) is directed towards objects, and this directedness is called intentionality (Husserl, 1970).

According to Cohen (1987), phenomenology was first described by Immanuel Kant, in a scientific context, as the study of phenoma or things. However, it did not have the philosophical meaning that it came to subsequently. Husserl is generally acknowledged as the founder of phenomenology, and this was achieved by building on and developing Kant's original work, by integrating his own desire to develop a reductionist approach and by adapting some of the psychological work of Wilhelm Dilthey (Husserl, 1970; Churchill and Wertz, 2015; Giorgi, 2009; Todres and Holloway, 2004). Dilthey was concerned with how the uniqueness of our own embeddedness in the world could be brought into psychology through pattern and meaning (Rickman ed, 2015), at a time when experimental approaches were dominant. Whilst Husserl (1970) was critical of psychologism, he was interested in Dilthey's descriptive emphasis, exploring it further from a philosophical perspective into a more epistemological direction about experience. Husserl also derived his inspiration and approach from Brentano, who viewed philosophy as a science (Brentano, 1995). Husserl (1990) maintained his concern for the rigorous nature of a scientific approach, and this is evident in his and (subsequently) Giorgi's (2009) descriptive nature of participants' experiences.

3.4.2 Hermeneutics

The second strand, known as the hermeneutic phenomenological approach, was developed by those who took their lead from Heidegger (1962). Heidegger's work was largely influenced by Husserl, whom he worked under. However, with the publication of Heidegger's *Being and Time* (Heidegger, 1962), there was a separation that was mostly influenced by their disagreement regarding phenomenological reduction. Hermeneutic phenomenology attempts to discover the meaning of human experiences as they are lived (Heidegger, 1962). This is in contrast to Husserl, who searches for the truth, reality or essence. Therefore, hermeneutic phenomenology is less objective and more personal (reflexive) on the part of the researcher. It takes a (wholly) interpretive, rather than a descriptive, method of analysis. Prominent phenomenological academics, such as Levinas (1991), Merleau-Ponty (2012) and Ricoeur (1973), further developed the philosophy of phenomenology throughout the twentieth century, but more along the interpretive lines of Heidegger than the descriptive approach of Husserl.

Langdridge (2008) commented that both descriptive and interpretive phenomenology are concerned with the description of '*the things in their appearing'* through a focus on

experience '*as lived',* and that the only differences are in their descriptive and interpretive research methods, while the underpinning philosophy is the same. Although Langdridge (2008) preferred to minimize the degree of difference between the two approaches to phenomenology, Applebaum (2011a) argued this thought is oversimplifying a complex aspect. Applebaum (2010; 2011a; 2011b; 2012) concurred that whilst the philosophical underpinning of the approaches are similar, and that any differences should not lead to antagonism between them (Applebaum, 2012), tension does remain due to the lack of understanding that qualitative work does not need to be *exclusively* interpretive, emphasising a lack of understanding of qualitative descriptive methods. Whilst favouring the descriptive approach, he believed that both offer fundamentally different conceptions of perception, understanding and method (Applebaum, 2011a). Clearly, as mentioned previously, it is the phenomenological reduction and where interpretivism sits that, ultimately, underpins any philosophical tensions between the Husserlian (descriptive) and Heideggerian (interpretive) approaches.

Heidegger (1962) argued that we cannot detach ourselves from the world in which we live or our interpretation of it. Thus, he argued that to set aside previous experience and assumptions is not possible. Heidegger went on to challenge Husserl by continuing to question the notion of bracketing; forging an argument that, as humans, we are embedded in the world and therefore this influences our understanding of it. Heidegger believed interpretation through language was needed to understand the world, and therefore experience. Heideggerian phenomenology is based on two essential notions, namely historical understanding and the hermeneutic circle, which requires researchers to visit their presuppositions and question their implicit and explicit understanding. Heidegger (1962) held that consciousness could not be separated from being in the world, suggesting that we are unable to bracket our prior conceptions and knowledge completely because we are necessarily embedded in a particular historical context. That said, he also described an ideal whereby a person should step back in the world to see how the taken for granted is presented (Heidegger, 1962). Here, and in the hermeneutic circle, it could be argued that he is describing a form of phenomenological reduction.

To conclude this discussion, when using Husserl's phenomenology to conduct a study the researcher should acknowledge and set aside their advanced knowledge or assumptions (through phenomenological reduction) that might guide the results in a certain direction (Haggman-Laitila, 1999). Whereas, when using Heideggerian phenomenology to undertake research, the researcher does not insist on an (attempted) objective investigation of the phenomenon under examination, and their own reflection on experience is used to co-create interpretation from the physical reality described by the participant.

This research will take the approach of Husserlian phenomenology. Whilst descriptive phenomenology does offer a complex approach, it also offers a structured way of examining experience. By limiting attention back to the thing itself using of a range of elements, such as phenomenological reduction, imaginative variation and descriptive analysis, interpretation can be applied to an overall discussion chapter when applying the descriptions of experiences to nursing practice (chapter 6).

3.5 Summary of chapter

This chapter has demonstrated the philosophical and methodological framework that guided this study. In summary the process is as follows:

Overarching philosophical paradigm: *Phenomenology*
Ontology: *Relativism*
Epistemology: *Constructivist / Interpretivist*
Research methodology: *Descriptive phenomenology*

The following chapter will specifically explore how these approaches have been applied to the research methods within the context of this study: the application.

Chapter 4: Application of research methods

4.1 Introduction to the chapter

This chapter details the design and application of the research methods of the study in order to meet the research aims, which is to explore the lived experience of people who have experienced disclosing SA to nurses, and experiences of nurses that have received disclosures of SA. The methodological framework was rationalised and is summarised below:

Overarching philosophical paradigm: *Phenomenology*
Ontology: *Relativism*
Epistemology: *Constructivist / Interpretivist*
Research methodology: *Descriptive phenomenology*

The study, from beginning to end, has been influenced by the philosophical phenomenological works of Edmund Husserl. This chapter explores how that philosophical thinking is interpreted and further developed by Amedeo Giorgi, and then pragmatically applied to a practical research method that describes the essence and structures of the lived experience.

4.2 Undertaking sensitive research

All research studies involving human participants require ethical approval prior to the research study starting. This approval ensures that dignity and privacy is protected, whilst potential risks to participants are considered and minimised (Denzin and Lincoln, 2005). Research ethics is an essential component of all contemporary research practice, demonstrating the moral responsibility that researchers must demonstrate they have undertaken for their participants.

This research was immediately deemed high risk due to the nature of the topic and the recruitment of participants that have experienced SA. Not surprisingly, research in the arena of sensitive topics is methodologically challenging, and these challenges will be explored throughout this chapter. However, defining what is meant by a sensitive topic aids in contextualising some elements of the design of this study.

Lee (1993) states that the difficulty in researching sensitive topics is that the phrase is often used as if it were self-explanatory. However, the interpretation is broad and could encapsulate research that explores issues with ethical, political and legal implications, research that poses a threat, physically and psychologically to the researcher and

participant, or studies that are seen to explore participants' experience of the more non-standard elements of human life, such as domestic violence, sexual practice, invisible crimes (Lee, 1993). Sieber and Stanley (1988) define studies in which there are potential social consequences or implications, either directly for the participants in the research or for the class of individuals represented by the research, as socially sensitive.

It is clear that this research exploring experiences of disclosing and receiving disclosures of SA is socially sensitive, not only in consideration of the participant, but also in that it seeks to explore an area of human behaviour that, for a large proportion of human existence has been kept hidden, as a taboo subject due to the nature of both societal power and gender imbalance. Even in the current climate of sexual violence and gender-based violence activism, increased public knowledge and awareness, improved services, and talking about rape still incites a level of discomfort for a large proportion of people. Unfortunately, this contributes to a lack of willingness to disclose and a lack of understanding of the needs of survivors of SA. Therefore, it is important that I acknowledge this research is sensitive in nature: sensitive to the participants, sensitive to me as the researcher, and sensitive to the reader. Considering this, the ethical perspective of this study is highly important to ensure all are protected from harm.

4.2.1 Ethical considerations and approval

This study received ethical approval from the Northumbria University Faculty of Health and Life Sciences Ethical Review Committee, therefore demonstrating safe ethical practices that protected the participants, the researcher and the organisation. Organisations involved in research must take responsibility to promote the development of high-quality, ethically-sound research with processes available to facilitate ethical scrutiny (DoH, 2005). Therefore, ethical (and governance) approval was also gained via gatekeepers from both NHS Trusts where recruitment was carried out, via the Integrated Research Application System (IRAS) and Health Research Authority (HRA). Ethical approval for participant recruitment was also granted by a regional organisation that supports survivors of SA; however, no participants volunteered from this organisation.

May (2011) states that a reflexive approach is essential to assure ethical inquiry which informs the conduct of, and promotes, the integrity of the research process. The main concern of any research should be to ensure the confidentiality, dignity, rights, and safety of participants are maintained and supported. To ensure these ethical obligations were met, key issues were addressed as part of the ethics application. These included the participant information sheet (see appendices 4) to ensure participants were making an informed decision about engaging in this study, including highlighting the potential risks involved in

participating. Informed consent is an essential aspect of ethical practice and, without the participant information, prospective participants would not have enough information to make an informed decision regarding their participation (Bryman, 2000). Participants must be able to volunteer their consent to participant free from coercion, and the participant information sheet allowed them to access information regarding the study and understand any risks of taking part. Informed consent is an essential aspect of ethical governance in research practice (DoH, 2005). Each participant gave voluntary informed consent by signing the consent page (see Appendix 5)

An in-depth debrief sheet (see Appendix 6) was given to all people participating in this study. This allowed for signposting to specific services should the participant need on-going support following engagement in the study. Specifically, the aim to reduce and limit harm was considered throughout all aspects of this study; for example, the choice of the data analysis framework used was used as it negated the need for the researcher to go back to the participant with a transcript of experience/interview to be re-read or reviewed for clarity or accuracy. Ultimately this would have increased the number of times the experience is re-lived, therefore increasing the risk of psychological trauma.

Because the focus of this research is SA and/or rape disclosure, and due to the nature of the topic, it was identified early in the study that during the data collection process there was a possibility that reliving traumatic experiences would bring emotions to the fore, or that participants may use the opportunity to disclose additional previous or current SA never disclosed in the past. Whilst disclosing an experience they had previously never disclosed to a professional did not happen in the study, consideration was put into place regarding the clarity of the information sheet and supportive nature of the debrief paperwork. Some of these considerations included ensuring confidentiality (within professional limits) and providing contact details of the most appropriate services (e.g., local SARC, a range of regional sexual health services, GP access, Rape Crisis Tyneside and Northumberland, student support and wellbeing, and employer occupational health services). This was discussed at the beginning of every interview. It was also fully explained to all participants at the beginning of every interview that, if they had identified themselves or someone they knew who might be at risk of immediate harm, as a registered nurse, in line with the NMC Code (2018) and safeguarding responsibilities, I would have to disclose this information to seek guidance from my academic supervisor and potentially the relevant safeguarding team. I also made it clear that, in the event of participants becoming distressed when recounting their experience, as a research interviewer I would be sensitive and flexible to this. They would have the option of the interview being terminated or to take a break, and pausing and debriefing would commence at this point and then again at the end if the interview was re-started. Dempsey *et al.,* (2016) highlight this as an essential approach of

any researcher undertaking sensitive interviews in qualitative research. I did not have to terminate any interview; however, there were times when participants became upset when recounting their experience and all were asked if they wished the interview to end, and none said yes. Verbal debriefing (alongside the debrief sheet for participants to have the option to take with them) was an integral part of this research plan, and had several purposes. It was a chance for participants to explore any questions that they may have had throughout the interview, and for me to thank the individual for participating and sharing their experience, whilst also discussing the participants' perception of the research experience to gain essential feedback. It is hoped that participation resulted in a therapeutic (reflective) value for participants, a view that has been highlighted in previous research (Lewis-Beck, Bryman and Liao, 2004), although Corbin and Morse (2003) state the importance of not using the interview as a counselling session. Clarke (2006) confirms the importance of the researcher being empathetic and taking the lead from participants as whether to probe or not with areas of discussion that are clearly highly sensitive or upsetting to the participant. Unfortunately, participants' reflections on the value of participating was not captured as part of the study; this would be a beneficial area for future research in the sexual violence arena.

Other considerations for the participants were put in place such as tissues and water being available, a choice of environment in the setting being a community-based booked private room or on university campus (all participants chose a pre-booked room on university campus) and the offer of breaks added to the interview.

Beauchamp and Childress (2013) identified four key principles that underpin all aspects of research to make it ethically sound: respect for autonomy, non-maleficence, beneficence, and justice. As indicated in the section above, these principles underpinned the development of an ethical framework for this study, ensuring participants were not put at risk of harm. They received information that ensured they were fully informed about the purpose of the research, were able to give informed consent to participate and were made aware that they were able withdraw from the study should they wish to do so.

All participants were informed of the right to refuse to take part or withdraw from the study at any point, with no explanation and no impact on their current professional role (for healthcare practitioners) or future care that they may receive (service users). Participants took part voluntarily, free from any coercion. There was no financial remuneration or other incentives or inducements to encourage people to take part in this study. All participants were over the age of 18, and were able to provide individual verbal and written consent to participate.

There was no occurrence of unforeseen ethical dilemmas or withdrawal/termination of participation during this study. However, there were three incidences of complaints made regarding the nature of the topic being studied at the point of recruitment for participants. On the first round of recruitment (invite email sent to all students studying at the participating institution) for the survivor participant group, three separate individuals (x2 academic staff and x1 student) complained to the Faculty Director of Ethics, and Chair of the Faculty Research Ethics Committee regarding both the nature of the topic and the recruitment strategy. All three individuals were given reassurance that the study had received ethical approval and all considerations had been made to ensure recipients of the email and individuals volunteering to participate were given support and debriefing information if, and when, needed. Additionally, the phrase 'topic of a sensitive nature' was added into the email subject box and the first line of the email advised of the topic and to delete if not interested. As both a researcher and nurse, I recognise that this topic might trigger secondary trauma, or ignite concern and anger, and therefore appreciate the worry that people must have experienced in order to express their concern that the study was being undertaken and advertised in what they perceived as a bold way. That this research received complaints of this nature highlights the (potentially) provocative and sensitive (taboo) nature of this topic, thus demonstrating the importance of normalising research in the field of sexual violence. It was imperative from the beginning of this study that the research process was carried out with sensitivity and support due to the nature of the topic. It also highlights a need to normalise inquiry into sexual violence, giving survivors a voice to explore their experience should they desire to. Subjects that are, and continue to be, taboo are kept in the dark and a desire to improve services will be missed unless they are explored.

4.2.2 Confidentiality

Confidentiality is another key requirement of ethically-sound research. The anonymity of participants must be assured at all times of the research process. Therefore, all participants' personal information and data was managed in line with the university's data protection and governance policy (Research and Ethics Governance Handbook, 2019). As confidentiality is also an integral part of being a nurse, the NMC code of conduct was adhered to (NMC, 2015).

4.2.3 Data storage

All processing of personal data complied with the terms of the Data Protection Act (1998) at the point of data collection and then the General Data Protection Regulations (2018) subsequently. All data collected were anonymised, as per the Research Ethics and Governance Handbook (2019). There was no personal identifying data used for the purpose

of this study. Records were stored in accordance with the Data Protection Act (1998) / General Data Protection Regulations (2018) and the Research Ethics and Governance Handbook (2019). All records will be destroyed as per the university research records retention schedule, seven years following completion of study.

4.3 Research methods

This study has adopted descriptive phenomenology, as previously mentioned, but more specifically Giorgi's interpretation and method. Giorgi further developed the descriptive phenomenology of Husserl (Giorgi, 1985; 2009; 2010; 2012). Giorgi's aim, inspired by Husserlian philosophy, was to develop a rigorous descriptive empirical phenomenological research approach by focusing upon essential structures (or essences) of phenomena as they appear in consciousness (Giorgi, 1985; 1994; Giorgi and Giorgi 2003). Giorgi's (2009) methodological development of phenomenology incorporated philosophical, scientific and psychological approaches, and is heavily dependent on the thoughts of Husserl and, later on, despite his interpretive views, Merleau-Ponty (Giorgi, 2000; 2010). As evident from his work, phenomenological research is about a mode of discovery to clarify experience, not a means to confirm a theory-laden hypothesis or to develop new theory. The intention in this study is to apply Giorgi's descriptive phenomenological psychological method (Giorgi, 2012) appropriately to the study of the lived experience of giving and receiving disclosures of SA in nursing practice. This contributes to the rationale of adopting the philosophical and methodological groundings of phenomenology and, specifically, descriptive phenomenology. It does so within the context and understanding of the philosophy of phenomenology. The result of Giorgi's (2012) method is a structure of experience created from elements that depict (describe) the phenomenon. As understanding the lived experience is built on Husserl's (1970) phenomenological philosophy, essence of experience is generated and transformed to discover structures and meanings in the data. To do this, researchers need an attitude that is open and naive enough to let unexpected meaning appear. Therefore, for the application of methods, the phenomenological attitude and reduction is used not only in data analysis, but also in data collection. The application of this is explored as I move into each section of the methods. However, to undertake the process of phenomenological reduction and, in turn, bracketing, requires putting aside one's own beliefs about the phenomenon and what is already known about the subject. It is important to add here that, as a researcher and a human *being* in the world, I am aware that I cannot empty or remove my thoughts, judgements and experiences to create a blank canvas or empty shell. However, I do believe through the application of the descriptive phenomenological method of inquiry, I can use reflexivity to acknowledge my thoughts, beliefs, and biases regarding SA disclosure. This way, I can put them to one side whilst I adopting a phenomenological attitude that will add a level of naivety to inquiry; allowing me

to get to the essence of experience without tainting that essence. Adopting the phenomenological attitude and bracketing my own beliefs about this topic demonstrates additional authenticity of the voice of the survivors throughout the data collection and analysis process (Ahern, 1999). This also reveals the efforts to ensure the approaches taken are judiciously informed by the philosophical framework that is used to guide this study.

The methods used to apply phenomenology to study of the experience of SA disclosure in this research were Bevan's (2014) phenomenological interview structure (data collection) and Giorgi's descriptive phenomenological psychological method (Giorgi, 2009; 2012) (data analysis). These approaches allowed a pragmatic and transparent phenomenological process to address the research questions.

Research question and aims of study:

Having provided context for this research, it is apparent that my research question has two elements:

- What is the experience of survivors of sexual assault in making disclosures regarding their assault to nurses?
- What is the experience of nurses receiving disclosures of sexual assault?

The intended aims are to:

- Explore individual experiences of sexual assault disclosure to nurses within the UK.
- Explore individual experiences of receiving sexual assault disclosures in UK nursing practice.
- Develop an insight into sexual assault disclosures in a healthcare setting.
- Offer an original research contribution in understanding experiences sexual assault disclosures in nursing practice.

4.3.1 Sampling strategy

To get a fuller sense of the experience of disclosure, it was imperative that this study explored the experience from the perspective of the survivor disclosing the SA and nurses receiving disclosures (experiences were not linked with one another). Therefore, there are two separate participant groups in this study: survivors and nurses. Convenience and then purposive sampling was used for the recruitment of both groups of participants.

Convenience sampling is drawn from a source that is conveniently accessible to the researcher (Braun and Clarke, 2013). This method was used in accessing both survivors and nurses that were studying or working at the university in which this study was

undertaken, within two regional NHS organisations, and a regional support voluntary sector organisation. However, beyond this, there was a purposive approach. It was made clear on the information distributed regarding the study (see Appendix 4) that participants must (for survivors) have had experience of disclosing their personal experience of SA to a nurse or (for nurses) have experienced disclosures of SA in their professional role as a nurse. Experience was necessary for participation, hence the purposive sampling strategy. Gronmo (2020) refers to this as self-selection sampling, with the starting point being individuals receiving information about the study, then coming forward to participate if they wish. With this method, the researcher has no control over who comes forward to participate. Thus, one benefit of this is reduction in bias when exploring such a specialist topic. However, there is an acknowledgement that those individuals who volunteer may do so with an underlying agenda, such as to reflect/vent about poor experiences, to explore a complex case if they have been unable to access support, or to disclose an experience for the first time. In the event, to my knowledge, none of these scenarios happened during the data collection process.

4.3.2 Recruitment

To obtain a diverse survivor participant group, alongside accessing university students, I approached two regional services to provide more information about the study and to invite their service users to participate: one that specifically supports black and minoritized women (BMW) who have been subject to domestic and/or sexual abuse, and one that provides specialist counselling support services for adults having experienced rape. The latter organisation agreed to advertise the study and displayed my poster (see Appendix 7) to inform people using their service about the study, should they wish to inquire/ participate. The BMW organisation declined to advertise due to what they felt was the lack of overall focus on BMW or diversity in the study. It is important that this refusal of access is acknowledged in the study to highlight these specific needs, and allow for reflection on my part in the use of tokenism in research when it comes to this sensitive topic. Diverse voices need a place to be heard that focus around individual needs. This is further addressed in Chapter 7.

A recruitment call for participants from the university was undertaken twice: once pre- the #MeToo movement (summer 2017) and again, post-#MeToo (Summer / Autumn 2018). The #MeToo movement was founded in 2006 by survivor and activist Tarana Burke in order to build a community of advocates determined to interrupt the lack of support to survivors of sexual violence via providing resources and pathways (www.metoomvmt.org). In October 2017, in the wake of sexual abuse allegations pertaining to Harvey Weinstein, the #MeToo hashtag went viral overnight. The allegations triggered a tsunami of abuse allegations at

men from every corner of society and the world. Women used their voice online via the #MeToo to share experiences of sexual abuse and demand change. At a similar time, there was many high-profile sex abuse cases being exposed in the media. I believe this movement had an impact on those that were willing to come forward and participate in this research by sharing their experiences.

Inclusion criteria

Participants expressing interest must have answered yes to one of the following questions (depending on the group they were entering as a participant) and fit in the inclusion criteria:

- *(Nurse) Have you experienced sexual violence disclosures in your professional practice?*
- *(Survivors) Have you experienced disclosing a personal experience of rape or sexual assault to a nurse?*

A clear inclusion and exclusion criteria was used for the sample group (see Table 3). Whilst it is not ideal to have a criterion to exclude people from participating in research, in this study there were specific reasons to add this, and these are highlighted in the table below.

Inclusion Criteria	**Exclusion Criteria**
Self-defined experience of sexual assault	The participant is under 18 years old *As previously touched upon, there is a wide range of literature in supporting those having experienced child sex abuse (rape) under the age of 18 and a very limited focus on adults.*
18 years old or over	The sexual assault took place when the participant was under 18 years old. *Safeguarding implication and due to the adult focus of the study.*
Able to have the mental capacity to consent to participate in the research study	There are current legal proceedings regarding the sexual assault discussed (*so as not to potentially jeopardise ongoing legal cases*).
Disclosed their episode of sexual assault to a nurse	Where the perpetrator of the sexual assault discussed is identified as a current partner (*for all parties' safety*).

Table 3: Inclusion and exclusion criteria

Capacity to consent was assumed in the first instance (Mental Capacity Act Code of Practice, 2007). The criteria for mental capacity involved the following, as required by the Mental Capacity Act (2005). Prior to asking participants to sign the consent form, each point was discussed. As a researcher and nurse, I was prepared that if there was any doubt with regards to a participant's mental capacity, they would not be included in the research.

4.3.3 Sample size

Qualitative research does not investigate variables but events and incidents that are informative and specific to the needs of the study (Patton, 1990). To this end, the depth of the information provided by participants often explains the comparatively small sample size that is used in qualitative research. Small sample sizes are required due to the potential of large volumes of data collected from participants. The qualitative approach sacrifices large sample sizes in favour of more detailed analyses of phenomena and individuals' own experiential accounts, highlighting that human experience is complex in its entirety. Undertaking this inductive in-depth approach to the study is appropriate for the exploration of experience of sexual assault disclosures (Crouch and McKenzie, 2006; Myers, 2000).

Giorgi (2009) asserts, from a phenomenological perspective, that the sample size is not as important as the depth of the description of the experiences. He goes on to support that, for some research studies, one participant can be adequate (Giorgi, 2009). For others, where the topic may be more complex, he suggests there should be sufficient participants to recognise a range of variation in experience. To achieve the variation, he advises three or more participants. For this research, ten from each participant group was proposed. However, due to the complexity and sensitivity of the topic being explored this number needed to be flexible, in line with Giorgi's descriptive method (Giorgi, 2012).

There is much talk about saturation with regards to data collection (Glaser and Strauss, 1967; Braun and Clarke, 2013; Guest, Bunce and Johnson, 2006). It is important to remember that with phenomenological data, the focus is not on saturation, but depth of meaning. The decision to cease collecting data in this study was supported by re-reading and analysing the transcribed data, a reflexive approach that allowed me to identify those similar experiences which were being described. This was coupled with the awareness that it was especially important in conducting this research to not be oversaturated and overwhelmed in large amounts of data, so that the voices and experiences of the participants did not risk getting lost. There was also a pragmatic awareness of the limitations of a part-time doctoral study with no additional resources. That said, it is also acknowledged that Giorgi (2009) states that ending data collection cannot be fully decided upon until the data analysis is completed. Therefore, an open mind to the potential of a further need to collect data was acknowledged until after the data analysis process. For this study, the end of data collection came after the completion of the eighth (nurse) and ninth (survivor) interview.

The quality and richness of data collected through interviews relies on the skill of the researcher in drawing out participants' experiences and perspectives. Whilst larger sample sizes do allow for generalisability, they do not provide an exploration that is rich in depth of

the experience. One of the greatest merits of phenomenological research lies in the rich and substantial data collected during these studies (Colaizzi, 1978; Giorgi, 2009). Studies such as this, with smaller, more descriptive, in-depth data, can do more to increase the understanding of rarely studied groups/phenomena than surface-level, quantitative studies, no matter the quantitative study's sample size (Englander, 2012).

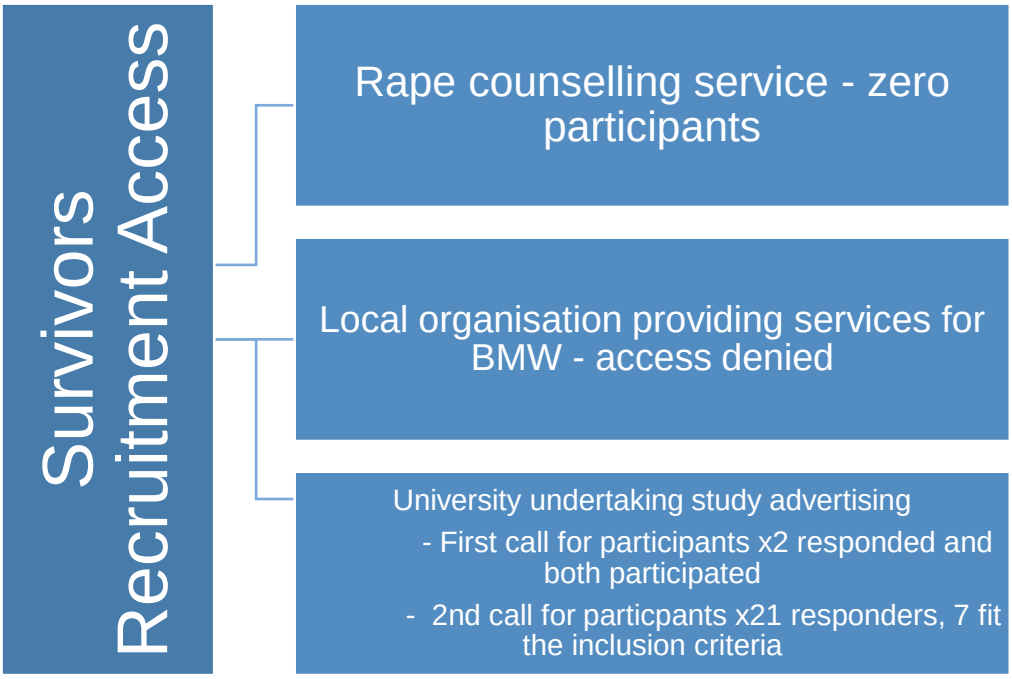


Figure 2: Survivor participant recruitment

Survivor participants' age range was 19-51, with eight identified as female and one as male. Age and gender were optional questions prior to the interview and asked to explore if they fit with the statistical demographics suggested in the literature. No other demographics were collected.

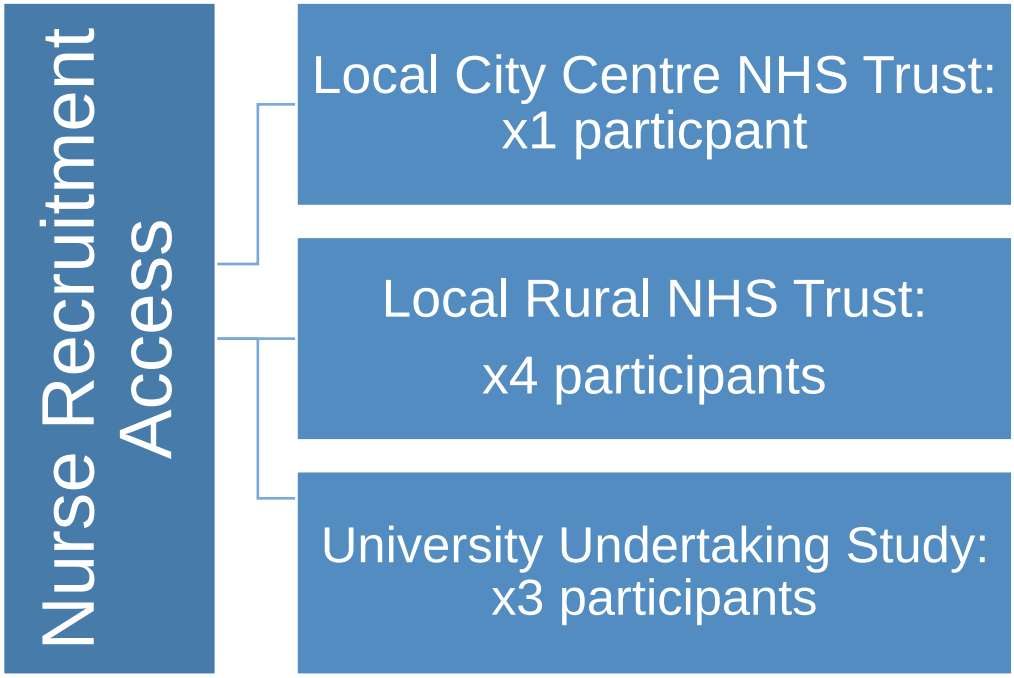


Figure 3: Nurses participant recruitment

Demographics from the nurse participant group were (optionally) collected and differ slightly from the survivors' demographics. This was due to the nature of the role / experience and whether this would impact experience. Of the eight nurses, all had been qualified as a registered nurse for 10 years or longer (longest 40 years), and all identified as female. The range of areas the nurses worked in (within their current practice) were as follows:

- Sexual health (x3)
- Emergency care (x2)
- Oncology specialist (x1)
- Education (with backgrounds in general and surgical medicine) (x2)

However, the experiences of rape disclosures (all experience of disclosure were of rape) for some were in previous roles in other specialist areas (general medicine, emergency nursing, practice nursing, community nursing).

This sampling strategy resulted in seventeen participants (9 survivors and 8 nurses), none were dyadic interviews.

4.3.4 Data collection

Data collection took the form of digital audio recorded interviews with all participants (this was optional for the participants, but all consented). As mentioned previously, to ensure rigor, it is important that the data collection and the data analysis are part of a unified process, with the same underlying approach. In this case, they both followed a descriptive phenomenological approach (Englander, 2012). Giorgi (2009) points out:

> *"There are many books with advice on how to conduct an interview, but none happens to be written with explicitly phenomenological criteria in mind" (p. 122).*

There is much written about the process of data analysis from a descriptive phenomenological perspective and, specifically, the importance of phenomenological reduction (Giorgi, 2009; Colaizzi, 1978; van Kaam, 1966; Moustakas, 1994), yet little about the interview process. Bevan (2014), however, addressed this gap and explored the structure of phenomenological interviewing; providing a structure to the interview that can be applied when undertaking the descriptive phenomenological approach (see appendix 8). My interviews all took an open-ended approach with underlying structure, supported by Giorgi (2012) and Bevan (2014). Bevan (2014) suggests, no matter how vague, that as an important starting point interviews should have an underlying structure and, as a novice researcher, this structure was essential to ensure focus on the phenomenological attitude remained throughout the interview process. Bevan's (2014) structure of phenomenological interviewing provides an explicit approach for researchers on how to conduct interviews from a Husserlian phenomenological perspective.

Bevan's (2014) structure was particularly helpful for clarifying (rather than assuming because of previous experience) with that naive approach and in ensuring the depth of the experience was described. For example, in my interviews, I probed where meaning was unclear: "*you used the word 'nurse' how did you know they were a nurse?" or* "*tell me how you think your experience would have changed if the nurse was wearing a uniform?".* Although the interview is somewhat structured, it is also imperative that the subjective character of the data is left intact and untainted (Crotty, 1996), hence the open-ended approach to clarifying questions to allow for expansion on experience, rather than the traditional semi-structured approach. This is philosophically underpinned by Husserl's (1970) point that inquiry should be embedded within the lifeworld. To maintain a phenomenological attitude, it is essential that the researcher embraces reduction and asks open questions of the phenomena (Todres and Holloway, 2004; Bevan, 2014).

To apply this approach, I ensured the interviews were as flexible and open as possible by asking questions to clarify and illustrate the full meaning of the participants' descriptive experiences (but ensured I was not leading the participant). For example this included questions, such as: *"Can you describe the room in more detail?", "You said felt sick, can you describe to me how you experienced this feeling?", "you used the word dismissed, can you give me an example of what was communicated to make you feel this way?" and "Can you describe to me what you mean by dismissed?".*

Finlay (2011) emphasises the importance of the application of this exploratory approach, suggesting researchers often fail to pose appropriate follow-up questions that are linked to previous descriptions and are often focused on the next question they have in their semi-structured list. Subsequently, it becomes difficult to elicit more detailed descriptions and therefore they fail to gain descriptions of the lifeworld variants as they focus on their own questions. I undertook phenomenological reduction to attempt to adopt this embodied approach whilst probing for further meanings through empathy, openness, and attentive listening (Finley 2011; Bevan 2014).

The interviews naturally came to a close when indicated by a period of quiet. I posed a final question to ask whether they had anything else that they would like to share regarding their experience. The digital audio recorded interviews were transcribed, verbatim, for data analysis (Moustakas,1994; Parahoo, 2014).

4.3.5 Interview safety

It is acknowledged that with all face-to-face individual interviews there is an element of risk. A risk assessment was completed with specific action to be undertaken in certain circumstances. All interviews took place on campus in booked private rooms. My PhD supervisor had access to my diary with venue and room allocation (but not participant identifiable information).

4.3.6 Data analysis

Within descriptive phenomenology, there are several approaches to data analysis. Four methods are used widely within healthcare, those by Colaizzi (1978), van Kaam (1969), Giorgi (1985; 2009; 2012) and Moustakas (1994 - a modification of van Kaam's approach). These methods of data analysis comprise of several pre-defined steps and facilitate the meaning of an experience through emergent themes. Key features from all frameworks of the analysis stages involved the use of phenomenological reduction, intuiting, analysing and describing experience. I decided to use Giorgi's (2012) modified Husserlian approach, the phenomenological descriptive psychological method. Whilst I found the structure pragmatic and practical to use, I also valued the aspect of Giorgi's (2012) updated literature, emphasising the process that negates the need to validate the essences with the participant. In contrast, Colaizzi's (1978) 7 step descriptive phenomenological method describes the verification of the fundamental structure as the final step of his analysis, to ensure participants are satisfied it captures their experience, participants can also add to structures at this point. Whilst the benefit of this aspect of data analysis can be appreciated,

I considered the nature of the topic and the ethical approach to this study and deemed it unnecessary to expose the participants to the transcript and their experience for a second time. Whilst it is appreciated that many researchers use this approach to confer trustworthiness, the participants had already relived the experience through their description, and for some this was upsetting at times. The decision to choose a method that omits this aspect of validation was solidified by knowing each transcript was typed verbatim as an identical reflection of the interview. Therefore, to minimise risk of re-trauma, a decision was made not to send the essences back to the participants for confirmation of accuracy.

The goal of phenomenological research is to enhance critical awareness and strengthen reflective thoughtfulness about what is important in the taken-for-granted aspects of everyday life (Powers and Knapp, 1990). Swanwick and Barlow (1994) suggest the analysis of several people's experience often leads to a deeper understanding of the phenomenon being explored. Whilst Husserl aimed to gain universal essential features of phenomena (Husserl, 1970), Giorgi aimed to gain, through scientific phenomenology, a generality of features (Giorgi and Giorgi, 2003). This led to the most obvious modification made by Giorgi (2012); whilst Husserl's philosophical phenomenology was developed to allow or facilitate the philosopher in their exploration of their own lifeworld, Giorgi's empirical approach allows researchers to develop their understanding of other people's lived experience. This is a demonstration of how philosophical phenomenology underpins the ongoing development of this research approach.

As previously highlighted, Husserl's phenomenological philosophical thinking (1970) is credited with revealing the fundamental characteristics of exploring the lived experience and introduces the process of reflection on meaning and eidetic analysis using imaginative variation. Giorgi (1985) began by turning this philosophical phenomenological approach into a method for studying consciousness, but his work then systematically modifies the philosophy for use in scientific investigation and ends with an outlining of the procedures in such approaches (Giorgi, 2012). Giorgi also offered explanations of the procedures of phenomenological reduction and subsequent bracketing of judgements, and biases. The method that has been developed by Giorgi over the last four decades is readily understandable and practical in terms of application of this complex philosophical approach.

Giorgi provides a description of his method, including a detailed staged approach to analysis (Giorgi 1985; 2000; 2009; 2012), and it is the 2012 detailed method this analysis has been founded upon (see Table 4). For my own sense of understanding (as a novice researcher) and to clarify the process, I have slightly changed the names of some of the steps for this research. This is demonstrated in Figure 4 and explained as I describe the analysis process.

Step 1	This step is undertaken within the phenomenological attitude, by reading and re-reading the data (transcripts) to get a sense of the whole. It is clearly advised that the phenomenological approach must be holistic in nature and that no further steps can begin until the researcher understands the full data.
Step 2	Every time the researcher experiences a transition in meaning, a mark (highlight) is made on the data.
Step 3	In this step, the data is still in the words of the participants. They are highlighted to indicate the expressions that are directly revelatory of the psychological import of what the subject said. The use of imaginative variation is essential for this step.
Step 4	Essential structures are highlighted in this step. This is to highlight the direct and psychologically-more-sensitive expressions. These are then reviewed with the continued use of imaginative variation, indicating a complete essential structure.
Step 5	Throughout this step, all essential structures are used to clarify and interpret the raw data of the research. These are divided to directly influence the development of the themes.

Table 4: Giorgi's phenomenological psychological method (Giorgi, 2012)

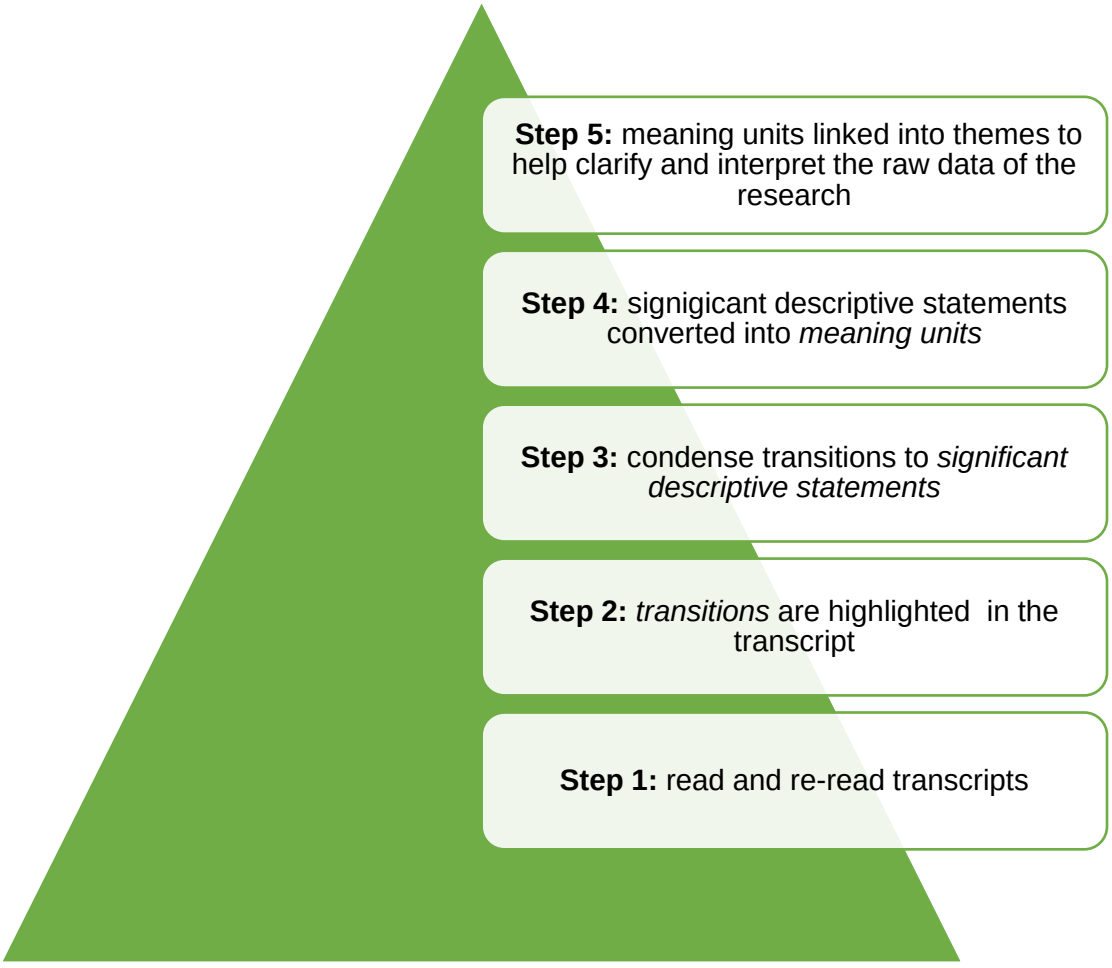


Figure 4: My descriptive analysis interpretation of Giorgi's (2012) phenomenological psychological method

4.3.7 Application to research data

To undertake the descriptive phenomenological psychological method, Giorgi (2012) indicated the researcher must begin by assuming the correct attitude. This is first undertaken by assuming phenomenological reduction, and resisting from putting forward bias. As discussed above, this is a controversial element of descriptive phenomenology and mainly misunderstood. Giorgi (2012) addresses this by suggesting:

> *"the researcher still considers what is given to her but she treats it as something that is present to her consciousness and she refrains from saying that it actually is the way it presents itself to her" (pg. 4).*

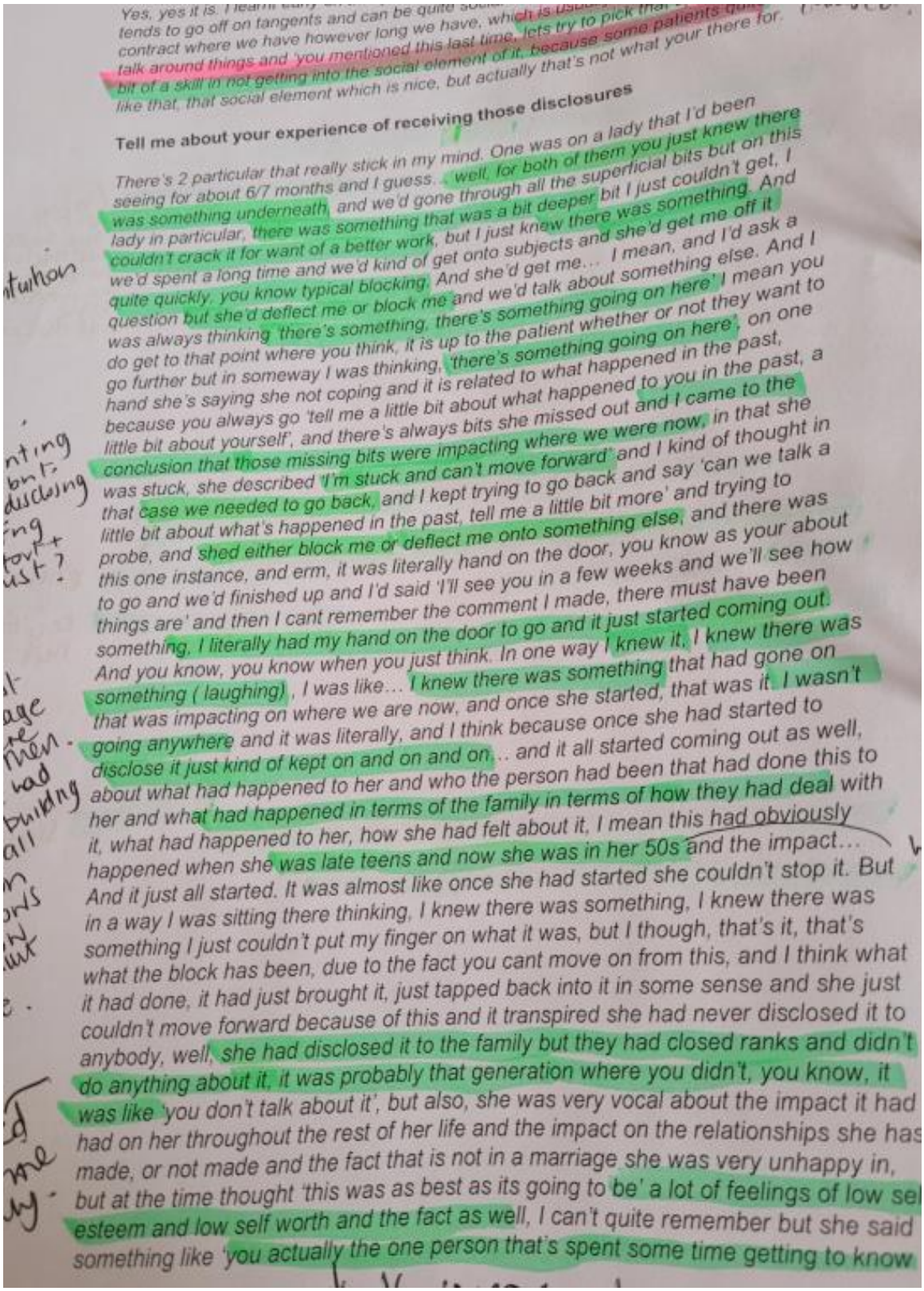
Step 1: Reading and re-reading the transcripts

Analysis commenced with re-reading the transcripts. They were read numerous times to get a sense of the entire description (Giorgi, 2009). When entering phenomenological reduction and re-reading the transcripts, it was uplifting to completely focus on the data and how the participants had described their experiences. Each transcript highlighted the individual experiences that were unique. However, whilst undertaking this aspect of the research, I also started to see similarities between descriptions of experience. I took this time to observe and enjoy immersing in these, rather than allowing it to begin impacting my overall sense of the data. From a reflexivity perspective, it is important to address here that undertaking this step was an emotional experience, both as a researcher and a human. This was not a quick process for me and, due to the nature of the topic, it was difficult to read more than one transcript a day, or at times a week. Not only was the topic and the description emotive, but the honesty and vulnerability that the participants demonstrated whilst sharing their descriptions and having their experiences unfold was overwhelming. I used my reflective diary to capture this feeling. van Manen (1990) suggests that this textual emotion brings to the fore a deeper understanding of our worldly engagement.

Step 2: Identification of transitions

Once the re-reading of all the transcripts has been undertaken, this stage identifies transition of meaning. Whilst undertaking this stage, I noticed that the aspects of the transcripts I had previously highlighted were not always defined with complete sentences. As Giorgi (2009) suggests, sentences are units of grammar and not always sensitive to the experience of the participant's lifeworld. Because of the application of phenomenological reduction and depth of focusing needed, this part of the process was undertaken by hand. I tried to do this electronically but found I was unable to immerse myself as well as I needed whilst looking at a screen. Examples of a section of a nurse (see Figure 5, Deb [pseudonym used throughout findings]) and survivor (See Figure 6, Anne [pseudonym throughout]) highlighted transcript are below. Full transcripts are not provided to protect the

confidentiality of the services accessed and areas / names of perpetrators and survivors used (unintentionally).

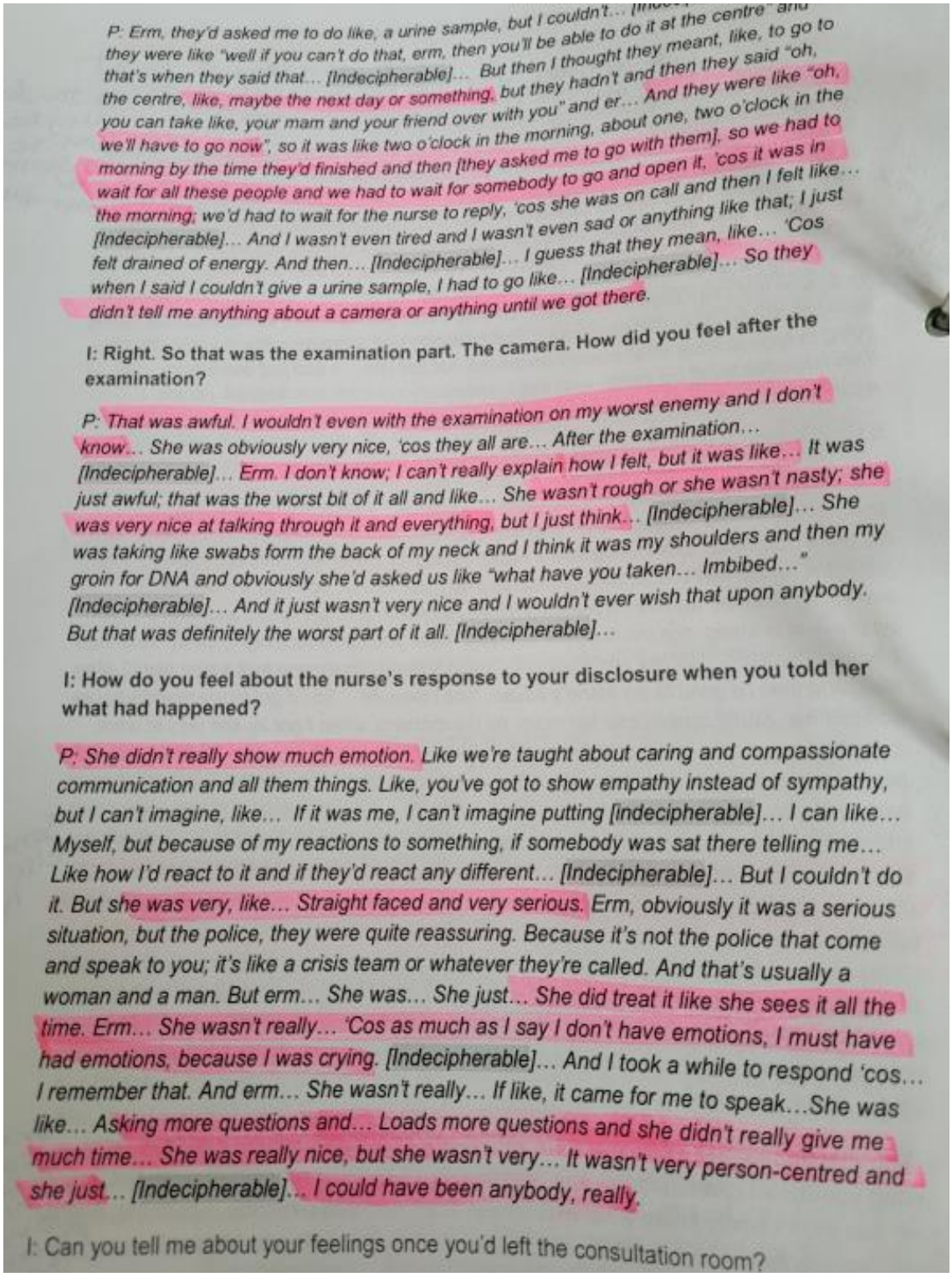


Yes, yes it is. I learnt early ... tends to go off on tangents and can be quite ... contract where we have however long we have, which is ... talk around things and 'you mentioned this last time, lets try to pick that ... bit of a skill in not getting into the social element of it, because some patients ... like that, that social element which is nice, but actually that's not what your there for.

Tell me about your experience of receiving those disclosures

There's 2 particular that really stick in my mind. One was on a lady that I'd been seeing for about 6/7 months and I guess... well, for both of them you just knew there was something underneath, and we'd gone through all the superficial bits but on this lady in particular, there was something that was a bit deeper bit I just couldn't get, I couldn't crack it for want of a better work, but I just knew there was something. And we'd spent a long time and we'd kind of get onto subjects and she'd get me off it quite quickly, you know typical blocking. And she'd get me... I mean, and I'd ask a question but she'd deflect me or block me and we'd talk about something else. And I was always thinking 'there's something, there's something going on here' I mean you do get to that point where you think, it is up to the patient whether or not they want to go further but in someway I was thinking, 'there's something going on here', on one hand she's saying she not coping and it is related to what happened in the past, because you always go 'tell me a little bit about what happened to you in the past, a little bit about yourself', and there's always bits she missed out and I came to the conclusion that those missing bits were impacting where we were now, in that she was stuck, she described 'I'm stuck and can't move forward' and I kind of thought in that case we needed to go back, and I kept trying to go back and say 'can we talk a little bit about what's happened in the past, tell me a little bit more' and trying to probe, and shed either block me or deflect me onto something else, and there was this one instance, and erm, it was literally hand on the door, you know as your about to go and we'd finished up and I'd said 'I'll see you in a few weeks and we'll see how things are' and then I cant remember the comment I made, there must have been something, I literally had my hand on the door to go and it just started coming out. And you know, you know when you just think. In one way I knew it, I knew there was something (laughing) , I was like... I knew there was something that had gone on that was impacting on where we are now, and once she started, that was it. I wasn't going anywhere and it was literally, and I think because once she had started to disclose it just kind of kept on and on and on... and it all started coming out as well, about what had happened to her and who the person had been that had done this to her and what had happened in terms of the family in terms of how they had deal with it, what had happened to her, how she had felt about it, I mean this had obviously happened when she was late teens and now she was in her 50s and the impact... And it just all started. It was almost like once she had started she couldn't stop it. But in a way I was sitting there thinking, I knew there was something, I knew there was something I just couldn't put my finger on what it was, but I though, that's it, that's what the block has been, due to the fact you cant move on from this, and I think what it had done, it had just brought it, just tapped back into it in some sense and she just couldn't move forward because of this and it transpired she had never disclosed it to anybody, well, she had disclosed it to the family but they had closed ranks and didn't do anything about it, it was probably that generation where you didn't, you know, it was like 'you don't talk about it', but also, she was very vocal about the impact it had had on her throughout the rest of her life and the impact on the relationships she has made, or not made and the fact that is not in a marriage she was very unhappy in, but at the time thought 'this was as best as its going to be' a lot of feelings of low self esteem and low self worth and the fact as well, I can't quite remember but she said something like 'you actually the one person that's spent some time getting to know

Figure 5: Step 2 of data analysis: Example of nurse transcript highlighted section (handwritten notes made at a later stage – please ignore)



P: Erm, they'd asked me to do like, a urine sample, but I couldn't… [Indec… and they were like "well if you can't do that, erm, then you'll be able to do it at the centre" that's when they said that… [Indecipherable]… But then I thought they meant, like, to go to the centre, like, maybe the next day or something, but they hadn't and then they said "oh, you can take like, your mam and your friend over with you" and er… And they were like "oh, we'll have to go now", so it was like two o'clock in the morning, about one, two o'clock in the morning by the time they'd finished and then [they asked me to go with them], so we had to wait for all these people and we had to wait for somebody to go and open it, 'cos it was in the morning; we'd had to wait for the nurse to reply, 'cos she was on call and then I felt like… [Indecipherable]… And I wasn't even tired and I wasn't even sad or anything like that; I just felt drained of energy. And then… [Indecipherable]… I guess that they mean, like… 'Cos when I said I couldn't give a urine sample, I had to go like… [Indecipherable]… So they didn't tell me anything about a camera or anything until we got there.

I: Right. So that was the examination part. The camera. How did you feel after the examination?

P: That was awful. I wouldn't even with the examination on my worst enemy and I don't know… She was obviously very nice, 'cos they all are… After the examination… [Indecipherable]… Erm. I don't know; I can't really explain how I felt, but it was like… It was just awful; that was the worst bit of it all and like… She wasn't rough or she wasn't nasty; she was very nice at talking through it and everything, but I just think… [Indecipherable]… She was taking like swabs form the back of my neck and I think it was my shoulders and then my groin for DNA and obviously she'd asked us like "what have you taken… Imbibed…" [Indecipherable]… And it just wasn't very nice and I wouldn't ever wish that upon anybody. But that was definitely the worst part of it all. [Indecipherable]…

I: How do you feel about the nurse's response to your disclosure when you told her what had happened?

P: She didn't really show much emotion. Like we're taught about caring and compassionate communication and all them things. Like, you've got to show empathy instead of sympathy, but I can't imagine, like… If it was me, I can't imagine putting [indecipherable]… I can like… Myself, but because of my reactions to something, if somebody was sat there telling me… Like how I'd react to it and if they'd react any different… [Indecipherable]… But I couldn't do it. But she was very, like… Straight faced and very serious. Erm, obviously it was a serious situation, but the police, they were quite reassuring. Because it's not the police that come and speak to you; it's like a crisis team or whatever they're called. And that's usually a woman and a man. But erm… She was… She just… She did treat it like she sees it all the time. Erm… She wasn't really… 'Cos as much as I say I don't have emotions, I must have had emotions, because I was crying. [Indecipherable]… And I took a while to respond 'cos… I remember that. And erm… She wasn't really… If like, it came for me to speak…She was like… Asking more questions and… Loads more questions and she didn't really give me much time… She was really nice, but she wasn't very… It wasn't very person-centred and she just… [Indecipherable]… I could have been anybody, really.

I: Can you tell me about your feelings once you'd left the consultation room?

Figure 6: Step 2 of data analysis: Example of survivor transcript highlighted sections

Step 3: Development of significant descriptive statements

This step involves the development of the highlighted text in the transcript (transitions) into significant descriptive statements. For this stage, I took the highlighted data (transitions) away from the main transcript (unhighlighted it) and then highlighted (and put in italics) the significant descriptive statements of those transitions. Giorgi (2009) states that this stage is the centre of the method and fundamental to descriptive data analysis. Utilising free

imaginative variation made this easier as the descriptions comprised of aspects of the participants' experiences that had not previously been brought to my consciousness via my previous experiences, knowledge or judgements. An example of this process can be found in Figure 7.

then ***she was like "do you think that you maybe implied…?"*** And then I said "No" and then I thought: oh… ***And you think: oh… Maybe I did.*** But then… You shouldn't think like that. ***So then she said: "'cos if you had said something like that, then if it was to go to court, like inside of the… Like the jury or whatever, they can like take things differently".*** So they've got to ask you the questions so **they're prepared** for what's going to happen next time. ***But it was quite intimidating because she's like put in my head that they think…***
It's like *a* ***ball that you can't stop rolling once you've even mentioned something***. But then it made me think, like: ***oh, maybe I shouldn't have came…*** Like because ***if I did do that, I would look really stupid now***. But then she said some things and ***it made me like really question*** *it,* ***but I think of what she said or… "Had you implied anything before***" (Anne)
But I think in terms of ***the way you're judged***, just… ***Victimised in a way and… It's wrong***. You know, it's… erm… ***Stereotypical in a way, of gay men.*** And when I described the man that had done it, ***as if they'd heard it all before They judged it as a case of me just wanting a bit of fun and getting drunk and being silly***, but I wasn't ***I was taken advantage of*** through alcohol and being misled
I felt judged by all of that.
… ***I think female***, like 'things down there' ***are sort of more… Less judged. Whereas a man, they'll think straight away, 'cos… You've had a dodgy one night stand or something***, so…
I guess the man's manner. I just felt like I was being judged as like a young kid who's been silly because I was just so…. ***Scared*** of the whole thing.(Jack)

Figure 7: Step 3 of data analysis: Development of significant descriptive statements

Giorgi (2012) states the importance of this process is the description; however, whilst phenomenology is descriptive, it is acknowledged that interpretations do take place (Husserl, 1970). Description is the use of language to convey the intentional objects of participants' experience, and Giorgi (2012) makes it clear that each researcher would have different significant descriptive statements. In this step, I ensured that I kept the significant descriptive statements in the words of the participants, as in stage four the descriptions took on another level as they were compared, contrasted, and given a presented descriptive overall meaning (this is also why I called stage 4 'meaning units', as it seemed to best describe the process for me when carrying out the analysis).

Once this process of the research has been undertaken, each transcript was left with a series of significant descriptive statements (188 for the nurse data analysis and 170 for the survivors). For transparency, a copy of both the nurse and the survivor significant descriptive statements can be found in appendices 10.

Step 4: Converting significant descriptive statements into meaning units

Stage four of the analysis sheds light on possible meanings of the experience in a more general way. During this process, the transitions undergo their descriptive alterations to enable more general insight (Giorgi 2012). Giorgi (2012) refers to this as the construction of the essential structures; this allows the ability to create a level of descriptive meaning from experience. In phenomenological research, essential structures refer to *"expressions of patterns or wholes that coherently make sense of the examples on which they are based"* (Todres 2005, p. 111). For this research, I found that this step identified the essence of descriptions, as they uncovered collective and individual meaning. Therefore, I referred to these as the 'formulated meaning units', not essential structures as Giorgi does. These meaning units are used to link the quotes to descriptions of experience throughout the findings chapter. These meaning units also typify elements of the phenomenon and then can connect to form unity of experience across participants. The survivor participants have 68 meaning units (see Appendix 9) and the nurse participants have 75 meaning units (see Appendix 10).

To undertake the process of establishing meaning units, I was required to interrelate participants' experiences. The process of moving from significant descriptive statements to meaning units involved a synthesis that I found the most difficult aspect of the data analysis. Whilst the meaning units are still descriptive, here I was transforming the descriptive language used by the participants to help provide more general descriptions and meaning to the phenomenon. And whilst Giorgi (2012) describes stage 3 as the heart of the descriptive analysis process, personally, stage 4 was (although difficult) illuminating and exciting for me as the researcher. When reflecting, this is the part where in my reflective diary I started to truly understand the experiences and appreciate the descriptions coming to life into something tangible.

A brief example of the survivors' significant descriptive statements converted into formulated meaning units can be found in Table 5, and for further transparency the full nurse and survivors' significant descriptive statements into meaning units can be found in Appendix 11.

Significant descriptive statements (170) – broken into similar language/ repetitive words. **(the colours represent the different participants).**	formulated general meaning units (68) **These meaning unit numbers are used to cross reference in the findings chapter**
1. she was like "do you think that you maybe implied…?" And you think: oh… Maybe I did. So then she said: "'cos if you had said something like that, then if it was to go to court, like inside of the… Like the jury or whatever, they can like take things differently". But it was quite intimidating because she's like put in my head that they think… 2. ball that you can't stop rolling once you've even mentioned something. oh, maybe I shouldn't have came… if I did do that, I would look really stupid now. but I think of what she said or… "Had you implied anything before" 3. Victimised in a way and… It's wrong. as if they'd heard it all before 4. They judged it as a case of me just wanting a bit of fun and getting drunk and being silly, 5. I felt judged 6. Whereas a man, they'll think straight away, 'cos… You've had a dodgy one night stand or something, so… 7. I guess the man's manner. I just felt like I was being judged as like a young kid who's been silly. 8. And she kind of said it wasn't rape, because I was drunk… 9. but it was the kind of attitude that 'you've just got to get on with it'. 10. She said, you couldn't do anything about it in a court of law, because you were drunk, kind of thing. So you've just got to move on. 11. once she'd picked up on that, focussed straight in on it and didn't really listen to me when I said that I've had these issues far longer than the kind of two years it's been since I was assaulted 12. I didn't feel listened to… 13. Eyes widening type thing, kind of like: 'oh yeah. Gonna write that down!' 14. And the posters on the back of the toilets, 'We believe you' as well. Now, I see those every day of my working week and I'm like: well actually, no. You didn't believe us at the end of it all. 15. I just remember feeling really sick and also contemplating not going 16. even though I knew that it was real, that someone might say "well actually, no. It wasn't" and be like "this didn't happen to you, so why are you here crying about it?" 17. I maybe would have explained it in a way that somehow made it my fault a bit more. "oh, well you know, I was drunk, so…" Yeah 18. why am I bothering to do this again with a nurse? If a GP didn't believe me, then what's saying she will? 19. said that the police would have to get involved – erm, who didn't believe me either – 20. I was terrified, but you hear of the police not doing anything all the time, so it's like: "well, you were out. What were you dressed like?" And I was like "well, I wasn't asking for it?" and then I	1. The nurse suggesting she had given implied consent made her question what had happened. This leads to anxieties over what people will believe too. 2. Nurse using language that indicated the survivor has some responsibility in the assault increases self-doubt and regret at attending and disclosing 3. Disclosure being questioned makes survivors feel as though they're being judged as making 'silly choices' 4. Disclosure not being taken seriously, leads to feelings of being judged 5. If alcohol is involved then survivors feel as though the nurse focuses on this, meaning they have some responsibility towards the assault 6. Once rape/SA is mentioned survivor felt not listened too as the rape became the focus 7. Feelings of not being believed 8. Not being believed can lead to feelings of regret, regret for attending and regret at disclosing

Table 5: Example of significant descriptive statements into meaning units process

Step 5: Meaning units converted into themes

Step 5 allows the meaning units to be collected into themes. This helps clarify and interpret the data of the participants. The aim of formulating the meaning units into themes is to describe how the structural elements function collectively and demonstrate how they interlink to form the unity of the experience across the participants.

Themes are diagrammatically demonstrated below, along with subthemes. For transparency, Appendix 12 demonstrates all meaning units collected into themes and themes identified, for both sets of participants.

The addition of subthemes allowed for a deeper concentration on certain structures of the meaning units. Whilst writing the findings chapter, some meaning units overlapped into more than one theme/subtheme, aligned with the perspective that experience is complex and does not fall into categories neatly. From the diagram below, you can also see the cyclical nature of disclosure via the subthemes. Participants experience theme 1 then move into theme 2. Following this, the process starts again as they ready themselves for the next disclosure (whether that is to social support, further HCPs or the police). Participants expressed that this cycle does not end as they are never not a survivor of SA. Thus, they feel that further disclosure is always a possibility.

4.3.8 Research themes identified

The research themes are identified below in Figures 8-12.

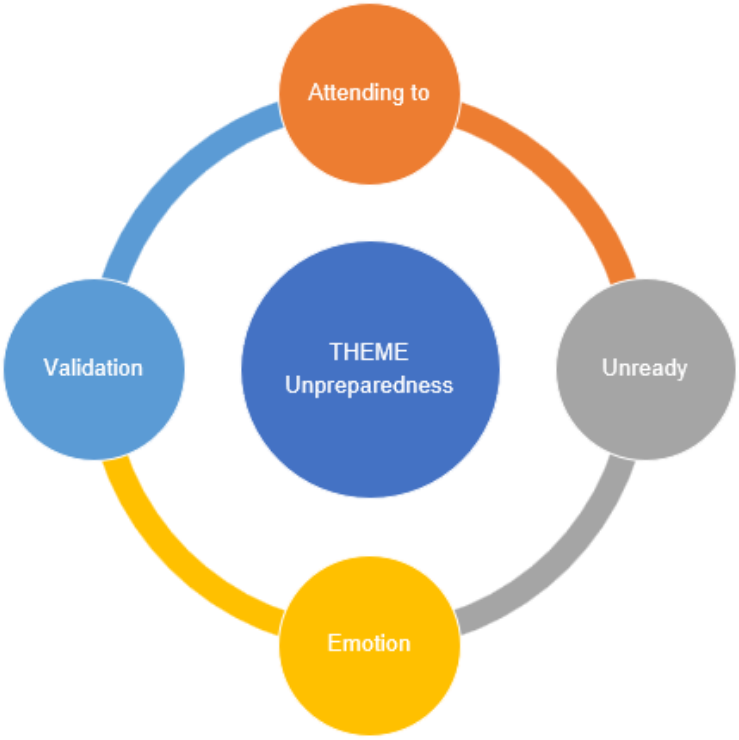


Figure 8: Survivor participant theme one: Unpreparedness

Figure 9: Survivor participant theme two: Not knowing

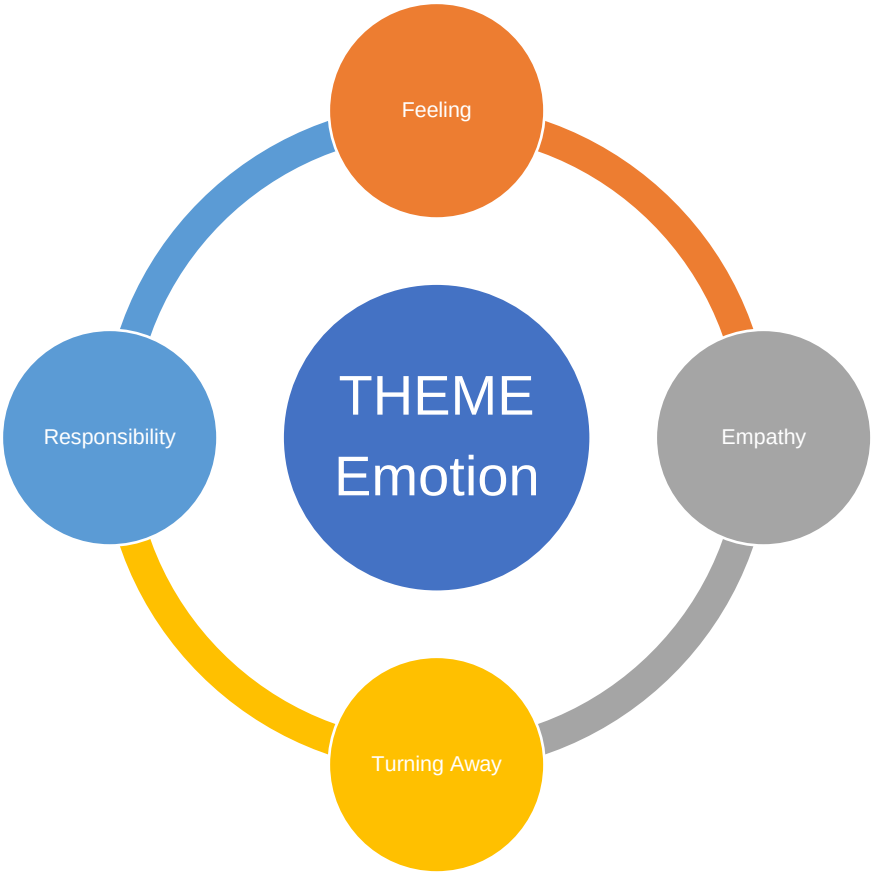


Figure 10: Nurse participant theme one: Emotion

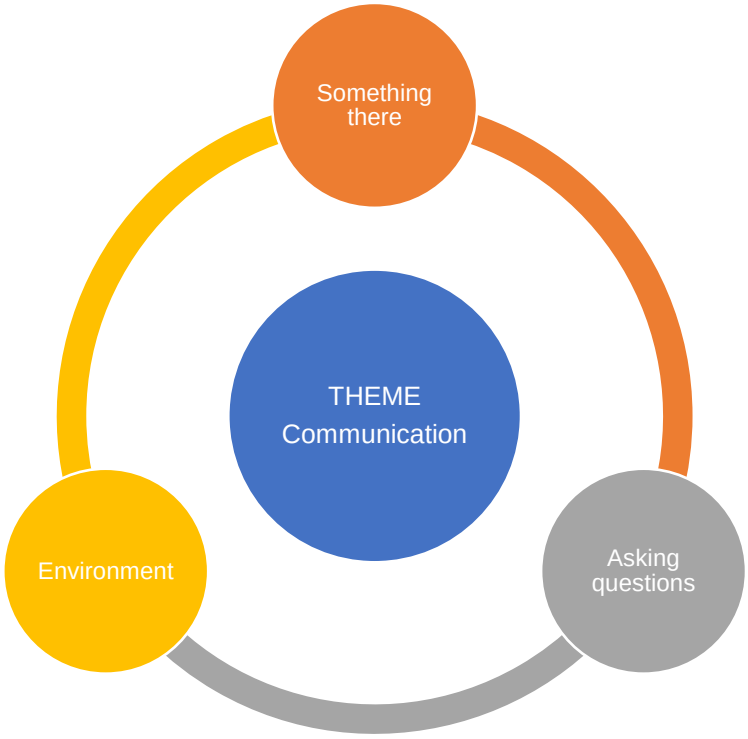


Figure 11: Nurse participant theme two: Communication

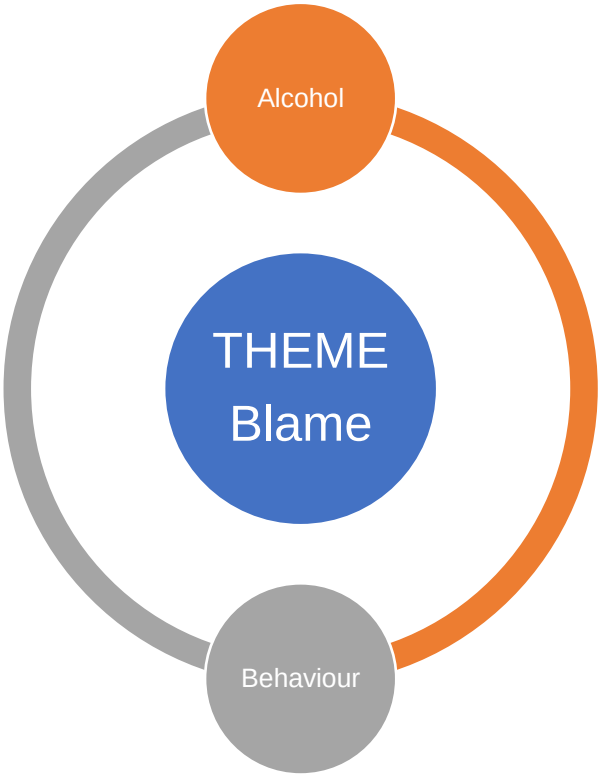


Figure 12: Nurse participant theme three: Blame

4.4 Rigour and trustworthiness

This chapter has focused on demonstrating the application of the research methods in order to solidify the trustworthiness of the study process. Beck (1993) states that trustworthiness in research, specifically qualitative research, is exemplified by rigour; therefore, aspects of the research undertaken must be addressed in relation to credibility.

This research demonstrates trustworthiness (Guba, 1990; Lincoln *et al.,* 2011; Sorrel & Redmond, 1995) through its alignment with the indicators of credibility, confirmability, dependability and transferability. Credibility is adopting an appropriate and transparent sampling strategy (see section 4.4) and conducting the study in alignment with a well-established research method, in this case Giorgi's (2009) descriptive psychological phenomenological method (see section 4.3). Confirmability is producing authentic findings derived from participants' data (see section 4.3.6), incorporating reflective practice (reflexivity is demonstrated throughout the thesis (specifically, see 4.2)) and frequent debriefing (undertaken with my PhD supervisor). Conformability in producing authentic findings is more complex in qualitative research, as there is a difficulty of demonstrating absolute objectivity. This is because (as previously explored) qualitative research does not seek to be objective, as exploring the subjectiveness of experience in depth is how we understand *being* in the life world. Therefore, objectivity in the quantitative sense is not obtainable or indeed desirable. The concept of confirmability therefore is addressed as a comparable concern to objectivity, in the transparency of this study. It has been

demonstrated (see section 4.3) that steps have been taken to help ensure, as far as possible, that the findings are the result of the experiences and descriptions of the participants, rather than the suggestions and preferences of the researcher. However, it has been acknowledged that the intrusion of the researcher's biases is often seen as unavoidable (Shenton, 2004), hence the use of descriptive phenomenology to reduce his occurrence. Dependability is demonstrated through a transparent account of the decisions made during the completion of this study (Koch, 2006), which is recorded and documented throughout this chapter for transparency. Transferability of the study to the reader's own field of practice (Boswell & Cannon, 2017; Gray, 2014) can be made through weighing up the methodological details of the study (chapter 3 and 4) and demonstration of the findings' application to the field of practice (see Chapter 6).

4.4.1 Reflexivity

An essential part of rigour, for phenomenological research, is the use of reflexivity by the researcher. Reflexivity essentially aids transparency, quality and integrity within qualitative research inquiry. Finlay (2002) states that the researcher should engage in self-awareness of their own place within the research and make that clear to the reader.

Reflexivity is a process of continuous reflection for the researcher, specifically on how their own actions, values and judgements may affect data collection and the analysis process (Lambert *et al.,* 2010). Clear explanation of research methods necessitates that sampling, data collection and data analysis processes are well-defined, described in detail, and transparent. This allows the reader to assess whether the data supports both the participants' experiences and the trustworthiness in the way that the researcher has engaged in these methods. Within this thesis, I have been open regarding my knowledge and background. This is to acknowledge the essential nature of the phenomenological method and the role phenomenological attitude / reduction and bracketing play in data collection and data analysis. In doing this, I have demonstrated complete transparency in the research methods process. This reflexivity also involved being aware of my own relationship with this research, which I have reflected on in the introduction and literature review chapters.

Reflexivity is a process mostly aligned to qualitative methods, whereby the researcher adopts a commitment of continuous reflection about how their values, judgements and actions affect the research process (Lambert *et al.,* 2010,). It is therefore essential to adopt an explicitly self-aware and self-critical manner when conducting the study to demonstrate

how the researcher's experience has, or has not, influenced the research process (Payne and Payne, 2004). Whilst undertaking this research this involved keeping a personal reflexive diary which recorded aspects of introspection throughout the research process. This allowed me to be aware of being in the moment, of what was influencing my internal and external responses and of my relationship to the research (Dowling, 2006). This was particularly useful throughout the data collection process. For example, self-reflecting after every interview allowed for acknowledgement of the phenomenological method, but also highlighted where my adoption of the phenomenological attitude was beginning to falter slightly. For example, in the first interview at approximately 70-80 minutes I began to pose questions in an assumptive way, rather than phenomenologically. The participant said they felt exhausted by the disclosure, and I accepted that. However, a more phenomenological approach would have explored what they meant by exhaustion to capture true meaning of experience. Following this, I used the reflection to ensure at this point in future interviews, I was aware to also focus on my phenomenological attitude to ensure descriptions were being explored in-depth. This captured an ongoing self-reflective awareness of the relationship between me (as the researcher), the object of the study and the study participants within the nature of this research process. The reflective diary also allowed for a release after exploring this emotive topic, as following interviews the gravity of what had been shared was often overwhelming, and humbling.

The development of reflexivity began in this thesis with a pre-reflective account of my existing views of the phenomenon explored. This has been demonstrated within the introduction and literature review, identifying my natural attitude towards SA disclosure. From a phenomenological perspective, is it suggested that a literature review is not undertaken until after data analysis has been completed so as not to phrase questions in a certain way using specific language, or look for themes that may already exist, either consciously or subconsciously (Hamil and Sinclair, 2010). However, in reality this is not practical. The rationale for the study and the supporting literature review allows for development of the research question. Therefore, I acknowledge that the phenomenological attitude is not effective in all aspects of this study. To counteract this (and as discussed in Chapter 2,) a light touch literature review was undertaken and then a final substantial literature review completed four months prior to completion of this thesis. The use of reflexivity allowed for recognition of this potential gap in the phenomenological framework, and I was able to acknowledge and practically plan in order to conduct the study phenomenologically. Maintaining a phenomenological attitude is one of the most important characteristics when undertaking phenomenological research (Giorgi, 2009). I would further suggest that this process is not just for the data analysis (as is interpreted by so many), but is an essential aspect of the underpinning philosophy of the researcher's approach and a thread that runs from start to finish in a study (and indeed, a way of seeing and *being* in the

world outside of research). This is described by Husserl's initial writings that one should '*go back to the things themselves'* (Husserl, 2001 pg. 168). Clearly, my initial rationale for undertaking this study was born out of a concern that survivors were not receiving the support they required, and that nurses were not prepared adequately to support them. This highlights my personal, academic, and professional interests in this topic and further identifies the rationale for the descriptive approach in this study to *'go back to the things themselves*' (Husserl, 2001 pg. 168) in exploring the lived experience of those disclosing and receiving disclosures of SA.

4.5 Summary of chapter

This chapter has presented a detailed exploration of the research methods used to answer the research questions. A recap of this, alongside the philosophical frameworks, can be found below:

Overarching philosophical paradigm: *Phenomenology*

Ontology: *Relativism*

Epistemology: *Constructivist / Interpretivist*

Other theoretical considerations shaping the research: *Symbolic interactionism*

Research methodology: *Descriptive phenomenology*

Research methods: Data collection:

- *Purposive sampling*
- *Bevan's (2014) method of phenomenological interviewing*

Data analysis: *Giorgi's (2009) descriptive phenomenological psychological method*

The descriptive phenomenological philosophy as a research method provides a thorough and transparent means to provide clarity to the phenomenon under investigation, and detailed examples have afforded transparency to clarify the key decisions made throughout the data analysis process.

The following chapter is an exploration of the meaning units and themes communicated via the voices of the survivor participants. The nurses' experiences are explored in Chapter 6. The volume of data that came from these experiences warranted them to be separated. The intersubjectivity will be explored in depth in Chapter 7 (discussion chapter).

Chapter 5: Survivor participant experiences

5.1 Introduction to chapter

This chapter focuses on the themes generated from the data analysis process of the survivor participant experiences: unpreparedness and not knowing.

The descriptive phenomenological psychological method of analysis proposed by Giorgi (2012) was used to explore descriptions and analyse experience. This resulted in significant descriptive statements that were then reduced to formulated general meaning units (see Appendix 11). Themes were then derived from those meaning units (see Appendix 12). Throughout this chapter, themes for the survivors are explored related (and signposted) to the meaning units (MU) (for ease of access throughout this chapter, the MUs for survivors are listed below in Table 6 for transparency), and then typified by participant quotes.

1. The nurse suggesting she had given implied consent made her question what had happened. This leads to anxieties over what people will believe too 2. Nurse using language that indicated the survivor has some responsibility in the assault increases self-doubt and regret at attending and disclosing 3. Disclosure being questioned makes survivors feel as though they are being judged as making 'silly choices' 4. Disclosure not being taken seriously, leads to feelings of being judged 5. If alcohol is involved then survivors feel as though the nurse focuses on this, meaning they have some responsibility towards the assault 6. Once rape/SA is mentioned survivor felt not listened too as the rape became the focus 7. Feelings of not being believed 8. Not being believed can lead to feelings of regret: regret for attending and regret at disclosing 9. Worried that someone was going to tell them that they were wrong, that they hadn't been assaulted or that it was their fault because of alcohol use	37. Anxiety of not knowing what would happen next manifested as physical symptoms – sick 38. Realisation and relief of someone else knowing and that something might be done/support given 39. Concern about not knowing the impact on other people 40. Anxiety of planning what to say when reporting it, repeating in mind. This causes anxiety and makes survivor want to not report 41. Feelings of concern about reporting then manifest into anxiety about who will find out 42. Not knowing if they are believed, making them feel judged by nurse 43. Emotionally shutting down. Feeling nothing 44. Shutting down emotions to self-protect 45. Unexpected things trigger memories and cause emotions to return 46. Disconnected from emotions as a self-protection and the nurse emphasising the importance of the disclosure

10. Because of the dismissive reaction of the nurse, feelings of embarrassment and being ashamed of the situation caused survivor to shut down and decide to not make any further disclosures	47. Repressed emotions over a period of time to cope, then the feeling of relief once she disclosed to a nurse (first hcp). Realising she could feel emotional about what had happened – permission giving
11. Survivors are worried that someone will recognise them in the waiting room	48. Feeling of shame and guilt when disclosing and not getting words out
12. Worry that other people in the waiting room are judging them (in sexual health services)	49. Suppressed emotion about assault, seeing the nurse gave permission to acknowledge and recognise how it had impacted behaviour
13. Panic that you see someone you know leads to increased anxiety	50. Feeling uncomfortable with process, having to re-disclose with every appointment was like re-living the trauma
14. Looking for a friendly face among staff moving around the clinic, worry about who they will see and if they will be nice	51. The process of follow-up care was repetitive and exhausting to have to re-live the trauma
15. Not a welcoming reception when there is already worry about being there	52. Needed someone to say – this has happened to you, before acknowledging it. Permission giving
16. Anxiety about what will happen next. Not knowing the process causes heightened anxiety	53. Relief at being supported because it made it real
17. No knowledge on what will happen next	54. Terrified at disclosing as had not processed what happened herself. Felt vulnerable emotionally and manifested physical symptoms – sick /crying
18. Not knowing if the person you see will be nice	55. Procedure after reporting was unclear and not explained. The unknown
19. Vivid lurid colours still resonate with negative memory	56. Repetitive and intimidating questioning made it like you were not believed
20. What's behind the closed door, what happens once you are called in?	57. Didn't feel emotion from the nurse. Felt like she just sees this all the time
21. General equipment in the clinical area can trigger a memory of attack, this was unexpected, for example, brand of stationary called Rapesco	58. The nurse was asking questions but didn't give her time to answer them, didn't feel she was listening and made her feel worse
22. The feeling of everything going in slow motion, journey to clinic, waiting room, walking to consultation room – the lack of knowledge what is going to happen – all heightens anxiety and can contribute to regret at attending	59. Felt as though the nurse was not supportive. However, showing empathy towards the nurse as the nurse had been called out in the early hours of the morning to come and see the survivor
23. Journey to the service gives time for thoughts around what might happen. This increases anxiety	60. No introduction, name given by the nurse. This increased anxiety
24. Lack of engagement with support services as was reported on her behalf by	

family member. Didn't feel ready mentally to be prepared for police involvement or reporting at the time, no choice given 25. Relieved at someone taking charge and not having to make decision 26. Feeling of being pushed into accessing services elevates anxiety on what will happen next 27. Worried that reporting it will mean lack of confidentiality, people will find out what happened 28. Resigned to the thought that no evidence means nothing will happen once the assault is reported 29. Process moved so fast there was a lack of time to make or contribute to decisions 30. Someone else taking charge helped formulate a plan of what happens next, when maybe this decision making was too much 31. Disclosure felt daunting and scary. Frightened/fear. 32. Concern about the impact on assailant and his family made reporting a difficult decision 33. Worried reporting it would mean people would find out and not believe it was an assault. That it was consensual and would be judging her 34. Did not feel informed about the process. Thought she couldn't say no throughout process. Phrasing of questions did not leave room for an open/optional answer 35. Not wanting to show upset or emotion in front of stranger 36. Feelings of guilt and being ashamed made emotional health worse	61.The nurse being caring (being believed) was seen as motherly, this was reassuring 62. Having to disclose the assault to 3 people in one visit was emotionally difficult 63. Feeling the nurse believed them made them feel more positive about getting help: 'motherly' nature 64.Repetitive disclosure causing emotional distress 65. Didn't accept that she had been assaulted until she was told by nurse. Almost like permission giving 66. Was supported and believed, this makes survivors feel like they made the right decision to disclose 67. The response of the nurse indicated she was uncomfortable, this made the survivor regret disclosure and feel judged 68. Was expecting sympathy and maternal instinct as the nurse was female but felt let down by lack of support/ belief

Table 6: Formulated general meaning units for survivor participants

All names are pseudonyms to maintain confidentiality. It should also be noted that all experiences from both sets of participants explored experiences of rape. Therefore, this term will be used throughout this chapter, and Chapter 6, rather than SA.

Themes are described from the participants' narratives, which underpin their own lived experience of disclosing rape to nurses. Below is a diagrammatic example of the themes (green) and sub-themes (blue) identified for each participant group and the order in which these are explored within their subheadings throughout this chapter.

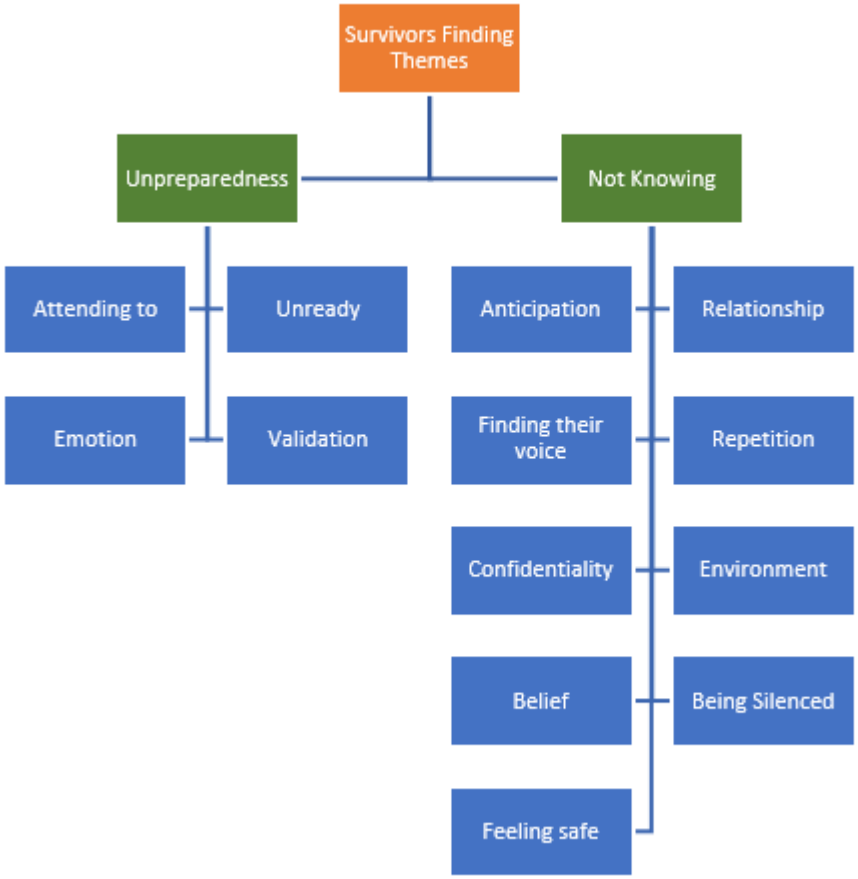


Figure 13: Survivor themes

There is also an identification throughout of how these themes (and meaning units) and subthemes overlap, demonstrating the complexity and temporal nature of disclosure. Some aspects of experience are revisited with each stage of disclosure (pre-, during and post-disclosure), for example blame / self-blame.

5.2 Theme one: Unpreparedness

The first theme discussed within this section of findings is that of unpreparedness. Participants, when exploring their experiences, described feelings of being unprepared throughout their disclosure. Unpreparedness can be defined as a state of being unready, or unequipped (Collins Dictionary, 2020). It can also be described as an inability to deal with something, therefore being at a disadvantage when that thing is unearthed (Collins Dictionary, 2020).

Disclosure of sexual assault is complex; it has many elements of uncertainty for the survivor. For example, uncertainty of the ability to allow the experience to come to the fore, uncertainty about whether their experience was consensual, uncertainty of the language used to describe what happened adequately defining the experience, uncertainty of the response they may receive from the nurse, and uncertainty of their reaction to this response. Because of the level of uncertainty attributed to disclosure, there is great difficulty expressed by the participants in being able to prepare for any aspect of the experience after the assault has physically occurred. The whole experience of the disclosure itself then becomes emotionally charged. This, in turn, adds a layer of anticipation to an already uneasy experience. These structures of experience are described below through the words of the participants.

Whilst the participants described states of unpreparedness, their focus of discussion seemed to become stronger around their feelings of being disadvantaged by being unprepared for the next step, once the rape was unearthed (they describe it as being buried, pre disclosure). Although they did not use the word disadvantage, they did use words to describe the feeling of being in an unfavourable position. They used words such as vulnerability, scary, daunting, shame and guilt to describe their openness or emotional rawness once the disclosure had been made (MU:29/48/54). However, this language was not only used when the disclosure had been unearthed. They use it pre-, during and post-disclosure, indicating that unpreparedness is not an aspect of their disclosure that specifically starts with vocalising their experience or ends with making the disclosure.

5.2.1. Attending to

One characteristic of unpreparedness is the powerful effect of emotion in altering behaviour. Altered behaviour following experiences of SA can manifest in different ways, but typically, alcohol abuse is a more common demonstration of altered behaviour (Dworkin *et al.,* 2021). The change of behaviour, for some, brings the reality to a point of visibility and thus demands attention. This makes it unavoidable, although not everyone has this clarity. Heidegger referred to this action of being unprepared to deal with onself as fleeing from

authenticity (1962). He goes on to suggest that Dasein (*being*) finds 'itself' proximally in what it does, uses, expects, avoids; in those things environmentally ready-to-hand with which it is proximally concerned (Heidegger, 1962 p. 155). It is when those tools begin to break down that they are suddenly faced with themselves (and others) in a more traditional way that is visible to the self, if only temporarily. Thus comes the foresight to need to ***attend to*** oneself, and the authenticity that has been hidden. This finding of itself by *being* is a response to the voice of inner conscience. Not in terms of a moral imperative to do the right thing, but rather a focused listening to oneself and observing of one's unique capabilities and potential to bring this experience of rape to the fore, or an awareness of the need to attend to oneself (MU:49).

This is typified by Vicky as she explored the way the rape impacted her behaviour and how unprepared she was for it to do so. The experience caused more emotion than she had been prepared for, and she attributed this to her change in behaviour. She was able to recognise this behaviour was a consequence of the rape. Subsequently, recognising it prepared her to disclose in order to seek support:

> *"I think I'd been more stressed and worried about it than I thought, and I think it was affecting my behaviour because I didn't feel that it had been acknowledged in any way and it was quite serious and… So I'd begun drinking and I think it was actually kind of through that that I decided to erm… think about telling" (Vicky, MU49).*

Jack described how *attending to* himself added to an already established feeling of vulnerability:

> *"So, for me to have broken down, it was quite… I felt like I was very vulnerable anyway" (Jack, MU54).*

It is clear from the voices of the participants that unpreparedness and disclosure experience are not mutually exclusive. For example, the survivor could be ready to disclose their experience, but unprepared for the range of emotions that may wash over them. They can be unprepared for disclosure (especially if this is a last-minute decision due to the comfort they may feel with their practitioner) but ready to receive guidance and support. They may be prepared to describe their experience, but not prepared for the possibility of the nurse making decisions about their ongoing care they did not expect. This puts the survivor at a

continuous disadvantage since it is difficult to prepare for a situation that cannot be controlled or foreseen.

Being unprepared, or unready to disclose (*attend to*), leads to an indecisiveness regarding disclosure. Indecisiveness is characterised by a range of emotions that contribute to a difficulty in making decisions such, as dread and fear (MU:31/40/54). For these participants, there was an anticipation of whether telling someone would be the right next step in their experience, and being unprepared for the outcome contributed to the indecisiveness.

Jane discussed her position between wanting to disclose, and the unpreparedness of what might happen following this, causing her to go back and forth:

> *"I was like: well I might not go. That walk was kind of like: right, you're going. You sort of have to… If you're going to turn back, this is the time to do it now. Erm, but I kind of knew in my heart of hearts that I had to go and do it" (Jane, MU40).*

This quote typifies that survivors may be ready to disclose to seek support, however are not prepared for the next part of the process of disclosure. It also describes the nature of apprehensiveness involved with deciding to disclose a rape experience; to attend to oneself unfolds a future of uncertainty which clearly increases emotions surrounding disclosure.

Phenomenological theory often turns its attention to matters that 'bear our attention'. Here, research participants describe bringing something to someone's attention, with an awareness of uncertainty of what is about to unfold; however, an insight into the desire for support is clear. The concept of Sorge (Heidegger, 1962) is a prominent example of this. Sorge can be described as an existential-ontological state characterised by both anxiety about the future and a desire to care for or attend to something. Sorge implies an adjustment to the future. Being human is moving forward, and disclosing is moving forward (although it might not always seem that way to the participant). From a phenomenological perspective, by making the decision to disclose, the participants are moving forward to care for themselves, even if the care is not always recognised as the motivating factor from the outset. Heidegger (1962) argues that the act of caring for oneself and for others, and the attitude of carefulness, typifies being a human-being. To care is the essence and structure of *being*, and he posed the concept of Sorge as the basic form of authentic being, signifying someone's existence and making it meaningful. He takes the phenomenon of Sorge to circumscribe the structural whole of *being* (Dasein). For participants in this study, whilst they have described their lived experience, the phenomenological analysis has highlighted they

have an awareness (at times subconscious) of something that needs attending to (despite trying to flee from it). That need, and the subsequent implications, has a relationship to a sense of anxiety that overarches every structure of experience in this finding chapter.

5.2.2 Unready

Being unready for disclosure was touched upon previously (MU:45/47/49). Two participants described their unpreparedness for the disclosure to happen when it did; they considered the experience resolved, but were unready for the consultation to evolve into a disclosure of their assault. Vicky explained she thought the experience had been buried in her subconscious and was unprepared for the disclosure to come to the fore when it did, thus unexpectedly attending to herself:

> *"I kind of buried it away after that and it was later I was, erm… At the GU clinic, erm, and it was more… I hadn't gone in to disclose at all, but it was just throughout discussion that things…" (Vicky, MU49).*

This description of feeling unprepared for the disclosure to rise was echoed by another participant, who described feelings that she thought she had accepted and moved on from.

> *"At the time, I had thought: Oh, like I'm totally over this; like I got over it really fast and all this stuff. Like I realised later [when I told the nurse], like later on that actually I wasn't over it and I was just hiding it. Like, it all kind of came out later on, that actually like, I wasn't okay and I'd just been kind of pushing it down on the inside, but at the time, I was kind of thinking like: I don't really need to talk about this… I just thought… well I've never needed to tell anyone. Like surely if I'd needed to tell someone, it would have been like, years ago" (Lucy, MU47).*

Both participants described how they thought the experience of rape had been buried or hidden; however, they indicated that this was possibly their way of trying to forget or remove the experience from their mind (fleeing from the authentic self). This led to a false sense of having dealt with their emotions, which makes the *attending to* more emotionally complex. This notion of fleeing from the authentic self is an example of Sorge, in that the participants are demonstrating a *care* that is associated with self-protecting from the unknown futurity of the consequence of disclosure. Due to this, there was not only an unpreparedness for

the disclosure to come to the fore, but also the associated emotion that came with this unexpected disclosure.

Both survivors described a belief that if they had needed support following the assault, it would have been soon after the rape. This indicates a lack of awareness of the long-term emotional consequences of rape.

The difficulty of disclosure often came not with the unpreparedness to disclose, but with the unpreparedness of acknowledging the experience in their own consciousness. This *not attending to* the event as an assault, psychologically, made the disclosure seem more problematic as they struggled to know what to say, and how to say it out loud, when they had not yet articulated it in their own minds. Participants described how they had not *attended to* the assault; therefore, they were unsure about how they could then describe to someone else, causing a conflict regarding whether they would disclose (MU:40). Holly explored her experience of this feeling and it was clear that, even a long time after disclosure, there was uncertainty or conflict of where the mindset was pre-disclosure:

> *"Erm, terrifying, 'cos I was very emotional anyway and erm, I don't think I… I didn't want to tell her; I just wanted to… Not that I didn't want to tell her. I just… I hadn't really processed what had happened myself" (Holly, MU40).*

The experience of not having processed the rape themselves and then having to find the language to describe it in order to express it to someone else caused an increased emotional response. As above, this included both the emotion surrounding how to literally disclose, and then the subsequent consequence of re-living the experience as they *attended to* themselves (MU:50/51/54/62/64).

This was also typified by Sarah's experience. However, it was noted that the post-disclosure experience ended up becoming a part of the rape experience, when Sarah reflected there is no separating the two:

> *"you're reliving that all the time and then it ends up getting just merged into one little Groundhog Day of what's happened during your rape and what's happened afterwards" (Sarah, MU51).*

This structure of experience was an important part of all participants' descriptions and is explored in more detail within the not knowing theme. However, it is important to recognise that experience is interlinked and does not break into neat subthemes.

5.2.3 Emotion

Participants described not being prepared to re-live their experience through the disclosure and, consequently, were unprepared for the emotional impact of this. Emotions are often associated with thoughts, feelings and behavioural responses, and tend to have a degree of pleasure or displeasure. From leading up to the disclosure, to reflecting on their disclosure, the experience was (as already discussed) relived over and over, evoking a range of emotions (MU:31/45/54). Whilst anxiety or words associated with anxiety is a main structure of emotion throughout all aspects of experience (MU:16/22/23/26/37/40/41), specific negative reactive emotions contributed to the anxiety of emotion, making disclosure more difficult.

Anne and Vicky both described their awareness of how their emotions were manifesting throughout the disclosure:

> *"So that [disclosing] was quite erm… Daunting, really daunting. "Yeah, it was… Yeah. Very tough" (Vicky, MU31).*

> *"Scary" (Anne, MU31).*

These emotions can be so overwhelming that they can manifest in physical reactions. Feelings can manifest as physical sensations. This experience is a description of embodiment, a lived experience of the body, in that it is reflecting on the experience as a whole body rather than a mind-body split. Nausea and crying were structural elements of this sub-theme. Three participants described that the period leading up to disclosing the assault caused such emotional responses they manifested bodily (MU37/54), contributing to the behavioural response to the rape:

> *"I just remember feeling sick" (Jane, MU37).*

> *"I felt sick. I just felt really sick" (Sarah, MU37).*

"Just felt sick the entire time" (Holly, MU37).

They all describe this as 'feeling sick', therefore displacing their emotional response with a physical recognition of the build-up of emotion. This makes the impact of their experience unquestionable, whereas the experience, from their perspective, can be seen as questionable.

Jane and Vicky's physical experience is typical of the other participants; they describe how once they had disclosed their emotional state shifted to that of relief. Thus, another physical response (crying) affected their behaviour, caused by a release of emotion. This demonstrated the power of embodiment in their experience. The relief is embodied, however the only way they could show it or even see it was physically:

"Like it just all hit me, really. It was very emotional, and I couldn't stop crying and I was with her for quite a long time" (Vicky, MU54).

"Erm, yeah, just massive anxiety and mass like… Holding back tears or fighting off tears continuously" (Jane, MU54).

The relation of the body in object encounters is observed in both sets of findings in this study. Merleau-Ponty's (2012) concept of embodiment is thus a useful and valid component in approaching object encounters (feeling, empathy, physical). Merleau-Ponty firmly roots the experience a person has of the world through their body, and regards the physical interactions a person has as the foundation for the description of a person's experience (Tilley, 2004, p.2), making his approach very useful for this aspect of the research. The body-subject experience of a person is particular to them, and different from others as they do not occupy the same space and do not live through the world with the same mind (Tilley, 2004, p.3). Therefore, the phenomenological approach, and descriptions from individuals, seeks to capture what is unique to each person's experience from an embodied perspective.

5.2.4 Validation

One of the structural elements of the experience of unpreparedness for the participants is the notion of unreadiness. So, where participants may have decided to attend to an experience they have had (disclose something), they are not ready to *attend to* the rape itself (not able to acknowledge they have been raped). They described a lack of ability to be prepared to self-acknowledge that the experience was rape until someone confirmed their experience as sexual assault and/or rape. There is a need for permission before they can *attend to* themselves, holding them in the self-protection mode they have established for themself. The confirmation, in this case given by a nurse, gave three participants permission to acknowledge their experience (MU:47/49/52). Holly described the relief of having the assault confirmed:

> *"Erm, terrifying, 'cos I was very emotional anyway and erm, I don't think I… I didn't want to tell her; I just wanted to… Not that I didn't want to tell her… I just… I hadn't really processed what had happened myself to even tell her that I didn't really understand what had happened, so for me, it was like…a big realisation when she confirmed it" (Holly, MU52).*

It is evident that disclosure contributes to providing a validation of the sexual assault for participants; validation that the participants are seeking. Having a professional repeat their words back to them, and confirm it solidified the experience. By having the experience confirmed by a nurse, permission is given to allow for acknowledgment, and to continue in *attending to self.* This important part of the disclosure experience indicates belief. And, whilst belief will be explored in detail further in the chapter, it is important to recognise that this validation reflects that the nurse believes the survivor's experience. This acknowledgement is beneficial to the survivor as it makes the experience a real event in their life (MU:52/53/65). Here, Vicky and Jane's description of disclosure typifies the need to have the experience confirmed:

> *"Yeah, it was like immediate. It was like "yes. That is a sexual assault. You did not have the capacity to consent" and it was quite like… Straight. Which I think is what I needed to hear. that's when I like, fully broke down and was like crying and… I think… It was kind of like my moment of realisation that I knew that she was going to say that that was what it was and… Yeah. It was instant. And I kind of said to her, like… You know… "It kind of wasn't really real 'til you said that" (Jane, MU65).*

"Helped me realise that it was rape that had happened and that it wasn't just my… confusion" (Vicky, MU55).

Affirmation is defined as a statement of the existence of truth, to confirm something exists (Collins, 2022). For survivor participants, a validation of their experience was sought and when this occurs, and the result is one of relief (MU38). For Jane, this affirmation resulted in a range of emotions she was unprepared for:

"I sort of knew that what had happened wasn't quite right, but I'd sort of shrugged it off and never really done anything about it and then my friend who was from social work had had a talk from Rape Crisis here and she basically said to me: she was like "Look, what happened to you wasn't right; you didn't consent to that; you didn't have capacity to consent to that. Like, I needed to hear it from someone who actually knows about it, to sort of say "yes or no". Erm, and I got myself in a bit of a state about it" (Jane, MU38).

"Kind of relieved because I'd finally got it off my chest and someone had, like confirmed it, but maybe just kind of… Sad. Sad that from there on in, that was it; that... I'm always going to be someone that that happened to and somehow would have to deal with that and… Now that it's not just in my head, like, it's an actual real thing someone of like a professional level, who was experienced in that kind of thing, they knew about it and confirmed it. So yeah" (Jane, MU49).

From the quotes above you can see how participants described that they were unprepared to acknowledge their experience as rape, and hearing the words describing the event from another person (a professional) gave not only affirmation but also then the hope that they would receive support.

5.3 Theme two: Not knowing

Participants described the internal complexities that came with not knowing throughout their disclosure experiences. This notion of not knowing cloaked all aspects of their disclosure. Anderson *et al.,* (2019) states that uncertainty or not knowing can affect the brain's ability to use information from the past and present to help prepare for a desired outcome for the

future, demonstrating the temporal nature of experience. This, in turn, leads to anticipatory thinking; using the past and present to try to make sense of what may be to come. Not knowing the future creates a space into which insecurities and worst fears are imagined. It is not uncommon to project worst-case scenarios regarding the future into the vacuum created by not knowing (for example in MU:1/4/6/7/8/11/12/13/15/16/27/32/33/36/41/42/48). It can be mentally and emotionally challenging to the participants. For this theme, the subthemes are directly linked to not knowing. For example, anticipation is intrinsically linked with not knowing what is to come, and participants find their voice in order to disclose but are concerned with: not knowing who it may be that they will disclose to (will they be kind, nice, receptive to the disclosure and will they believe), who else they may need to tell (repetition), who will find out (confidentiality), if they will be believed and/or silenced following the disclosure, if they will be safe, and how the environment may make them feel. There is no stage in the participants' experience of disclosure whereby they are not concerned about not knowing what is to come.

5.3.1 Anticipation

Participants described anticipatory thinking throughout their whole experience of disclosing rape; this is demonstrated by a constant concern about what is to come next, whether this is pre-, during or post-disclosure. Their anxieties are always forward facing. To navigate through their experience, their anticipatory thinking allows them to speculate what would happen next in the disclosure process, as they struggle to know or prepare for what might come next in their experience. Unfortunately, this anticipatory thinking is based on their past knowledge of rape (since it cannot be based on anything other than their experience). Heidegger (1962) states that our past reaches forward into our anticipation of the future; this is a fundamental aspect of Sorge. Heidegger makes the link between the future (Zukunft) and to come towards (zukommen). Insofar as *Dasein* anticipates, it comes towards itself. The person is not confined to the present, but always projects towards the future. For those who experience rape, the projection of the disclosure is often clouded with negative associations due to their experiences in the world relating to this topic. For example, this includes influences from media coverage, or from friends' / family / their own past experience. Heidegger refers to this as 'having-been-ness' (Heidegger 1962). The anticipation that the next step will be a non-supportive one causes increased emotional stress.

Anticipation can be defined as the action of expecting something that is yet to happen (Collins, 2022). As mentioned above, being future facing is a fundamental structure of *being*. Whilst anticipation is often used to describe feelings of excitement about something

pleasant that you know is going to happen, the emotion of anticipation does not always align with positivity. With a feeling of anticipation there often comes anticipatory thinking. Anticipatory thinking allows for forward-facing movement (navigation) through uncertainty. It is the process of recognising and preparing for difficult challenges, many of which may not be known or clearly understood until they are encountered, or situations unfold. It is a form of sense making in that it entails asking oneself 'what's next?', ultimately risk assessing what will happen to progress.

Anne's quote typifies this notion of anticipatory thinking. When she considered whether her experience of rape was being doubted and whether it would continue to be doubted, the anticipation of not knowing how this would result caused increased concern to her:

> *"then she was like "do you think that you maybe implied…?" And then I said "No" and then I thought: oh… And you think: oh… Maybe I did. But then… You shouldn't think like that. So, then she said: "'cos if you had said something like that, then if it was to go to court, like inside of the… Like the jury or whatever, they can like take things differently". So, they've got to ask you the questions, so they're prepared for what's going to happen next time. But it was quite intimidating because she's like put in my head that they think…" (Anne, MU1).*

The language the nurse used in her communication with Anne caused her to think twice about taking the disclosure further. There was concern expressed by the nurse that there was an uncertainty she would be believed and that, by following through with the disclosure into a more formal setting (police and criminal court), Anne needed to be aware she would go through a challenging experience. The not knowing the future thus increases the level of anticipation in an already heightened emotional situation.

The consequence of this approach by the nurse and increased anticipation caused Anne to second guess whether she had a level of responsibility during the assault, and whether this would be focused on in future proceedings. This led to the participant regretting the disclosure:

> *"It's like a ball that you can't stop rolling once you've even mentioned something. But then it made me think, like: oh, maybe I shouldn't have come… Like because if I did do that, I would look really stupid now. But*

then she said some things and it made me like really question it, but I think of what she said or… "Had you implied anything before" (Anne, MU1).

When survivors tell friends or family members that they have been assaulted, the uncertainty of the future, whilst there, is often not as dominant in their experience, since they can often predict how that person will react. This is due to their previous relationship with others. Participants were concerned that their disclosure to someone with whom they did not have a previous relationship. would lead them to become emotional. Being overcome with emotion in front of a stranger was regarded as leaving the survivors feeling vulnerable.

Lucy's quotes demonstrate the expressed anticipation of not knowing the future (MU:16/17/35):

"Like I'm very, very, very guarded and I just thought like: I'm worried in case I end up crying or something like this, like in front of a stranger, 'cos I really just feel really… Like I would be feeling too exposed" (Lucy, MU35).

Although the context of the discussion is focused around not knowing the person to whom they are disclosing the assault (MU:35), their ultimate concern was future outcomes (MU:16/17):

"Again, just like on edge, you know? Just sort of like: aah, what's going to come out here? Am I going to cry, or like what's going to happen here" (Lucy, MU17).

Not only is there anxiety about how the experience can be brought to the fore in the shape of a disclosure, but there is also anxiety attached to not knowing how the nurse might respond to the disclosure. Participants anticipated the type of nurse they hoped to see and began describing how they anticipated that nurse would respond to the disclosure; the present is always future facing. Anticipation about not knowing the person or how that person will respond to the disclosure is part of the experience to which participants kept referring (MU:7/14/16/17/18/35). This future-facing anticipation about the nurse's response was typified by Jane:

"I was worried that I was going to go and even though I knew that it was real, that someone might say "well actually, no. It wasn't" and be like "this didn't happen to you, so why are you here crying about it?" Sort of thing" (Jane, MU7).

5.3.2 Relationship

Not knowing who they would see is difficult as they struggle to be future facing when the future is blank; when there is no previous experience or relationship on which to draw upon. As previously mentioned, there can be a presumption about how friends and family might respond due to previous relationships. However, with a stranger, that is not there. Therefore, the future facing becomes an anticipatory approach, whereby survivors start looking for clues about the person they are seeing; they are trying to push through into their future-facing consciousness since this is usual behaviour. This caused participants to imagine the type of person they would eventually see (built from the past – their previous knowledge of what or who a nurse should be). There is hope that the person will be friendly, understanding, and empathetic (MU:7/14/18). From a phenomenological perspective, empathy is understood as a unique form of intentionality. The phenomenon of empathy takes its starting point in the idea that empathy is a way of feeling oneself into the experiences of the other person (Stein, 1989). Participants are searching for understanding and empathy, and that, in turn, suggests that they want the nurse to experience their experience through their lifeworld, and respond in a visibly empathetic and understanding way. However, this is not possible, as all lifeworlds are unique to the individual.

As the survivors cannot predict how the nurse will respond, this leaves this aspect of experience in an unknown state for them, and they then start searching for empathy. They described this as observing nurses coming in and out of the waiting room; looking for clues about the nurse's personality or approach. Jane described her experience, which typifies survivors' behaviour of judging whether the nurses will be supportive, based on their appearance and tone of voice:

"Erm, came and got us and I just remember thinking: oh, she looks really friendly. She had like a nice smile; she had really nice ginger curly hair; I remember that" (Jane, MU 14).

When it comes to anticipating whether staff will be supportive, there is also an added eagerness about whether that staff member will be the person who will undertake their appointment. Being unable to identify between professional roles seemed to cause

additional confusion, since the survivor is unaware whether this individual is just guiding them to the right room or seeing the appointment through. This caused the survivors to be thrown into uncertainty by the unexpectedness of not being able to recognise or differentiate between roles. This is an aspect of experience that Sarah referred to:

> *"All of the staff were dressed in their own clothes. There was no distinguishing who was a doctor, who was a nurse, who was a healthcare and it made me feel confused" (Sarah, MU14).*

Whilst distinguishing between roles is seen as important, knowing another person's name makes a human connection. Knowing the staff member's name contributes to the survivor humanising the nurse. After spending time anticipating the type of person they will see, this seems to be a big part of the process of feeling comfortable disclosing their experience and reducing anxiety (MU:60):

> *"So at first, I thought: Just tell me your name; I don't know who you are or what your role is. So stressful" (Jack, MU60).*

The lack of previous relationship with the nurse leads to an emotional anticipation of response, causing survivors to feel as though they are in a vulnerable position (MU:35/36/48). This was illustrated by Jane:

> *"I'm sitting there, thinking: I'm going to have to say this out loud to someone I don't know. Like, can they tell that I've been crying? Like, all that kind of stuff" (Jane, MU35.)*

For survivor participants, telling a stranger about their traumatic experience emphasises the feelings of guilt and shame aligned with the experience that were already there:

> *"Erm, which for me was upsetting, because I was young, I felt guilty and ashamed of what had happened, terrified, I didn't even know them [the nurse]" (Jack, MU36/48).*

5.3.3 Finding their voice

In addition to the anticipation of not knowing what to expect, and the feelings of shame or that there may be guilt on their part for the assault, participants described the impact of these feelings on their ability to communicate their experience (MU:48). Being able to find the words to articulate the experience to the nurse was difficult. This was described by Sally:

> *"I just… Felt so disgusting. Erm… So low… Erm, my anxiety was all over the place. Erm, I didn't really know what to expect. I didn't know how to tell them or anything like that" (Sally, MU48).*

Jane described her experience in more detail:

> *"I didn't speak for like half an hour, 'cos I just, like, physically find it hard to say things out loud" (Jane, MU48).*

The anticipation of not knowing what to say, or how to say it, contributed to increased anxiety about how to find their voice prior to the consultation, and throughout. There are points in disclosure experience that render the survivor speechless. Heidegger (1962) suggests that our words are accrued based on our experience, and our words do not enforce experience. Therefore, in this instance, it seems that the experience is so alien to survivors that it renders them speechless; there is no accrual of words from the experience.

Steinbock (1995) provided an interpretation of Husserl's (1960) phenomenological concept of normality and abnormality into homeworld/alienworld. Homeworld is defined as a sphere of ownness that is constantly in the making and changing as we navigate through *being.* The homeworld is unique to each person, and it is from this perspective of the home as a lifeworld that the alienworld is perceived as not normal for us (not home), and therefore can take our lifeworld by surprise. Within this group of participants, the alienworld can be described as the disclosure; it renders them speechless, causing difficulty in navigating through the disclosure process.

The alienworld starts for the participants in the pre-disclosure stage; immediately following the assault. The awareness that this is not their normal lifeworld and subsequent anticipation of being unable to find the words (in the future), caused participants to practice what they wanted say about their assault multiple times, as they tried to find their voice and words to describe what had happened to them (MU:40). This was typified by Jane's description of preparing for the disclosure:

> *"I was really anxious and really like… Planning what I was going to say and how I was going to say it and like, you know when it's going like over and over and over in your head?" (Jane, MU40.)*

Whilst Heidegger (1962) talks about temporality and the impact of the past on the future, he does make it clear that individuals are not condemned to the past, and can make decisions that will impact the future. He refers to this as '*resoluteness*', meaning the present is something that can be seized hold of and decisively made one's own, and experiencing the alienworld contributes to this look into the future. Jane's quote is a good example of this in action; she went over and over the experience in her head to plan how she will use her voice to disclose. However, survivors re-living the experience in their minds to help gather the words to describe what had happened contributes to causing their emotions to be heighted (MU:50/56/62).

5.3.4 Repetition

Survivors discovering ways to find their voice to describe their experience is both an essential and powerful part of disclosure. However, it is also seen as having a detrimental impact on their wellbeing, in that it can add to the psychological trauma of the rape experience. For some, they find their voice by repeating the words they have accrued (see Jane's quote above), and this means they are re-living the experience of their rape every time they go over it in their head and then again every time they disclose. Jack described how the feeling of shame and guilt was amplified with every disclosure to different nurses within the same visit to a clinic:

> *"Well each time, I just… I felt more ashamed and disappointed with myself that I was… I'm a sensible young lad, but this had happened and each person was different in their recognition of what I was saying and, you know, erm…" (Jack, MU50).*

Participants focused a large proportion of their experience on describing their frustration at the repetitive cyclical nature not only of the disclosure, but also what comes with the after effect. This was characterised by Sarah's experience:

"… I mean, I was exhausted with the amount of appointments that there was. Absolutely exhausted" (Sarah, MU56).

Also, whilst the repetitive nature had a physical consequence for Sarah, it is clear the psychological toll was equally as traumatic; again, demonstrating the embodied nature disclosure can have on a survivor through their exhaustion. The experience of not knowing, and the anticipation that is associated with that, appears with every part of that on-going cycle; who you will see, what you will say, how they will respond, and then again after the disclosure when reflecting on the visit. Sarah described this feeling clearly:

"have to go back again and again and again and it was just reliving the trauma, you know" (Sarah, MU62).

One of the further consequences of this cyclical nature of disclosure is how the need to repeat their experience makes participants feel that they are being questioned (MU56). For Anne, this resulted in her wondering if she had answered the questions rightly or wrongly, indicating the need to say the right thing to be believed:

"Because you'd had to relay it so many times. Like, I had to tell a police officer like, in general, just…and then I had to tell them again, so they could write down exactly what I'd said and then I had to go out to the place and tell the nurse and because I'd relayed it so many times, it was just coming off naturally, but after you get questioned… It was a little bit intimidating, 'cos she was like asking questions that like, implied that they were going to trick you. Like you know they haven't…. you're not telling the truth, sort of thing. But like, she was asking so many questions and she was asking something like…And then it was… I can't remember what it was… But it ended up making me think: oh, have I answered that right or wrong…?" (Anne, MU56).

The experience of repeating disclosures multiple times in the healthcare setting was often because survivors saw more than one healthcare professional (including the nurse) about the incident. With the introduction of a new person came a request to explain why they were attending the service, resulting in another description of the rape. Sarah and Jack described seeing and disclosing to three members of staff within one visit (MU 62). Interestingly, Jack suggested that reliving his experience led to deeper feelings of self-judgement:

"Well each time [I disclosed], I just… I felt more ashamed and disappointed with myself that I was… [I'm a] sensible young lad, but this had happened, and each person was different in their recognition of what I was saying and, you know, erm… I guess the first two, erm… Females were nice and very like motherly, but then the male at the end, it felt more… Erm, it was less sort of compassionate and more… Not like a telling off, but you know, "you must have safe sex" and this… "You can't allow this to happen again, because it's obviously…" He just had a different manner. And I don't know if it was because it was a male to male thing or whether he was straight and… Or… Don't know. It was the third time; it felt a bit more intrusive talking to a man. I don't know if that was because of the subject and the content of the talk or, erm… But three times is quite…Excessive" (Jack, MU62).

It is clear Jack valued the female maternal atmosphere in that consultation, and the male voice caused increased emotion. The gender impact on experience is touched upon further in the chapter.

5.3.5 Confidentiality

Whilst not knowing what might happen next causes a great deal of anxiety for participants, confidentiality added another layer of concern (MU:11/13/27/28/33/41). This was described in two different contexts: people seeing them as they attend their appointment, and who the nurse may tell following the disclosure (and the consequences of this).

Jane characterised this when describing her disclosure and the potential involvement of other professionals, namely the police:

"Like, not was putting me off, but made me think about it was… Straight away, they say "did you report it? Are you going to report it? Do you want to report it? Do you know the way in which you could?" And I know that… I know all the ways in which I could, but I just like, I couldn't do it, because if you do that, then everyone has to know and nothing would... Not like nothing would come of it anyway; there would be no evidence; there would be no…" (Jane, MU27/28).

There appears to be concern that if the disclosure is taken further (to the police) then more people would know about the assault. Keeping the people that know about the assault to a minimum was important (MU:27/33/41). The experience of rape is deeply personal and left participants feeling vulnerable in many ways. Having people know about this added to the feeling of being exposed further. When considering Heidegger's (1962) Sorge / care, it has been discussed that participants are *attending to* their rape by disclosing, and they are aware that they cannot anticipate how people might respond. Thus, keeping those that know to a minimum could be attributed to their form of self-protection, or their self-care. Their concerns regarding confidentially and ways of managing that exposure is their *resoluteness*. However, there is an unknown element of whether, once the rape is disclosed, confidentiality will be maintained.

That said, although the concern regarding confidentiality can be seen as the protection of self, survivors also expressed concern regarding the perpetrators and other people's futures when considering who might find out about the rape (MU:32/39). This study demonstrates that the notion of *Sorge* is both inwards and outwards in its focus (care for self, care for others and an awareness of the implications of care of self has on others). Anne typified this with her experience of wanting to protect the perpetrator's family:

> *"But he had children as well and if something happened, then obviously it's something that would be taken very seriously. And obviously something will come of it, whether it goes to court or it doesn't; something will come of it and then I didn't want people to find out" (Anne, MU32).*

Another participant also touched on this from a wider perspective; demonstrating that in a time of extreme emotional pain, survivors consider the impact of their assault on other people. This adds another level of responsibility to their anxieties:

> *"And it would ruin many other people's lives other than just mine" (Jane, MU39).*

Privacy and confidentiality are clearly important to survivors, and it has been highlighted in this chapter that telling an individual about the experience can be daunting, especially if survivors have no connection to that person. As suggested earlier, with the uncertainty of not knowing, survivors become increasingly concerned that someone will either recognise them in the clinic they attended, or that other patients would know why they were waiting to be seen (MU:12/13/15):

"The colours [in the waiting room] weren't very welcoming; but it was more the fact that there was other people there" (Jack, MU15).

This contributes to the survivors feeling open and vulnerable. Feeling open, emotionally, allows the thought that other people can see into you, or see through you; that they can see what you are thinking, demonstrating an embodied experience. On top of feeling open to people trying to guess why they were in the clinic, survivors expressed increasing feelings of guilt and shame as they felt that they are being judged, not only by the nurse, but by others in the clinic. Participants alluded to other patients being able to tell that they were there because an assault had taken place. Jack characterised this experience with the following description:

"You felt like people were looking and thinking: what's their story? And you were panicking if you'd see someone you knew. It wasn't huge, but it was still quite busy. I still felt quite panicked, and ashamed, really" (Jack, MU12).

Adding:

"I know in clinics, you can feel a bit up a height, because you don't want to be there. It's the panic, the worry of…you know, your privacy and your confidentiality" (Jack, MU13).

Jane echoed this feeling of questioning who knew about the assault and was concerned that she did not know who would be told:

"in my head, it was like: yeah, do they know…? And then that's kind of like… Goes on to the bigger thing of: do you want people to know? Will people know? How many people are you going to tell?" (Jane, MU12).

Jack described his experience of another member of staff coming into the consultation room as he disclosed his assault. His apprehension about whether someone would find out why he was there felt very real in that moment. The nurse who saw him allowed another member of staff in the room; this was a violation of his confidentiality. His experience was also a typification of how a physical interaction can result in an embodied experience:

"someone knocked and came in, the first time it was… The nurse said "yeah, come in" and I thought: you know, who's this? This is a private conversation. I'm disclosing stuff that's very sensitive, and I'm scared about. [The staff who came in] only wanted to borrow something from one of the trays, but… I mean I could hear her walking along the corridor, so… 'Cos you don't know who it is and again, my mam being a nurse, I don't know if she had any friends working in that area and if she had, it would have been awful, embarrassing, I felt sick" (Jack, MU13).

5.3.6 Environment

As previously discussed, the anticipation of not knowing what is to come next, how survivors would find the words to disclose and what the nurse's reaction may be, heightens and contributes to survivors experiencing a wide range of emotions (MU:11/15/16/17/20/21/22/23). In addition to this, senses are also enhanced to the surrounding environment, as participants were aware of the impact the environment had on their emotions and saw the need to follow through with their *attending to*, until they had made the disclosure. This demonstrates Heidegger's (1962) notion of resoluteness; participants were aware the emotional impact may affect their future and were making decisions to shape this, or to care for themselves.

Sarah's description of travelling to the clinic to make the disclosure typifies this experience:

"Getting on the metro with the other half and it was just… The longest metro journey ever. Sitting in the waiting room… Walked around from the metro station It was just really, really upsetting. Really slow walking across the road" (Sarah, MU22).

She went on to describe the next aspect of her experience, where she had an awareness of holding it all together to get through the disclosure:

"A whole melting pot of emotions and you just try and keep it in check, because there's other people around you and it's just not a very nice environment to be in, because I think… Because I didn't know what was going to happen. I just didn't know" (Sarah, MU16).

Participants are acutely aware that there are other people around them, from an environmental perspective, and described how this made them feel (MU:11/12/13/15). These emotions were expressed physically, such as when they were walking toward the consultation room. The not knowing heightened this aspect of experience, making it feel physically longer (embodiment of lived experience). The apprehension to meet the authentic self is amplified here:

> *"And I remember having to climb the stairs and I just was like… Just the actual psychology of climbing the stairs and it was like… Just like the last thing… A horrible place to climb the stairs to.. I think if you're thinking about where you're going, up the stairs, what's going to happen to you?... An awful long 10 seconds when you're walking down there wondering what's going to happen" (Sarah, MU16/17/22).*

Sally went on to describe the emotions she felt when navigating around the clinic:

> *"Even though it's like a narrow corridor, it just felt so open and so spacious and… It kind of took forever, but it was the shortest walk" (Sally, MU22).*

This illustrates another aspect of the disclosure experience, that being when survivors consider changing their mind about the disclosure. The authentic self is there, but the not knowing what the future will bring can cause increased anxiety, and that results in the desire to meet (or show) the authentic self wavering. Thus protecting themselves from what might come next by keeping the experience buried:

> *"It was busy and it was loud. Well I thought it was louder. Like, everything was just amplified. Erm… And then my name beeped and I thought: can I bottle out of this? Can I just go? But then in my head, I cannot stand people wasting appointments, so I was like: no, I need to do this, so I went in and saw him first" (Sally, MU22).*

5.3.7 Belief

As participants described their experience of disclosure, fear of judgement was at the core of many of these descriptions (MU:1/2/3/4/5/7/8/9/10/12/14/33/ 36/42/48/56/67/68). Whilst

it may not be the focus of their description (although it is at times), there is an undertone that the experience is defined by the worry they will not be believed, and in turn judged for their par' in the rape. It can be seen in the meaning units that this is cyclical of the process of disclosure; however, I have situated it in the not knowing theme. This is because the overwhelming concern with this aspect of disclosure is the not knowing how someone may respond to the disclosure and, due to this, the participants preparing for the worse. Within this chapter the notion of Sorge was outlined, particularly Heidegger's (1962) thoughts that our past reaches forward into our anticipation of the future. Participants are preparing themselves (anticipating) to be judged, not believed, and blamed for their assault (based on their past, this could be previous knowledge about victim blaming approaches in society etc.). This is in their self-protective nature (prepare for the worst). When considering experiences of rape and sexual assault, society has an undertone of victim blaming in its narrative. Participants are attuned to this and it causes concerns about being blamed or judged regarding the circumstances around their assault. The guilt lies around feeling responsible. Responsible (within the victim blaming narrative) for elements of the circumstances that would lead up to the assault, for example having consumed alcohol, putting themselves in a position whereby it was their word against another's, seeing themselves as usually sensible (in other words considering it their own fault they had engaged in risk taking behaviour), or being gay and young (naivety associated with this). Survivors have these narratives etched in their minds, causing an increased sensitivity to being blamed, and thus increasing the emotional response when disclosing. However, in order to *attend to* themselves and follow through with this disclosure, they are also describing that they hope for the opposite (in looking for the friendly, kind nurse). This juxtaposition between hope and expectation causes constant emotional cycles in their experience.

Whilst the disclosure clearly takes its emotional toll on the survivors, the underlying notion of guilt and fear of potentially being made to feel at fault for their assault continues to build up. Having these thoughts contributed to the anticipation pre-disclosure. Similarly, having these responses voiced by the nurses solidifies their anticipatory anxiety, causing disappointment that was somewhat expected as a source of self-protection, but not hoped for.

As an example of this, Jack and Vicky typified the reality of the fears above, as both described being made to feel responsible due to having consumed alcohol on the night of their attack:

"They judged it as a case of me just wanting a bit of fun and getting drunk and being silly, but I wasn't; I was taken advantage of through alcohol and being misled" (Jack, MU2/5).

"Cos I got raped. And she kind of said it wasn't rape, because I was drunk, so it was… Yeah". (Vicky, MU5).

Fear of being told by the nurse her experience was not assault was a concern for Jane. She went on to suggest that had she disclosed earlier and not had time to reflect on her experience, she may have dismissed the assault as a consensual experience, even though she said no and did not have the capacity to consent. This demonstrates the way survivors attribute blame to themselves based on their past knowledge (of what rape is and who is responsible), and then re-live the experience and continuously reflect:

"Yeah, I don't know. I think I might not have been ready to do it sooner. I think if I'd done it sooner, I maybe would have explained it in a way that somehow made it my fault a bit more. I think at that time, I was kind of a little bit more accepting that it wasn't me and if I'd done it sooner, I don't think… I think I would have [just said] "oh, well you know, I was drunk, so…Yeah" (Jane, MU5).

5.3.8 Being silenced

Participants have found a voice to *attend to* their rape and it appears they are being silenced because of their use of alcohol. This has not only the immediate effect of not being believed (which is also to be silenced), but the dismissive approach rules out reporting the assault to the police, even before discussing this as an option with the survivor (again, being silenced). Not only did the nurse tell Vicky she had not been raped, she indicated that this disclosure would not be taken seriously by the Crown Prosecution Service, and that Vicky had to put this behind her and move on. This came after Vicky had found the courage to *attend to* the experience:

"She said, you couldn't do anything about it in a court of law, because you were drunk, kind of thing. So you've just got to move on" (Vicky, MU5).

Another participant experienced a similar approach by a nurse with regards to dismissing reporting this rape further:

> *"so she said that in these circumstances, there would be no point in going to the police; it would be my word against his and it would probably cause more harm than good" (Holly, MU7).*

Participants feared this response and often their fears were validated, which led to disappointment because, although they had prepared for the response, they had not hoped for it. Jack described his experience and used the word 'victimised' to further describe how he felt about the nurse's response:

> *"victimised in a way and… it's all wrong, As if they'd heard it before" (Jack, MU4).*

These responses are confirmation of their anticipatory fears. Judgemental or dismissive responses from nurses immediately following disclosure is a common thread. This solidified the concerns participants already had surrounding feeling judged or blamed for the assault, based on their past experience / knowledge of the topic. When this reaction was received, it heightened emotion and survivors became upset; this caused frustration and anger for some. It has been previously discussed that patients anticipated this response, but hoped for support. This frustration shaped the remainder of the consultation, with a lack of trust causing barriers to communication. This contributes to the survivor wanting to leave the situation, thus illustrating the regret of *attending to*, or to change their mind about following through with the disclosure (MU:4/8/10). Feeling wounded or wronged brings the need to retreat as a form of self-protection, and to continue their self-care:

> *"Just awful. I felt just ashamed, judged. That's probably the best word. I felt embarrassed and… More embarrassed because I'd then got upset in front of her and that was her reaction" (Holly, MU4).*

> *"No. I just wanted to get out of there. I didn't want to see anyone. I thought… In my head, I thought they all know what's happened now. They're judging me and I just wanted to get out" (Sally, MU10).*

Jack went on to describe how he felt that the nurse's judgemental attitude was related to his sexuality, and this trivialised his experience. He came back to this point three times, demonstrating the impact the nurse had on his experience:

> *"Whereas a man, they'll think straight away, 'cos… You've had a dodgy one-night stand or something, so…" (Jack, MU6).*

> *"I guess the man's manner. I just felt like I was being judged as like a young gay kid who's been silly because I was just so…. Scared of the whole thing" (Jack, MU3).*

> *"And I felt ashamed and guilty when I was disclosing everything" (Jack, MU4).*

To feel guilt implies an inward level of responsibility that lies with the survivors for the assault. It is thus a self-judgement that develops into expectation when the response of the nurse is not as supportive as they hoped for (that is, victim blaming comments), and this amplifies the feeling and somewhat solidifies that guilt.

The reaction of the participants to not being believed, or being made to feel somewhat responsible for their rape, causes a range of emotional responses (MU:4/8/10/56). The response is typified here with two different reactions from participants. One response pushes through with the need to *attend to*, recognising this is essential for the survivor to show their authentic self:

> *"Angry. Like nobody believed me. Erm, I didn't know what to do. Erm, I didn't want to walk out of there and then possibly do something, like harmful or anything like that, erm, so… I was like: no. I need to tell somebody. Somebody needs to help me before I get to that point" (Sally, MU 4).*

The other has the opposite effect, causing the survivor to re-bury the disclosure, hiding their authentic self-further:

"And I completely felt like: that's just where I completely felt like, ashamed of whatever. And you know, it's a normal feeling to coincide with that – that heightened… Me feeling ashamed of that situation, I think I was already embarrassed by it, but then it completely shut anything down for me disclosing it to anyone else" (Holly, MU10).

Considering the nature of disclosure explored previously, following a response of blame from the nurse the ongoing environmental factors play a part in triggering the frustration of not being believed. This is characterised by Sarah's description of the posters she sees regularly relating to this topic:

"And the posters on the back of the toilets, 'We believe you' as well. Now, I see those every day of my working week and I'm like: well actually, no. You didn't believe us at the end of it all" (Sarah, MU7).

She saw the material as misleading (like propaganda), causing an ongoing emotional response.

Participants explored how they felt their emotions became dull during the disclosure (MU: 43/44). This was typified by two participants' experience, described below:

"Because I was talking like, as if I was talking about the weather. Like, just very sort of like, matter of fact" (Jane, MU43).

"But it wasn't erm… I had a reaction to it where I just completely switched off, but I didn't really get any… I didn't really get that much of an emotion. Then I just felt… emotionally, I felt nothing" (Anne, MU44).

The same participant suggested this lack of emotion lasted long after the disclosure, signifying that the showing of the authentic self can be transient or estranged at times:

"And I never really had much [emotion] to it, but I couldn't tell you what it was like afterwards, 'cos I thought I just switched off completely and then I didn't even think about it until… After that, I didn't think of it until a good few months after" (Anne, MU43)

Holding in feelings and becoming detached allows for a brief period of time to anticipate how survivors would be treated by the nurse, based on their response. They then could tailor their emotional response in line with how there are treated. This can also be seen as a contribution to the self-care part of the disclosure process. Revealing their authentic self is anxiety inducing, and is continuously self-assessed by the survivor as to what they are willing to reveal.

The response of the nurse evoked some feelings of frustration or disappointment in participants. Whereas previously emotion is based on anticipation of blame and being not believed, in this part of disclosure it is caused by a lack of emotion or response (MU57). Sarah described the nurse's response in her experience of disclosure:

> *"The whole interaction was quite frosty – it's the last place on earth you wanted to be" (Sarah, MU57).*

Meanwhile, whilst Anne described her emotional response as matching that of the nurse, and switching off, she also talked about how upset she was, to the extent that she started crying. This indicates her emotions were mixed at this time and the reaction to her authentic self being dismissed was not emotionless. She did not get the empathetic response she was hoping for from the nurse, and this contributed to her emotional vulnerability:

> *"She did treat it like she sees it all the time. Erm… She wasn't really… 'Cos as much as I say I don't have emotions, I must have had emotions, because I was crying" (Anne, MU57).*

She added the lack of compassion demonstrated caused barriers to her responding to some of the questions asked in the clinical assessment (MU58). She had exposed her authentic self, and now felt exposed:

> *"And I took a while to respond 'cos… I remember that. And erm… She wasn't really… If like, it came for me to speak…She was like… Asking more questions and… Loads more questions and she didn't really give me much time to respond… She was really nice, but she wasn't very… It wasn't very person-centred and she just… I could have been anybody, really" (Anne, MU57/58).*

Interestingly, even though the nurse made Anne feel emotionally exposed, she tried to make excuses for the nurse's behaviour, placing blame on her experience and circumstance for the nurse's lack of compassion (MU59). It is also clear from this quote that there are continued descriptions of being silenced: *'she didn't really give me much time to respond.'* This demonstrates that the notion of Sorge is not only about self-care, but for most it is a way of *being*. Thus, care is projected both outward and inward, even in such exceptional circumstances:

> *"I feel like she maybe wasn't the best nurse. But I can understand as well, 'cos it was like three o'clock in the morning, so they'd probably just dragged her out of bed, 'cos she was on call. She was probably thinking: Oh, I've got out of bed for this" (Anne, MU59).*

Holly's experience was similar to Anne's. The participants clearly picked up on nurses' attitudes and perceived discomfort (MU57):

> *"So for me to have broken down, it was quite… I felt like I was very vulnerable anyway and… I er, was very… As soon as I could see that she wasn't… It was almost like she was a bit stand-offish. Erm… [Indecipherable 10:10] so I was expecting… That - but her responses were just not… They were just very blunt and to the point. Erm, and I just as soon as I could see that she almost felt uncomfortable" (Holly, MU57).*

Rather than the supportive conversation the survivors were looking for, it appears from their descriptions that the consultations were practical and instructional (which does link with the nurses' experiences of disclosure; particularly the desire to provide tangible, concrete support):

> *"I didn't use words like 'assault' or anything like that; I told her literally what had happened and, erm, yeah. That was her response. And I wasn't looking for her to tell me to go to the police; I was looking for, er… For… I don't know. A bit more of a sympathetic. Instead of, it was that, followed by "I'll give you the morning after pill; there's chlamydia tests on your way out but if you want any more STI tests you will have to go to a sexual health centre…she obviously didn't feel comfortable talking to me about it, there*

was no offer of where I could go to speak to someone, or… Who would be the best person to then go to and speak to. There was nothing like that. It was just very… "I'll give you this. If you want this, there's that"" (Holly, MU57).

This description of the experience indicates that survivors found this practical support without emotion to be unhelpful. It also highlights the survivors' desire to receive a personal, emotional reaction from the nurse, particularly a one that is understanding and empathetic. Survivors do expect a more empathetic response, whereby the nurse responds to the needs of the survivor instinctively. This response was assumed when the nurse was female. When that was not shown, participants were surprised. Again, Holly typified this aspect of the experience and expressed disappointment that the female nurse did not show solidarity when she reviled her authentic self:

"I thought, going to a female nurse, it would have been received differently. That it was the first… I think the first… I think that affected me was the fact that it wasn't received the way I feel like it should have been. The fact that she handled it badly and then, because she was female, there was no empathy at all" (Holly, MU68).

Rape is a gendered crime, and with that there is an expectation that women would be more sensitive to the emotional needs of the survivors. There is also a recurring description from participants that female nurses should have a 'motherly', natural empathetic instinct (MU63 – see section 5.4.9 quotes from Vicky and Jack), thus gendering the emotional expectations of the nurse.

Frustration was also expressed about not being signposted to other people who might help after receiving a negative response from those to whom they disclosed (MU67). Sally characterised this when describing searching for help and not getting what she was looking for. This shows her facing the authentic self, and being left to feel vulnerable for doing so:

"Erm, it was firstly to GP and then to a nurse, because they kind of just went… "I cannot deal with this". Erm, and it left me a in a bit of a situation. I was like, well, someone needs to help me" (Sally, MU67).

As previously mentioned, increasing the need to disclose to another person risks the survivor retracting their authentic self, thus increasing the risk of ongoing negative psychological wellbeing. Natalie described the experience of the nurse being shocked at the disclosure. She found that once she had disclosed the assault, all the reasons she was seeking counselling support for were attributed to the rape, and this experience of assault took priority over the support she had been receiving (MU6). This was frustrating to her as she had (at that point) deemed them not related, and felt as though she was not being listened to:

> *"but kind of my major experience of it was that my nurse counsellor, kind of once she'd picked up on that, focussed straight in on it and didn't really listen to me when I said that I've had these issues far longer than the kind of two years it's been since I was assaulted" (Natalie, MU6).*

Natalie's quote above continues the descriptions of being silenced within the disclosure experience: *'didn't really listen to me'.*

5.3.9 Feeling safe

Throughout the descriptions there were positive experiences described, and these were often linked to feeling safe and believed. It is clear the motherly/maternal instinct is what was valued in these experiences (MU:61/63). There is an expectation that the nurse should have a maternal instinct. Maternal instinct is often described as a fixed behavioural response to provide safety and security. Whilst this is usually attributed to mother and child, there is a societal assumption that women have an automatic maternal instinct, and this is even more so if the woman is a nurse. It is interesting that the participants that typified this experience associated maternal instinct with gender. The UK population of nurses is predominantly female (88.6%, England.nhs.uk, 2021); however, this assumption further supports phenomenological considerations in that societal norms from our past are used to shape, not only, our future anticipatory thinking (*seeing a nurse = female = motherly instinct*) but also our reflective nature (*she was female so should have been more understanding*). Vicky and Jack typified this by describing their reflections:

> *"She was kind of like 'motherly' really, in a sense" (Vicky, MU63).*

> *"But she was very like… Erm… Caring, the whole time. Very, erm, patient. I felt quite reassured by it" (Jack, MU61).*

"and I think she was very [comforting] and accepting and quite motherly and she was nice" (Jack, MU63).

Survivors expressed that having a positive compassionate response made them feel safe and supported (MU:61/66). Feeling like the nurse was on their side, indicates that they felt believed and that someone was going to help them; having their authentic self-accepted and supported by the nurse was seen as a good disclosure experience. Sally and Vicky characterised these meaning units below with their descriptions:

"There was something that meant I felt safe enough to talk to her and I'm not sure… Erm… Kind of almost like… I think it felt like she was on my side…I haven't often kind of felt that able to speak to somebody or also looked after in the… You know, within what happened. So almost it felt like she was going to help me get some help" (Vicky, MU66).

"She was just very, very, very like, sympathetic, like just very nice" (Sally, MU61).

It was clear throughout the participants' descriptions that they undertook post-disclosure reflection. Safety, security, empathy, and compassion were all attributed to belief throughout their descriptions; thinking about the experience and coming to terms with the magnitude of what had happened to them within this whole process. The reflection allowed for a process of acceptance and, in turn, relief for two participants (MU:63/66). They had *attended to* themselves and shown their authentic selves, and that had been received positively, and they felt the benefit of that post-disclosure:

"I did feel like a weight had been lifted. A little bit, like just a feeling of like relief a little bit. Yeah. Just sort of like: I feel better now; I'm going to go and have a good day" (Lucy, MU66).

"Erm, I just remember, kind of feeling, thankfully… Quite supported" (Vicky, MU63).

5.3.10 Choice

A prominent aspect of communication evident throughout survivors' descriptions was that of choice; by which they mean the removal of and having no choice in what happens after the assault, after the disclosure and in their future care (MU:24/26/29/34). Making a decision implies that one has the merits of multiple options that will have been communicated to them in some way, and are then able to choose one. Participants described having this choice removed in many ways. Before accessing healthcare, social support is often the first source of disclosure, and survivors can feel safe disclosing to family or friends. However, once the survivor had revealed their authentic self, there is often no control of what the person revealed to does with that exposure. Thus, the social support can then take it upon themselves to decide who should know next, if anyone.

This experience was typified by Anne's description:

> *"But I would have told her. And then she said it herself and she said… I didn't really know what to do after that and I was like going "shut up" and then she was… And then she told my mam. But it made me… I think maybe that made it worse, 'cos I hadn't quite told myself yet, like I hadn't quite got everything round in my own head" (Anne, MU26).*

This increased Anne's anxiety about the future as, at that point, she was still coming to terms with what the assault was. It was still an abstract event in her mind and she was yet to find her voice in articulating her authentic self. Having the control of decision making removed, and no choice in who knows this very personal experience, can make survivors begin to withdraw their authentic self. Thus, being disengaged with the practitioner can be seen as a way of regaining control for oneself. This experience was, again, typified by Anne. Anne's experience was a wave of people making decisions for her. Having the police involved was not her choice; they are not who she revealed her authentic self to, so she chose to block them out and would not communicate with them:

> *"Cos it happened on a Thursday night and then… I usually get home the next morning for like seven o'clock in the morning and then I'd gone to my friend's house, 'cos I didn't go home, so then… She didn't convince me [to tell my mam], so she basically told [my mam] and then my mam did something about it, but it wasn't like until nine o'clock at night that the police came on the Friday night. So, really, then she [mum and friend] had decided to phone the police and to begin with, I wouldn't even speak to the police; I was very uncompliant" (Anne, MU24).*

Holly and Vicky also typified this experience in being pushed to access services:

> *"and erm, I was in quite a state and an older girl that worked there came and picked me up and as soon as she picked me up, she knew that something was wrong and she basically told me to make an appointment, so she was all like kind of… made me do it" (Holly, MU26).*

> *"she kind of… Said… Almost "you need to go to hospital A&E straight away" (Vicky, MU26).*

However, when Holly and Vicky described the removal of choice, and a move to the introduction of, what felt like, instructions, it was ultimately seen as a positive support:

> *"I don't think my mind was on that at the time, Erm… I think she helped kind of formulate a… Not a plan, but like a "you need to do this first off; you need to go and do this"" (Holly, MU30).*

> *"… I kind of felt like it was out of my hands a little bit. Not in a bad way, but in a helpful way. It was kind of the way it was kind of being 'lifted'" (Vicky, MU25).*

Instruction rather than choice was an element of experience also typified by Sarah. What is apparent is that it is not made clear to the survivors that they have a choice in what happens next, or which services they engage with:

> *"it was: you're going to have to go to the sexual health centre. Go to sexual health and get it done and I was… I really just don't want to go. I don't want to go" (Sarah, MU26).*

Jane explored the speed at which she was moved along in the consultation following her disclosure. She had described how she had revealed her authentic self and needed time to process that to consider what would happen next (future facing). However, she was not given the time to do this:

"Erm… but she's so fast at doing things, like she'll make a decision instantly and it's like: hang on, but you haven't thought about this and she'll just say it straight away and if things had had been a bit slower, something else might have made a bit more sense. She had just asked me what had happened, and I just blurted everything out. If I think she had tried to slow it all down, then it would have made a bit more sense. She was like: "right, we've got to do this; we've got to do that… I've got to do this…" Like, okay, but like now what's going to happen? I didn't have a chance to ask questions, like… Well now what's going to happen? It was just pretty much: you need to report it to the police" (Jane, MU29).

The lack of choice about their future was also attributed to the specifics, or practical elements, of the consultation. There was a lack of awareness that any part of their consultation could be declined, and an acceptance and trust that these elements were just what happened:

"Cos she'd told me before I'd even gone into the room and then once you get into the room, erm, a police officer who comes down like… Round the curtain… Erm, so I had to agree" (Anne, MU34).

"I just didn't want to get undressed. I didn't want to expose myself to strangers again. And I just really wasn't prepared for it and I didn't know whether or not I could refuse. Yeah, I didn't know whether I could refuse to disclose to the nurse and just say "look, I'm not very comfortable; I've gone through a… I thought this was part of the process" (Sarah, MU34).

When Sarah described her experience, she considered the language used by the nurse to influence Sarah into undertaking personal questions and the internal examination:

"But I think the phrasing of "are you going to be alright with that?" Is different to "You don't need to answer if you don't want to". cos I thought: this has to be done" (Sarah, MU34).

This quote demonstrates that knowing may have improved Sarah's experience. She did not know that she did not need to answer all (if any) questions being put to her.

5.4 Concluding thoughts of chapter

Temporality is a process with three dimensions which form a unity: past, present and future. For survivors disclosing rape, this temporality process is broken down into pre-, during and post-disclosure for this experience. However, as demonstrated by the movement and use of the meaning units, the same emotions and experiences follow through the three phases of disclosure. To gain insight into rape disclosure, it is important to look at this with both experiences, the survivor and the nurse, to gain an understanding of the whole and how one impacts another. This will be undertaken in the discussion chapter.

The next chapter focuses on the nurses' experiences of receiving rape disclosures in professional practice.

Chapter 6: Nurse participant experience

6.1 Introduction to the chapter

This chapter focuses on the themes generated from the data analysis process of the nurse participant experiences: emotion, communication and blame.

The descriptive phenomenological psychological method of analysis proposed by Giorgi (2012) was used to explore descriptions and analyse experience. This resulted in significant descriptive statements that were then reduced to formulated general meaning units (see Appendix 11). Themes were then derived from those meaning units (see Appendix 12). Throughout this chapter, themes for the nurses are explored related (and signposted) to the meaning units (MU), as per the previous chapter (for ease of access throughout this chapter the MUs for nurse participants are listed below in Table 7 for transparency). These are then illustrated by participant quotes.

1. The disclosure came at the end of the session. The supportive nature of the session had encouraged disclosure as she had previously disclosed, and had a negative experience which caused on-going barriers to disclosure 2. The need to follow guidance and policy dictates what happens next. However, the nurse is aware the individual gets lost in this 3. The nurse experiences mental exhaustion when considering the impact the disclosure will have on her workload 4. The unique bond the nurse has with the patient encouraged disclosure 5. When a person disclosed assault, the nurse sees it as their role to try to persuade the survivor to report to the police. At times this is done despite the survivor's wishes 6. The nurse often uses her observation and communication skills to recognise there was something wrong with the survivor prior to disclosure 7. Using communication skills to recognise a private area to talk was needed	39. The experience and memory of receiving a rape and/or sexual assault disclosure stays with nurses for months and years after the case 40. Feeling sick when receiving disclosures, physical manifestation of emotions 41. Feeling sorry for them. Empathy 42. The desire to make the experience of disclosure as easy as possible 43. Nurses feel anxiety that they managed the disclosure correctly 44. Receiving disclosures of SA and rape can be highly stressful 45. After receiving a disclosure there is often a need to seek support from senior colleagues. 46. There is an awareness that the consultation will last longer than standard and will be more complicated. This causes anxiety 47. The nurse will often reflect on the disclosure consultation and be anxious that they have not managed it right, or could have done something better

8. Warning the survivor on role boundaries before disclosure took place 9. Nurse used communication skills to manage an unexpected public disclosure that may have been triggering for other people 10. The disclosure was unexpected and not in the context of the conversation 11. The nurses don't specifically ask about sexual violence, but disclosures can happen when the conversation opens up around a similar context, or where SV may happen – such as domestic violence 12. The nature of the topic means nurses often have to mentally prepare themselves to explore. 13. Nurses using communication skills to identify potential psychological distress or those that need emotional support 14. Nurses use their intuition and other communication skills to be aware of when to explore an issue further 15. Being aware that people disclosing need extra emotional support to feel able to talk about it 16. Empathy contributes to communication skills when nurses are receiving disclosures 17. Nurses believe that having a maternal instinct emphasises care given in this situation 18. Being tactile with patients that are distressed contributes to what nurses see as supportive responses 19. Once a patient has made a disclosure, their previous behaviour and actions become easier to understand 20. Nurses feel a sense of responsibility for saying the right thing in response to a disclosure. The concern is that the survivor won't talk further 21. The nurses worry that they have given the patient all the right information and options following disclosure	48. There is an awareness that the clinical environment can be intimidating to some of these patients. 49. Depending on the role of the nurse, it can be better to see the patients in their own environment in order to remove the power imbalance 50. In the home environment you can use more skills to pick up on potential issues. 51. There is an awareness that patients are often pre-disclosing to reception staff in busy areas, to make sure they see the right practitioner. However, there is no confidentiality with this. The nurses are aware of this, but no changes are made to ease this process 52. The nurse called the police to come straight after disclosure 53. They try to keep the atmosphere as relaxed as possible 54. There is an awareness that confidentially is key in facilitating disclosures of SA&R 55. There is an awareness that an informal counselling-style room rather than a clinical room can aid in facilitating effective communication during a SA&R disclosure 56. Nurses believe that the consultation will be managed more effectively if there is a comfortable environment 57. There is a belief that the computer can cause a barrier in the consultation 58. Permission giving (to disclosure) is best facilitated in the right environment, this being a comfortable and relaxed space 59. There is a use of the word 'girls' to describe survivors of SA and rape. This gives a very specific impression of who the nurses think are survivors of SA&R are 60. Nurses associate sexual assault and rape with injuries

22. This is a topic that nurses don't forget easily. They continue to remember and reflect on this type of consultation for months and even years

23. Verbal communication changes depending on the questions asked. When asking sensitive questions their voice becomes quieter

24. Sexual violence disclosure makes nurses anxious

25. Nurses feel anger on behalf of the patient after they have disclosed rape

26. Worry that they won't know what to do with the information given. Feeling responsible for holding the information

27. Nurses feel torn between the compassionate desire to help the patient make their own decision and whether the sexual assault needs reporting or policy to be followed. Responsibilities are blurred so they look for guidance to instruct

28. In order for nurses to manage the anxiety that comes with sexual assault disclosures they benefit from clinical supervision to reflect on their management

29. There is a level of guilt when a disclosure has resulted in police being called when the survivor may not have wanted this

30. Anxiety that continuing the relationship, once you have reported the assault to the police, without the patient's consent can be detrimental.

31. Nurses feel sad that 'girls' are experiencing this and believe alcohol is a contributing factor

32. Listening to experiences of sexual assault and rape can be very emotionally distressing to nurses

33. Whilst empathy is felt, there is a need to keep emotions compartmentalised during the consultation, so the main focus is the service user and their experience

34. Once a shift is finished the emotion of what has been disclosed stays with the nurse

61. Nurses often link distressed presentation with 'genuine' rape cases

62. Nurses believe alcohol plays a large part in experiences of rape and sexual assault

63. Some areas will immediately refer 'girls' to sexual assault referral centres if there is any suggestion of rape or sexual assault

64. There is a belief, in some clinical areas, that when alcohol wears off the 'girl' will backtrack as they panicked into the accusation and then retract their accusation

65. Nurses do not want to pressurise patients into reporting, but do want to encourage it. Striking the balance can be difficult

66. Lack of understanding as to why the individual would put themselves in a presumed dangerous environment, 'not taking care of themselves'

67. Some nurses are aware that a patient may not want to speak to the police but call them anyway as it makes them feel like they have done the right job.

68. It is frustrating for nurses that there is, at times, disjointed care with often numerous other staff involved.

69. Nurses believe they are giving the patient options as to whether they want to contact the police. However, at times these are not options via cleverly-worded questions, 'so I would ask their consent, do they want me to ring the police? Do you want to ring the police yourself?'

70. There is a level of persuasion in most areas, by most nurses, to get the survivor to report the assault to the police

71. Due to the nature of certain clinics there is a lack of continuity of staff for survivors

72. The importance of safeguarding an individual can be very stressful for nurses

73. There is an awareness that cases are complex. However, there is also an

35. A nurse's main priority is to help the individual, to be her advocate 36. Receiving and managing these disclosures can be emotionally distressing 37. Being able to switch off emotions to deal with the management of some cases is essential to get through them 38. Disclosures are often unexpected	awareness that there are other patients waiting to be seen 74. Documentation is a very important element of management for nurses when considering the legal implications 75. Supervision is used if a nurse feels they need to explore particular cases they have managed. This often has to be asked for. However this is often with managers and there are power issues with thinking they may have not quite managed correctly

Table 7: Formulated general meaning units for nurse participants

As a background, the nurses received disclosures in the following settings. Some nurses received disclosures in their previous nursing roles and/or multiple settings, and those roles are as follows:

- Accident and emergency
- Sexual health nursing
- Oncology specialist nurse
- Education and training (higher education and clinical area education)
- General surgery/medicine
- Primary care

All names are pseudonyms to maintain confidentiality. It should also be noted that due to the nature of nursing practice and the language used in different clinical areas, survivors of rape (those making the disclosure) are referred to as survivors, patients, service users, and clients, to align within participants' language and descriptions of experiences.

As with the survivor experience, the nurse experiences of receiving disclosures of rape are complex. Not only are nurses overwhelmed with emotion regarding the nature of the assault, but they are also quite often torn between their societal perceptions of rape, what they believe is best for the survivor, and their professional responsibilities. Every aspect of disclosure is therefore underpinned with emotion. Whilst this is identified as a theme, it is also clear from the experiences described that the impact of this emotion is not one that dissipates with time. This is exemplified by the clarity of the descriptions the nurses gave whilst recounting their experiences, and the emotional impact they felt at the time of disclosure still being felt in the interview.

Themes are described from the nurse participants' narratives, which underpin their experience of receiving disclosures of rape. Below is a diagrammatic example of the themes

(green) and sub-themes (blue) identified, and the order in which these are explored within their subheadings throughout this chapter.

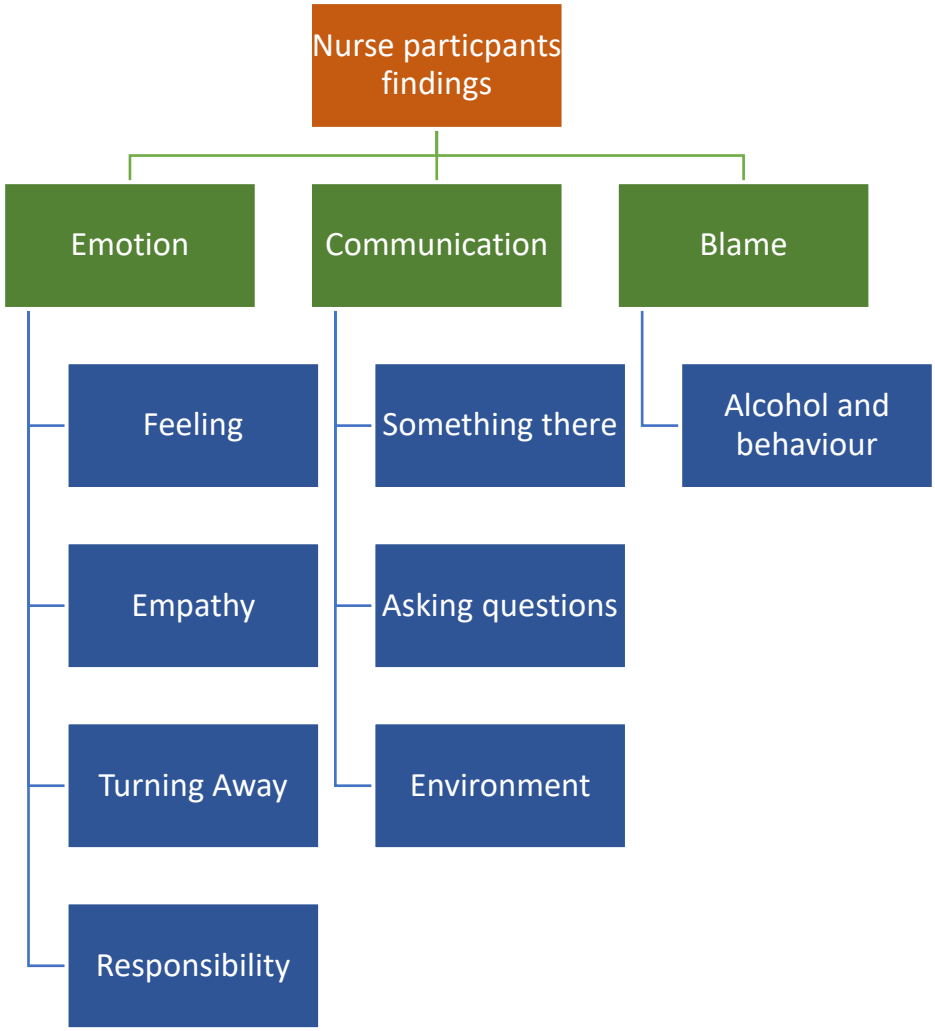


Figure 14: Nurse themes

As with the survivors, the experience of receiving disclosures of rape and the language used to describe those experiences is complex; because of this, not all meaning units (MU) sat comfortably in each theme, and some straddled over two or all three. Where this happened, I use the quotes to determine how the experience sat best within the context of the ongoing narrative.

6.2 Theme one: Emotion

Receiving a rape disclosure evoked a range of emotions for all nurse participants (MU:3/11/12/18/22/24/25/28/32/33/34/36/37/39/40/41/42/43/44/45/46/47/75). This was the first theme from the data that became apparent immediately throughout the descriptions; the emotional impact a rape disclosure has on the nurse was experienced and described in many ways. There is often an emotional toll of hearing another person had experienced this

crime, and this emotion then becomes complex as the realities of the nursing role set in. These include, for example, wanting to help emotionally support the survivors, ensuring professional responsibilities are met, and recognising this as a crime. This results in knowing SA disclosure will be complex to support from a patient-centred perspective, and therefore places a level of uncertainty that adds to the emotional impact rape disclosures have on nurses receiving them.

Emotion can be defined as a strong feeling deriving from one's mood or relationship with others (Oxford English Dictionary, 2022). Emotions are often how individuals deal with matters or situations that present themselves and can be negative or positive. The nurses in this study demonstrated their emotions in three ways: being shocked and anxious about supporting the survivor; feelings of anger, sadness and nausea; and then overly expressive responses of providing (what they consider to be) tangible help, for example phoning the police.

6.2.1 Feeling

Rape disclosure in healthcare does not always start with the actual disclosure. Disclosures are not always planned or indicated at the time of making an appointment / attending a service. However, there are times when practitioners will be aware that a disclosure may be coming (for example, when individuals tick the 'have you experienced sexual violence?' box on a triage sheet, or the survivor has declared this at reception). Should this be the case, a pre-disclosure anxiety begins to affect the nurse; there is an awareness of what is to come (MU:24/12/33). This experience was described by Betty:

> *"It makes me a little bit anxious if I know they're coming in for that reason" (Betty, MU24).*

Anxiety can be described as feelings of unease, worry or fear, and often leads to feelings of tension and some physical symptoms such as feeling nauseous or increased blood pressure (Shri, 2010). Heidegger (1962) explores anxiety as a complex but essential nature of *being* that is directed towards existence and related to his notion of fear. He states that whilst fear is directed at something specific (for example, experience of being raped – see quote on following page by Nicola (MU32), anxiety is about existence itself (the concept of rape - see quote above by Betty (MU24)). In this study, these are all emotions that overwhelm the nurse when they receive disclosures of rape.

Heidegger's (1962) conclusion is that this is through the revelations of the mood (*being*, is always driven by being in a mood, whether happy, sad, bored etc., and there is never no mood) which therefore shapes emotion, of which anxiety is an essential one described in this study (nurses describing worry and feelings of unease demonstrates a typification of the notion of anxiety). As part of the pre-disclosure stage, the awareness that the next patient is disclosing a rape experience can change the nurse's mood and therefore be detrimental to their emotions (MU:24). The time nurses have to think about what may happen next and the anticipation of what they need to do is not always beneficial from an emotional perspective. The unplanned disclosure does not allow for the emotional response of worrying about what will happen. This is also typified by Betty, as she compared the two experiences of knowing or not knowing the disclosure was coming:

> *"if it's disclosed unintentionally, it makes me feel less nervous" (Betty, MU24).*

Whether there is an awareness of the disclosure or not, most nurse participants expressed how their mood regarding the rape impacted their emotions during the disclosure. They described their experience by using descriptive words often associated with increasing emotion deriving from the mood (MU:25/32/34/40/41/44). This is illustrated below:

> *"you think. How are they like that [calm] and I'm so mmmm angry and upset but they're the ones that have been through it and they're just so calm. It's quite upsetting" (Betty, MU25).*

> *"it's upsetting to hear what some girls have experienced" (Sandra, MU32).*

> *"just really just horrible. It was just horrible" (Nicola, MU32).*

> *"it was just sad really" (Deb, MU41).*

Betty returned to the feeling of being angered:

> *"it [rape] makes you feel angry that it's happened. It makes you feel really really angry" (Betty, MU25).*

Participants used descriptive terms to cover a range of emotions when hearing about survivors' experiences. They felt sad that the survivor had experienced this traumatic event, felt angry that the rape happened, felt worry or concern for the survivor, and experienced a lack of understanding about why the survivor may be calm and not as 'angry' about experiencing the assault as they are at hearing about it. This touches on the conflict nurses feel when dealing with the reality of a rape disclosure. This range of moods and subsequent emotions alter the internal emotional solidity of the nurse, and the emotion they feel from this does not leave the nurses quickly. Instead, the experience is something they remember and reflect upon (explored later in the chapter). It is clear from their description that there is a lack of understanding about why they feel so emotional, while a survivor can appear calm (expectation = survivors will be upset vs. reality = survivors can appear calm [Chivers-Wilson, 2006]). The nurses then try to make sense of this by assuming the emotion of the survivor, and this begins building the notion of empathy:

> *"What a horrible thing to happen to somebody, to go through that and experience those feelings and emotions. It must just be awful. Like beyond awful. I always feel very sorry… A lot of sorrow for them. I think that's the main thing" (Helen, MU41).*

6.2.2 Empathy

This is the point in the disclosure where there becomes an emotional shift: from anger/upset/sadness to sorrow, and this sorrow is where empathy becomes apparent in experiences. There are many places in the nurse-participant experience when the mode of focus changes from *care for (Sorge* [Heidegger, 1962]*)* oneself, to *care for* the survivors and back again. While Heidegger's (1962) philosophy of *being* has many facets, such as moods, authenticity and angst, *care* is a preeminent part of his being-in-the-world. He argues that *Sorge* encapsulates the two elementary actions of human existence: towards others and towards the future. When the nurses adopt the towards the future aspect, the Sorge is often focused on the future and potential implications (this is explored later in section 6.6), both for the survivor and for their role/professional responsibilities. This is the first example of this switch in focus within the temporal nature of disclosure. Their emotional response moves from how they feel about the rape to how the survivors must feel.

The term empathy is often used to describe a wide range of emotions. Empathy in the traditional sense is often defined as an ability to imagine what someone else might be thinking or feeling. So, whilst the nurses try to come to terms with their own emotions about

rape, they are also trying to understand the survivors. From the nurse's perspective, empathy also allows (or excuses) for an understanding of why the survivor is not showing the emotional reaction they believe they should be (for example, Betty's quote above regarding the survivor being calm). This traditional understanding of empathy is typified by Sandra:

> *"Dear me' you know it's just empathy, empathy just kicks in. What must that have felt like, to go through that experience?" (Sandra, MU41).*

> *"empathy kicks in straight away, how on earth must this poor girl be feeling" (Sandra, MU41).*

If we consider Heidegger's notion of mood, and being in the right mood to see reality, it is understandable that the nurses would find this difficult, considering the fluctuation in their own mood (and emotions) whilst trying to empathise with others is a difficult position for the nurse.

There is an empathetic approach in consultations by the nurses, as they believe that survivors want to be comforted:

> *"the most important thing those girls need then is sympathy, I think they need to be comforted and reassured that they are then safe" (Sandra, MU41).*

Whilst empathy is an emotion that is expressed, sympathy is also used as a descriptive term. These words are often confused. Sympathy involves understanding from your own perspective, whilst empathy is understanding from another's. In this case, when talking about sympathising, Sandra described participants' experience using words and phrases such as sorrow, feeling sorry for her and it must be awful. Thus, she is describing empathy. There is no indication from Sandra that she has herself experienced sexual violence, which would allow for sympathy. Sandra took the need to empathise further, and she mentioned this twice in her interview, signalling the importance it played in her experience of receiving a disclosure. Demonstrating empathy is also typified by her desire to physically express this feeling in a maternal, physical way (MU:17/18):

> *"I go into mam mode straight away…just a very, very young girl and I just felt so sad for her and I just wanted to comfort her and I think typically as a mam and a nurse a hug just makes…' 'but, I can't put any of my evidence onto her because it could interfere with the police investigations" (Sandra, MU17).*

This quote signifies an alignment between empathy, nursing and a maternal instinct, as she indicated a particular mode of *being* that she saw as not being experienceable by others (for example, those that do not have children). Thus, whilst it only appeared from one nurse's experience, there is a perception of gendered caring that appeared in the survivors' findings too.

The focus of looking in, rather than out, continues through this stage of the disclosure; this is where nurses expressed an experience of empathy that moves into embodiment. Levinas (1991) described the most extreme sense of embodiment, nausea, as amounting to being-there; what Husserl called "self-positing" (Husserl, 1982). Nausea posits (penetrates our natural attitude) itself, not only as something absolute, but as the very act of self-positing: it is the affirmation itself of being (experiencing the object) and demonstrates the nurse being exposed to (seeing) the reality (object). This aspect of embodiment is also reflected in the survivors' experiences. Laura and Deb typified embodiment below:

> *"I felt sick, I felt really sorry for her, I just remember feeling sick inside and thinking 'wow'" (Laura, MU40).*

> *"you know, your head starts spinning" (Deb, MU32).*

Another embodied perspective was when Sandra explored her experience and discussed empathy, as there is a clear indication that she felt the desire to demonstrate this empathy, from a physical sense. However, she acknowledged that this can be difficult and inappropriate. This physical form of feeling is an example of how empathy derived from emotion can embody the nurse, through the psychological and physical being as one. In the survivors' section, the notion of embodiment was touched upon also, emphasising the importance this has on experience. Sandra demonstrated the desire to do something, or to demonstrate empathy physically, as this is important to her in order to provide visible care (or what she perceives as care in this situation) for the survivor. The language Sandra used suggests that this care (*Sorge)* is moving direction towards herself, and considering her needs that may be motivated by her own sadness that the survivor has experienced this

rape. She was aware that physical emotion was (possibly) inappropriate. However, she felt denied in her role as a nurse for having an awareness that this may not be able to be carried out. Therefore, the shift in *Sorge* is concerned with meeting the needs of Sandra and the inability to carry out what she thinks is best for the survivor:

> *"I don't feel I can do my job properly when I can't do that [hug her], to offer comfort and support to somebody. it's like a denial, it's part of my job, and I feel sad because most if the time that's, that's what I feel that these girls really want and need, just somebody to hug them, you're going to be OK and I feel denied of that part of my job, it's, I don't like it" (Sandra, MU18).*

6.2.3 Turning away

As the disclosure experience moves on, the initial emotional impact begins to alleviate. However, this creates space for the nurse to consider the enormity of the disclosure (MU26), as illustrated by Nicola's description below:

> *"but then it was like reality sets in and I think: you've just… That reflection of: oh my god. All of that's just happened; she's told me all of this" (Nicola, MU26).*

The emotional response of the disclosure initiates a reaction from the nurses of turning away, the opposite of attending to, which was discussed in the previous chapter. Heidegger (1962) refers to this as fleeing: turning away from inward looking (reflection) and from their mood (self), to outward and forward looking that is foreshadowed by a futurity of processing a rape case. Whilst the nurses feel a sense of privilege that they have been trusted with the disclosure, it is overshadowed when the responsibility of the disclosure begins to feel real, and an acknowledgment of the gravity of that responsibility begins to take place (further explored in section 6.2.4). This shift is typified below by Deb:

> *"I'm a health professional, I'm supposed to help her but what do I do? that was really quite scary as well, the reality of it and the fact it was quite a privilege" (Deb, MU26).*

Participants described their experience at this point, with a need to compartmentalise their own feelings (emotions) to support the survivors. This is a key example of turning away

from (blocking or hiding from) one's mood (their own feelings) in order to do the job of supporting the survivor, thus denying the dominance of the emotion that they feel following the disclosure. Thus, this illustrates the process separating the mind and body (becoming task orientated) to make this aspect of the experience functional, by recognising the emotional affectivity would have affected their ability to carry out some of their tasks. They acknowledged the impact their emotions may have on their ability to support the survivor, but do not consider if this approach is beneficial to the survivor. Their focus is caring for themselves, and specifically their role to get things done and to carry out tasks. This is Illustrated by Nicola:

> *"Nurses are very good at processing things later; you don't process at the time because if you processed at the time, you wouldn't be able to do what you had to do" (Nicola, MU33).*

The ability to compartmentalise is a skill the nurse participants indicate they must learn/accept in order to carry out their role, as Nicola and Sandra both describe below (MU:33/37):

> *"I need to… everything else is switched off and I'm very good at switching off" (Nicola, MU33).*

> *You very quickly learn that you move from one experience to the next" (Sandra, MU37).*

This quote below by Nicola provides further context around the nurse's change of direction of Sorge, as she explained that turning away from her true self was essential to support the survivor. This also recognises that their next step is complex and often traumatic in itself:

> *"So if you processed at the time, I wouldn't have been able to let the pathologist do all the things, because she'd been through enough" (Nicola, MU33).*

The focus is on becoming task orientated to do (what they perceive as essential) aspects of their job following a rape disclosure, rather than facing (attending to) those emotions to consider whether that task is appropriate at that time for the survivor. For example, there was no description as to whether the survivors need for an advocate was addressed over

the need to undertake the task. That said, throughout the interviews, the nurses described their desire to support the survivor (MU12). However, there is also an awareness the consultation will be emotionally challenging, especially when there is an insight that a disclosure is going to take place. This adds to an increasingly pressured sense of responsibility to support the survivor in the best way possible. Lisa's description below demonstrates the concept of turning away as preparation of the pre-disclosure experience, (here she is addressing a situation when she is pre informed the person she will be seeing has experienced a SA, for example if the service user has disclosed this as the reason for making the appointment):

> *"I want to help this person, but I do sometimes think 'this is going to be difficult', so I need to like, be mentally ready to have that difficult conversation… You're in the middle of doing something down here (the senior staff office) and you're asked suddenly to go into, you know, something that's going to be challenging" (Lisa, MU12/33).*

However, this preparation can only be carried out if there is pre-knowledge that the disclosure is coming in the consultation. What is also clear through description of experiences is that the processing of emotions goes further than the present (the disclosure) as it also impacts their future (post-disclosure), demonstrating the temporal nature of the disclosure. For example, when the nurse's day at work is over, they then get the chance to reflect on their experience of the disclosure and their emotions attached to it continue to develop. However, they do not go away (MU:12/13/22/33/34/37/39).

Even though there is an expressed need to compartmentalise emotions, disclosure continues to emotionally impact nurses when they begin to reflect upon their day (MU:22/34/39). A typification of this experience was given by Sandra, as she indicated that turning away from one's emotions regarding rape is a continual process following disclosure, not just an aspect of the immediate disclosure:

> *"You've got to learn very quickly how to keep your emotions in check. It's afterwards, it's sometimes when you're driving home in the car when it comes back to you and you think 'I wonder how that girls getting on' and then you do, you think about, again you reflect on what they've told you and its sad isn't it?" (Sandra, MU22).*

It is interesting that the participants expressed such a range of emotions when they first receive the disclosure, then once they feel a sense of responsibility there is a switch to hiding or blocking these emotions. Following which, then next stage was described as a return of those emotions (as demonstrated by Sandra above). Reflecting and remembering these consultations sometime after the event was described by other participants:

> *"considering how long ago it was, just how vivid it is" (Laura, MU39).*

> *"Oh, I still think about that one regularly… That one still sort of hangs around a little bit" (Jess, MU39).*

> *"They [rape patients] stay on my mind. if it wasn't straightforward, maybe something had happened, or if I felt I could have done something better, it would stay on my mind" (Lisa, MU22/39).*

Nurses clearly continue to reflect on their experience for some time after the disclosure. When the memories are on the mind of nurses it still evokes a level of emotion that brings the embodiment to the fore again, as described by Betty:

> *"I can't stop thinking about it, because it does, it makes you feel sick" (Betty, MU34).*

Nurse participants also described the need for support from colleagues in the immediate period following disclosure to reduce their anxieties surrounding their management (or support) of both the disclosure and survivor:

> *"I wanted to reflect on how I'd managed it, I would take it to supervision, clinical supervision…My clinical supervision comes from my manager, so I could take it there" (Lisa, MU75).*

This reflection and supervision allow the nurse to consider the support they had provided the patient, and explore the disclosure experience (MU:28/45/46/47/75) as a way of also turning back towards themselves and their emotions attached the disclosure:

"because I get clinical supervision, which is always a godsend in terms of my role, that allowed me, allowed me to go back and say 'what do I do with this' and he was able to pull it apart from my point of view" (Deb, MU28).

However, this form of supervision and support was not always seen as a positive element of practice and instigated a return of emotions, which themselves caused additional stress for the nurse. Helen explained this feeling:

"I used to feel highly, highly stressed when I had to go and speak to somebody [senior] about a sexual assault. Highly stressed" (Helen, MU47/75).

Although there are benefits of the clinical supervision or support in practice, the experience of a rape disclosure and the memories it evokes do not leave the nurses, even following support. This is an example of how the co-experience of rape through the descriptions of the survivors and subsequent support provided added a temporal weight to their actions, as described by Betty:

"I don't think it goes away [the worry]. Talking about it makes you feel better but you can't get rid of it" (Betty, MU45/35).

6.2.4 Responsibility

Responsibility was identified very quickly when analysing the nurse transcripts (MU:2/5/8/20/21/26/63/69/27/28/30/35/52/65/67/74/70). The pressure of responsibility to both best support the person making the disclosure, and also to ensure the (perceived) responsibilities of their role were carried out, caused mixed and heightened emotions. When considering the role of the nurse, responsibility can be described as having a duty, or feeling the need to do something (good) from a moral imperative and ethical perspective that is instilled from the start of nurse education (NMC, 2019). Nurse participants in this study continually expressed a need to ensure they had got it right from several angles throughout their experience of supporting disclosures of rape. The pressure to get it right or, later, feel they had got it right was clearly on their mind, thus exacerbating concerns surrounding the desire to do the right thing. However, the feeling of emotional flux lies at (not) knowing or understanding what the right thing is. It became evident that doing the right thing for the patients may be a different type of support or management than doing the right thing with regards to clinical guidance, or the nurses' personal belief of what the next step should be

for a survivor of rape disclosing their experience. The juxtaposition between all these elements appeared to overshadow the option of allowing survivors to make their own decision regarding the level of support they needed/wanted. The feeling of pressures of responsibility caused increased emotional toll and confusion for the nurses that ultimately led to them following the path of support down a clinical route, rather than a patient-centred one. The reasons for this appeared to be twofold: to not to work outside their organisation's / professional registration guidance; and to ensure that they felt all post-disclosure policies and procedures had been followed. Reasons for this are touched upon later in this section. However, it is ultimately due to the anxieties surrounding feeling a level responsibility to do something with the information that has been given to them:

> *"Yep, I've opened Pandora's box. Where do I go now? And how do I deal with this? where do we go from all of this. You have a responsibility of what you do with that information" (Deb, MU26).*

In order to gain information, nurses describe their need to initiate discussion from the survivor around their experience of rape, and once a disclosure has been made the nurse asks additional questions to gain more information. This is where the sense of responsibility becomes heightened. Sandra's experience of moving through the disclosure process typifies the process of gathering the information, and then feeling a sense of co-ownership and, therefore, responsibly. She did not feel she was doing her job properly if she does not have all the information she (perceived that she) needs:

> *"We need quality and quantity don't we, we need all of the information together. So, it's asking a lot of questions and again, I feel that because that's the job we have to do" (Sandra, MU74).*

There is an awareness and acknowledgement that by asking questions within a consultation surrounding a sensitive or personal nature, there comes a responsibility of taking this information and moving forward with it in a supportive manner. However, it is at this point the nurse may not know what the most helpful way would be, in terms of the needs of the survivor. This was discussed by Deb below:

> *"then it was a bit like, blooming heck, this is awful. You know, what do I do? She's given me all of this information, but what do I do with it and where do I go with this?" (Deb, MU26).*

Whilst Deb felt this pressure of responsibility, not only with the information given but also with the trust that had been bestowed on her by the survivor, she felt lost at what to do with the gravity of the information shared:

> *"A level of responsibility that someone has actually trusted you to disclose that, now what do you do with that [information]" (Deb, MU26).*

Emmanual Levinas' (1991) phenomenological philosophy takes the form of description and interpretation, and explores the ethical responsibility having knowledge of another's experience (essence) may feel. His concept of responsibility indicates that our embodied sensibility gives rise to acts of having responsibilities to others and is rooted in our subjective nature. He suggested that the encounters we have with others implore a command to respond, and in responding comes a responsibility to the other. This responsibility is grounded in ethics, and followed through with association of virtue and duty, aligning itself well to the healthcare setting where the importance of professional responsibility and duty is continuously stressed. For the nurse, seeing the other (the survivor) creates the clear moral dilemmas touched upon in this chapter. And it is here that the ethics of Levinas articulates an embodiment of the moral imperative, particularly the imperative of responsibility which is manifested corporeally (embodiment as feeling sick etc.)

The nurses described an awareness of their professional responsibility when it comes to disclosures of rape. The responsibility aligned with their nursing professional standards (NMC, 2018) and came to the fore automatically (for example, this is an illegal activity and there may be safeguarding implications). This puts the practical elements of disclosure at the highest concern: safeguarding, following organisational policies, and documentation:

> *"they are based in an educational setting and obviously in this role, but obviously RNT (registered nurse teacher), so you're still a registrant (nurse) and you're still abiding by the code (Nursing and Midwifery Code of Conduct)" (Jess, MU2/27).*

However, there is still an awareness of providing support for the patient during this time, whilst also trying to capture and process the information given. This was irrespective of the environment they were working in, as all participants touched on this aspect of responsibility. Nicola's description characterised the feeling associated:

"remember a lot of the stuff and then write it down later, 'cos you can't just leave somebody when all of this is coming out" (Nicola, MU35).

Alongside the professional responsibility to document all information given, the nurses also expressed a reliance on policies or guidance to provide a way forward with survivors that they could follow. One participant described looking for guidance that would direct her in what to do next when she became lost at where to go with the information disclosed:

"I don't think there was a policy that covered it" (Deb, MU27).

Guidance or policies are seen as a map or a process to follow in order to guide the nurse to what they need to do next in order to adequately treat (and support) patients. When they are not able to find that support, there is a sudden awareness of the nurse's place in that situation. Heidegger refers to this as ready-at-hand (Heidegger, 1962). This phenomenological concept refers to the breakdown of a tool or aspect of life that is often used but overlooked. Once that tool breaks or is not available we are forced to face ourselves, and this highlights the taken for granted. In this case, the nurse is faced with the responsibility of doing the right thing, however (as described throughout this chapter) the nurse often is not aware of what the right thing (for the survivors) is. Thus, they then focus on the professional right thing, such as reporting the rape or documentation, or the perceived societal right thing, such as reporting the rape so it doesn't happen to other women (people), getting justice, etc.

Disclosures of rape often cause concern for nurses as they are aware of the legal pathway the survivors may potentially enter. This is another example of the temporal nature of rape disclosure, and its futurity. They feel the responsibility to ensure concise documentation, and display an immediate concern for the survivor's future, and this causes concern for the nurse. This thought was described by Lisa below:

"You're talking about, you know, something obviously really difficult; it's a serious situation. I mean, the documentation itself, around sexual assault does have to be erm, very accurate, contemporaneous, in case it did become… I mean all documentation should be. But in those particular cases, you're thinking about documentation as well, because… I suppose if it did become a legal case and the police… You know, it goes to court and then they ask for the notes. 'Cos that does happen" (Lisa, MU74).

Nicola also described concern for the future, from the perspective of supporting the survivor:

> *"And then you just click in to… I need to remember everything, 'cos I need to write this down; I need to help her" (Nicola, MU35/74).*

The responsibility for helping the survivor, and the need to ensure robust documentation, is clearly linked with the possibility of documentation being used in a legal case, demonstrating the professional burden of foreshadowed futurity. There is a fear that if these notes are not robust, they will be detrimental to the case in court, and this would have implications for both the nurse and the survivor.

The foreshadowing of futurity is very much linked with the police/law involvement. Nurse participants felt a responsibility to contact the police. This description of experience is typified by the following quotes:

> *"so typically, if a girl makes a suggestion that they've been in any sort of sexual assault we would send them directly there [sexual assault referral centre] and to the police" (Sandra, MU65).*

> *"then just reminded her that perhaps because of the disclosure I would be reporting it to the police, I might feel that I need to take this out and further, erm.. if it was something perhaps to do with the law, and you know involve the police" (Laura, MU5/8).*

As demonstrated from the language Sandra and Laura used, this is described as an essential part of the process of disclosure, irrespective of whether the survivor wanted to disclose the rape to the police. This was also a part of Nicola's experience:

> *"You know, I can't remember if we asked permission – if she wanted this reported to the police" (Nicola, MU5).*

Here, Nicola has demonstrated an awareness of asking permission from the survivor as to whether she can contact the police. However, if that permission is not there, or there is uncertainty of whether this route is what the survivor may agree to, persuasive language is used to involve the police:

> *"I can't remember whether we persuaded or whether erm, you know… we just did it"… "I would have remembered having to persuade her, 'cos I remember other people who I have to persuade to get sort of the police and things" (Nicola, MU5, 70).*

Sandra described how she used this coercive language in consultations that ultimately left the survivors little room for any other option:

> *"Well I ask the patient, have they reported to the police already and we give them the option do you want to report this to the police, so I would ask their consent, do they want me to ring the police? Do you want to ring the police yourself?" (Sandra, MU69).*

Informing the police of the disclosure was described as something they feel a responsibility to do: it also gives the nurse a solid direction of what to do next regarding the information they have been given:

> *"She had disclosed it, and we had to go to the police"… "There is a sense of 'this is just what we have to do'" (Deb, MU52).*

The nurses also view reporting the rape as a way of helping the survivors, as described by Nicola:

> *"So, we explained that we had to preserve things, but we wanted to look after her as well, so there's things that we had to do. Erm, phone the police and they came very quickly; they were really good" (Nicola, MU52).*

However, the responsibility of allowing the survivors to contribute in making the decision was acknowledged (MU65) by Betty:

"you then decide whether you then refer them elsewhere', based on what they want to do, because obviously you can't force anyone to do anything whether it was months ago, year or weeks. It has to be their decision. I give them information and then it's their choice, so I act upon what they want me to do" (Betty, MU65).

Although there is an acknowledgement of the survivor's role in this decision from Betty, it is secondary to the police having been told about the rape. She went on to describe her disappointment at the survivor's decision to ultimately not move forward with the case with the police, showing her perception of co-owning the experience. However, she felt like she had carried out her responsibility from a professional perspective, regardless of the survivor taking the case further in to investigation:

"unfortunately, when the police came she wouldn't speak. but I felt better because I did what I was supposed to do" (Betty, MU67).

Reporting the assault to the police makes the nurses feel they managed the disclosure effectively. The idea of shared responsibility allowed for a peace of mind for Betty. One aspect of consideration described by Helen during this part of the disclosure was the desire to ensure the survivor did not feel pressurised, which was a different perspective to the other nurse participants:

"I guess when you're talking about reporting to the police with a patient. Again, it's trying to strike that balance between encouragement and you don't want to… You don't want them to feel pressured into it. You know, like they somehow have to be the person to fight the fight for everybody else who's ever been assaulted… I'm quite conscious just to make it sound like I'm just giving them information [about police reporting]; not selling it as some kind of like, personal crusade" (Helen, MU65).

Betty described her hope that the patient will see sense, meaning going to the police. This indicated that she saw the right route for all survivors following their experiences of rape as reporting it to the police. In this incidence, whilst she clearly felt a weighted responsibility, she also saw reporting the assault to the police as a given responsibility of the survivor:

"you leave it with her in the hope that she see's sense" (Betty, MU67).

Interestingly, participants that described their need to contact the police did so whilst also reflecting on their awareness of the impact this may have with the survivor (without their permission). With the awareness of impact comes a subsequent layer of guilt for the nurse. This guilt is focused on the survivor having developed trust in them to open up about this personal experience. Subsequently, recognising their actions following disclosure may not have been undertaken in the best way to support for the survivor, they become aware of this dilemma (and guilt) as to whether their responsibility lies with advocating for the survivor or the need to report to the police. This was discussed by Nicola and Deb:

> *"cos I'm her advocate; I'm allowing the police to do this, but what's the best for her" (Nicola, MU35/29).*
>
> *"somehow policies take over, it's very… tick, tick, tick. We lose the individual" (Deb, MU2/27).*

One participant came back to describing this numerous times throughout her interview (indicating it was a large part of her disclosure experience), and explored the burden of foreshadowed futurity regarding her on-going relationship with her patient:

> *"you kind of feel privileged that someone trusts you enough to disclose that. But then you feel a bit awful that you've got 2 police guys knocking at the door" (Deb, MU2/29).*

There was concern it would be seen as betrayal and impact the ongoing therapeutic relationship:

> *"I felt nervous about going back in, because it was a bit like the elephant in the room"… "it was always a strained relationship because she always used to have different HCPs [healthcare professionals] in. It was almost like 'yeah, you're another one, you are going to sit here and disappear again', that relationship we had, well I don't think it ever seemed as good" (Deb, MU29/30).*

This concern and emotional impact was also expressed by Betty:

"But you just worry about saying something wrong and then then closing up" (Betty).

It is clear there is a feeling of responsibility to say or do the right thing, whether this is reporting the survivors' rape to the police or allowing them to make the decision. But it is unclear if getting it right means getting it right for survivors or getting it right for their documentation/professional responsibility, and nurses are confused by this juxtaposition. They are therefore thrust into a dilemma that has a potential cost to the ongoing relationship with the survivors. However, at times, they continued to make the decision to report this regardless. Nurses described being in a position where they do not know what to do for the best when a survivor discloses rape, and their confusion on what to do following the disclosure causes them to follow a path that may not be fully thought through. Thus, the concern of getting it right and protecting themselves from getting it wrong (for example, getting reprimanded for documentation not being completed, or the patient stopping communicating) overtakes getting it right for the patient by incorporating their choice of what will happen next. Again, this demonstrates Heidegger's (1962) concept of *attending to* and how this focus swings from the survivor to themselves, ultimately causing increased emotion and confusion throughout the disclosure experience. This was discussed by Nicola:

"it was quite upsetting, quite distressing. You know? I just wanted to do the best for her and you don't know what's the best" (Nicola, MU 35).

The intention to do the right is clearly demonstrated through the examples of experience given in this section. Nurses expressed worry or concern that, when reflecting on the consultation, they had not supported the survivor or managed the disclosure to the standard they thought was needed for the individual, or that they may have missed an essential element of care needed. This made them question their practice. This is an added emotion of worry, resulting in anxiety that not enough has been done to support the survivor. This emotional reflection is added to an already heightened sense of responsibility, and a fear that something may have been missed. Thus, it begins a new wave of emotion for the nurses, with the fear they have missed something they should have done. These emotions are typified by the participants below:

"am I telling them everything they need to know? Am I giving them the right information Am I scaring them off?...you then start panicking you have done everything like: oh my god, have I missed anything? Did I tell her about

this? Did I give the information about this? Did I offer that?" (Betty, MU21/26).

"erm, you know, just mentally reminding myself all of the things that I need to address on behalf of, you know, the patient"(Lisa, MU21/35).

"Where do I go now? Do we go that way, do we go this way, do we just leave it open? It was really… And then you just start to question your own skills" (Deb, MU26).

Helen described her fear around the impact of the support she was giving the survivor. There was a concern she had added to the distress the survivor may be experiencing:

"I always think and hope that I've made it as easy as possible for them. Whatever they've had to do; whatever they've had to answer, be asked about, talk about…. I just hope that we've made it as comfortable and as stress free as we can possibly make it for that…. That's what I always think about. No matter what they've told us or what's happened to them, I'm always quite conscious about that when they go. Did I do that enough? I always ask myself that. Did I do that enough? Kind of, did I… Was there at any point where I could have upset this person more than, you know… Whether that was inadvertently I always think about, when they've gone. Every single time" (Helen, MU27/43).

This quote illustrates how the responsibility of doing the right thing is linked with the reflective process, As such, the concern stays with the nurses and rarely allows for an emotional release from having had a rape disclosure.

The need to do something pragmatic is instrumental in elevating their initial heightened emotions. However, with reflection comes an awareness that the process they have taken may not have supported the survivors in the way they imagined:

"actually, you walk out the door you just think, actually have I changed anything? Have I made anything better?" (Deb, MU29).

> *"Safeguarding for the patient, really, in case, you know, if it's someone that they know, are they going back to a situation that's going to be dangerous for them? Erm, and how are we going to make that patient safe? And how are we…? You know, after five O'clock on a Friday, what are we going to do to ensure that everything is done for this person that needs to be done?" (Lisa, MU72).*

The ideal of doing something is not only from following a process or emotional support perspective, but it also practically comes from an environmental perspective too:

> *"Just didn't want her to feel stressed, well she looked stressed, take her away to somewhere a little more peaceful and calmer" (Laura, MU42).*

This visible aspect of doing something is seen as both a supportive element of the disclosure and an essential aspect of communication experience, and will be explored within that theme.

6.3 Theme two: Communication

The second theme that unfolded from the nurse experiences focused on communication within the disclosure consultations. The nurse participants described the use of their communication skills in order to support survivors. They felt that being aware of communication, both verbal and non-verbal, gave the survivors permission to be open about their assault (MU:1/4/6/7/9/10/11/13/14/15/16/17/19/38/48/49/50/51/53/54/55/56/57/58/60/71/73).

Communication is often described as the imparting or exchanging of information by speaking, writing, or using some other medium, including non-verbal communication, and is a vital skill for nurses (NMC, 2018). Communication is key to establishing a therapeutic relationship and essential to a successful outcome for individualised care. There is a clear indication that many factors impact communication in the context of rape disclosure, and participants voiced this when describing their experiences. Nurses pick up on both verbal and non-verbal cues to identify there may be something sensitive a patient wants to discuss.

6.3.1 Something there

Prior to disclosure, those nurses that had a previous relationship with the survivors expressed there was a sense that there was something the patient (or colleague) wanted to, or potentially wanted to, discuss. This was described by Betty:

> *"Sometimes there is a sense of something there" (Betty, MU14).*

Whilst describing her experience, this was an aspect of disclosure that Deb came back to numerous times, highlighting the importance she felt her skills played in the disclosure to facilitate a glimpse of something hidden:

> *"you just knew there was something underneath" (Deb, MU14).*
>
> *"There was something that was a bit deeper" (Deb, MU,6).*
>
> *"I couldn't crack it, for want of a better word" (Deb, MU6).*
>
> *"I just knew there was something" (Deb, MU6).*
>
> *"We'd get on to similar subjects and she'd get me off it quite quickly. You know, typical blocking" (Deb, MU6).*
>
> *"There's something going on there, those missing bits were impacting where we were now" (Deb, MU14).*
>
> *"you get very skilled at picking up the question" (Deb, MU14).*

She was describing using her noticing skills to un-layer the experience from the survivor. That ability to recognise comes in the form of noticing, sensing a change in behaviours and/or language, or recognising someone may be changing the subject as they feel uncomfortable or uncertain with the topic, yet keep returning to the outskirts of the topic. The nurses behaviour is in response to the survivors incongruency. The recognition of these communicative inconsistencies allows the nurse to ask further questions on the survivor's wellbeing, thus opening an option for them to talk. This was described by Laura:

> *"'are you alright, I'm not sure you look alright, or like yourself' and she said after a bit of hesitation 'no, I'm not' and looked really upset" (Laura, MU6).*

Laura went on to describe how she felt her communication encouraged disclosure. This was also a example of how one participant quote can straddle multiple meaning units:

> *"I said I don't want you to tell me anything you don't want to talk about, but I'm concerned about you being on the shift when you look so upset'. And she said 'I do want to tell you actually' and I said ' ok' and she just said ' I've been raped at the weekend' [silence for 3-4 seconds]" (Laura, MU6/13/16).*

Whilst Deb described how her non-verbal communication skills foresaw the disclosure, she also outlined how her persistence at encouraging disclosure paid off for her in that she received the disclosure. She sensed there was something the patient was toying with discussing (the incongruity), and believed they were opening up, but then kept stopping short of talking about a specific issue:

> *"She'd either block me or deflect me onto something else" (Deb, MU6).*

It was like a puzzle Deb was trying to complete:

> *"I knew it, I knew there was something" (Deb, MU14).*

Betty also described how she saw a glimmer of an experience and probed to get more information from her patient:

> *"sort of probe a little bit more to get more information" (Betty, MU14).*

There was satisfaction in that (the nurse perceived) the survivor trusted her enough to disclose, rather than acknowledging the time she had spent encouraging the disclosure by supporting the survivor to attend to themselves:

> *"But the fact someone has actually got or made a decision to inform you is really quiet a privilege" (Deb, MU4).*

However, this then returns to the emotional toll and burden of responsibility that comes with disclosure. Thus, the satisfaction is an emotion that is short lived:

"Sometimes as a nurse you kind of get quite exacerbated and exhausted by it because you are thinking, yeah, but now I've got all of this to do as well" (Deb, MU3).

6.3.2 Asking questions

When describing their experience, the nurses kept coming back to how the disclosure came about. There were some that had built up a therapeutic relationship over time, and others that had met the survivors for the first time immediately before disclosure. In both situations the role that asking questions played within rape disclosures is an important part of their experiences. However, the nurses demonstrated different levels of comfort and confidence in asking questions about sexual violence in general. Whilst the aspect of pre-disclosure explores how it takes time to develop a relationship built on trust that supports the survivor to disclosure, there are times due to the nature of some services (emergency department, sexual health clinics) where the disclosure comes within the only meeting the nurse has had with the survivor. The participants saw this disclosure (and subsequent communication) as dependent on both the working environment and the skills of the nurse.

Some clinical areas specifically ask questions about sexual violence as part of their clinical history taking, and that may immediately open an opportunity for disclosure. These are often areas that a survivor would specifically go to in order to make a disclosure, or attend with the consideration of making a disclosure. In others, where the relationship will be long-term, it seems from the nurses' descriptions of their experiences that it is more appropriate to build a relationship and touch on sensitive points gently, rather than ask about sexual violence from the outset. This thinking was illustrated by both Deb and Betty:

"It took a long time to get that confidence and trust" (Deb, MU4).

"My experience [of disclosures] of the people I see, they are either in a relationship with them [perpetrator] or it's been someone they know I'd like to think I have built up a relationship therefore that's why they have chosen to disclose it to me" (Betty, MU4).

However, Lisa described her emergency department's history taking practices regarding to sexual violence:

"it has occasionally come up within the domestic violence – we ask about domestic violence within there, but we don't specifically ask about sexual assault within the nurses' consultation" (Lisa, MU11).

"We don't ask that specifically (sexual assault experience)" (Lisa, MU11).

This gives an indication that there is little acknowledgement (or awareness) that sexual violence is part of most people's (specifically women's) lives, and unless the survivor discloses this explicitly then there would be no encouragement or support of disclosure.

In those areas where sexual violence questions are part of the clinical history taking, participants expressed they were not always confident in asking such sensitive questions. There was a fear of reaction from the patients due to the nature of the questions about sexual violence. However, Betty expressed that, on the whole, questions about sexual violence are asked in a more timid manner than other questions:

"the majority of people are alright, because you do prepare them [to ask about SA]' 'but some people come in and despite telling them that [we're going to ask some personal questions] in the beginning, they appear quite offended by the question" (Betty).

Betty described her experience of some service users becoming offended by the questions on sexual violence, as this is a taboo topic and not one that is readily talked about. The nurse uses their assessment of the patient's demeanour to determine how they will communicate in order to ask the questions. This use of empathy allows a recognition that the survivor my need permission to *attend to* themselves, should they have experienced rape:

"erm, it [my voice] seems to be different, I don't know why but it's different with every patient' 'I seem to ask if there's any violence in the relationship or if they're frightened by anyone quieter" (Betty, MU 23/16).

Sometimes the link between the way a survivor may have been communicating and their actions becomes clearer to the nurse after the disclosure. Jess described this:

> *"Because if you've always looked at the subjects of her essays, it was always to do with GU stuff and fertility and contraception and… And it wasn't 'til latterly did she make that disclosure, she said that she wanted to work in sexual health. I kept thinking: I wonder if… That's part of the healing process" (Jess, MU19).*

Following the disclosure, the nurse also has insight into how a previous experience of disclosure impacted the willingness of the survivor to further communicate the rape (the fear of a second disclosure experience). Following Deb's persistence in asking questions of her patient, she discovered a previous experience of disclosure that was not positive for the survivor. This allowed for an understanding of the glimpses of an experience that the survivor kept coming back to, and this was her way of communicating:

> *"It was in her late teens, she was now in her twenties…. She had disclosed it to her family but they had closed ranks and didn't do anything about it, it was probably that generation where you didn't, you know, it was like, you don't talk about it" (Deb, MU1).*

6.3.3 Environment

Nurse participants recognised that the environment can influence communication within disclosure (MU:10/38/58/51/53/48/54/58/49). They described that communication can be hindered by the environment, and recognised survivors need an environment they feel safe in. However, they also acknowledged this was not always possible in the healthcare environment. Toombs (1987) writes about the fundamental features of embodiment when it comes the patient's self and worlds. Environmental factors are a disruption in this embodiment and, whilst the rape survivor may not be ill in the traditional sense, the process of accessing healthcare allows for transferability: by disclosing the rape they are asking for support in this experience that had embodied their wellbeing. Schutz (1962) suggests that it is the face-to-face relationship that allows for two people to share a space and time, thus constructing the social world together. Sharing this time is what he referred to as a 'vivid present', or a mutual experience of living simultaneously, which causes a synchronicity in an ongoing relationship. This allows for both to be mutually directed to and engaged in experiencing the object (rape disclosure) together. However, what the nurses are describing in their experience is an imbalance in this vivid present, and they are actively trying to fix this. In the context of healthcare, a vivid present is not always achievable, as there is an end to the relationship once the illness (support given for the rape disclosure) has been

attended to. There is also a power imbalance. However, it could argued that within any connection there is always a power imbalance in some aspects of the relationship.

A recognition of the power difference between a home(ly) environment and a clinical one is identified and illustrated by Deb below:

> *"I used to like seeing people in their homes because I used to think 'it's their environment' and they feel more in control. But whereas in hospital its more about, I suppose we have the power" (Deb, MU49/48) (Whilst the quote above is about care in general, she goes on to relate it to the experience rape disclosure:)*

> *"Seeing patients at home I used to find you got a lot more from that interaction, you just picked up that vibe… maybe again, if you're in your own home you feel safer to disclose" (Deb, MU 50).*

Recognition of the role the environment plays in communication is also characterised by the following descriptions. Laura discussed moving the survivor from a busy clinical ward environment to a private room outside the ward:

> *"it was just a more comfortable environment than, you know… but I think it was probably trying to remove the power thing" (Laura, MU48/49).*

Her quote demonstrates that she related the environment to a potential power imbalance and actively tried to remove that to allow for open communication. Deb also identified the clinical environment as a barrier to communication:

> *"is more artificial' 'I personally don't think I would have elicited that information [had the discussion been in a clinical environment]" (Deb, MU48).*

> *This awareness that the environment plays a large part in communication, but specifically the clinical environment as a barrier, was also highlighted by Lisa:*

"So I think it's about giving the person to talk about this really difficult situation and giving them permission requires the right environment and the right communication skills" (Lisa, MU16/53).

"It's obviously a difficult disclosure; it's a difficult conversation. It's not going to be easy or straightforward and I guess… It's about making the patient more… Erm, or the woman, man, more comfortable and more able to go into the detail that they need to without being in a clinical environment" (Lisa, MU7/56/58).

Such descriptions of the clinical environment as barrier to communication, from a healthcare perspective, are culturally and socially instilled in the nurses enough that they can recognise the need for change. However, there is often little they can do to change the environment. For example, there is a recognition that the environment is not just the room the service user discloses in: from the entrance to the building the survivor must feel welcomed and safe, and that their experience of disclosure will be confidential. The fear of a lack of privacy is also an environmental barrier to disclosure, and the nurse recognises this, as described by Sandra:

"So, the patient would first of all have to self-present to the department, book themselves in to create an account within the department so they're verbalising to the receptionist" (Sandra, MU51).

She went on to identify that patients may not know their rights when it comes to what they share on entry to a clinical environment, further demonstrating the power imbalance and how this is set from the initial moment a survivor walks through a clinic / ward / department door. Again, this was discussed by Sandra, as she continued with the description of her experience:

"people might not realise they're well within their rights to say 'Actually I'd rather not talk about that here' or 'I would want to wait and speak about it in private' So potentially there's other people overhearing what could be said" (Sandra, MU51/54).

Thus, whilst there is an awareness that the clinical environment may be off-putting to disclosure, in most services there is no choice but to use clinical surroundings. However,

nurses are aware of how intimidating this may be to a person who has experienced rape. One participant was aware the instruments used for intimate examinations may frighten survivors, so they considered keeping these items hidden from view:

> *"Room is sort of, almost semi set up…" "…you could fully set it up before they come in, but I don't know if that's a good thing" (Betty, MU55).*

Betty also touched on the benefits of leaving medical equipment out in view after getting them ready in advance of the consultation so the survivor is prepared:

> *"Leave them [the clinical equipment] in a trolley, you can prepare them [service users] better… I think if they saw that, that might, might frighten them a bit" (Betty, MU55).*

It is clear these experiences illustrate confusion in what may be best for the survivor with regards to hindering communication, but also in what the nurse can actually achieve practically when they are in a clinical environment that often cannot be changed or set up differently for each patient. This is particularly the case when there is an unexpected disclosure.

For those nurses that are aware of the impact the environment may have on communication with the survivor, and are willing to (and able to) take this into consideration by accessing other rooms that are less clinically visual, they look for rooms with the consideration of comfort as a key:

> *"It is literally just… You know, kind of chairs, comfy chairs, kind of you know… A couple of serene pictures. Small, erm, tissues to the ready and it's just… Yeah, it's just more like, just a very informal room as opposed to… You know, you go in and like I say, there's a lot of clinical equipment, bins, trolleys, beds, overhead lights. It's just very very different.. They're a lot smaller. I think, I guess 'cosier' might be the kind of better word. Erm, they don't have any clinical equipment in them whatsoever. With kind of comfortable chairs and the chairs are kind of arranged in kind of more of an adjacent way" (Helen, MU58).*

Whilst comfort was identified as key to effective communication, the nurses also wanted to make sure there was as little distraction as possible to the survivor. The privacy and confidential nature of the environment was as important as comfort to the nurses. These elements were taken into consideration to maximise communication and aid disclosure. Although it is clear from the descriptions of experience that the initial disclosure is often not confidential, or in a comfortable environment, it is once the survivor states they have been raped that they can possibly move to another environment (depending on availability), thus benefitting the remaining part of their disclosure experience (MU:54/53). This is illustrated by the participants below:

> *"Yes, it was off the ward [the room I took her to]. Because even on the ward if you put don't enter on the door people did feel they could just knock and come in, so we just removed ourselves" (Laura, MU54).*

> *"So we're in a room, erm, a private room; there was no curtains, it was a room that shut, so it was completely private" (Nicola, MU54).*

> *"But it's still not in an enclosed room, it's behind a curtain, So it's still not private enough. If someone did though say something's happened to them, or if they are having like a PV bleed for example, any sort of intimate personal problem, we would always say 'right we need to go to a different area and we would take them to a confidential kind of, where a confidential conversation could take place. 'it will always be in a private room where there's a door, where it can be closed so only the people in that room can hear what's being said" (Sandra, MU54).*

> *"that we could sit down and wouldn't be disturbed" (Laura, MU54).*

> *"Quite relaxed [the tone of the room]. Not sort of like… So not unprofessional, but like not really strictly professional sort of stuff. Just a nurturing sort of thing, really. 'Cos I think, you know, she'd been through a pretty horrific ordeal, so it wasn't just sexual assault" (Nicola, MU53).*

These quotes from the nurses demonstrate an awareness of the primacy of privacy, and an understanding of how the environment aids communication for rape disclosure.

Whilst the impact of the environment is at the fore of nurse's descriptions when touching on communication, the role technology plays also was considered. Using computers to take clinical assessments and document consultations is now used over paper records in most organisations. However, nurses identified this as contributing to a barrier in communication:

> *"but rather than sit at the computer and kind of tap and not look at them and kind of look at the screen and not look at them, I'll usually get a paper copy of the template and have it on a kind of clipboard, just either on my knee or next to us, 'cos I can kind of… I can make notes quite easily without kind of… Breaking eye contact – It tries to be a bit more of a normal conversation" (Helen, MU57).*

Eye contact and facing a patient is crucial to acknowledging experience and conversing with the patient communicatively, both verbally and non-verbally. Even having the physicality of a desk and computer in between the nurse and the patient was seen as a barrier, even if the computer was not being used. This barrier contributed to a power imbalance that may impact communication, as described by Lisa below:

> *"I personally think that kind of discussion is better done without constantly referring to a keyboard, because the person, you know, they're in the moment, aren't they? They're offloading they might be feeling quite stressed about what they're saying when they see it going into a computer; they feel like they've maybe lost a bit more control than just someone who is actively looking at them and intermittently making notes. Being able to listen actively, reflect conversations back, summarise conversations…" (Lisa, MU57).*

Whilst the nurse was considering the impact of all these elements explored on disclosure, there was also a concern of a lack of continuity for the patient, with participants describing the frustration of the survivor potentially moving between two or three practitioners within their visit to the department. The nurses expressed they preferred to see the patient up to the end of their visit, as they are aware that the survivor will need to begin to build up trust / a relationship with another individual, and this may be hard for them:

"Sometimes it can take up to an hour, by which time the person they were originally booked in with has had to move on to the other patients and they're kind of… It's going to put their clinic behind. So sometimes there has to be a reshuffling and they end up seeing somebody else. Lack of continuity" (Helen, MU71).

There was also frustration that they have built a positive relationship and environment for disclosure and then may need to hand this over to someone else. They do not get the benefit of seeing the consultation through, or the satisfaction of supporting the survivors after putting in the hard work of gaining their trust and contributing to the unfolding of the disclosure. This is illustrated by Betty's experience:

"the ones we see we tend to pass on to our health advisors. We pass them [survivors] on to discuss giving them Hep B and further services. I get frustrated because I feel like I have built up that relationship. Why can't I see them through to the end. Instead, I have the trust of them and then I am passing them on to someone else, to then pass them on to someone else" (Betty, MU68).

There are other external factors that contribute to these environmental pressures that impact communication, particularly those of having a consultation that may last longer than the time allocated within the clinic:

"It can be a bit heart sink. 'Cos you think: right, we've got a much longer consultation and it's going to be more complicated now in many ways" (Lisa, MU46).

This may impact the choices the nurse makes surrounding encouraging and supporting the disclosure, and contribute to increased pressure when considering their responsibility on the other people attending their service. Lisa continued with her description of these pressures:

"You know, you've got a room full of patients and you haven't got the time to ring other services and you're thinking: can I leave this 'til the next day? Can I pick it up tomorrow? All of that sort of thing" (Lisa).

From this theme, is it clear that communication is a contributing factor to the emotional responsibility the nurse has when supporting the survivor. This is because they are always considering what can hinder and what can help support the disclosure experience.

6.4 Theme three: Blame

The third theme that became apparent within the nurse participant experiences was that of blame. When analysing the data, it became apparent that there was a level of responsibility placed onto the survivor with regards to their assault. Participants touched on this responsibility in relation to the survivor and their behaviour before, during or after the rape. The descriptions are a typification of the cultural and societal assumptions of rape (e.g., rape myths adherence, and victim blaming attitudes). However, in order to be fully transparent to the descriptive phenomenological process and the rigour of braketing, it is important (reflexivity wise) to acknowledge this theme aligns with my personal thoughts and bias's surrounding nurses supporting survivors of rape. Therefore, whilst there is a clear identification of rape myth adherence and victim blaming approaches throughout this study, it cannot be assured my natural attitude has not seeped through the phenomenological attitude during the analysis process of this theme/finding. Whilst this is recognised, I do feel there should be an importance placed on this aspect of experience. For those participants who described this aspect of their experience, it was an area they kept re-visiting, highlighting its importance. Therefore, it deserves to be part of a wider discussion.

6.4.1 Alcohol and behaviour

There appeared to be a need from the nurse participants to attribute a rationale to the assault happening to the survivor, seen as somewhere to lay blame or responsibility. It seems that if the nurses could identify a causing factor, they could then begin to understand why the assault had happened, and then their support could be more practical and specific. In turn, these assumptions result in the nurses assigning a portion of responsibility on to the survivor, causing judgemental descriptions in their experiences discussed. Judgemental attitudes are forming an opinion, usually acritical ones, about another person's actions. In the case of rape disclosure, the participants came to the opinion that the survivor had either drank too much alcohol or had not taken enough care in their actions. Thus, they then attributed that to blame (MU:59/60/61/62/64/66/31).

The use of alcohol by survivors played a large part in these nurse participants' discussion about the context of the assault. These descriptions are illustrated by Sandra:

“it can be made worse by the fact they've got alcohol on board usually, I've not dealt with a girl yet who hasn't had alcohol on board where this has allegedly happened” (Sandra, MU31).

Whilst nurses blamed alcohol for contributing to the opportunity of the rape occurring, they did not comment on the levels of alcohol the survivor had been drinking. Instead, it was just articulated that alcohol had been consumed and that it might have contributed to the assault. Both times (above and below quote) this was highlighted by Sandra when she indicated ‘alcohol on board’. This acts as a shorthand for her point of view and opens the communication in a way the content can be implied:

“when you hear the girls trying to relay what has happened, it's very upsetting, to, you know, because again they're very often very young girls and they've got alcohol on board” (Sandra, MU62).

When talking about alcohol and sexual assault, the use of the word alleged was used throughout. It was not used through the rest of their interviews when exploring sexual assault that had no alcohol involved, indicating alcohol may play a part in survivors’ perception of sexual assault experience, and also indicating doubt for the nurse. This highlights that the nurses do not consider those that have been drinking alcohol and have been raped as seriously as those that had not consumed alcohol. The nurses made assumptions that the survivor is not able to take care of themselves or control the situation/environment/perpetrator when they have been drinking alcohol, thus insinuating this is a contributing factor to the rape happening:

“it's just so frustrating to think that, they're just not taking enough care of themselves, they'll go out, drink and they're not in full control of what they're doing and it's worrying” (Sandra, MU62).

Sandra was suggesting if the survivor had not been drinking alcohol, they may have been able to control the situation and not be raped. Helen echoed this thought and described her lack of understanding at how survivors have placed them self in an unsafe situation. She believed that the survivor has a choice in this and compares it to herself, believing she would make different decisions to the survivors that would have not resulted in being raped:

"Just a bit perplexed by. I want to know what in their head made them think that that was a… Safe situation? You know when somebody tells you something and you just think: God, I'd never do that. Or: I'd never put myself in that situation. How did you find yourself exactly in the mindset that you thought that that wouldn't be… Wouldn't be… Risky, I suppose". (Helen, MU66).

By suggesting she would never allow herself to be in the same situation, she was applying blame to the survivor via describing a risk assessment of a situation she was not present for. Describing the actions of the survivor as risky is attributing blame, and by suggesting she would never put herself in that situation she is setting the survivor against her imaginary (perceived) standards. She went on to add:

"and I was just perplexed… couldn't understand why somebody would do that…'Cos in my head, oh God, that feels so dangerous. Such a dangerous thing to do, to go off driving with somebody that you don't…" (Helen, MU66).

The participants continued to link the experience of the survivor into their own personal life. Comparing what they think they may have done in that situation and going as far as describing how they use these disclosures to consider what to tell their children on how to take care of themselves in order to avoid rape, this demonstrates how social norms and judgements around rape myths and victim blaming can become entrenched in society. Lisa's description is a typification of these experiences being described and how the thoughts about safety and rape avoidance is part of a cultural and societal hand-me-down:

"As a mother of three teenage girls, I think it does, because you become a little bit… Well a lot more conscious really of the potential for danger when they're out and about, especially alcohol, which always seems to be a part of… Or frequently is involved with assault and so I think it heightens your awareness of the dangers and when you're putting yourself at risk… Maybe not putting yourself at risk, but… You know… Just trying to sort of advise my girls to think about safety when they go on nights out in town. You know, all this sort of stuff about having enough money for a taxi and not leaving their friends and having their keys. Not travelling in taxis alone. That sort of thing. So, I think I'm probably a little bit more aware than maybe…" (Lisa, MU62/66).

The notion of ensuring and being responsible for your own safety when it comes to rape avoidance is set into the nurses' ideals and further described by Sandra:

> *"They come into us after being separated from their friends and then alleging that something has happened to them" (Sandra, MU66).*

The term alleged begins to come back into the description of experiences of disclosures, therefore indicating a lack of taking responsibility for one's own self which results in doubt being placed disclosures of rape. The nurse was therefore describing a lack of belief in the survivor's experience:

> *"We find now a lot of girls where they've had a lot of alcohol to drink and they'll allege that things have happened and then they've maybe panicked or typically girls who are in relationships and then they'll backtrack and retract that nothings actually happened" (Sandra, MU 31/64).*

It is clear from Sandra's descriptions she was suggesting that survivors may have consented to the sexual activity and regretted this afterward due to numerous reasons. These include that they are in a relationship and may have misjudged the 'sex' as rape, or possibly describing a casual encounter whilst in a relationship that they don't want their partner to find out about. She went on to add:

> *"by the time the alcohol's stared to wear off their system and I think the information, they've absorbed it for themselves and then they'll come out and say 'I actually just want to go home, I don't think anything happened to me at all" (Sandra, MU64) .*

Participants also indicated there is an ability to visually differentiate between those patients whom may or may not be genuine in their disclosure; the obvious and not acknowledging the hidden:

> *"She had been raped, quite nasty as well because she had some injuries" (Sandra, MU60).*

If a patient has obvious signs of injuries associated with rape, then that provides the nurse with tangible evidence that the person has experienced rape, making it more believable. The belief that an individual is telling the truth about their assault is also linked with them being clearly distressed. The need for visual evidence is high on the participants' list for belief, as it authenticates the rape. This demonstrates an underlying judgementalism (stereotyping of rape victims) and is verified by the use of the word genuine. There is a perception that if a survivor has no injuries and is not showing emotional upset or distress, then they may not be telling the truth about their experience of assault:

> *"it's a very sensitive issue and you know, a lot of genuine cases where we do see where girls have had things happen to them you know and they're very distressed and it's not pleasant is it" (Sandra, MU61).*

This is a point Sandra came back to numerous times throughout her description of experience, emphasising the need to authenticate the rape.

6.5 Concluding thoughts of chapter

This chapter has presented the findings of both the survivor experience of disclosure of rape, and the nurse experiences of receiving disclosures. The essence of the participants experiences has been presented through their descriptions and aligned with the phenomenological conceptual framework as it appeared.

The chapter has also clearly demonstrated a level of intersubjectivity between the experience of the survivors and experience of the nurses, with many of those overlapping. One of the main aspects of this is the nature of disclosure with regards to temporality. Disclosure is complex and often moved from one set of moods to the next, through the process of pre-, during and post-disclosure. There seems to be no ending to these experiences, as time acts as a reflector. However, it is an experience that is not easily (if ever) accepted or forgotten (finished) about (for want of a better term). In phenomenology, temporality references not only the existing world, but also in the potentialities of consciousness, which are nothing but the multiple possibilities of our life situations. Time is an intricate analysis pertaining to intentionality in phenomenology (Heidegger, 1962; Husserl, 1964). Therefore, impressions of the participants' experience are related to their temporal past (retention or memory) and temporal future (hope), constituting the context of understanding. Therefore, it is evident that the emphasis of the temporal nature of the participants' experience must underpin the discussion chapter.

Chapter 7: Discussion: implications for nursing practice and concluding thoughts

7.1 Introduction to the chapter

The previous chapter presented the data from this research. This chapter will discuss those findings and their implications for nursing practice, future research and concluding thoughts. In line with the phenomenological approach, the previous chapter focused on sole descriptions from the participants' experience. Therefore, this chapter will analyse the contributions this study has made to contemporary literature and nursing practice. This stage of the study allows for the interpretive phase to be included in the thesis (Georgi, 2009).

The layout of this chapter differs slightly to the traditional discussion chapter whereby titled themes are explored in relation to contemporary practice. This chapter will explore the themes organised and in relation to application of the conceptual framework, that being phenomenology. The first section will explore the themes linked to three core phenomenological concepts that aligned with the finding of this study (authenticity, empathy and embodiment), and then the remaining sections of the chapter will discuss the implications of these to contemporary nursing practice. Concluding thoughts are also included in this chapter to get a sense, from the discussion, of the future direction of how this study informs practice, research and my identification as a nurse researcher.

7.2 Reiterating the research questions and aims

To provide context to this chapter it is important to revisit both the research questions and study findings.

Research questions:

- What is the experience of survivors of sexual assault in making disclosures regarding their assault to nurses?
- What is the experience of nurses receiving disclosures of sexual assault?

Research aims:

- Explore individual experiences of sexual assault disclosure to nurses within the UK
- Explore individual experiences of receiving sexual assault disclosures in UK nursing practice
- Develop an insight into sexual assault disclosures in a healthcare setting

- To offer an original research contribution in understanding experiences of sexual assault disclosures in nursing practice

7.3 Summary of findings and reiterating the research themes

The research themes in Chapter 5 have been summarised below. The diagrams illustrate an assimilation of the data themes within each participant group. In order to remain in contact with the findings, this overview condenses the themes into a brief summary of a statement of essential elements. These elements will be explored throughout this chapter.

7.3.1 Survivors findings

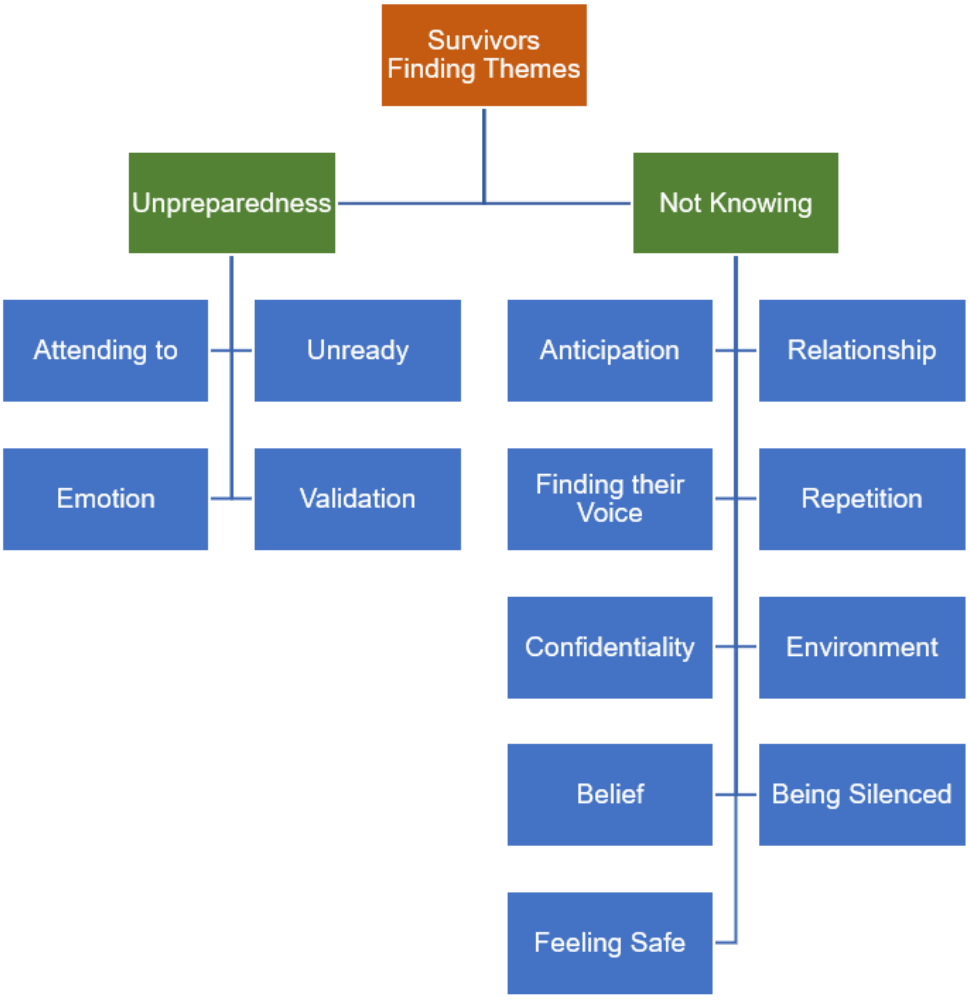


Figure 15: Survivor participant themes

Theme 1: Unpreparedness establishes the complexity of disclosure for survivors of rape and how unprepared they are for what follows the physical experience of rape. Participants described being in a position of both hiding from their experience (turning away from), and then facing it (attending to). They indicated using coping mechanisms to avoid facing it when they were not ready to (unacknowledging rape, change in behaviour) as a form of self-

protection. A decision to disclose SA is an uncertain one, as it initiates an overwhelming experience of embodied emotion that continues to be felt throughout the disclosure. As they make the decision to disclose, they are overwhelmed in anticipation of how the nurse will respond to their disclosure. When the disclosure is met with validation, the survivors see this as a permission to begin to acknowledge the experience. However, this does not make them any more prepared for what may be to come.

Theme 2: Not knowing identifies that once survivors face their experience and acknowledge their desire (or need) to disclose, the emotional uncertainty of not knowing what is to come contributes to increased emotional experiences. Immediately, anticipatory thoughts overtake their mindset as they try to foresee the future, particularly how people will respond, will they be believed, who will find out, and what will happen next.

Participants expressed a desire to disclose to someone who is understanding and empathetic, describing and looking for these characteristics as they waited to be seen by the practitioner. Not knowing the identity of the practitioner they are seeing amplifies the emotion of the experience, and this contributes to the difficulty some survivors have in finding their voice to articulate this alien experience. The nature of disclosure involves re-living the trauma of the rape, which is amplified by the procedural repetition of disclosing to more than one person; it is relived for the benefit of the professional and to the detriment of the survivor. There was also a lack of choice in what happened following disclosure expressed as a negative contribution to emotional wellbeing.

Once disclosure had taken place, survivors described a concern regarding confidentiality, both relating to the environment they were in and out of concern for the perpetrator. Again, this contributed to the stress and emotions attributed to the disclosure experience. There was also an identification of what made survivors feel safe, and this was aligned with a gendered stereotype of the nurse being seen as maternal. Although they use the words maternal, there is often an underlying indication that they associate being maternal with compassion and being believed.

The most prominent finding from both themes is the survivors' fear of being doubted by others, even though there is clear self-doubt expressed. Almost every aspect of their experience indicates a fear of not being believed by the person they will disclose to.

7.3.2 Nurse Findings:

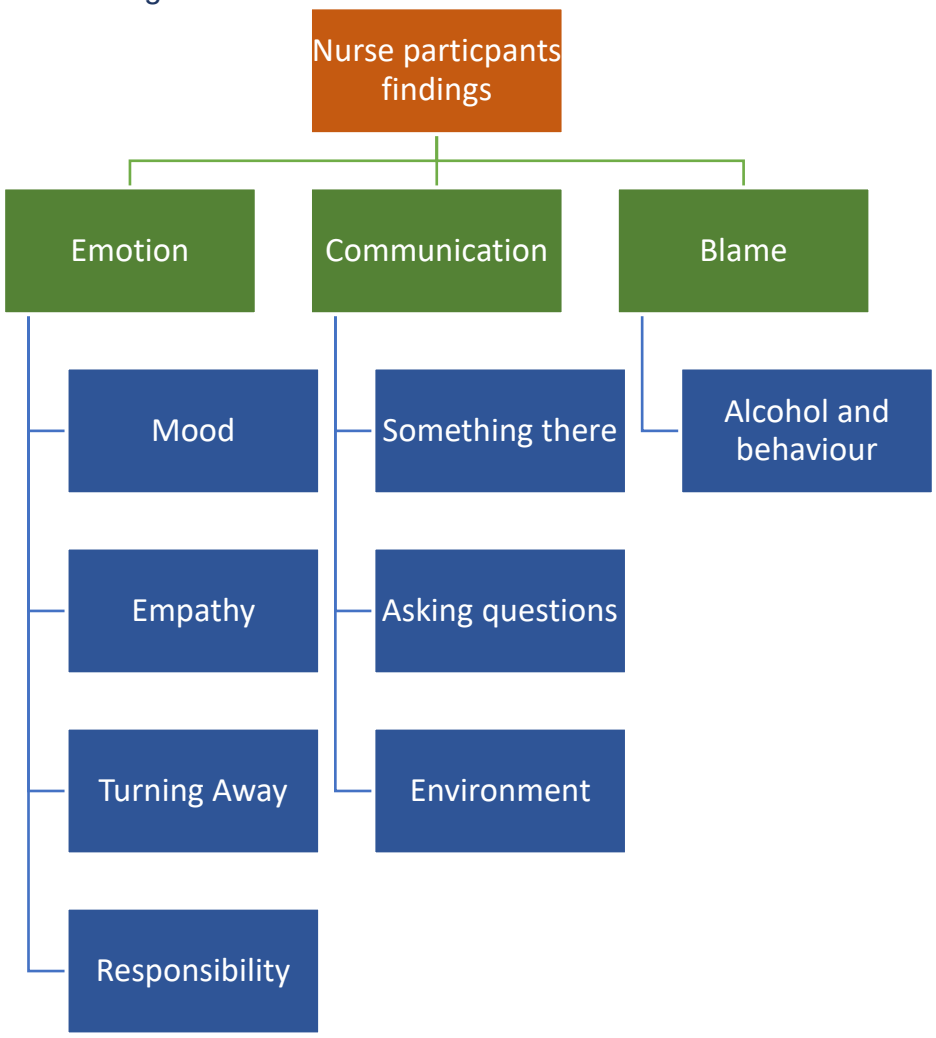


Figure 16: Nurse participant themes

Theme 1: Emotion identifies the embodied emotional impact rape disclosure has on the nurse, both pre-, during and post-rape disclosure. There is a juxtaposition between feeling overwhelmed emotionally, and a professional responsibility to ethically do what they feel is right (the procedural, rather than emotional, right thing to do). There is an acknowledgement that they do not know what the right thing is to do, and a lack of guidance is identified as a barrier to supporting survivors. The uncertainty is overcome by focusing on the legal aspects of rape (reporting to the police) and safeguarding to provide a sense of structure to the support given. The nurses felt they have undertaken their professional responsibility when they formally hand the disclosure over to someone else. To get through this feeling, and in order to carry out their responsibilities, they emotionally distance themself.

Theme 2: Communication identifies the importance of involvement and what communication skills aided them within the disclosure. Being open to and noticing the

person's demeanour as a possibility for disclosure, and the importance of listening and "plucking" out the words that follow questions, the nurses feel assists the person to disclose. Place plays an important part in the experience of disclosure and nurses are aware that the clinical environment may inhibit disclosure.

Theme 3: Blame identifies the adherence to rape myths and victim-blaming assumptions undertaken by the nurse. The nurses felt a need to attribute blame to something/someone for this happening and, often due to the language used, this was assigned to the survivor. Thus, there was a focus on the use of alcohol and/or engaging in behaviour the nurse did not deem as safe. Again, it is recognised here that my natural attitude may have seeped into the phenomenological attitude. Post doctorly, this area explored in theme three will be the focus of future research to gain further understanding.

7.4 Phenomenological concepts aligned with themes

In Chapters 5 and 6 there has been an exploration of phenomenological concepts aligned with the participants' experiences. This demonstrates the conceptual framework of phenomenology and its place in this study. It is important to add here my thoughts on how (and why), as a phenomenological study, these concepts are not separated into the standard Husserlian/Heideggerian, descriptive/interpretive split whereby a study will use one or the other theorist (or approach) to critically explore their findings. Whilst there is acknowledgement that this separation is more important at the methodological and methods application stage, the split is often carried throughout the remainder of most studies, suggesting alignment rather than integration of phenomenology as a philosophical framework. The concepts and theories that derive from the philosophical exploration of the lifeworld, and therefore researching the lived experience, is phenomenology. This way of understanding the world and our *being* in it has been academically and theoretically considered by many phenomenologists (see chapter 3). These thoughts and concepts shape the theoretical and conceptual framework that is phenomenology, and therefore are considered an essential aspect of how we begin to understand and make sense of experience. As such, in this chapter you become aware of how concepts of phenomenological thinking from more than one prominent phenomenological philosopher/theorist will demonstrate a congeniality with the approaches to conceptualise this work into nursing practice. That said, in line with Giorgi's (2012) descriptive approach, the interpretive phase is being included in the discussion chapter, and considering Husserl's *'back to the things themselves'* (2001, pg 168), examples of the findings will be used to demonstrate the analysis of the literature. This will be in the form of signposting to sections of the findings chapter and meaning units.

It is evident from the findings of this study that for both sets of participants there is an overlapping of experiences, or an intersubjectivity of experience. The structures that encapsulate the essence of their experience are divided into three phenomenological categories: authenticity, empathy and embodiment.

Whilst each concept is discussed separately below, it is important to acknowledge that the findings from this study do not adopt a linear process, but are interweaved and directly affect one another. For example, the concept of authenticity attributed to almost the full experience of disclosure (which is why this section is much longer than the others), from both the nurse and the survivor perspective, and all three concepts are affected by one another. As such, facing the authentic self within the context of a rape causes an emotional response that embodies our whole being, effecting how we see the other and communicate with the other. This in turn impacts our ability to empathise.

7.4.1 Authenticity

Disclosure, for the survivor, begins as soon as the physicality of the rape is over. Immediately, this is where the anxieties surrounding disclosure start to manifest as they begin to try to understand their new life as a survivor (or victim) of rape. This label is one they will never not have, and facing this version of their authentic self and accepting the label as someone who has experienced rape is hard to acknowledge.

Heidegger (1962) describes two fundamental ways in which people live their lives that are related to Dasein's *being-in-the-world*: authenticity, and inauthenticity. Heidegger suggests that, as humans, we mostly live our life in an inauthentic way, by concerning ourselves more with how others perceive us, and by getting on with every aspect of daily life that is often shaped by superficiality and tending to those things that have immediacy (trivia, gossip, mass media, social expectations, thinking about what is happening next in our live – tea, work, childcare, paying the bills, for example). This allows us to flee from authenticity, which Husserl describes as our natural world (Husserl, 1970). This way of living often results in the meaningful and significant encounters to be taken for granted, for example the happiness and joy of being in a loving relationship whereby intimacy is consensual by both partners, or walking home from a party late at night and the relief of getting home safely. The meanings behind those feelings go unnoticed. These feelings and encounters (the natural lifeworld) are described by Heidegger as being *ready-at-hand*, and often illustrate how we move through our lives and take things for granted, for example the pen we use or

the chair we sit on. It is not until something breaks or malfunctions that we start to think about (have an awareness of) or turn our attention to it. When someone has experienced rape it directs us to look to our future and actions, and urges us to question our mortality (or being-in-the-world). There is often an immediate switch to authenticity, as our experiences become *present-at-hand* rather than *ready-at-hand*. Following experiences of trauma many people experience shock and uncertainty, facing the uncertain future is often not welcomed, therefore, they continue try to live ready-at-hand, until there is no choice but to face oneself.

Heidegger suggests that to live authentically ultimately means being aware of oneself, and to do this there needs to be an awareness of one's own mortality. Experiencing trauma often gives that glimpse, and rape immediately puts the survivor in this position to question their mortality. Dasein (being there) is a journey to death in which there is no escape and being inauthentic allows a distraction from this. Easteal and McCormond-Plummer (2006) demonstrate that fear of death is one of the most terrifying symptoms of trauma following an experience of rape. Once this has been experienced, the survivor begins to turn to themselves, as their authentic self becomes more prominent. Thus, they come *unready-at-hand,* and this unreadiness exposes the foresight of needing to *attend to* oneself, to seek care or to seek a desire to be protected/supported. *Attending to* is a finding from this study that survivor participants were aware of, as they had to recognise this before disclosing, whether subconsciously or consciously (see chapter 5.2.1). From a nursing perspective, it is essential that nurses understand the basic concept of authenticity and *attending to,* thus informing the severity of the impact of rape on the survivors' lives. Only when this is appreciated can the nurse begin to support the survivor pre-, during and post-disclosure of rape. This study indicates that the trauma of rape (and hearing of experiences of rape through disclosure) interrupts the inauthentic way we live our lives.

Facing the authentic self can be challenging, specifically when it comes to experiences of rape. Survivors in this study all disclosed their rape to a nurse, and therefore it is clear they attended to themself (faced their true self) to seek support. Facing one's authentic self when one has been living inauthentically goes against natural behaviour and can be frightening to acknowledge. Therefore, people often enter a stage of denial and start engaging in their own coping mechanism to try and bury the experience as to not face it. This is not a new concept and has been explored in research for many years across a range of health conditions (Olff, Brosschot and Godaert, 1993; Wagener and Much, 2010). Denial is often a psychological defence that is ubiquitous throughout the human experience of adapting to change, trauma and / or health. It preserves the hope that things will not change, therefore avoiding experiencing painful feelings and their affect (Cramer, 2015). Rape, as an assault,

is a physical act of violence. However, rape is also an assault on the self. The assault changes how survivours see themselves and how they interact with the world. These changes and the denial or avoidance of acknowledging the assault results in self-injurious behaviours that contribute to PTS (Ahrens, Cabral and Abeling, 2009; Starzynski *et al.,* 2005; Ullman, 1999; Starzynski *et al.,* 2007; van der Kolk, 2022), and are often associated with experiencing trauma. This research has found that, when disclosing an experience of rape to a nurse, it is an exceptionally complex and challenging task that needs to be understood by nurses who are aware of how rape can impact behaviour, and thus health and wellbeing (this finding may be transferred into disclosure in any health setting).

As far back as 1979 Burgess and Holmstrom identified that people who have been raped use adaptive coping mechanisms to try and continue with their life following the assault. This thesis has demonstrated that in 43 years this process has not changed for survivors. There is a recognition that the assault has impacted their life and cannot be changed, and that the confrontation of that is not always welcomed. Thus, a turning away from is the survivor's way of side-lining or trying not to face the authenticity of their self in this new world. There are many reasons for this behaviour: Burgess and Holmstrom (1979) showed suppression (trying not to think about it) and minimisation (downplaying the assault) as two of their four main coping mechanism (others being: explanation – identifying a reason why this had happened to them, and dramatization – repeatedly talking about the event). Since their study was undertake the post-assault support and avenues of support have grown exponentially within the UK (O'Doherty *et al.,* 2022). Despite this, both this thesis and other recent studies continue to identify those coping mechanism being used today (Sweeney, *et al.,* 2018), although it is often measured in terms of consequences or impacts. For example, a person may be suppressing their experience to try and not think about it, and the consequence of this is emotional dysregulation that can often lead to substance abuse, lack of engagement in healthcare services, low self-esteem or increased risk-taking behaviour, for example. This study, therefore, emphasises the need for nurses to be aware of the consequences and impact rape has on survivors. Only then can they identify some of the indicators of SA.

Turning away from the authentic self is a way of being that is also reflected by the nurse participants (see chapter 6.2.3). Nurses described compartmentalising, or a switching off of emotions, to be able to carry out their role tasks rather than *attending to* their patients' immediate needs. Here they are both *attending to* themself (getting their professional duties undertaken) and *fleeing from* themself (turning away from their emotions) in order to perform their role. Emotion in nursing has been explored for decades (Bolton, 2001; Delgado *et al.,*

2017), with an emphasis on the nurse's ability to manage their emotions in order to present a desired appearance. Hochchild (2003) first coined the term 'emotional labour' and suggested that people adapt their emotions depending on the various context they are in, for example work and home. This adaptation in itself provides labour for the nurse as they engage in adapting emotions. The introduction of self-strategies to manage emotions involves compartmentalising emotions, a skill long applied to nursing practice and often attributed to self-care. This study indicates that disclosure causes such an overpowering response that the nurse cannot carry out their role if they do not *flee from* the emotional impact of the disclosure. This is because nurses often witnessing heightened emotions from survivors suppress their own emotions to remain professional and maintain the therapeutic / professional relationship. Without realising it, the nurses are undertaking a form of bracketing of their emotions (and pre-judgements of what rape is and how it affects people, both of which contribute to affecting their feelings and emotions). Nurses see the ability to compartmentalise as an essential nursing skill. However, this study identified that it leaves the nurse unable to advocate for the survivor (for example, see pg. 150, MU33), which is a fundamental part of a nurse's role (NMC, 2018). It also leaves the nurse in a situation whereby, upon reflection of the case, emotions rise as they have not been explored fully at the time, and this contributes to the long-term emotional impact disclosure has on a nurse's wellbeing. That said, Williston and Lafreniere (2013) state it is the practitioner's ability to remove the subjectivity from the situation that ultimately allows them to engage with their patient, regardless of the outcome of the consultation. Whilst their research is focused on intimate personal violence, the transferability into sensitive adult SA disclosure management is clear.

The ability to empathise with the survivor in the moment is the concept of caring for the other (Sorge). By the nurse turning away from that emotion it impedes their ability to empathise, therefore limiting the care or advocacy they can provide. When it comes to focusing on their professional responsibilities, the nurses often do what they think is right (see chapter 6.2.4), not necessarily what is best for the survivor (for example, see pg 158). This is a skill that the nurse moves into without hesitation due to being future focused (whether considering forensics, legal pathways, police input, or their role responsibilities). However, it could also be suggested that at this point the engagement in turning away from is an ethical one, as they recognise, using the art of futurity, they may be distracted by emotions and not be able to help unless they turn away from them.

For Husserl (1970), time is not an objective item, as he suggests it is something we construct with the power and capacity of our memories. These are only memories because

we are looking forward, often in anticipation. We expect, postulate, and plan for things to happen, but these thoughts are held in the now. We know a before and after, but the now is harder to engage in as we are constantly planning for the future based on the before. This is demonstrated by the nurses in this study as they consider their tasks that will come from the disclosure and their concern for getting it right (for example, see pg. 153-4 and 158). From a responsibility perspective the nurses are beginning, at this point, to embody the concept of futurity. Both Husserl (1970) and Heidegger (1962) address the concept of time from a phenomenological perspective and agree that as living in the world we (humans) are always oriented to and constituted by the future (guided by or past), rather than preoccupied with the living-present. For example, we are immersed in thoughts of future actions such as: will there be busy traffic on the way home (this is rush hour and there usually is lots of traffic), what will one cook for tea (what did we have yesterday?, what do we like?), booking a holiday a year in advance (where have we been before? We will need a rest at that time of year), paying for life insurance, collating near misses in healthcare as a risk assessment, eating a balanced diet and exercising. These are all considering the future whilst living in the present.

Whilst the nurses describe turning away from as essential to be able to carry out their role/support, the survivors pick up on this behaviour and see it as unsympathetic. It is seen as comparable to the nurse not seeing their needs or hearing their voice at a time when they feel they need someone to empathise with and support them (for example, see chapter 5.4.8 pg.131-132, MU 57/58). Ahrens (2006) reported that rape survivors are often punished after speaking out about their relationships by being subjected to negative reactions. Negative reactions will often result in survivors disengaging from services and stop talking about their assault, therefore ultimately being silenced. As well as contributing to the survivors feeling silenced, the compartmentalising approach and subsequent lack of advocacy can leave the survivors feeling like they have a lack of choice in their care and support (see chapter 5.4.10). Choice and partnership in support given after disclosing SA grants survivor's advocacy and promotes wellbeing in the long term (Greeson and Campbell, 2011). Supporting disclosures of SA includes giving accurate information of services available, so the individual can make a truly informed decision regarding their own care and regain an element of control within this traumatic situation. When this happens, survivors are then more inclined to continue with legal proceedings (Pillai and Paul, 2006; Du Mont and Parnis, 2003; Fitzpatrick *et al.,* 2012; Home Office, 2010; Temkin and Krahe, 2008). Whilst this route must always be a choice, research indicates that survivors have better psychological outcomes when they see their assailant brought to justice (Home Office, 2010; Starzynski *et al.,* 2005). However, the decision to report to authorities, or even receive psychological support, must be the decision of the adult survivor (unless

safeguarding responsibilities override this) after receiving the information in order to make an informed decision.

From a phenomenological perspective, the nurses in this study focussed on the future, and this overrides their ability to be present and empathise with their patients. Futurity is an essential concept in how we navigate through our lives. It is demonstrated from the discussion above that, when reflecting on *turning away* or *fleeing* from their emotions, the nurses do recognise why they have done this: to overcome the emotional impact, and to carry out what they see as the responsibilities of their role (informing the police, forensics, testing for sexually transmitted infections). However, they are not aware that their behaviour is contributing to societal assumptions leading to rape myths and victim-blaming behaviours. For example, those that are telling the truth would want this to be reported to the police, and we need to report it to keep other women safe (Heath et al., 2013; Ahrens, 2006; Clay-Warner and McMahon-Howard, 2009; Sigurvinsdottir and Ullman, 2015; Ullman, Lorenz and O'Callaghan, 2018).

For the nurse participants in this study, that sense of responsibility is aligned with their whole structural experiences of disclosure. Being told this information by a survivor commands a response that has many threads for the nurse. These include responsibilities to get it right for the patient, right for their role responsibilities, and right for the safeguarding / legal elements they perceive to be important with the aim of 'doing good. The nurses have an embodied sense of professional ethics, or the desire to do good. Haahr *et al.,* (2019) state that for nurses, doing good often involves a focus around their patients' wellbeing and dignity. However, there are times in clinical practice whereby an ethical dilemma arises that creates a conflict between patients' interests and the nurses' values, norms and interests, causing tension within the clinical decision-making process. In this study, the dilemma was characterised by a concern that the documentation is completed appropriately, both in regard to their own documentation and in ensuring policies have been followed (for example, see pg. 155 and 158). This is where the anxieties often begin to rise, as despite there being a desire for healthcare professionals to include sexual or interpersonal violence screening in history taking for some clinical areas (sexual health, mental health services, maternity services and primary care) for some time, there is little guidance on how to respond or what to do when receiving disclosures of adult rape experience (British Association for Sexual Health and HIV, 2016; National Institute for Health and Care Excellence, 2014). The nurses have been entrusted with this sensitive information that they then have no idea what to do with (a keeper of secrets, as such), but they feel an overpowering responsibility to do something with the information due to the significance of

the assault (see chapter 6.2.4 pg. 153-154, for example). Therefore, the logical step the nurses follow is the legal/safeguarding approach: this is a crime and therefore must be reported to the police/sexual assault referral centre (see chapter 6.2.4 pg. 156-158, for example). This is often done with a disregard of whether the patient wants to report or not, but does allow the nurse a sense of doing something. The desire to do something overtakes the ability to listen and advocate for the survivor. Nurses focusing on their professional outcomes results in survivors having choice removed and, ultimately, being silenced after disclosing their experience. Survivors, therefore, experience feelings of being silenced at two points during their disclosure; when the nurse turns away from their emotions and when they do not involve the survivors in decision making regarding referral to other formal services, such as the police.

The pressure of responsibility clearly lies heavy on the nurse's mind when supporting survivors of rape. A pressure to get it right has been identified by nurse participants, along with the insight from reflection that they do not always do this, and their actions may not have been beneficial for the survivor. This is a important finding for nursing practice: it demonstrates not only a lack of knowledge or insight into appropriately supporting survivors, but also that this topic is one that nurses feel emotionally overwhelmed by. They struggle to control those emotions without putting them to one's side, and there is a long-term psychological effect as the nurses reflect continuously on their experiences of disclosure (for example, see chapter 6.2.3 pg. 151). Tarlier (2004) suggests all nurses experience a desire to be morally responsible and often the response to patients reflects their personal moral knowledge and ethical responsibility. This study supports this statement, demonstrating that the pressure to get it right and morally do the right thing (report to police, for example), the dilemma the nurses face, overshadows the survivors' need. Levinas (1991) describes responsibility in ethical terms rather than the traditional definition of undertaking a duty that you are to deal, with so you may be blamed or held accountable for if something goes wrong. He goes on to suggest that in ethical responsibility we must assume responsibility for the other, that ethics is not an addition to our existence, but entwined in a way that our whole existence becomes about the responsibility of ethics. In this study the nurses feel that embodied sense of ethical responsibility although there is asymmetry. The nurses feel a personal responsibility to empathise with the survivors, but at the same time feel powerless to help in the sense that they cannot remove this experience and are often overcome with emotion. Levinas (1991) refers to this as being held hostage with total responsibility: having the power to help, but also feeling powerless. Therefore, they see their power in being able to help in the professional perspective of 'doing something', but this is actually the ethically moral responsibility of informing the police (this

is a crime, you are a victim, I will help you report this to the police) taking over. This study demonstrates the complexity responsibility has for the nurses.

Another finding aligned with the structure of responsibility for nurse participants is cause. Nurses are searching for something responsible for this experience. A fundamental aspect of nursing care is an approach to patient management that explores cause and effect (Edelman and Kudzma, 2021). Nurses are educated to incorporate health promotion in the care they give, and this can only be undertaken by identifying risk factors that contribute to the cause of ill health. By finding contributing factors of ill health, nurses are then able to give tangible advice to stop adverse effects on health. This is the cause-and-effect theory in health (Anderson, 2016). For example, stop smoking and reduce the risk of lung disease, exercise and reduce the risk of obesity, drink less alcohol to reduce the risk of heart disease and cancer, if you have diabetes – follow this diet, you have a stomach ulcer – avoid these foods and take this medication, and so. Nurses are taught that with almost every health condition there are contributing factors that exacerbate that condition. Therefore, it is no surprise that following disclosures of SA, a nurse's response is to look at what may be responsible to give the survivor advice (health promotion) on how to minimise their risk going forward (don't walk in the park at might alone, don't drink too much alcohol, don't get separated from your friends). Every day nurses facilitate behaviour change linked to health promotion, whether that is associated with reducing alcohol intake to minimise the risk of heart disease, advising to wear sunscreen to reduce the risk of skin cancer, or prescribing contraception to reduce the risk of unwanted pregnancy. The variable leads to the cause, so therefore we adapt the variable and the risk of experiencing the cause decreases. This study indicates that the responsibility nurses feel during a disclosure is twofold: to provide concrete care / advice and that a disclosure of rape is reported to the police, or other safeguarding avenues, even when that goes against the direct wishes of the survivors. Having an outlook that is cloaked with both the concept of futurity and the pressure of responsibility takes the focus away from attending to the survivors.

Themes identified from the survivor participants also reflect adopting the concept of futurity, for example not knowing (who will I see, how will they respond), blame (will I be judged/ blamed), or confidentiality (will people find out). As mentioned previously, disclosure puts survivors in a position whereby they are re-confronted with their assault. They are also torn with the perspective of acknowledging this assault and turning away or burying the experience, as this allows for the futurity of the assault to be gone. This study has identified that the labelling and reporting of rape is a self-actualisation for survivors, as it makes their experiences concrete and real. Many people believe this can harm their identity and/or limit opportunities in the future (considering futurity). Therefore, survivors predict their future

experience of rape disclosure based on their past (experiences, understanding of what rape is, media influences). Kahn *et al's.,* (2003) and Peterson and Muehlenhards' (2001) studies both suggest labelling a rape experience is influenced by multiple factors: attitudes and beliefs towards rape and SA, the use of drugs or alcohol in that experience, and a feeling of victimisation. This study also finds those contributing factors exist in a healthcare/ nursing disclosure context (see chapters 5.2.2, 5.4.1 and 5.4.7, for some examples of this) but would further argue that the underlying factor is the desire to find something responsible for the attack. Not having anything responsible allows thought that this type of experience just happens to anyone, by anyone.

The findings in this thesis also support previous research that feelings of shame, guilt, embarrassment, fears of not being believed, perceptions of not having enough evidence, fear of implications for the perpetrator and not wanting people to know can all lead to survivors' anxieties around acknowledging (*attending to*) their experience as rape, and subsequently being labelled as a rape 'victim' (Ahrens 2006; Fisher *et al.,* 2003; Sable *et al.,* 2006; Zinzow and Thompson, 2011). All these feelings are barriers to disclosure and nurses must be aware of the impact they have on survivors, specifically around labelling and the language used to describe experience. This study highlights that by focusing on responsibility, nurses are inadvertently adhering to rape myths and victim-blaming assumptions. These approaches to support not only cause barriers to disclosure, but also confirm survivors' fears that cause the original complexity of attending to themselves: that they are being judged or blamed for their assault in some way (for examples, see chapter 5.4.7 and 6.4).

Throughout this study, the concept of being believed has been demonstrated to be complex, from both sets of participants. Whilst the survivor participants do not use the term 'miscommunication' in this study, there is a presentation of hesitation in accepting they have experienced rape (MU's 38/40/49/52/55). This hesitation identifies that survivors are often looking for validation of experience (see chapter 5.2.4) before they acknowledge it. It is with this validation that they then can begin to accept their experience as rape. Validation, in this study, is aligned with being believed, when survivors talked about their desire to seek support, what is identified is that they mean being believed (as identified in the literature review, the fear of not being believed is associated with deep-rooted societal victim blaming and rape-myth adherence - see pg. 129-130 and chapter 5.4.7, for example). The concerns of not being believed are a contributing factor to survivors not facing their authentic self, and to protect themselves from judgement and therefore pain and disappointment (Cramer, 2015). To not *attend to* themselves for fear of being judged is, again, linked to futurity and

pre-empting behaviours based on experience / knowledge. It is key to acknowledge that, within this study, the fear of not being believed is weaved through every aspect of disclosure experience for the survivor. Even positive experiences that are described led to concerns about the next professional they encounter not offering the same support. This is the nature of the understanding of rape in our society, as the way people may respond cannot be predicted, and survivors are very aware of this. And, when there is self-doubt the experience was rape, there then cannot be confidence that someone else will believe you. This doubt then leads to the survivors taking responsibility for the assault, and therefore believing the experience was not rape but misunderstanding (for example, MU55 see pg. 112).

This study adds to the current debate regarding survivors questioning that they will be believed. The insight this research adds is that survivors fear they will not be believed when accessing healthcare services (an area that has not been fully explored in previous research), even though healthcare professionals pride themselves in having a professional upholding that should be free from judgemental behaviour (Nursing and Midwifery Council, 2018; General Medical Council, 2019; Health and Care Professionals Council, 2016). Survivors do not assume they will be met with a non-judgemental and compassionate approach. When considering Heidegger's Sorge (Heidegger, 1962) one could argue that the lack of confidence in how someone may respond could largely be attributed to a subconscious self-protection / self-care act on the part of the survivors (as discussed on page 183 above), as if they expect the worst they will not be disappointed. Acknowledging and articulating you have experienced rape opens a conversation that cannot be taken back and often leaves the survivor on a vulnerable path to uncertainty and potential hurt (for example, in not being believed, being judged, having people know about the experience, facing your abuser in court, or potential media coverage). It is understandable that your psyche would want to protect yourself against this, and that this experience may be so alien that it renders survivors speechless and unable to find the language to disclose (for example, see pg. 119).

Rape myths and victim-blaming adherence contribute to the survivor's constant worry they will be judged, blamed or not believed. Below is an example from survivor participants of how these encompass almost every aspect of disclosure:

Theme / Sub theme	**Quote**	**Link to rape myths and victim blaming**

Not knowing	'she was like "do you think maybe you implied?" (meaning consent) (Anne, MU1)	Here Anne is suggesting that the nurse believes she may have implied she wanted sex or signalled a desire to have sex, therefore attributing blame.
Anticipation	'I was worried that I was going to go and even though I knew that it was real, that someone might say "well actually, no. It wasn't" (Jane, MU7)	Jane is signalling her concern that the nurse would not believe she had not consented
Validation	'i didn't really understand what had happened' (Holly, MU52 'it wasn't just my… confusion' (Vicky, MU55) 'I sort of knew that what had happened wasn't quite right, but I sort of shrugged it off' (jane, MU38)	This demonstrates a lack of understanding of the solid boundaries of consent and the self-attributed blame that comes with these experiences.
Repetition	''Cos she was asking questions that like, implied that they were going to trick you. Like you know they haven't…you're not telling the truth sort of thing' (Anne, MU56)	Anne is suggesting the nurse would not believe her and that the repetitive questions were a way to 'get the truth' (that she had not been raped).
Confidentiality	'Straight away, they say "did you report it, are you going to report it" Not like anything would come of it anyway, there would be no evidence' (Jane, MU27/28)	Jane's experience aligns with two myths: 1 – that if one has really been raped then it should be reported to the police, and if you don't then it questions the validity of the assault, and 2 – a lack of physical evidence means the case cannot be prosecuted.
Environment	'I still felt quite panicked, and ashamed really' (Jack, MU12)	Self-attributed blame, feeling shame indicated that they somehow 'let' it happen.
Belief	'they judged it as a case of me just wanting a bit of fun and getting drunk and being silly' (Jack, MU2/5) 'And she kind of said it wasn't rape, because I was drunk' (Vicky,MU5)	These quotes that appeared in this theme demonstrate widespread adherence to rape

	'Oh, well you know, I was drunk, so…yeah' (Jane, MU5) 'She said you couldn't do anything about it in a court of law, because you were drunk, kind of thing (Vicky, MU5) 'She said it would be my word against his and it would probably do more harm than good' (Holly, MU7) 'I felt like I was being judged as like a young gay kid who's been silly' (Jack, MU3) 'I felt ashamed and guilty when I was disclosing everything' (Jack, MU4) 'Angry, like no one believed me' (Sally, MU4) 'And I completely felt like: that's just where I completely felt like, ashamed or whatever' (Holly, MU10)	myths and victim-blaming concepts: - Associating blame with alcohol use - If it's one word against another nothing could be done - Shame and guilt - Obvious lack of belief

Table 8: Example of survivors worry of being judged

These participant quotes demonstrate multiple examples of self-adherence to rape myths and victim-blaming thoughts. This is not surprising considering the social construction of rape (Horvath and Brown, 2022). In this case, the survivors are attributing these thoughts to their experience, so it is understandable that they would expect the same level of adherence from others.

The tendency to lay blame at the survivor is a consequence of rape, and therefore disclosure, that has been well researched and linked to adherence of rape myths (Ahrens, 2006; Clay-Warner and McMahon-Howard, 2009; Sigurvinsdottir and Ullman, 2015; Ullman, Lorenz and O'Callaghan, 2018). This research finds examples of adherence throughout, by both sets of participants. However, it is important to explore fully that, although societal assumptions and media bias often contribute to rape myths, there are other factors that align people's thinking with blaming something they can see as being able to be changed (for example, behaviour). This type of bias involves acknowledging multiple factors about the human psyche. In relation to rape and SA three factors contribute to this way of thinking:

- attributing other people's behaviour to internal, personal characteristics rather than acknowledging the external forces is known as the fundamental attribution error.
- Hindsight bias is where we look at an event in the past and believe we should have been able to predict the outcome.
- The just-world phenomenon stems from our needs to believe the world is a fair and just place.

Each one of these theories that psychologically explore why we attribute blame are phenomenological in nature, in that they are fully encompassing of futurity. Heider's (1958) assumption theory suggests that people try to explain the behaviour of others with assumptions that they cannot verify, thus assuming reason as to why others act the way they do. Further, fundamental attribution error theory comes from a desire to control the social environment and the future (Ross and Nisbett, 1991). Blame attribution to rape survivors often falls into two approaches when explored. Firstly, the socio-psychological approach, this focuses on the rape perception framework, highlighting the reputation of the survivor, their physical allure, sexual history, what they were wearing, the use of alcohol or/and drugs and whether they resisted the rape (Anderson, 2004). The second approach attributes blame to the survivor by applying the just-world phenomenon mentioned above, where we assign blame based on our belief that people get what they deserve for their behaviour (Lerner, 1980). This fulfils the illusion that our social environment a safe, and this reduces anxiety and meets our need for security (Lerner, 1997). This way of seeing the world allows us to stay as our true unauthentic self, providing a buffer to reality and the future self. This demonstrates the place futurity has in rape myths and victim-blaming assumptions, as people are protecting their future.

Whilst it is argued that those who believe in rape myths and victim-blaming assumptions are protecting their future self from judgement, it is also evident in this study that the survivors are protecting themselves by assuming the response that they will be met with following the disclosure. Survivors in this study anticipated they will not be believed and will be judged by the nurse. However, they also expressed that they hope for kindness and a non-judgemental attitude. This level of uncertainty and complex thinking adds to the lack of ability to be fully prepared for the response to their disclosure. Having both thoughts allow the survivors to try and prepare themselves for both responses, and as such the unpreparedness they feel is heightened. This shift in anxiety crosses into the structure of the not knowing theme and is driven by an uncertainty that causes fear. Fear is guided by not knowing if they will have an unempathetic or judgemental nurse throughout and, following disclosure, leading directly back to the fear not being believed. The perception of support for the survivor is focused on being believed and not being judged (see chapter5.4.1). This part of disclosure is where the survivor's anticipation increases regarding what might happen in the future. To try and ease that anticipation they search for signs, and they do this by searching for aspects within the environment that will ease their anxiety and give a sense of hope for comfort. For example, can they identify the nurse (from other staff members) and what the nurse looks like (i.e. does she smile and look friendly) (for example, see pg. 117). They are looking for physical attributes of compassion, support, and safety, and all these attributes indicate belief.

The nurse-patient relationship is exceptionally important in order to build trust when engaging in therapeutic interventions (Watson 1999; Royal College of Nursing [RCN], 2003; Baillie, 2004). A first and positive impression contributes to building these relationships. In this current climate, nurses are experiencing high workloads, fatigue and stress, which can hinder them from smiling at patients (Fitriana, Santoso and Dharmana, 2021). This, in turn, increases anxiety and stress for patients. Therefore, when it comes to survivors of SA it is essential nurses recognise the benefits of a first impression, and consider the implications of the survivors not being faced with this (deciding not to disclose and disengaging with services which will result in poorer health outcomes).

Facing one's authentic self puts the survivors in a world that may have been alien to them previously. Thus, looking for familiarity and kindness is a way of then navigating this alien world. Initially, Husserl's (1970) concept of the lifeworld explored the application of normality and abnormality (meaning a deviation or break), and was used to describe the concept of facing something in our world. It was then developed further by Heidegger (1962), who structured a large part of his writing in *Being and Time* around the concept of inauthenticity and authenticity, and then latterly by Steinbock (1995), who developed the notion of the home world and the alien world. For survivors, the home world is pre-rape and the alien world is post-rape. This includes, for example, Jane and Sally (see pg. 118 and 119 MUs40/48) as they struggle to consider how they will physically describe their experiences, as the alien world has rendered them speechless. When waiting to see the nurse and looking for empathy, survivors are in this stage of considering how to use language to describe their experiences, and having an environment that promotes an empathetic setting and a reduction in anxiety is essential to facilitate disclosure. This finding may have transferability to many other areas of healthcare, due to the stressors often induced by ill health or heath concerns.

7.4.2 Empathy

Empathy is a concept that weaves through both sets of participants' experiences of disclosure. As both nurses and survivors explore their experiences, they describe an emotional change that results in one group searching for empathy (survivors) as the other tries to block it (nurses). That said, the structural experience of empathy in this study is complex, and does not present in a way that is typical of the definition of empathy (see chapter 6.2.2). For the nurse participants, the immediacy of the emotional mood is aligned with feeling empathy of the other (see pg. 145-146, for example). However, as mentioned

previously, they often (very quickly) turn away from this emotion (for example, see pg. 149-151), as they are overwhelmed by empathy (See pg. 148 and 151 MU34). As addressed in the section above, survivors pick up on this shift of emotion and see it as a barrier to communication with the nurse, demonstrating that empathy directly impacts the relationship with the other (the survivor).

Husserl (1970) presents his own theory of empathy throughout his work, although his thoughts and mindsets of how we see and understand the world and other people (by empathising) develops and changes as his own reflexivity progresses. Whilst Husserl's early theories on empathy influenced the development of Edith Steins' seminal work *On The Problem Of Empathy* (1917/1989), his later theories were inspired by her writings. Both Husserl (1970) and Stein (1917/1989) address the explanation of empathy as the same, defining it as an experience of foreign consciousness. They are explaining it in largely the same way; that empathy is understood as a unique form of intentionality that allows a person to experience a foreign consciousness, therefore indicating that empathy allows us to experience others, but only given in the intersubjective context in which others can exist. This suggests that, from a phenomenological perspective, empathy is a particular kind of perception that gives us something directly, and you can only experience this if you can see the reality through mood (Heidegger, 1962; Husserl, 1970; Stein, 1917/1989). What this translated to in this study is that the empathy the nurse described is often interlinked to multiple stands of experience, for example their emotions regarding the survivors' experience of rape, their specific feelings or perceptions of rape, their societal assumptions of rape, or their own experiences and projection onto people they know like their children / family. This makes the affectability of empathy come through in a different way to what may be expected in the traditional sense (the ability to imagine what someone else might be thinking or feeling).

Empathy is a skill that has largely been associated with nursing practice, as it helps build trusting relationships with patients and is often used to build a connection by focusing on the patient's point of view with their health concerns. As such, compassionate care requires nurses to engage in empathetic responses (Hunt, Denieffe and Gooney, 2017). Hodges and Klein (2001) suggest empathy bridges the gap between self-experience and that of others. This study has demonstrated nurses turning away from their empathetic response, and this is concerning as a lack of empathy is often associated with compassion fatigue and emotional burnout. This questions whether nurses are already experiencing such conditions, or whether they are aware of the risk and are protecting themselves by turning away. Either way, a lack of empathy is an emotional consequence that results in a lack of

motivation to provide compassionate care. It is clear that more research is needed on supporting survivors of sexual violence and the impact on empathy.

Fernandez and Zahavi (2021) suggest that a lack of defined conceptual framework for understanding empathy is contributing to the impact of empathy on nurses' wellbeing. There is a clear difference in empathising with the other to provide compassion, as opposed to trying to experience the same emotional response/feelings/moods/sensations which can lead to an embodied response. Nurses can empathise with the other by drawing upon theoretical knowledge, rather than pulling from their own emotional empathy:

> *"a central task of the nurse is not to imagine what it must be like to be the patient, but to attend to and help the patient find a voice of their own, where they can express and articulate their viewpoint" (Fernandez and Zahavi, 2021 pg 35)*

Therefore, it could be argued that the traditional "put yourself in their shoes" approach to empathy is morally questionable because it is impossible to do, and as such will always inflict a sense of failure upon the nurse. This sense of failure becomes a professional measure of competence and a contributes to self-assigned failure on the part of the nurse. This discussion demonstrates a need to define and establish professional empathy where the nurse can be aware of the impact their emotional response may have on themselves and their patients. In this study, survivor participants indicated that if the disclosure has been made and the nurse does not respond in a way the survivor had hoped (empathetic and therefore belief), regret immediately sinks in and the emotional impact is evident. This then contributes to survivors disengaging with the service, demonstrating the importance of that initial response from nurses. The findings demonstrate that this initial response should focus on the survivors, continuing to allow them to find their voice. Therefore, it becomes about the nurse suppressing their initial emotional reaction, letting the survivors speak and futurity, focusing on what happens next.

When receiving disclosures of SA, nurses described that their empathetic emotion response often results in feeling highly stressed and anxious (for example, see pg. 152). Heidegger explores anxiety as an essential nature of being that is directed towards existence and related to his perception of fear. However, whilst fear is directed at something specific (for example, experience of being raped), anxiety is about existence itself (the concept of rape) and revealed through facing the authentic self. When touching on anxiety, Heidegger (1962) is seeking not only disclosure of something in the world, but rather the world as a totality: the structural whole from both an existential and ontological position. His conclusion is that

this is through the revelations of the mood (*being*, is always driven by being in a mood, whether happy, sad, boredom, there is never no mood) which therefore shapes emotion, of which anxiety is an essential one described in this study (by the nurses describing worry and feelings of unease, demonstrating a typification of the notion of anxiety). While the mood of fear is directed towards a particular object in the world (the survivors' experience of rape), anxiety reveals the deathly nothingness at the heart of Dasein's world as a whole, which influences our involvement in the world (how the nurse will support the survivor, what they need to do, whether there is guidance to help them support, what will be the impact on the survivor, what will be the consequence for the nurse). What Heidegger is suggesting is that reality can only be seen if the mood (and therefore the emotion) first allows it, and this is a difficult task with anxiety often overtaking the mood. What the nurse participants expressed throughout their experience was a constant evolution of emotion that was linked to the temporal nature of the experience, therefore changing their moods to allow for them to see the reality of the object at times. Consequently, the mood the nurse is experiencing at the time will determine whether the reality of the survivors' experience can be seen. This then directly impacts the support the nurse can provide, which gives understanding as to why, when those emotions are bracketed, nurses are unable to see that they are not advocating or caring for the survivor in a way that is desired by those survivors. As such, they are not able to see the other.

An interesting finding in this study is the survivor's identification of wanting to feel safe and clarifying what 'safe' means to them (See chapter 5.4.9). Initially, it is clear that feeling safe means being supported, as the survivors are looking for an empathetic and supportive response to their disclosure. Later, it became apparent that being supported ultimately means being believed (when they are not believed, they do not feel supported). Therefore, findings from this study purport that feeling an empathetic response from the nurse is largely attributed to being believed. It is important to acknowledge that when survivors described receiving feelings of support this was surrounded by gender normative assumptions, for example the use of the term 'motherly' (see chapter 5.4.9). This could be because, in their experience, they saw a female practitioner (bar 1 participant), however, they associated that positive outcome with gender.

When nurses describe their initial emotional response to disclosures, one of the structural elements was to also align their empathy with a maternal instinct (see chapter 6.2.2). This finding signifies an alignment between empathy, nursing and a maternal instinct: indicating a particular mode of *being* that the nurse sees as not being experienceable by others (for example those that do not have children). Regardless of the gains made in promoting

gender equality in nursing, this study indicated that gender bias remains a problem (McRae, 2003;Carnevale and Priode, 2018).

These gendered assumptions also come to the fore when the nurses are trying to make sense of the assault (see chapter 6.4.1). There is an insinuation that as a mother (therefore a woman) you are more aware of the risks of being raped and could avoid them. Thus, there is an application of rape myths and victim-blaming assumptions that puts the responsibility onto the survivors (see 6.4.1 specifically, MU62/66) and dismisses the concept that a male practitioner would be able to provide just as adequate empathy to all genders of survivors. This is an example of multiple gendered assumptions within the structure of the nurses' experience and thoughts (for another example, see all quotes 6.4.1 pp. 171-174 – the use of the word 'girls' throughout). The engagement in this language indicates that nurses are continuing to demonstrate unconscious biases and, as discussed, those assumptions contribute to effecting their ability to empathise with the other (the survivor). This study's findings have highlighted that the nurses are unaware of how their reactions, responses and language during a disclosure (and the aftermath) will affect a survivor until reflection at a later date. However, at this later point, whilst there is reflection on some aspects of the care given, there is a no reflection on the gendered (or any of the) biases that the nurses engaged in.

7.4.3 Embodiment

In this study, findings identified that the emotional impact of rape results in an expression of disclosure that is not solely psychological or physical, but has a whole embodied response throughout the encounter to nurses and survivors. Merleau-Ponty (2012) suggests we are our body and, through this, perform as an individual human. However, more than this, our body and mind causally interact to contribute to how we preform (and interact with the other). This interaction is often subconscious and effected by our encounters with others. For example, a sexual assault and/or rape is an attack on the body, however this physical act leads to a violation that encompasses a fully cognitive response.

As previously discussed, a large proportion of the feelings associated with rape are attributed to society's acceptance of victim-blaming and rape-myth assumptions. This study demonstrates how these thoughts embodied the survivor's physical response throughout disclosure. Participants described the period leading up to the disclosure as causing such an emotional embodied response that they felt physically sick (for example, see pg.110). Ultimately, it is their fear of the response from the person being disclosed to that was

contributing to the physical symptoms (will they be believed, for example). This indicates that the external interaction with the other (regarding this topic, from society, media etc.) and an internal self-interaction (based on their own thoughts and assumptions [Blumer, 1969]) aligns symbolic interactionism with the place embodiment has on the survivor. Participants also described the cognitive emotional response becoming somewhat physical, for example survivors described feeling exhausted (see chapter 5.4.4) and feeling disgusting (see chapter 5.2.3). This bodily experience is often pre-reflective, as we experience and use our bodies before we think, and it is through using our bodies in our everyday activities that we perceive the world and relate to others. This is often as we live our life unauthentically, as facing the authentic self is what brings the embodiment to the fore. It is often not until an experience like this that we realise how intertwined the body and mind are, demonstrating that this shift in bodily experience rarely occurs in isolation. It is instead accompanied by a paralleled shift in how one experiences one's environment (emotions, mood etc.). This study demonstrates this alignment (for example, see pg. 125) Sarah described the physicality of climbing the stairs, as she had previously described her anxiety and feelings towards disclosing and wondering what might happen. She then went on to describe the walk up the stairs as ‘long’, ‘awful’ and a ‘horrible place to climb’, thus demonstrating the cognitive mood becoming a physical experience, therefore embodying.

It is important to acknowledge that embodiment is not just about the physical consequence of mood, as there was an environmental factor that was addressed within both the survivor and nurse participants that contributed to the embodied emotional response. Embodiment reveals the objects around one, and reshapes the sense and meaning of the environment (Fernandez, 2020), which in turn can affect mood (and therefore emotions). An example of this is when a survivor participant sees a sign on the back of the bathroom door stating ‘we believe you’ regarding rape/sexual assault. This triggered the survivor’s emotions as she felt she had not been believed (see pg. 130). The nurses’ experience of feeling emotionally embodied also provides insight into the expression of the desire to provide a physical demonstration of empathy to the other (see Sandra’s quotes on pg. 147 and 148), indicating when the experience was reflected back it became about her and not the survivor.

Embodiment is not a concept to be overlooked within this research and is a good demonstration of how the conceptual framework of phenomenology can be applied to experience. It is in this situation that Toombs (1987) suggests clinicians (in this research, the nurse) may fail to address the issues of most concern to the patient because they do not appreciate the lived experience of the illness (the rape) and how it fully embodies the patient (survivor). This supports previous discussion that suggests nurses are unequipped

and unaware of how to respond to disclosure of SA due to a lack of understanding of their own needs.

As mentioned previously, this study identifies the experience of disclosure as one of embodiment affected by empathy. Another example of this is the use of the body for information gathering (by the nurse) without consequence for the mind (causing the survivors to re-live the trauma). Nurse participants described history taking, reporting to the police (for further information gathering because of this attack on the body) and forensic testing as essential tasks within their role following disclosure (see pg. 155-157). It is here within this context nurses first described that their engagement in turning away from their emotions (empathy) was essential to see these tasks through. In doing so, this results in not acknowledging the survivors as an embodied other, as they are reduced to focusing on instrumental functions and focusing on only the physical aspects of their role responsibilities. Again, this further demonstrates the nurses' lack of understanding of the survivors' needs during and following disclosures of SA.

7.5 Implications for nursing practice

The consequences of rape are troubling, specifically considering how many individuals may have experienced it. Therefore, as a nurse, it is essential to be not only be aware of these consequences, but to also have an understanding of how to explore them in a safe and supportive way that allows the survivor to feel listened to and supported. This study has demonstrated that this does not always happen, and this has implications on both the survivor's experience and nursing practice.

7.5.1 Implications for the survivor

Survivors of rape use their own coping mechanisms to live through the aftermath of their experience. This is not a new finding (Burgess and Holmstrom, 1979), however it is a consistent one in both male and female survivors (Widanaralalage, 2022; Sharma and Moten, 2022). Thus, in 40 years this process of self-support and self-coping prior to seeking formal support has not changed. This indicates that rather than accessing support via health services, there is still a notion of 'getting on with it' for people who have been raped. This is disappointing evidence as there is greater awareness and more services focusing on supporting the needs of survivors of sexual assault/violence than ever before. Therefore, it is concerning to find that survivors continue to bury or hide their experience as a first

reaction, rather than access health services for support. Literature explored in Chapter 2 has already highlighted that those who access services sooner will have fewer health impacts following an experience of SA. Clearly healthcare providers need to undertake more work to ensure those that have experienced SA are aware of where to access support. The first step would be to ensure healthcare professionals are appropriately educated and resourced to facilitate disclosure and its sequalae. However, an essential component to this is further research at a national level to determine ways in which services can externally demonstrate their accessibility and foster a culture of trust, support, and confidence.

Social and emotional factors inhibit communication in interpersonal situations when survivors do disclose SA. Survivors must be greeted and supported by nurses who are aware of the emotional challenge survivors experience. If not, the practitioner runs the risk of exacerbating detrimental coping mechanisms the survivors may have adopted. This study contributes to the discourse that SA is likely to be associated with alcohol and substance abuse (Kilpatrick, 2001) and leads to PTS (Scott *et al.,* 2015; Tolin and Foa, 2008). Studies have found that experiencing a SA significantly increases levels of depression, anxiety, suicidal ideation, and behaviour among survivors (Carey *et al.,* 2018; McDougall *et al.,* 2019; Bryan *et al.,* 2015; Chang et al., 2019; Dworkin, 2008; Ullman, 2004; Ullman & Nadjowski, 2009). PTS is a serious health condition that includes symptoms of recurrent and involuntary memories of the traumatic event, dissociation, negative changes to mood, feelings of detachment or estrangement from other people, hypervigilance, sleep disturbance, and problems with concentration (Dworkin *et al.,* 2017). This response is a natural consequence of trauma, and is also associated with greater functional impairment in social relationships and job performance, as well as increased use of healthcare services, nurses need to be able to recognise this impact. Sareen *et al.,* (2007) found that people diagnosed with PTS often experience higher levels of cancer, chronic pain, and gastrointestinal, cardiovascular, and respiratory disease. Also, in the longer term, male and female victims of sexual assault were found to have higher rates of cholesterol, heart disease, and stroke compared to non-victims (Smith and Breiding, 2011). In a meta-analysis of 290 articles, Tolin and Foa (2008) found people who experienced SA were more likely to experience symptoms of PTS than any other form of trauma, stressing the need for nurses, and other healthcare professionals to be acutely aware of the indicators and implications trauma has on health and wellbeing from an embodied perspective.

Health services in the UK pride themself on being open and trusted public services (NHS England 2022), however, this message is not reaching survivors of SA. This study, and statistics demonstrated in chapter 2, has indicated a high number of survivors are not accessing health support therefore demonstrating a disconnect between health services being approachable to all, and what they actually provide when it comes to supporting survivors of SA. A way this gap in practice can be addressed is through the use of the

Theory of Planned Behaviour (TPB; Ajzen, 1985). The TPB is a cognitive theory that proposes individuals' decision to engage in specific behaviour (such as not accessing health services for support following SA) can be predicted, the intention is to capture motivational factors that influence these behaviours. The model's use is determined by three variables: **personal attitudes** (a personal attitude towards a particular behaviour – such as attitudes and prejudices towards SA) , **subjective norms** (the influence of the perception of others' view on the specific behaviour – for example, blame culture with regards to SA), and **perceived behavioural control** (the extent to which we believe we can control our behaviour, burying the rape experience, for example). The TPB would provide a framework for understanding why adults tend not to disclose their assault to healthcare services. The key component to the TPB model is largely focused on behavioural intent and often supports work around behaviour change with individuals to predict a wide range of behaviours that impact health. However, TPB is not without its limitations: it assumes that behaviour is a result of linear decision making and does not consider that this can both change over time, and be influenced by other viables such as fear, threat, mood or past experience, all variables described by participants in this study that are caused by stigma and contribute to disclosure barriers. Despite this, evidence continues to demonstrate that TPB over all is a successful model in explaining and predicting behaviour, specifically when stigma is attached (Nichols and Newhill, 2022; Kennedy and Prock, 2016). However, whilst it is important to recognise that using it for the process of improving access to services is not as common, it would contribute to providing a pragmatic insight into why SA survivors are not accessing services and give specific immediate outcomes that could drive change. From this grounding, services and strategic managers can continue to use the TBP process to examine the broader constructs (i.e., attitude toward the behaviour, subjective norm, and perceived behavioural control) that influence behaviour via intentions alongside other appropriate models such as stigma theory (Link and Phelan, 2001). This would contribute to understanding the internal stigmatisation and barriers survivors of SA face regarding disclosure in a healthcare setting.

If the NHS invested in undertaking this research, in partnership with survivors, across a range of services and geographical locations, a picture can begin to form on how to improve access. An understanding of why people do not come into healthcare services to disclose allows services to consider changes in their approaches, thus reducing serious health consequences.

Nurse participants in this study often referred to 'girls', and of the research studies that explore disclosure of rape and SA a large proportion are approached from a gendered direction, with most research focusing on women and girls. Although it has been, and

continues to be, acknowledged throughout this study that rape is a gendered crime, this societal assumption that rape victims are female and 'girls' could be contributing to the lack of men and older people coming forward to disclose. Anderson and Overby (2020) found good reliability for women's victimization acknowledgment but assessed an insufficient number of male participants to address the question. Additionally, most strategies that impact change in practice or high-profile cases that are highlighted in the media are focused on young women's' experiences, negating the voices of older survivors, men and those from more diverse backgrounds (HO, 2021). All crimes that are considered as sexual offences are prosecuted as part of the Crown Prosecution Service (CPS) Violence Against Women and Girls strategy (CPS, 2019), another factor that might detract men from coming forward to disclose. Assumptions regarding who may experience rape makes considerations of whether patients have experienced it less likely, again demonstrating an insight into the rape-myth assumptions that impact practice and academic discourse. Consequently, it is unclear whether rape acknowledgment is being explored in valid, reliable, or optimal ways, and this is one of the contributing factors that impacts the knowledge base a nurse will have when caring for survivors of SA.

7.5.2 Unacknowledged rape, miscommunication, and validation

Literature identifies that many individuals who have been raped are often 'hidden victims' in the sense that most suppress their experience and do not disclose to others (Koss, 1985; Ullman, 1996). This is also referred to in the literature as unacknowledged rape. However, upon exploring the literature there is a difference between the two that is not always clarified. Hidden rape was originally used to describe women who suppressed their experience to get on with their lives and to try to forget what had happened to them (this seldom works and often caused more psychological harm), whereas unacknowledged rape was a term coined to understand situations whereby an individual does not believe their encounter falls under the range of legal (or societal) definitions of what constitutes as rape (Koss, 1989). These experiences are often self-labelled by the individuals as miscommunication or bad sex. The exact prevalence of both issues is difficult to ascertain. However, it is suggested that more than 60% of people who experience rape do not identify that experience as rape (Wilson and Miller, 2016), which contributes to an understanding of why so few disclose. Of those non-labelled rape survivors, a large proportion choose to describe their assault as miscommunication (Littleton, Axsom and Grills-Taquechel, 2000). The term miscommunication is ambiguous, and research is unclear as to why this label is used so frequently and by so many survivors. To facilitate disclosures, nurses need to be aware of and understand the principles accounting for unacknowledged and miscommunicated rape, while simultaneously the legal boundaries of consent should be clear to the nurse.

Whilst survivors may be using the principles of unacknowledged rape and miscommunication to protect their future self, there is a clear recognition in the literature that unacknowledged rape is actually associated with higher levels of psychological distress in the long term (Littleton, 2004). It is suggested to be easier to consider miscommunication when the perpetrator is known to you, rather than a stereotypical stranger violent rape (Cleere and Lynn, 2013), where survivors reported greater interference from emotional problems, more negative emotions, and more alcohol use. However, Marx and Soler-Baillo (2005) found no differences in the levels of PTS symptoms reported by unacknowledged and acknowledged survivors. Similarly, Frazier and Seales (1997) had previously found no differences between the two groups in their overall psychological distress or their rating of the rape's stressfulness. Several recent studies have noted differences between acknowledged and unacknowledged survivors, such as differences in rape characteristics, mental health outcomes, and risk for sexual re-victimisation (Littleton, Layh and Rudolph, 2018; Wilson, Newins and White, 2018). Lipinski *et al.,* (2021) explored rape acknowledgement linked to PTS symptoms with 131 college women, and their study indicates that acknowledged rape was associated with significantly higher levels of PTS. This is possibly due to the rape-myth association that if rape is violent and forced then it is often acknowledged as rape (Littleton *et al.,* 2007; Rape Crisis, 2022). This is an area of rape culture that needs further exploration, specifically nurses' adherence to it. Whilst this disclosure is important to understand the impact of self-given labels to rape experiences, it is also acknowledged that these are self-given and, as already demonstrated, those titles can change based on how long ago the assault was, if there has been a change in the level of understanding of rape, and the impact of social support in guiding survivors in self-defining these experiences.

From the discussion above it is clear survivors grapple with self-defining their experiences of rape. Nurses' understanding of these terms and their implications is essential, as those who supress or hide their experiences are less likely to access formal support (Resnick *et al.,* 2011). It is demonstrated in this study that those who may have not acknowledged their rape as rape often do have an awareness of what has happened to them, but they don't want to admit it until they have it validated by a healthcare professional. As such, this allows the experience to become real and is then acknowledged, thus contributing to the process of *attending to*. This finding has numerous impacts on nursing that affect survivors. Firstly, it is important to understand the difference between the two terms when supporting survivors of rape, as they mean various things and identify different stages in the acceptance of their experience and, therefore, what support may be required. Secondly, validation is the survivor looking for belief, as they have an idea of what has happened to them, but otherwise would not be tentatively (or otherwise) exploring it with the nurse. As

such, they are looking for belief by testing the response to see if their experience will be believed, and thus empathy is validation and acceptance, and validation is belief. Survivors in this study indicated a sense of relief when a nurse confirmed their experience. This seemed to allow a sense of validation, and encouragement that demonstrated they had been believed. Affirmation from the nurse appears to be key to moving onto the next step of disclosure and acknowledging the experience, thus making it an essential aspect of experience the nurse needs to be aware of. When this confirmation does not happen and there is a thread of doubt demonstrated by the nurse, the anxiety surrounding the disclosure increases exponentially for the survivor and impacts not only on ongoing wellbeing, but also ongoing desire to access services and a lack of trust in those nurses. The anxiety surrounding this is aligned with there being no concrete foresight of this situation for the survivors, especially as all survivors in the research did not have a previous relationship with the nurse they disclosed to. Therefore they cannot forecast how an individual is going to respond to their disclosure. Up to this point the survivor lives in a perpetual state of anxiety and vulnerability about what this moment will become, and they are constantly looking to the future for hope of being believed and supported. Implications for nursing practice include an awareness of how this anxiety and trauma can impact communication and the decision-making skills of the survivors (Chivers-Wilson, 2006). After experiencing trauma, it is sometimes difficult to make decisions about what support you need, and it is the nurse's role to know this and foster a compassionate experience that is patient and understanding.

7.5.3 Relationship with the nurse

Survivors value empathy as one of the fundamental aspects of the therapeutic relationship when disclosing experiences of rape, and its widely associated with better health outcomes for the survivor (Moudatsou *et al.,* 2020). It is certainly clear from this research that survivors of rape associate empathy with a non-judgemental and supportive response to their disclosure. As mentioned above, there is often no previous relationship with the nurse, and therefore there is intentional searching for hope, empathy and belief, and that search is based on first impressions of the nurse. Whilst continuity of practitioner in any healthcare consultation has both positive (trust, consistency health knowledge) and negative (reliance) implications, in the case of SA disclosure, to know the person you are disclosing to would reduce the anxiety and stress of disclosure. However, whilst continuity of care was promoted vastly in the 2000s (Gulliford, Naithani and Morgan, 2006; Guthrie *et al.,* 2008;) it is impossible to offer this approach across contemporary NHS services due to resources, sickness and the impact of COVID-19, for example. Thus, whilst it is demonstrated that consistency of practice would benefit the rape survivor, it is not an adaption that could be implemented easily. However, the insight of this thesis demonstrates that whilst continuity

is concerned with familiarity, what the survivors are looking for is compassion. Practice improvement suggestions to ease anxiety include staff professional biographies and pictures in waiting rooms for service users (survivors) to explore whilst waiting, and up-to-date website data for departments with staff professional biographies. While this does not give an insight into compassion, it does allow an insight into the staff which might contribute to easing anxiety. Research to support this would need undertaken. Whilst there is a range of literature exploring anxiety in the emergency and surgical waiting rooms (Yoon and Sonneveld, 2010), it is difficult to acknowledge the transferability as the focus is anxiety around declining health and waiting times.

As already established, survivors of SA are looking for an empathetic, compassionate nurse. This study has found patients judge this prior to any face-to-face verbal communication. This includes a judgement that the appearance matches or informs the expectations of what they are looking for and, therefore, this emphasises that first impressions are often how service-users (patients, survivors) form opinions of the nurses that will be involved in their care. One of the important factors in doing this is identification of the healthcare professional as nurse, with the most obvious factor being uniform. Porr *et al.,* (2014) suggests that the identification of the nurse via their uniform has continued throughout generations, and is especially important within the first few moments of the nurse-patient encounter, with uniforms being the primary factor of assessing professionalism too. Perceived confidence and competence are a by-product of the nurse taking the time to present a professional appearance. Porr *et al.,* (2014) go on to suggest that their research indicates that a patient's first impression of the nurse is contingent on how the nurse looks. When exploring the research surrounding nursing appearance and professionalism, again, uniform is the most common association (Spragley and Francis, 2006; Smart and Creighton, 2022). Most findings have supported the nurse's use of uniform due to links with professional respect and patient satisfaction. However, there is a growing discourse that the uniform is an outdated symbolic gesture that not only causes a power imbalance impacting communication, but also is not needed in modern healthcare (Wills *et al.,* 2018). This is because nurses want to be recognized for their knowledge, competence, and experience, and a uniform can influence assumptions of the role of the nurse (Wills *et al.,* 2018), unlike medical colleagues who often do not have that barrier. Conversely, a healthcare staff survey by the NHS Chain Supply in 2021 found that 88% of nursing staff said a standardised uniform style for NHS clinical staff was favourable, and 91% agreed this would be beneficial to service users in recognising the role of their care givers (NHS Supply Chain, 2021). Their large sample rates of 50,710 responders justifies its generalisability, and therefore implication to practice, especially into nursing, as more than half respondents are from the nursing profession. It is essential that plans for adopting

generic uniform standardisation are aligned to a patient's need to identify their nurse as someone who is professional and competent (Magnum *et al.,*1997; Porr *et al.,* 2014; Wills *et al.,* 2018). In healthcare practice, patients' voice is key, and therefore if the ability of patients to identify a nurse from other healthcare professionals reduces anxiety for the service user, then uniform should be seen as an important part of a nurses professional approach. In this study, no differentiation of identification between healthcare workers added an element of anxiety, uncertainly, or a reduction of hope for survivors. As nursing is often associated with compassion and non-judgemental care, it could be argued that the search for a professional appearance is less about knowledge or specialist level, and more associated with compassion.

As survivors move forward following the assault, they begin to navigate their understanding of what this experience of rape means for them, in terms of disclosure. Practitioners can support those who have experienced rape in any healthcare interaction, and therefore there needs to be an understanding of how SA impacts an individual from a trauma perspective, and how those impacts determine health choices and service engagement.

7.5.4 Implications for nursing practice

Considering the discussion above, survivors must be greeted and supported by nurses who are aware of the emotional challenge survivors experience following a SA. If not, the practitioner runs the risk of exacerbating detrimental coping mechanisms the survivors may have adopted. In addition to this, the nurse must be aware of the emotional impact receiving a disclosure of SA will have on them directly.

Nurses have an immediate emotional reaction to disclosures of SA. Hockenbury and Hockenbury (2007) suggest that emotional reactions are a complex psychological state that have three distinct components: a subjective experience, a psychological response, and a behavioural or expressive response. Throughout this study it can be seen how these components affect the nurse and impact the rape disclosure experience. For example: **a subjective experience** - the nurse interprets the survivor's experience based on their understanding and concept of what rape is and is shocked whilst trying to empathise, and anxiety about supporting the survivor develops; **the psychological response** - the nurse feels anger, sadness, nausea; and **a behavioural or expressive response** - the nurse brackets their emotional feelings to carry out their tasks, they call the police to report the rape, or experience a desire to hug the survivor as an expressive response. The emotional impact of receiving rape disclosures for nurses is complex, and appropriate support and

resources are a big implication for future practice. Whilst during the disclosure there is a process of compartmentalising in order to undertake certain aspects of what they deem is their professional responsibility, this study shows that the feelings and empathy the nurse feels at the time do not leave end at with the consultation. Instead, they described the exact emotional feelings they experienced even years later, demonstrating the need for psychological support post-disclosure.

Empathy is often described as the ability to understand other people's feelings, and in relation to healthcare this has many dimensions, as previously discussed. Conceptually, empathy is difficult to define from nursing literature as often the terms empathy, compassion and sympathy are used and defined interchangeably. If you asked nurses to define each one separately you may find descriptions of the same act, specifically when focusing on SA. This is because the literature surrounding empathy in healthcare is generic as a nursing skill or attribute. Due to empathy being seen as an essential nursing skill and difficult to understand from a clinical perspective, many nurses draw upon personal experiences of what empathy is to influence their skill clinically. You see examples demonstrating this in this research from the nurse participants, as their descriptions of their emotions following receiving disclosures of rape are very much based on their own personal feeling of rape from a societal perspective (horrid, awful, anger, describing how the survivor must have felt). Empathy within nursing practice tends to be separated into cognitive or emotional empathy (Santo *et al.,* 2014). Cognitive empathy can be defined as taking the perspective of another person. In contrast, emotional empathy is often described as taking on the emotional experiences or feelings of another person. Fernandez and Zahavi (2021) suggest that both concepts can be trained in nurses. However, much of the literature indicates that emotional empathy is more intuitive and indicative of the role of the nurse (Hochchild, 1983). The main concern and implication to practice of this argument is that by producing an understanding and sharing the other's feelings/experiences nurses can become easily overwhelmed, and it is this type of empathy that is often associated with burnout, distress and compassion fatigue (Duarte, Pinto-Gouveia and Cruz, 2016; Moudatsou *et al.,* 2020; Fernandez and Zahavi, 2021). Santo *et al.,* (2014) found that when nurses successfully manage their emotions following interactions with patients that trigger empathy, they are more satisfied and engaged with their work, and therefore less likely to experience some of these negative affects emotional empathy can cause.

Xie *et al.,* (2021) undertook a meta-analysis of all literature pre-2020 that focused on compassion satisfaction, burnout and secondary trauma in nurses. They found that the research around this topic has increased year on from 2010, with 2019 described as the

highest level of compassion fatigue thus far, indicating this is a significant and growing issue for nurses. However, whilst there is an acceptance that the change in rapid economic pressures and population growth and increase in natural disasters contribute to this growth, there is no inclusion of COVID-19 and the impact a global pandemic has had on the nursing workforce around the world in this study. Therefore, the levels of stress and fatigue nurses (and other healthcare professionals) are experiencing due to secondary trauma from all of these factors and following the COVID-19 global pandemic are phenomenal. Nursing has been recognised as one of the highest stress careers, and is linked with depression, anxiety, and posttraumatic stress disorder (PTS), with more burnout than other professions (Dyrbye *et al.,* 2017).

The results of this discussion have implications for nurse education, practice and research, and health care policy. Compassion is high on the nursing agenda in the UK (Department of Health, 2012; NMC. 2018, Health Service Executive, 2016), and it is known that burnout is higher than it ever has been in the UK following the COVID pandemic. Therefore, it would be pertinent to ensure reducing this risk is aligned with this research. The relationship identified between empathy and burnout in this chapter indicates that neither should be addressed in isolation, and both are consequences for nurses receiving disclosures of SA with little knowledge and support. Healthcare organisations can work to provide appropriate education and training to their nurses in order to prepare them to receive disclosures of SA. Provision of a supportive environment where nurses feel able to discuss challenges (both practical and emotional), without risk of stigma, is essential to healthy empathic engagement, and this could be implemented with trauma-informed approaches, which will be discussed further in the next section. The discussion in this chapter suggests that an ability to self-regulate emotions during empathic engagement may be an important factor for nurses supporting disclosures of SA, and therefore survivors too.

The implications for practice of not focusing on nurses being able to self-regulate their emotional empathy and providing supportive psychological support indicate a nursing workforce that is on the brink of emotional exhaustion, and receiving disclosures of SA contributes to that exposure to trauma. Suicide rates in doctors have been decreasing following a more robust structure of support systems. The same cannot be demonstrated for nurses, with recent statistics indicating that nurses are 4 times as likely to take their own lives than people working in any other profession in the UK (NHS Employers, 2022). Solutions for this must include (as mentioned earlier) improved access to and regular psychological support that is integrated into nurses' roles, and not an additional extra that can be accessed if needed, as busy lives often cause a barrier to accessing support.

Essentially, the nursing workforce is one that is continuously exposed to trauma as an everyday aspect of their role, and receiving disclosures of SA adds to this trauma. The impact of secondary trauma on nurses following disclosures of SA is a gap in healthcare education and research that has not been fully explored.

7.5.5 Trauma-informed care and practice

This study identified that nurses can be exposed to disclosures of SA at any time. It is therefore essential that all nurses are prepared in how to respond to and support disclosure. It is clear from this research that, from a nurse perspective, there are gaps in knowledge and consequences of disclosures. Those are:

- Lack of awareness of how response impacts the survivors.

- Lack of awareness of role responsibilities when it comes to supporting survivors of SA.

- A lack of awareness of unconscious bias that contributes to rape myths and victim-blaming adherence.

- A clear emotional impact of supporting survivors on the nurse.

The implication of these outcomes in practice are vast, and they indicate that nurses need education and support to be able to respond appropriately to disclosures. It is clear from the findings discussed in this study that there is a need for nurses to be more informed when it comes to the implications of SA on survivors, both pre- and post-disclosure. Quadara (2015) suggests that being in the moment to fully support survivors of rape can only be undertaken by nurses being trauma-informed with their care and in their practice. The effects of being exposed to distressing or harmful circumstances or events results in trauma; therefore, trauma is the effect rather than the event (Isobel, 2006). For survivors of SA, the absence of nurses being trauma informed results in fragmented services and re-traumatisation (Dworkin and Schumacher, 2016). Being trauma informed puts the full focus towards the experience and needs of the survivor. In fact, research increasingly is suggesting that all healthcare professionals need to be providing trauma-informed care in order to make any impact on improving health outcomes, specifically surrounding public health implications (The Kings Fund, 2019). Sweeney and Tagart (2018) state that whilst there is international interest, trauma-informed approaches can be complex to embed in services, with a lack of understanding often causing most services to suggest they are already trauma-informed. However, they do recognise that true trauma-informed approaches can potentially lead to a fundamental shift on how services (mental health support) are organised and delivered, a thread that has been supported by the NHS Long Term plan (2019). There is an argument in this thesis for all nurses to be trauma-informed, considering not only the percentage of the population with mental health diagnoses but also

those with health conditions which were contributed to by indicators resulting from trauma exposure.

Trauma-informed care and practice comes from the development of research that identified the more adverse events people are exposed to, the greater negative impact they will have on all health outcomes. Its approach is underpinned by strengths-based principles and grounded in an understanding of the impact trauma has on the individual, and involves creating opportunities for people to become empowered in order to rebuild their sense of personal control (Hopper, Bassuk, and Olivet, 2010). The key principle of trauma informed approaches can be found in appendices 12.

Many mental and physical illnesses and general emotional distress are now thought to be associated with unprocessed traumatic experiences (Felitti and Anda 1997; Anda *et al.,* 2010). The goal of trauma-informed care is also to avoid re-traumatising someone (Quandara, 2015). Re-traumatising can be described as inadvertently re-creating some conditions or memories of previous trauma that cause an individual to relive the traumatic experience in that moment. An implication for practice that has come from this study is the lack of awareness nurses have to trauma-informed care when supporting survivors of SA. It is clear in the findings of this study that nurses are inadvertently having the survivors relive their trauma at different stages of the disclosure. The benefits of a trauma-informed workforce are exponentially better than not when considering the implications of poor support, both in terms of the survivors health and wellbeing, and the cost to the NHS.

NHS (2018) published a ‘radial’ strategic direction for sexual assault and abuse services with an aim on lifelong care for victims and survivors. This document emphasised the importance of having a trauma-informed workforce. Unfortunately the focus of their strategic aims are on specialist services, such as those that carry out medical and forensic examinations and practical and emotional support (counselling and voluntary organisations that provide emotional support) services. This study highlighted that those services tend not to be where a survivor first discloses their assault, the study also emphasises that the response of the first person disclosed to is key in further engagement with services. Therefore, this radical strategic document fails to recognise that, whilst the services they identify are important, the general healthcare staff that work outside of these environments are essentially key to providing best immediate support to survivors and will go on to encourage engagement in those specialist areas. This demonstrates a big disconnect in

who the policy leaders are aiming their approaches and resources toward. This lack of insight has implication for both survivors and nurses.

Trauma informed approaches are having a moment of positive research and literature noting of its benefit, the police in the UK are being educated at their basic entry level of training to be trauma informed. This is mainly because of the amount of contact they have with people that have mental health issues however, it could be argued that the majority of patients adult field nurses come into contact with also have mental health issues and nearly all will have experienced trauma to some degree. Therefore there should be consistent in our approaches to education for first responders and public service providers.

Individual practitioners can implement trauma-informed care and practice, even where they do not work in trauma-informed organisations (see Sweeney *et al.,* 2019), however, research indicates that to undertake this approach in the most appropriate way, change is required at a cultural and strategic level, not just an organisational one (Sweeney *et al.,* 2016; Harris & Fallot, 2001). Despite the statutory requirement to ask about experiences of trauma and abuse, reported rates of asking are low (Xiao *et al.,* 2016) this finding is reflected in chapter 2 with research indicating practitioners often do not screen for SA experiences. It may be that nurses struggle to talk about trauma in general, rather than just SA, and worry that asking about difficult, distressing, and dangerous events may overwhelm both them and service users. This area of practice needs further research to fully explore the barriers.

7.5.6 Rape myths and victim-blaming adherence

Overall findings from this study indicate that nurses are engaging in rape-myth and victim blaming-adherence attitudes. These findings are identified from both the perspective of the survivor and the nurse. Staats and Patton (2013) define unconscious bias as adherence to stereotypes and cultural concepts that influence decisions and behaviours without realisation or intentional control. Subtle nuances in interpersonal interactions caused by unconscious bias can be perceived as a lack of provider concern (Hagiwara, Kashy, and Penner, 2014), and this has been identified by survivors in this study, therefore adding to the discourse. Unconscious bias affects patient trust and confidence, and results in decreased engagement in services. Worryingly, Chapman, Kaatz and Carnes (2013) found that unconscious bias tends to increase as nurses progress through their student education and into becoming a registered nurse. Further studies also indicate that healthcare providers are more likely to apply unconscious bias to patients when they feel overwhelmed, have limitations and experience stress (Teal *et al.,* 2012). The findings from this study

identify those nurses often feel overwhelmed and emotional after receiving disclosures of SA. This, on top of the usual daily stressors (personal and professional), such as staff shortages, patient demands and limited resources, indicates an environment that contributes to unconscious bias being adhered to. Schultz and Baker (2017) suggest the only way to tackle this adherence is constant exposure to challenging unconscious bias, at all levels of nursing education, and integrated into both academic and clinical settings, to make real change in mindsets and adherence. I would add that unconscious bias training needs further development to have more depth, and therefore add more insightfulness into other avenues of bias (such as rape myth and victim blaming adherence) other than a sole focus on the nine protected characteristics (Equality Act, 2010, NHS Staff Council, 2021).

To ensure best patient outcomes when supporting survivors of SA, unconscious bias associated with sexual violence needs to be recognised, challenged and reflected upon consistently. This requires educational strategies to incorporate the SV topic into equality, diversity and inclusion (EDI) training both in pre-registration education and healthcare mandatory/statutory training. This should include use of a supported space to challenge these assumptions, guided debriefing, and feedback and skills to reduce unconscious bias in clinical practice. However, this needs to be acknowledged from a trauma-informed perspective, as addressed previously. That said, this adherence cannot be changed unless there is an understanding of SA, particularly, what it is, what is means for the survivors, what the impacts are, how to support and where to signpost.

7.5.7 Implications for nurse education

Having nurses that are educated appropriately around the impact of trauma on behaviour, and trauma-informed care and practice to health support, will only improve barriers for service users accessing and engaging in support. Conversely, this would also allow nurses to feel more prepared to support survivors of rape. This study highlights that nurses do feel trepidation when an individual discloses rape. However, to implement trauma-informed approaches would take both integration into pre- and post-registration education and NHS organisations to provide education and training on the subject for others who work in healthcare. The impact of poor mental health in contributing to decline in physical health has been identified as a largely concerning factor in health practice (Prince *et al.,* 2007), yet there has been little integration of awareness of trauma on mental health support/indicators into mainstream adult nurse education. Therefore, the hope of a trauma-informed approach being adopted is low. Mental health problems represent the largest single cause of disability in the UK (NHS England, 2021), and the lack of insight into ensuring all nurses have an appropriate level of mental health education is astonishing. Light touch approaches do not

provide adequate levels of foundation knowledge for nurses not specifically studying mental health nursing. Normalising mental health and the impact on physical health in the adult nursing curriculum will contribute to challenging the discrimination people with mental health problems face.

Integrating trauma-informed approaches into nurse education and applying them to practice could potentially reduce the incidence of mental health issues on a monumental scale, especially when considering all types of trauma, not just sexual violence. Future research would benefit from an in-depth exploration of adult nurses' experiences of supporting those with mental health issues in practice, alongside how prepared they feel about integrating their mental health needs with their physical wellbeing. There is a focus on nurses providing holistic person-centred care. Holism in healthcare is often described as meeting an individual's physical, psychological, and social needs (Dossey and Keegan, 2008), however due to limitations of services and resources this is often unachievable, specifically the inclusion of social needs in its definition. It could be argued that being trauma-informed is more aligned with person-centredness, which is rapidly taking over holism in the overarching approach to patient care in nursing practice. It can be defined as an approach to care that is concerned with building mutual trust and understanding, treating people as individuals and respecting their rights with an emphasis on building the therapeutic relationship (McCormack and McCance, 2010). Person-centredness essentially has the same approaches to its framework as trauma-informed care. The implication of this on nurse education is a re-haul of some of the education around the fundamental aspects of nurse education, specifically replacing holism with an underpinning fundamental focus on trauma informed care and practice that is person-centred at its core.

There are many ways this can be incorporated into nurse education, one of which is to ensure the curriculum and support for students is trauma-informed to fully encompass the approach. The other is in its teaching with a range of practice-based learning scenarios alongside the use of low fidelity simulation, for example using scenarios within a simulated real-world environment to give a sense of reality. This then emphasises the use of peer support and safe environment learning with practical decision making and managing challenges which may occur when in clinical practice (Khan, Pattison, and Sherwood, 2011; Parker and Myrick, 2012; Ricketts, 2011). Krautscheid (2017) described the importance of simulation is to provide a psychologically supportive environment where teaching staff use deconstruction and simulation on students' performance to facilitate learning in a safe environment. This is also where biases could be explored and challenged. Simulation offers a reflexive approach to learning that will prepare students for managing complex clinical

practice that cannot always be prepared for outside of simulation, such as emotionally difficult situations like disclosures of SA, thus improving experiences for survivors. The NMC recognise this and have recently validated higher education institutions to provide up to 600 hours of simulated practice into their nursing programmes (NMC, 2021). However, Dieckmann *et al.,* (2012) suggests barriers to simulation can be difficult to overcome in education, these include: a lack of willingness to actively engage, not taking the role play seriously, alongside the risk of re-traumatising people who may have experienced the trauma being explored, this is specifically pertinent to SA. Emphasising the need for educational staff to be trained appropriately in simulated education and to be trauma informed.

7.5,8 Key points for recommendations to practice, policy and research

As this section draws to a close the following list is a summary of the key points highlighting the implications for nursing practice, policy and research:

- Promote the implementation of trauma-informed approaches to be integrated into pre and post-registration education
- Promote the implementation of higher education institutions providing nurse education and support within a trauma informed institution and curriculum, supporting students in order to align with trauma-informed approaches.
- Burnout is a consequence of empathic and compassionate practice. Receiving disclosures of SA challenges those empathetic and compassionate responses. Therefore, receiving disclosures of SA contributes to clinical burnout. Nurses need to be supported to understand and manage the emotional impacts of empathy to acquire well-developed cognitive empathy that includes self-regulation of emotions, thus reducing incidences of clinical burnout
- Healthcare organisations, policy makers, and educators should address the need for education in sexual violence of adults, for all healthcare students and staff.
- Nurses engage in rape-myth and victim-blaming adherence, this leads to bias and should be explored and challenged as part of education in trauma-informed approaches
- Survivors of SA are being referred to the police inappropriately and without consultation, contributing to negative implications on health and reduced trust of services. This behaviour could be addressed through education in sexual assault and rape in adults, and the introduction of trauma-informed approaches in pre- and post-registration nurse education
- The impact of secondary trauma on adult general nurses needs further exploration in the UK

- Simulation in nurse education should also focus ethical dilemmas and sensitive topics

7.6 Original contribution to knowledge

By attempting to answer the research questions this thesis has provided a breadth of new knowledge that has the potential to improve the experiences of both survivors and nurses when it comes to disclosing SA. Methodologically, using descriptive phenomenology has allowed for an in-depth exploration of the *lived* experience of disclosure in this context. The intention was to use descriptive phenomenology because it has, at its core, the philosophical intent to have an enhanced way to explore the lived experience, therefore, the potential to capture the individualised and unique nature of human experience. in this study it has done this by recognising and illuminating the nuances of participants' experience, rather than the pre-conceived ideas of the researcher, demonstrating that descriptive phenomenology provides a valid and important contribution to nursing research.

There are no other studies that have explored in depth the experience of disclosing rape to nurses, from both the perspective of the nurse and the survivors. Whilst this study confirmed some of the consequences of rape and SA discourse from other facets (e.g., adherence to rape myths and victim blaming attitudes / concern about confidentiality, self-blame and what the future may hold because of disclosing), it demonstrates that these are also factors that impact disclosure in the healthcare setting, and this is what is unique about this study of the lived experience.

This research has highlighted that survivors often feel silenced following disclosure to a nurse, and whilst the research establishes that this is not intentional behaviour from the nurse, it is a consequence of lack of understanding of the needs of survivors. This is a result of the repetitive nature of assessments and referring survivors on to other nurses or healthcare staff who ask the same questions, leading to the survivor re-living the experience. It can also be seen with the nurses' use of compartmentalising emotions; survivors see this shift in approach to the disclosure as silencing or dismissive. These are examples of healthcare work that are unhelpful and often unnecessary for adult survivors of SA.

When considering the nurse's role in healthcare there is a focus on compassion, empathy, non-judgemental care, and safeguarding people, this research identified gaps in this practice when supporting disclosures of SA identifying areas of nursing practice that clearly need further exploration if we are to truly support survivors from a person-centred perspective. This gap in practice is largely the result of nurses shifting their paradigms of

practice across multiple realities during the disclosure, in that their focus is shifting continuously between the present (the immediate disclosure) and the future (what happens next, what will come of this disclosure, preparing for what 'might' happen). Whilst these are important concerns, they exist at the detriment of being in the moment with the survivor and focusing on their needs. However, it is clear that this temporal nature of disclosure is also being experienced by the survivors as they are concerned with future and the consequence of their disclosure, whilst recognising they will always be labelled as a survivors of SV, a label they try to avoid by burying the experience post assault and pre disclosure.

Survivors describe how experiencing rape embodies them fully, because of how this makes them feel they want their experience of disclosure to be supportive and non-judgemental. This research identifies nurse's adherence to rape myths and victim-blaming approaches not only cause the survivor to feel silenced, thus resulting in barriers to disclosure, but also hinders the therapeutic relationship, and this could consequently cause survivors to disengage in services, now and in the future. There clearly needs to be an introduction of sexual violence in pre- and post-registration education focusing on the implications on BOTH the survivors and the nurse, via trauma-informed approaches to care and practice. Survivors are never not survivors, the experience (and label) is always with them, nurses need to understand how this experience fully embodies the survivor.

When considering safeguarding cases (which some types of sexual violence fall into), nurses have very specific guidance and policies they need to adhere to. However, this study has identified in the case of rape in adults, whilst safeguarding must be explored, it is not the immediate path to follow should no risk be identified. Adults (unless at risk of further severe harm) are entitled to contribute to the decision making as to whether their disclosure is reported to safeguarding teams and/or the police, this study has demonstrated this approach to patient care and support is not happening. This is an important find and is a consequence to lack of confidence and knowledge from nurses surrounding this topic. An awareness of this needs to be highlighted in any education moving forward.

NHS organisations need to explore their safeguarding policies to incorporate guidance for staff on how to support adult survivors of sexual violence. This will contribute to providing nurses with a supportive framework in order to provide care. There is clear evidence that disclosure of all types of sexual violence are on the rise, and thus nurses need to be prepared for this, just as they are with child sexual exploitation and other forms of sexual violence. Education around SV should not be a this-or-that focused educational path. All types of sexual violence, including rape, sexual assault and harassment, need to be taught alongside other types of abuse. This study demonstrates that nurses' responses to

disclosure have an unimaginable impact of survivors, and this needs to be taken very seriously and ingrained in public health and preventative health education.

This research has contributed and moved forward a discussion into how we define, educate, and encourage the use of empathy in practice. This skill is essential to providing compassionate and non-judgemental care, however, there needs to be an awareness of the impact it has on the nurse if not carried out appropriately. This, with the possibility of the nurse having experienced sexual assault themselves (considering that 1:4 women have, and the high female population of the workforce means this is likely, exposing staff to secondary trauma) contributes to the significant emotional impact rape disclosures have on nurses, both in the short and long term.

7.6.1 Limitations of the research

As with all studies there are strengths and limitations to this research. Therefore, in order to establish research credibility and trustworthiness alongside being transparent, it is important that potential limitations are acknowledged.

This research is unique in many ways. One way is the in-depth exploration of the lived experiences of nurses receiving disclosures of SA. However, a further insight into these experiences may have benefited from some background data from the nurse. For example, if they had experienced SA personally and whether their experiences may have impacted the support they gave. It is also recognised this study does not include voices from marginalised communities.

Several limitations were encountered as a single researcher working alone, rather than attached to a team. Although supervision was available and provided much-needed insights and guidance, the sole nature of the PhD journey was, at times, emotionally challenging, particularly considering the topic. Throughout, I feel I have maintained a reflexive position (and expressed this through the thesis). However, these reflections alone do not negate the impact to my emotional resilience and working as part of a team may have assisted in easing these emotions when they became overwhelming.

It is acknowledged that there are many interpretations of lived experience, meaning, and knowing, and it is accepted that the findings in this study are my analyses of the participants' interpretations and descriptions of their own experiences. Using descriptive phenomenology allowed for a bracketing of my pre-understandings, professional beliefs,

and experiences. However, these have also been acknowledged from the outset in order to ensure transparency and credibly of the descriptive research process to enable the reader to make a judgement of the rigour of this process.

7.6.2 Current impact of research

The implications of this study have already begun to make an impact on nursing practice and nurse education. The list below shows an insight into some of these impacts that are active:

- (unfunded) Quantitative study exploring rape myths and victim-blaming adherence with student healthcare professionals (data is currently being analysed).
- (unfunded) Quantitative study exploring rape myth and victim-blaming adherence with NHS healthcare professionals (ethical approval submitted Sept 2022).
- Freedom of information study exploring incidences of sexual violence on NHS property, and perpetrated by staff, patients, visitors or contract workers against staff, patients or visitors (ethical approval submitted Oct 2022) to examine the extend of this.
- Book contract with Routledge/Taylor *'A Guide to Support Healthcare Staff in Supporting Survivors of Sexual Violence'*. Currently writing, deadline 5th Dec, due to be published Spring 2023.
- Award for funding to provide (with colleagues) a conference for students studying healthcare programmes at Northumbria University: Supporting survivors of sexual violence as a healthcare student (undertook June 2020).
- Request to present research findings at the National HIV Nurses Association annual conference 2023.
- Due to the implications of these findings, the following postgraduate courses / module have been validated and approved to start running academic year 22/23:
    - 20 credit modules at level 6&7: 'Supporting Survivors of Sexual Violence' (part of the health and social care programmes pathway) – Starts Oct 2022.
    - Masterclass: 'Supporting Survivors of Sexual Violence' (accessible for all healthcare, social care and education workers) Started June 2020.
    - Masterclass: 'Trauma-Informed Approaches for Healthcare Workers – to commence Spring 2023.
- Request from other higher educational institutions to identify where sexual violence education can be incorporated into their pre-registration nurse education.
- Awarded £5000 funding via the Vice Chancellors equality, diversity and inclusion fund (with colleagues) to address Gendered Based Violence with college campus via a series of talks, workshops, guest speakers, and arranging a 'Northumbria

Against Sexual Violence' initiative. Also, to arrange for those engaged in the initiative to become interpersonal abuse peer champions trained by a regional domestic abuse charity organisation. We have aided these students into turning the initiative into an official university society

- Involved in the pilot scheme, set up, and training all Northumbria University staff can access in order to be first responders in the event students disclose sexual violence

7.6.3 Dissemination of findings

Dissemination of study findings is an essential part of any research practice. I have already disseminated at a range of conferences and will continue to do so.

- 8.7. 2022 Sigma Global Nursing Excellence: Phi Mu Chapter conference. Innovation, Sustainability and diversity: the role of nurse leadership. Oxford Brookes University (speaker)
- 23.7.2018 Centre for Research on Families, Life-course and Generations an Centre for Interdisciplinary Gender Studies. Postgraduate conference and workshop – After #metoo: where next? (speaker)
- 14-16.6.2017 Interpersonal Violence Interventions conference, University of Jyvaskyla, Finland (poster presentation)

Dissemination will also take place in the form of publishing in peer reviewed journals and with the submission of the textbook mentioned in 7.6.2 section above. I also plan to present the findings with relevant stakeholders from health organisations. Alongside this the findings will be shared with the participants of this study.

7.6.4 Future potential research from gaps identified in the literature

The outcome of discussions in both the literature review (chapter 2) and this chapter has highlighted key gaps in research. Identification of these gaps opens a route to post-doctoral studies. The undertaking of this research would further contribute to understanding and improving services for survivors of SA and providing support for nurses and healthcare staff that may be receiving disclosures of SA.

- Exploration into rape and sexual harassment myths and victim-blaming assumptions adherence levels in healthcare workforce and healthcare pre-registration students.
- Scale of sexual violence on NHS property (on staff and service users / perpetrated by staff, contractors and/or service users) A FOI request.
- Exploration of experience of marginalised people accessing healthcare support for experiences of SA

- In-depth exploration into survivors' experiences disclosing SA to healthcare providers and their journey through healthcare systems following disclosure. As above marginalized groups need specific focus to gain understanding. A wider range of participants with regards to age and socio-economic background would contribute to this research
- Sickness levels of healthcare staff who have experienced high levels of supporting survivors of SA or complex safeguarding issues, in relation to exploring a link between role, empathy and compassion fatigue / burnout
- Exploration into the opportunities nurses have to access psychological support and clinical supervision as an integrated part of their role
- Male experiences of disclosing SA to healthcare staff
- Future qualitative research would allow for an in-depth exploration of how survivors assigned their label (acknowledged / miscommunication), if this has changed over time, and how they feel this reflects their experience in accessing formal support. A wider range of participants with regards to age and socio-economic background would benefit in contributing to this research
- Exploration of exploring the impact researching SV has on researchers

Academic institutions are well placed to undertake such research in partnership with healthcare providers and service users to design and recruit to such studies.

7.7 Reflexivity as a researcher

Undertaking this research has been one of the most challenging events in my professional role. I came into this PhD with very little knowledge around philosophy or experience in undertaking research. One of the most difficult aspects for me has been understanding and aligning with philosophical theory. Learning about phenomenology has been intense, in fact there was time I was unsure I could complete the study because of the challenges I faced. Persistence paid off; however, I have been left with a lack of understanding as to why philosophy is not integrated into the first year of nurse education. I am now acutely aware of being-in-the-world and how we live in our natural attitude. The way we live in the word and the other is so integral to the choices we make about our health and communication; I believe an understanding of this would give nurses the insight to really consider how they provide care for individuals and should not be taught only when deciding in which methodological approach to use when undertaking a piece of research. I still see myself as a novice in the realm of philosophy, exploring it further (and its place in healthcare education) is something I wish to persuade following achievement of this PhD.

7.8 In conclusion

The research approach of descriptive phenomenology which underpins this enquiry is consistent with the philosophy of valuing and empowering survivors. Giorgi argues that *'the researcher may know theories and the literature, but he or she does not know the relevant dimensions of the concrete experience being reported by a participant'* (Giorgi, 2006). This quotation is considered to be directly relevant to the context of this thesis, as whilst I have extensive experience of receiving disclosures of SA it is limited to one clinical area – sexual health. To understand the wider context of nurses receiving disclosure of SA it has been essential to explore nurses' and survivors' experiences, as one group's experience cannot be improved without understanding the other. Whilst the nurse's experience is essential to understand and could have been the sole focus of this study, it was important to me that the survivor's experience should be recognised and valued. In fact, this should be the case not only in this research but in the healthcare setting, in order to improve support given to both survivors and nurses.

In conclusion, this research has provided a unique insight into the implications a SA disclosure has on a nurse, alongside the complex emotions a survivor feels throughout their disclosure experience. Interestingly, both sets of participants have demonstrated overwhelming emotional implications of the disclosure and an adherence to rape myths and victim-blaming assumptions. Whilst those aspects of disclosure are not new in the wider context of rape, it is essentially a new insight into experiences in accessing healthcare support. Additionally, it has made abundantly clear that, whilst there is a policy-driven focus to support survivors of SA seeking aid from healthcare staff, nurse education and support is lacking any investment or action when it comes to SA trauma. Many of the findings in the research identify the need for nurses to be trauma-informed, and the new knowledge generated highlights the impact disclosure has on nurses, even years later. Without educating and supporting nurses to be able to appropriately respond to and manage those who have experienced trauma (all trauma, not just those who have experienced SA), there is significant risk to the wellbeing of the nurse, and thus implications on patient safety and burnout. As such, healthcare organisations should take steps to prioritise these findings and begin to embed trauma-informed care and practice. Additionally, higher education establishments also need to take note of not only embedding this into undergraduate curriculum, but also acknowledging students are also exposed to trauma. Therefore, approaches to students in academic settings also need to be trauma-informed, and only by setting the example can the approach be all encompassing and entrenched, just as holism, person-centred approaches and reflective practice have been.

For those who encounter SA survivors in a professional context, there must be an appreciation that surviving SA is a life-long journey for most people. Symptoms and effects of that survival may reveal themself at any time, requiring appropriate trauma-informed intervention and treatment, as well as appropriate compassion, understanding and, most importantly, belief.

Appendices

Appendix 1: Grey literature search

Grey Literature search strategy:

It is identified in chapter 2 that grey literature exists in this thesis by identification of wider professional, charitable organisations, newspaper articles (that were often based on published research) and government publications. When beginning this thesis search terms used for the literature review was also used in search engines such as google and google scholar. These include:

- "Sexual assault disclosure in healthcare"
- "Rape disclosure in healthcare"
- "Sexual assault disclosure management in healthcare"
- "Rape disclosure management in healthcare"
- "Nurses management of sexual assault disclosures"
- "Nurses management of rape disclosures"
- "Disclosing rape to nurses"
- "Disclosing sexual assault to nurses"
- "Experience of nurses receiving sexual assault disclosures"
- "Experience of nurses receiving rape disclosures"
- "Sexual assault disclosure management"
- "Rape disclosure management"
- "Management of rape"
- "Management of sexual assault"
- "Sexual assault management"
- "Supporting survivors of sexual assault"
- "Supporting survivors of rape"
- "Rape management"

Much of this grey literature is focused on: violence against woman and girls (VAWG), Interpersonal Violence, intimate partner violence, sexual violence disclosure in mental health inpatient environment, disclosure in a forensic setting (i.e sexual assault referral centre) and statistics around sexual offences. It also includes guidance around supporting survivors post disclosure, rather than during disclosure, within an adult nurse setting.

Appendix 2: Literature review articles from original search

Themes 1: Disclosures of Sexual Assault

Ahrens, E, C., Stansell, J. and Jennings, A,. (2010) 'To Tell or Not to Tell: The Impact of Disclosure on Sexual Assault Survivors' Recovery', *Violence and Victims*, 25(5) pp. 631-648

Allen, T, C., Ridgeway, R. and Swan S, C. (2005) 'College Students' Belief Regarding Help Seeking for Male and Female Sexual Assault Survivors: Even Less Support for Male Survivors', Journal of Aggression, *Maltreatment and Trauma,* 24 () pp.102-115

Campbell, R., Jovorka, M., Gregory, K., Vollinger, L, and Wenjuan, M. (2021) 'The Right to Say No: Why Adult Sexual Assault Patients Decline Medical Forensic Examinations and Sexual Assault Kit Evidence' *Journal of Forensic Nursing,* 17(1) pp. 3-13

Clay-Warner, J. and McMahon, J. (2009) 'Rape Reporting: "Classic Rape and the Behaviour of Law"', *Violence and Victims*, 24(6) pp. 723-743

Du Mont, J., Kosa, D., Macdonald, S., Benoit, A. and Forte, T. (2017). 'A Comparison of Indigenous and Non-Indigenous Survivors of Sexual Assault and Their Receipt of Satisfaction with Specialised Health Care Services', *PLoS ONE* 12(11) pp. 1-15

Dunn, P, C., Vail-Smith, K. and Knight, S, M. (1999) ' What Date/Acquaintance Rape Victims Tell Others: A Study of College Students Recipients of Disclosure', Journal of *American College Health*, 47(5) pp. 1-9

Dworkin, R, E. and Allen, N. (2018) 'Correlates of Disclosure Cessation After Sexual Assault' *Violence Against Women*, 24(1) pp. 85-100

Hakimi D., Bryant-Davis, T., Ullman, S, and Gobin, R, L. (2018) 'Relationship Between Negative Social Reactions to Sexual Assault Disclosure and Mental Health Outcomes of Black and White Female Survivors' *Psychological Trauma: Theory, Research, practice and Psychology*, 10(3) pp. 270-275

Hunter, B, A., Robison, E. and Leonard, A, J. (2012) ' Characteristics of Sexual Assault and Disclosure Among Women in Substance Abuse Recovery Homes', *Journal of Interpersonal Violence,* 27(13) pp. 2627-2644

Huong, T, N. (2012) 'Rape Disclosure: The Interplay of Gender, Culture and Kinship in Contemporary Vietnam', *Culture, Health and Sexuality,* 14 (1) pp. 39-52

Jacques-Tiura, A, J., Tkatch, R,. Abbey, A. and Wegner, R. (2010) 'Disclosure of Sexual Assault: Characteristics and Implications for Posttraumatic Stress Symptoms Among African American and Caucasian Survivors', *Journal of Trauma and Dissociation*, 11(2) pp. 174-192

Lindquist, H, C., Crosby, C, M., Barrick, K., Krebs, C, P. and Settles-Reaves, B. (2016) 'Disclosure of Sexual Assault Experiences Among Undergraduate Women at Historically Black Colleges and Universities (HBCUs)', *Journal of American College Health*, 64(6) pp. 469-480

Munro-Kramer, l, M,. Dulin, C, A. and Gaither, C., (2017) 'What Survivors Want: Understanding the Needs of Sexual Assault Survivors', *Journal of American College Health,* 65 (5) pp. 297-305

Paul, L, A,. Walsh, K,. McCauley,. Ruggiero., Resnick, D, G. (2014) 'Characteristics and Life Experiences Associated with receiving a Rape Disclosure Within a National

Telephone Household Probability Sample of Women', *Journal of Community Psychology*, 42(5) pp. 583-592

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Appendix 3: Common rape myths

Rape Myths:

Myth: Women are most likely to be raped outside, after dark and by a stranger, so women shouldn't go out alone at night.

Fact: *Only around 10% of rapes are committed by 'strangers'. Around 90% of rapes are committed by known men, and often by someone who the survivor has previously trusted or even loved. People are raped in their homes, their workplaces and other settings where they have previously felt safe. Rapists can be friends, colleagues, clients, neighbours, family members, partners or exes. Risk of rape shouldn't be used as an excuse to control women's movements and restrict their rights and freedom.*

Myth: Only young, 'attractive' women and girls, who are flirtatious and wear tight clothes, are raped.

Fact*: People of all ages and appearances, and of all classes, cultures, abilities, genders, sexualities, races and religions, are raped. Rape is an act of violence and control; the perceived 'attractiveness' of a victim has very little to do with it. There is no excuse or mitigation for sexual violence and it is never the victim/survivor's fault. What someone was wearing when they were raped or how they behave is irrelevant.*

Myth: When it comes to sex, women and girls sometimes 'play hard to get' and say 'no' when they really mean 'yes'.

Fact: *Everyone has the legal right to say 'no' to sex and to change their mind about having sex at any point of sexual contact; if the other person doesn't stop, they are committing sexual assault or rape. When it comes to sex, we must respect the wishes of our sexual partner and believe what they tell us about what they do and don't want.*

Myth: If two people have had sex with each other before, it's always OK to have sex again.

Fact: *If a person is in a relationship with someone or has had sex with them before, this does not mean that they cannot be sexually assaulted or raped by that person. Consent must be given and received every time two people engage in sexual contact. It is important to check in with our sexual partners and make sure that anything sexual that happens between us is what we both want, every time.*

Myth: Alcohol, drugs, stress or depression can turn people into rapists.

Fact: *Drugs and alcohol are never the cause of rape or sexual assault. It is the attacker who is committing the crime, not the drugs and/or alcohol. Likewise, stress and depression don't turn people into rapists or justify sexual violence. There are no excuses.*

Myth: Someone who has willingly drunk lots of alcohol or taken drugs shouldn't then complain about being raped.

Fact: *In law, consent must be fully and freely given by someone with the capacity to do so. If a person is unconscious or incapacitated by alcohol or drugs, they are unable to give their consent to sex. Having sex with a person who is incapacitated through alcohol or drugs is therefore rape. No-one asks or deserves to be raped or sexually assaulted; 100% of the responsibility lies with the perpetrator.*

Myth: It's only rape if someone is physically forced into sex and has the injuries to show for it.

Fact: *Sometimes people who are raped sustain internal and/or external injuries and sometimes they don't. Rapists will sometimes use weapons or threats of violence to prevent a physical struggle or sometimes they will take advantage of someone who isn't able to consent, because they are drunk or asleep for example. Many people who are sexually attacked are unable to move or speak from fear and shock. Just because someone doesn't have visible injuries doesn't mean they weren't raped.*

Myth: Men of certain races and backgrounds are more likely to commit sexual violence.

Fact: *There is no typical rapist. People who commit sexual violence come from every economic, ethnic, racial, age and social group.*

Myth: Once a man is sexually aroused he cannot help himself. He has to have sex.

Fact: *Men can quite easily control their urges to have sex; they do not need to rape someone to satisfy them. Rape is an act of violence and control, not sexual gratification.*

Myth: People often lie about being raped because they regret having sex with someone or out of spite or for attention.

Fact: *Disproportionate media focus on false rape allegations perpetuates the public perception that lying about sexual violence is common when in fact the opposite is true. False allegations of rape are very rare. The vast majority of survivors choose not to report to the police. One significant reason for this is the fear of not being believed.*

Myth: People who were sexually abused as children are likely to become abusers themselves.

Fact: *This is a dangerous myth, offensive and unhelpful to adult survivors of childhood sexual abuse, which is sometimes used to explain or excuse the behaviour of those who rape and sexually abuse children. The vast majority of those who are sexually abused as*

children will never perpetrate sexual violence against others. There is no excuse or explanation for sexual violence against children or adults.

Myth: Men don't get raped and women don't commit sexual offences.
Fact: *The majority of sexual assaults and rapes are committed by men against women and children, but a small number of women do perpetrate sexual violence (less than 2%). Often people who've been sexually assaulted or abused by a woman are particularly fearful that they will not be believed or that their experiences won't be considered 'as bad' as being raped by a man. This can make it especially difficult for these survivors to access services or justice.*

(Rape Crisis England and Wales, 2022)

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Appendix 4: Study participant information sheet

Survivor Participant Information Leaflet

Faculty of Health & Life Sciences

Study Title: A Phenomenological Exploration into Adults Disclosing Sexual Assault Experiences to Nurses: a UK study

Investigator: Claire Dosdale

Participant Information Sheet

You are being invited to take part in this research study. Before you decide it is important for you to read this leaflet so you understand why the study is being carried out and what it will involve.

Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether or not you would like to take part.

What is the Purpose of the Study

My research aims to gain an understanding of your experience of disclosing sexual assault (rape and sexual assault) to nurses. Government policy wishes to increase rates of disclosures of sexual assault in order to improve conviction rates for perpetrators of sexual assault and to ensure you have adequate emotional support. However, research suggests victims making these initial disclosures may not always have a positive experience and in-turn this may have an impact on their health and wellbeing. The research we have tells us that once a complainant has made an initial disclosure of sexual assault the response of the person they disclose to is key in reducing future negative psychological consequences of the sexual assault. Currently the research is based on the experiences of those in the United States, I would like to gain an understanding of the experiences of those in the UK.

AIM

The aim of this research project is to explore the experience of adult who disclose (to nurses) a history of sexual assault from the age of 18 and above. The research will also explore the experience of those nurses to whom the sexual assault is disclosed to. The data collected will then be analysed to provide a better understanding of how to most effectively respond to disclosures of sexual assault in order to inform future practice.

Why have I been invited?

You have been invited to participate because you may have experienced one or more episodes of sexual assault. If you have not experienced this then please accept my apologies for this invite and disregard this letter. If you have, and you fill the criteria below, please do read on.

Do I have to take part?

No you do not have to participate if you do not want to, this is a voluntary study. If you are interested in being involved please contact me as soon as possible (my details are at the bottom of the letter).

What will happen if I take part?

You must fulfil the following criteria to participate:

Inclusion Criteria	Exclusion Criteria
Self-defined experience of sexual assault	If you are currently under 18 years old
If you are currently 18years old or over	The sexual assault took place when you were 17 years or younger
Able to have the capacity (and a sufficient level of understanding the risk and benefits) to consent to participate in the research study	There are current legal proceedings regarding the sexual assault discussed
Disclosure of your sexual assault episode(s) to a healthcare professional	Where the person that subjected you to sexual assault is identified as a current partner (for all parties safety)
	If you are unable to provide consent to participate

If you decide you would like to take part you will be invited to attend a face to face interview with myself to explore your experience of disclosing sexual assault to a healthcare professional, this will last between 30-60minutes. This interview will be audio recorded with a Dictaphone (no-one else will hear your interview). I aim for this interview to be at a time which suits you. This may be at Northumbria University, Coach Lane Campus (Long Benton) or within our city centre venue at Newcastle (I can book a private room at either to protect your confidentiality), at your preference and convenience.

.

What are the possible disadvantages of taking part?

It is not thought that participants will be subject to increase risk of physical or psychological harm through taking part in the study. The study has received ethical approval from the Faculty of Health and Life Sciences Research Ethics Review Panel at Northumbria University. Research tells us that those participating in research about experiencing trauma often find their participation beneficial. However, as the discussion may cause you to reflect on your experience it is appreciated this may be upsetting at times, all participants will be given the opportunity for a debrief following the interview by myself, a sexual health practitioner with considerable experience of managing disclosures of sexual assault. Should you raise any concerns regarding personal experiences with sexual assault these concerns will be kept confidential. However, should you identify yourself or someone you know who may be at risk of harm, in line with my professional regulations I must disclose this information

to the relevant safeguarding team. I will not disclose any information without discussing it with you first. You will also have the opportunity to have a direct referral into Rape Crisis for further counselling

What are the possible benefits of taking part?

At present there is very little known about the experience of adult sexual assault disclosure to any nurses within the UK. This is an opportunity to find out more about victim experience of making these important disclosures

Will my taking part in this study be kept confidential and anonymous?

The comments in your interview will not include identifying information to indicate who you are. Your personal data will be kept strictly confidential.

How will my data be stored?

All paper data, the typed up transcripts from your interview and your consent forms will be kept in locked storage. All electronic data; including the recordings from your interview, will be stored on the University U drive, which is password protected. All data will be stored in accordance with University guidelines and the Data Protection Act (1998). If you wish to withdraw your data then email me within 1 month of taking part and giving me the code number that was allocated to you (this can be found on your debrief sheet). After this time it might not be possible to withdraw your data as it could already have been analysed.

What will happen to the results of the study?

The results will be analysed and written up to form my PhD Thesis currently being studied at Northumbria University. The general findings might be reported in a scientific journal or presented at a research conference, however the data will be anonymized, you and the data you have provided will not be personally identifiable, unless we have asked for your specific consent for this beforehand. The findings may also be shared with other organizations/institutions that have been involved with the study. We can provide you with a summary of the findings from the study if you email the researcher at the address listed below.

Who is Organizing and Funding the Study?

Northumbria University.

Who has reviewed this study?

Before this study could begin, ethical approval and permission was obtained from Northumbria University.

The Faculty of Health and Life Sciences Research Ethics Committee at Northumbria University have reviewed the study in order to safeguard your interests, and have granted approval to conduct the study.

Contact for further information:

Researcher:

Claire Dosdale

Room C002

Clinical Skills Centre

Coach Lane Campus West

Northumbria University

Newcastle upon Tyne

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Faculty of Health & Life Sciences

Study Title: A Phenomenological Exploration into Adults Disclosing Sexual Assault Experiences to Nurses: a UK study

Investigator: Claire Dosdale

Participant Information Sheet

You are being invited to take part in this research study. Before you decide it is important for you to read this leaflet so you understand why the study is being carried out and what it will involve.

Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether or not you would like to take part.

What is the Purpose of the Study

My research aims to gain a better understanding of nurse's experiences of receiving disclosures of sexual assault (rape and sexual assault) from service users. Government policy drivers indicate nurses must encourage such disclosures in order to improve conviction rates for perpetrators of sexual assault and provide emotional support for victims. However research suggests victims experiences of nurse management of these initial disclosures many have a detrimental impact on their health and wellbeing and provide emotional strain for the nurse. Evidence indicates that once a victim has made an initial disclosure of sexual assault, the response of the person disclosed to is key in reducing the psychological consequences of sexual assault and the incidence of post-traumatic stress disorder. Sexual assault associated post-traumatic stress disorder is a significant public health concern due to the substantial ongoing health implications for the victim, these include (but are not exclusive of): anxiety; stress; fear; nervousness; social isolation; flashbacks; sleeping difficulties; drug/alcohol reliance; low self-esteem; self-harm; and suicide. Integrating what happens before, during and after disclosure may provide greater insight into how and why disclosure affects recovery.

AIM

The aim of this research project is to explore the experience of adult service users who disclose to nurses a history of sexual assault from the age of 18 and above. The research will also explore the experience of those nurses to whom sexual assault is disclosed to. The data collected will then be analysed to provide a detailed description of the intersubjective experience of this phenomenon to add to the limited body of evidence in order to inform future practice.

Why have I been invited?

You have been invited to participate because as part of your professional role, you may have received disclosure of sexual assault. If you do not receive these disclosures from people you come into contact with, please accept my apologies and disregard this letter.

If you do receive disclosures of sexual assault and are interested in participating please do read on.

Do I have to take part?

No you do not have to participate if you do not want to, this is a voluntary study. If you are interested in being involved please contact me as soon as possible (my details are at the bottom of the letter).

What will happen if I take part?

If you decide you would like to take part you will be invited to attend a face to face interview with myself to explore your experience of receiving sexual assault disclosures, this will last between 30-60minutes. This interview will be audio recorded with a Dictaphone (no-one else will hear your interview). I aim for this interview to be at a time which suits you. This may be at your place of work (I can book a private room within the trust or at Northumbria University Coach Lane Campus (Long Benton) or within our city Centre venue at Newcastle, at your preference and convenience. The comments in your interview will not include identifying information to indicate who you are. Your personal data will be kept strictly confidential in line with the Data Protection Act 1998.

What are the possible disadvantages of taking part?

It is not thought that participants will be subject to increase risk of physical or psychological harm through taking part in the study. The study has received ethical approval from the Faculty of Health and Life Sciences Research Ethics Review Panel and your employing NHS Trust. Staff in the study will have experiences of disclosure of sexual assault within their professional lives. However, as interviews and discussion may cause you to reflect on previous cases you have managed, all participants will be given the opportunity for a debrief following interviews by myself, a practitioner with considerable sexual health experience of managing disclosures of sexual assault and providing support for staff receiving these disclosures. Should you raise any concerns regarding personal experiences with sexual assault these concerns will be kept confidential and guidance on appropriate services to access will be given. However, should you identify yourself or someone you know who may be at risk of harm, in line with the NMC Code (2015) I must disclose this information to the relevant safeguarding team. I will not disclose any information without discussing it with you first.

What are the possible benefits of taking part?

At present there is very little known about the experience of adult sexual assault disclosure to nurses within the UK. This is an opportunity to not only find out more about how

professionals receive disclosures, but to look in depth at victims experience of disclosing to us.

Will my taking part in this study be kept confidential and anonymous?

The study will be disseminated (see below). **However, your interview will be made anonymous. Your involvement will only be known to me.** If you wish to withdraw your data then email me within 1 month of taking part and give me the code number that was allocated to you (this can be found on your debrief sheet). After this time it might not be possible to withdraw your data as it could already have been analysed.

How will my data be stored?

All paper data, the typed up transcripts from your interview and your consent forms will be kept in locked storage. All electronic data; including the recordings from your interview, will be stored on the University U drive, which is password protected. All data will be stored in accordance with University guidelines and the Data Protection Act (1998).

What will happen to the results of the study?

The results will be analysed and written up to form my PhD Thesis currently being studied at Northumbria University. The general findings might be reported in a scientific journal or presented at a research conference, however the data will be anonymized, you and the data you have provided will not be personally identifiable, unless we have asked for your specific consent for this beforehand. The findings may also be shared with other organizations/institutions that have been involved with the study. We can provide you with a summary of the findings from the study if you email the researcher at the address listed below.

Who is Organizing and Funding the Study?

Northumbria University.

Who has reviewed this study?

Before this study could begin, ethical approval and permissions were obtained from your employing NHS Trust and Northumbria University.

The Faculty of Health and Life Sciences Research Ethics Committee at Northumbria University have reviewed the study in order to safeguard your interests, and have granted approval to conduct the study.

Contact for further information:

Researcher:

Claire Dosdale

Room C002

Clinical Skills Centre

Coach Lane Campus West

Northumbria University

Newcastle upon Tyne

NE7 7XA

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Appendix 5: Participant consent form

Faculty of Health & Life Sciences

CONSENT FOR TAKING PART IN A STUDY WHICH MIGHT CAUSE PSYCHOLOGICAL DISTRESS

Project Title: A Phenomenological Exploration into Adults Disclosing Sexual Assault Experiences to Nurses: a UK study

Principal Investigator: Claire Dosdale

	please initial where applicable
I have carefully read and understood the Participant Information Sheet.	☐
I have had an opportunity to ask questions and discuss this study and I have received satisfactory answers.	☐
I understand I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice.	☐
I agree to take part in this study.	☐
I understand that by taking part in this study I may be exposed to situations that may generate some psychological distress that may become apparent during and/or after the study has finished. I accept the small risk of experiencing psychological distress as part of this research	☐

I hereby confirm that I give consent for the following recordings to be made:

Recording	Purpose	Consent
voice recordings	For recording of interviews in order to transcribe following the interview.	

Signature of participant.....

Name (IN BLOCK CAPITALS) ..... Date.....

Signature of researcher.....

Name (IN BLOCK CAPITALS)..... Date.....

Appendix 6: Participant debrief sheet

Northumbria UNIVERSITY NEWCASTLE
Faculty of Health & Life Sciences

Participant code:

PARTICIPANT DEBRIEF

Name of Researcher: Claire Dosdale

Name of Supervisor: Dr Mark Bevan

Project Title: A Phenomenological Exploration into Adults Disclosing Sexual Assault Experiences to Nurses: a UK study

1. What was the purpose of the project?

Thank you very much for participating as a research participant in the present study concerning your experience of sexual assault disclosure The present study aims to explore the experiences of both those disclosing sexual assault and those receiving the disclosure. The aim is to improve future practice in order that a disclosure is managed with best evidence based practice.

Again, I thank you for your participation in this study, your decision to share your personal experience is hugely appreciated. If you know of any friends or acquaintances that are eligible to participate in this study, please do pass on my details, although I request that you not discuss the process of the interview with them until after they have had the opportunity to participate. Prior knowledge of questions asked during the study can invalidate the results. I greatly appreciate your cooperation.

2. How will I find out about the results?

I would be happy to provide you with a summary of the findings from the study if you email the me at the address listed below.

3. If I change my mind and wish to withdraw the information I have provided, how do I do this?

If you wish to withdraw your data then email the investigator named in the information sheet within 1 month of taking part and given them the code number that was allocated to you (this can be found on your debrief sheet). After this time it might not be possible to withdraw your data as it could already have been analysed.

The data collected in this study may also be published in scientific journals or presented at conferences. Information and data gathered during this research study will only be available to the research team identified in the information sheet. Should the research be presented or published in any form, all data will be anonymous (i.e. your personal information or data will not be identifiable).

All information and data gathered during this research will be stored in line with the Data Protection Act and will be destroyed **7 years** following the conclusion of the study. If the research is published in a scientific journal it may be kept for longer before being destroyed. During that time the data may be used by members of the research team only for purposes

appropriate to the research question, but at no point will your personal information or data be revealed. Insurance companies and employers will not be given any individual's personal information, nor any data provided by them, and nor will we allow access to the police, security services, social services, relatives or lawyers, unless forced to do so by the courts.

If you wish to receive feedback about the findings of this research study then please contact the researcher at **Claire.dosdale@northumbria.ac.uk**

This study and its protocol have received full ethical approval from Faculty of Health and Life Sciences Research Ethics Committee. If you require confirmation of this, or if you have any concerns or worries concerning this research, or if you wish to register a complaint, please contact the Chair of this Committee (Dr Nick Neave: nick.neave@northumbria.ac.uk), stating the title of the research project and the name of the researcher

Should you feel the need for additional support following our interview I have provided details of services that you may find useful:

R.E.A.C.H

Many women and men experience difficulties coming to terms with what has happened, carrying on with their everyday life afterwards. R.E.A.C.H. offers helps to men and women who have been raped or sexually assaulted, aged 16 or over when the assault occurred. Please contact them for information on the full remit of all of the services they offer. They will also signpost you to other services should you need them. The centres are staffed by people who are experienced in dealing with the effects of rape and sexual assault. They will be happy to help you whether or not you wish to report to the police.

If you do decide to report to the police, advice and help will be available R.E.A.C.H is able to offer victims of rape or serious sexual assault, who do not wish to make a formal complaint of crime to the Police, the opportunity to receive support in two ways:-

- Access to a forensic medical examination - a fully trained chaperone is available to assist the complainants
- Practical support from one of their team of ISVA's (Independent Sexual Violence Advisor) who can help with any issues you may be experiencing

Contact REACH on: 0191 2219222 or reach@northumbria.pnn.police.uk

NORTH OF TYNE (sexual health services)

NEWCASTLE

New Croft Sexual Health service
Market street East
Newcastle upon Tyne
NE1 6ND
0191 229 2999

NORTHUMBERLAND

Northumberland Sexual Health Services
Morpeth Clinic
Gas House Lane
Morpeth
NE61 1SR
01670 51 51 51

NORTHTYNESIDE

1-1 centre
Brenkley Avenue
Shiremoor
North Tyneside
NE27 0PR
0191 2970441

SOUTH OF TYNE (sexual health services)

SOUTH TYNESIDE

South Tyneside Sexual Health Services
Stanhope Parade Health Centre
Gordon street
South Shields
NE33 4JP
0191 283 2525

SUNDERLAND

Sunderland Sexual Health Services
Sunderland City Hospitals
Kayll Road
Sunderland
SR4 7TP
0191 565 6256

GATESHEAD

Gateshead Sexual Health Service
Trinity Square
Gateshead
Tyne & Wear
NE8 3LL
0191 2821586

Rape Crisis Tyneside and Northumberland

Rape Crisis Tyneside provide free, safe, professional support and information for women and girls over 16 who have experienced any form of sexual violence at any time in their lives. Their team of highly qualified, specialist staff and volunteers are trained to support women survivors via face-to-face confidential counselling, telephone helpline, email support and specialist information.

Evening Helpline: 0800 035 2794 Tuesday, Wednesday, Thursday (6pm-8.30pm)
Friday daytime (11.00am-2.30pm)
Email support:
emailsupport@rctn.org.uk

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Appendix 7: Poster for study recruitment

Survivors participant recruitment poster

Appendices 2: nursing staff

Have You Experienced Disclosures of Sexual Assault?

Purpose of the study:

The main aim of this PhD research is to gain a better understanding of **your** experience of receiving disclosures of sexual assault

We know that the initial disclosure of sexual assault may have a big impact on the recovery process for service-users. Research tells us that when making disclosures, complainants have mixed experiences. It is important we hear about your experiences of receiving sexual assault disclosures in order to gain an understanding of how these are managed. This in-turn will allow us to gain an understanding of what support nurses need in order to provide a holistic, person centred approach to managing this highly sensitive topic.

What will be involved?

We are seeking nurses (male and female) to participate in this PhD research study. It is important you have experienced sexual assault disclosure to participate. Involvement will include a 30-60minute interview. We would like to hear, in your words, your experience of receiving sexual assault disclosures.

Interviews will be conducted face to face at your convenience. Interviews will be **confidential** and all your information will be **anonymised**.

To find out more information please contact me on the details below:

Principal researcher: Claire Dosdale (nee Robinson)

Email: claire. dosdale@northumbria.ac.uk

Telephone: **07894554059** or **0191 215 6154**

Supervisor: **Dr Mark Bevan**

Email: mark.bevan@northumbria.ac.uk

Tel: **0191 215 6127**

Nurse participant recruitment poster

Appendices 2: nursing staff

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Email: mark.bevan@northumbria.ac.uk

Tel: **0191 215 6127**

Appendix 8: Bevan (2014) Phenomenological Interview Structure

Phenomenological Attitude	Researcher Approach	Interview Structure	Method	Example Question
Phenomenological Reduction (Epoché)	Acceptance of Natural Attitude of Participants	Contextualization (Eliciting the Lifeworld in Natural Attitude)	Descriptive/Narrative Context Questions	"Tell me about becoming ill," or "Tell me how you came to be at the satellite unit."
	Reflexive Critical Dialogue With Self	Apprehending the Phenomenon (Modes of Appearing in Natural Attitude)	Descriptive and Structural Questions of Modes of Appearing	"Tell me about your typical day at the satellite unit,"or "Tell me what you do to get ready for dialysis."
	Active Listening	Clarifying the Phenomenon (Meaning Through Imaginative Variation)	Imaginative Variation: Varying of Structure Questions	"Describe how the unit experience would change if a doctor was present at all times."

Appendix 9: Survivor formulated general meaning units

1. The nurse suggesting she had given implied consent made her question what had happened. This leads to anxieties over what people will believe too. 2. Nurse using language that indicated the survivor has some responsibility in the assault increases self-doubt and regret at attending and disclosing 3. Disclosure being questioned makes survivors feel as though they are being judged as making 'silly choices' 4. Disclosure not being taken seriously, leads to feelings of being judged 5. If alcohol is involved then survivors feel as though the nurse focuses on this, meaning they have some responsibility towards the assault 6. Once rape/SA is mentioned survivor felt not listened too as the rape became the focus 7. Feelings of not being believed 8. Not being believed can lead to feelings of regret, regret for attending and regret at disclosing 9. Worried that someone was going to tell them that they were wrong, that they hadn't been assaulted or that it was their fault because of alcohol use 10. Because of the dismissive reaction of the nurse, feelings of embarrassment and being ashamed of the situation caused survivor to shut down and decide to not make any further disclosures 11. Survivors are worried that someone will recognise them in the waiting room 12. Worry that other people in the waiting room are judging them (in sexual health services) 13. Panic that you see someone you know leads to increased anxiety 14. Looking for a friendly face among staff moving around the clinic, worry about who they will see and if they will be nice	37. Anxiety of not knowing what would happen next manifested as physical symptoms – sick. 38. Realisation and relief of someone else knowing and that something might be done/support given 39. Concern about not knowing the impact on other people 40. Anxiety of planning what to say when reporting it, repeating in mind. This causes anxiety and makes survivor want to not report 41. Feelings of concern about reporting then manifest into anxiety about who will find out 42. Not knowing if they are believed, making them feel judged by nurse 43. Emotionally shutting down. Feeling nothing 44. Shutting down emotions to self protect 45. Unexpected things trigger memories and cause emotions to return 46. Disconnected from emotions as a self-protection and the nurse emphasising the importance of the disclosure 47. Repressed emotions over a period of time to cope, then the feeling of relief once she disclosed to a nurse (first hcp). Realising she could feel emotional about what had happened – permission giving 48. Feeling of shame and guilt when disclosing and not getting words out 49. Suppressed emotion about assault, seeing the nurse gave permission to acknowledge and recognise how it had impacted behaviour 50. Feeling uncomfortable with process, having to re-disclose with every appointment was like re-living the trauma 51. The process of follow up care was repetitive and exhausting to have to re-live the trauma

15. Not a welcoming reception when there is already worry about being there 16. Anxiety about what will happen next. Not knowing the process causes heightened anxiety 17. No knowledge on what will happen next 18. Not knowing if the person you see will be nice 19. Vivid lurid colours still resonate with negative memory 20. What's behind the closed door, what happens once you are called in? 21. General equipment can trigger a memory of attack 'rapeso', this was unexpected 22. The feeling of everything going in slow motion, journey to clinic, waiting room, walking to consultation room – the not knowledge what is going to happen– all heightens anxiety and can contribute to regret at attending 23. Journey to the service gives time for thoughts around what might happen. This increases anxiety 24. Lack of engagement with support services as was reported on her behalf by family member. Didn't feel ready mentally to be prepared for police involvement or reporting at the time, no choice given 25. Relieved at someone taking charge and not having to make decision 26. Feeling of being pushed into accessing services elevates anxiety on what will happen next 27. Worried that reporting it will mean lack of confidentiality, people will find out what happened 28. Resigned to the thought that no evidence means nothing will happen once the assault is reported	52. Needed someone to say – this has happened to you, before acknowledging it. Permission giving 53. Relief at being supported because it made it real 54. Terrified at disclosing as had not processed what happened herself. Felt vulnerable emotionally and manifested physical symptoms – sick /crying 55. Procedure after reporting was unclear and not explained. The unknown 56. Repetitive and intimidating questioning made it like you were not believe. 57. Didn't feel emotion from the nurse. Felt like she just sees this all the time 58. The nurse was asking questions but didn't give her time to answer them, didn't feel she was listening and made her feel worse 59. Felt as though the nurse was not supportive however, showing empathy towards the nurse as the nurse had been called out in the early hours of the morning to come and see the survivor. 60. No introduction, name given by the nurse. This increased anxiety 61.The nurse being caring (being believed) was seen as motherly, this was reassuring. 62. Having to disclosure the assault to 3 people in one visit was emotionally difficult 63. Feeling the nurse believed them made them feel more positive about getting help. 'motherly' nature 64.Repetitive disclosure causing emotional distress 65. Didn't accept that she had been assaulted until she was told by nurse. Almost like permission giving

29. Process moved so fast there was a lack of time to make or contribute to decisions 30. Someone else taking charge helped formulate a plan of what happens next, when maybe this decision making was too much 31. Disclosure felt daunting and scary. Frightened/fear. 32. Concern about the impact on assailant and his family made reporting a difficult decision 33. Worried reporting it would mean people would find out and not believe it was an assault. That it was consensual and would be judging her 34. Did not feel informed about the process. Thought she couldn't say no throughout process. Phrasing of questions did not leave room for an open/optional answer 35. Not wanting to show upset or emotion in front of stranger 36. Feelings of guilt and being ashamed made emotional health worse	66. Was supported and believed, this makes survivors feel like they made the right decision to disclose 67. The response of the nurse indicated she was uncomfortable, this made the survivor regret disclosure and feel judged 68. Was expecting sympathy and maternal instinct as the nurse was female but felt let down by lack of support/ belief.

Appendix 10: Nurse formulated general meaning units

1. The disclosure came at the end of the session. The supportive nature of the session had encouraged disclosure as she had previously disclosed and had a negative experience which cause on-going barriers to disclosure 2. The need to follow guidance and policy dictates what happens next however, the nurse is aware the individual gets lost in this 3. The nurse experiences mental exhaustion when considering the impact the disclosure will have on her workload 4. The unique bond the nurse has with the patient encouraged disclosure 5. When a person disclosed assault, the nurse sees it as their role to try to persuade the survivor to report to the police. At times this is done despite the survivors wishes. 6. The nurse often uses her observation and communication skills to recognise there was something wrong with the survivor prior to disclosure 7. Using communication skills to recognise a private area to talk was needed 8. Warning the survivor on role boundaries before disclosure took place 9. Nurse used communication skills to manage an unexpected public disclosure that may have been triggering for other people 10. The disclosure was unexpected and not in context of conversation 11. The nurses don't specifically ask about sexual violence, but disclosures can happen when the conversation opens up around a similar context or where SV may happen – such as domestic violence 12. The nature of the topic means nurses often have to mentally prepare themselves to explore.	39. The experience and memory of receiving a rape and/or sexual assault disclosure stays with nurses for months and years after the case 40. Feeling sick when receiving disclosures, physical manifestation of emotions 41. Feeling sorry for them. Empathy. 42. The desire to make the experience of disclosure as easy as possible 43. Nurses feel anxiety that they managed the disclosure correctly 44. Receiving disclosures of SA and rape and be highly stressful 45. After receiving a disclosure there is often a need to see support from senior colleagues. 46. There is an awareness that the consultation will last longer than standard and will be more complicated. This causes anxiety 47. The nurse will often reflect on the disclosure consultation and be anxious that they have not manages it right, or could have done something better 48. There is an awareness that the clinical environment can be intimidating to some of these patients. 49. Depending on the role of the nurse, it can be better to see the patients in their own environment in order to remove the power imbalance 50. In the home environment you can use more skills to pick up on potential issues. 51. There is an awareness that patients are often pre-disclosing to reception staff in busy areas, to make sure they see the right practitioner. However, there is no confidentiality with this. The nurses are aware of this, no changes are made to ease this process. 52. The nurse called the police to come straight after disclosure

13. Nurses using communication skills to identify potential psychological distress or those that need emotional support 14. Nurses use their intuition and other communication skills to be aware of when to explore an issue further 15. Being aware that people disclosing need extra emotional support to feel able to talk about it 16. Empathy contributes to communication skills when nurses are receiving disclosures 17. Nurses believe that having a maternal instinct emphasises care given in this situation 18. Being tactile with patients that are distressed contributes to what nurses seen as supportive responses 19. Once a patient has made a disclosure, their previous behaviour and actions become easier to understand 20. Nurses feel a sense of responsibility for saying the right thing in response to a disclosure. The concern is that the survivor won't talk further. 21. The nurses worry that they have gave the patient all the right information and options following disclosure. 22. This is a topic that nurses don't forget easily. They continue to remember and reflect on this type of consultation for months and even years. 23. Verbal communication changes depending on the questions asked. When asking sensitive questions their voice becomes quieter 24. Sexual violence disclosure makes nurses anxious 25. Nurses feel anger on behalf of the patient after they have disclosed rape 26. Worry that they won't know what to do with the information given. Feeling responsible for holding the information	53. They try to keep the atmosphere as relaxed as possible 54. There is an awareness that confidentially is key in facilitating disclosures of SA&R 55. There is an awareness that an informal counselling style room rather than a clinical room can aid in facilitating effective communication during a SA&R disclosure. 56. Nurses believe that the consultation will be managed more effectively if there is a comfortable environment 57. There is a belief that the computer can cause a barrier in the consultation 58. Permission giving (to disclosure) is best facilitated in the right environment, this being a comfortable relaxed space 59. there is a use of the word 'girls' to describe survivors of SA and rape. This gives a very specific impression of who the nurses think are survivors of SA&R are 60. nurses associate sexual assault and rape with injuries 61. nurses often link distressed presentation with 'genuine' rape cases 62. nurses believe alcohol plays a large part in experiences of rape and sexual assault 63. some areas will immediately refer 'girls' to SARCs if there is any suggestion of rape or sexual assault 64. There is a belief, in some clinical areas, that when alcohol wears of the 'girl' will backtrack as they panicked into the accusation and then retract their accusation 65. Nurses do not want to pressurise patients into reporting but do want to encourage it. Striking the balance can be difficult 66. Lack of understanding as to why the individual would put themselves in a

27. Nurses feel torn between the compassionate desire to help the patient make their own decision against whether the sexual assault needs reporting or policy to be followed - responsibilities blurred so they look for guidance to instruct 28. In order for nurses to manage the anxiety that comes with sexual assault disclosures they benefit from clinical supervision to reflect on their management 29. The is a level of guilt when a disclosure has resulted in police being called when the survivor may not have wanted this 30. Anxiety that continuing the relationship, once you have reported the assault to the police, without the patient's consent, can be detrimental. 31. Nurses feel sad that 'girls' are experiencing this and believe alcohol is a contributing factor 32. Listening to experiences of sexual assault and rape can be very emotionally distressing to nurses. 33. Whilst empathy is felt, there is a need to keep emotions compartmentalised during the consultation, so the main focus is the service user and their experience 34. Once a shift is finished the emotion of what has been disclosed stays with the nurse 35. A nurses main priority is to help the individual, to be her advocate 36. Receiving and managing these disclosures can be emotionally distressing 37. Being able to switch off emotions to deal with the management some cases is essential to get through them 38. Disclosures are often unexpected	presumed dangerous environment 'not taking care of themselves' 67. Some nurses are aware that a patient may not want to speak to the police but call them anyway as it makes them feel like they have done the right job. 68. It is frustrating for nurses that there is, at time, disjointed care with often numerous other staff involved. 69. Nurses believe they are giving the patient options as to whether they want to contact the police however, at times these are not options and cleverly worded questions 'so I would ask their consent, do they want me to ring the police? Do you want to ring the police yourself?' 70. There is a level of persuasion in most areas, by most nurses, to get the survivor to report the assault to the police 71. Due to the nature of certain clinics there is a lack of continuity of staff for survivors 72. The importance of safeguarding an individual can be very stressful for nurses 73. There is an awareness that cases are complex however, also an awareness that there are other patients waiting to be seen 74. Documentation is a very important element of management for nurses when considering the legal implications 75. Supervision is used if a nurse feels they need to explore particular cases they have managed, this often has to be asked for - however this is often with managers and the power issues with thinking they may have not quite managed correctly.

Appendix 11: Significant descriptive statements into formulated general meaning units for all participant groups

Significant descriptive statements (170) – broken into similar language/ repetitive words. **SURVIVORS** **(The colours represent the different participants).**	formulated general meaning units (68) **These meaning unit numbers are used to cross reference in the findings chapter**
1. **she was like "do you think that you maybe implied…?" And you think: oh… Maybe I did.. So then she said: "'cos if you had said something like that, then if it was to go to court, like inside of the… Like the jury or whatever, they can like take things differently". But it was quite intimidating because she's like put in my head that they think**… 2. **ball that you can't stop rolling once you've even mentioned something. oh, maybe I shouldn't have came… if I did do that, I would look really stupid now. but I think of what she said or… "Had you implied anything before**" 3. **Victimised in a way and… It's wrong. as if they'd heard it all before** 4. **They judged it as a case of me just wanting a bit of fun and getting drunk and being silly**, 5. **I felt judged** 6. **Whereas a man, they'll think straight away, 'cos… You've had a dodgy one night stand or something, so…** 7. **I guess the man's manner. I just felt like I was being judged as like a young kid who's been silly.** 8. **And she kind of said it wasn't rape, because I was drunk…** 9. **but it was the kind of attitude that 'you've just got to get on with it'**. 10. **She said, you couldn't do anything about it in a court of law, because you were drunk, kind of thing. So you've just got to move on**. 11. **once she'd picked up on that, focussed straight in on it and didn't really listen to me when I said that I've had these issues far longer than the kind of two years it's been since I was assaulted** 12. **I didn't feel listened to…** **13. Eyes widening type thing, kind of like: 'oh yeah. Gonna write that down!'** 14. **And the posters on the back of the toilets, 'We believe you' as well. Now, I see those every day of my working week and I'm like: well actually, no. You didn't believe us at the end of it all**. **15. I just remember feeling really sick and also contemplating not going** 16. **even though I knew that it was real, that someone might say "well actually, no. It wasn't" and be like "this didn't happen to you, so why are you here crying about it?"** **17. I maybe would have explained it in a way that somehow made it my fault a bit more. "oh, well you know, I was drunk, so…" Yeah**	1. The nurse suggesting she had given implied consent made her question what had happened. This leads to anxieties over what people will believe too. 2. Nurse using language that indicated the survivor has some responsibility in the assault increases self-doubt and regret at attending and disclosing 3. Disclosure being questioned makes survivors feel as though they're being judged as making 'silly choices' 4. Disclosure not being taken seriously, leads to feelings of being judged 5. If alcohol is involved then survivors feel as though the nurse focuses on this, meaning they have some responsibility towards the assault 6. Once rape/SA is mentioned survivor felt not listened too as the rape became the focus 7. Feelings of not being believed

18. why am I bothering to do this again with a nurse? If a GP didn't believe me, then what's saying she will? 19. said that the police would have to get involved – erm, who didn't believe me either – 20. I was terrified, but you hear of the police not doing anything all the time, so it's like: "well, you were out. What were you dressed like?" And I was like "well, I wasn't asking for it?" and then I had to go through all the rigmarole again. Obviously it's already on the records; she's just read them. What is she trying to hear different from the first time? 21. She said that in these circumstances, there would be no point in going to the police; it would be my word against his and it would probably cause more harm than good. 22. I completely felt like: that's just where I completely felt like, ashamed of whatever. Me feeling ashamed of that situation, I think I was already embarrassed by it, but then it completely shut anything down for me disclosing it to anyone else. 23. Just awful. I felt just ashamed. I felt embarrassed, more embarrassed because I'd then got upset in front of her and that was her reaction. Like it was my fault, so…	8. Not being believed can lead to feelings of regret, regret for attending and regret at disclosing 9. Worried that someone was going to tell them that they were wrong, that they hadn't been assaulted or that it was their fault because of alcohol use 10. Because of the dismissive reaction of the nurse, feelings of embarrassment and being ashamed of the situation caused survivor to shut down and decide to not make any further disclosures
24. it's like a tiny room. It's not even bright or nice or anything 25. I hope nobody kind of who I know saw me come in, they're going to be like: oh, what's she doing going in there? 26. Finding the place, it was so like, out of the way from the main hospital… You're not wanting to stop someone to say "do you know where the GUM clinic is?" 27. I can't really remember the whole… I think, 'cos I was so panicked, I can't really remember the whole like, checking process 28. The colours weren't very bright and welcoming; But it was more the fact that there was other people there. 29. You felt like people were looking and thinking: what's their story about? 30. It wasn't huge, but it was still quite busy. I still felt quite panicked and ashamed, really. 31. And you were panicking if you'd see someone you knew, 32. I know in clinics, you can feel a bit up a height, because you don't want to be there, 33. It's the panic, the worry of… You know, your privacy and I guess your confidentiality. 34. I suppose slightly more hospital or sterile… 35. I remember the noise of the automatic doors and being guided by a pretty frosty receptionist. Just that whole interaction was quite frosty 36. The smell of the building. I remember the smell 37. it's the last place on earth you wanted to be.	11. Survivors are worried that someone will recognise them in the waiting room 12. Worry that other people in the waiting room are judging them (in sexual health services) 13. Panic that you see someone you know leads to increased anxiety 14. Looking for a friendly face among staff moving around the clinic, worry about who they will see and if they will be nice 15. Not a welcoming reception when there is already worry about being there 16. Anxiety about what will happen next. Not knowing the process causes heightened anxiety

38. And I remember having to climb the stairs and it was like… Just like the last thing… A horrible place to climb the stairs to.. if you're thinking about where you're going, up the stairs, what's going to happen to you? Are you going to have to get undressed? Are you going to have to go through all this again? Are you going to have to go through what you think as [being] violated with swabs and questions asked and probing questions asked? What are the people going to be like? Yeah? Is it going to hurt? **39. I remember being struck by these lurid coloured lime green and purple couches with several suspicious looking stains on them and you just remember it as clear as day** 40. **A whole melting pot of emotions and you just try and keep it in check, because there's other people around you** and **it's just not a very nice environment to be in**… **Because I didn't know what was going to happen. I just didn't know.** 41. **You get a snapshot of who's going to see you and you just hope it's going to be somebody nice and [they call out] with a friendly voice** 42. **All the staff were dressed in their own clothes. There was no distinguishing who was a doctor, who was a nurse, who was Healthcare it made me feel… Confused**. **43. It was like this massive place going round the corner. Huge place**… **And it was quite scary and quite intimidating and people… You walk past people and they have little trays with things on and… stuff**… **an awful long ten seconds when you're walking down there**, **wondering what's going to happen. What's in that room?** 44. **There was a hole punch and a file and they both said 'Rapesco' on them. And it really really upset me**. **… I thought: Oh, that's a bit of an unfortunate name, and then in that environment, it really was… It was triggering for me, And it's taken many many years to use the word 'rape'**… **'Cos it's not a pleasant word, well it just conjures up everything and to see it in black and white on stationery equipment was quite triggering.** 45. **members of staff walking out of their office or out of the kitchen or whatever and just yeah, sort of thinking: ooh, what if that's the person that I'm going to speak to** 46. **I just remember thinking: oh, she looks really friendly. She had like a nice smile; she had really nice ginger curly hair; I remember that.** 47. **private and it was comfortable** 48. It was **busy and it was loud. Well I thought it was louder. Like, everything was just amplified.** Erm… **And then my name beeped and I thought: can I bottle out of this? Can I just go**? 49. **Even though it's like a narrow corridor, it just felt so open and so spacious and… It kind of took forever, but it was the shortest walk**. 50. **I thought: if I clear my head beforehand, then hopefully that would help. It seemed to take forever and ever and I was looking around my shoulder every step, pretty much. Every corner, erm… I didn't want to see anyone.**	17. No knowledge on what will happen next 18. Not knowing if the person you see will be nice 19. Vivid lurid colours still resonate with negative memory 20. What's behind the closed door, what happens once you are called in? 21. General equipment can trigger a memory of attack 'rapeso', this was unexpected 22. The feeling of everything going in slow motion, journey to clinic, waiting room, walking to consultation room – the not knowledge what is going to happen– all heightens anxiety and can contribute to regret at attending 23. Journey to the service gives time for thoughts around what might happen. This increases anxiety

51. **It wasn't a very positive experience Like, informed the police and then they'd taken me straight there [to see the nurse]** 52. **A police officer who comes down like… Round the curtain… Erm, so I had to agree** 53. **She didn't convince me [to report it], so she basically told [my mam] and then my mam did something about it.** 54. **so then she [mum and friend] decided to phone the police and to begin with, I wouldn't even speak to the police; I was very uncompliant** **55. And then she told my mam. But it made me… I think maybe that made it worse, 'cos I hadn't quite told myself yet, like I hadn't quite got everything round in my own head,** **56. she kind of… Said… Almost "you need to go to hospital A&E straight away".** 57. … **I kind of felt like it was out of my hands a little bit. Not in a bad way, but in a helpful way. It was kind of the way it was kind of being 'lifted'.** **58. you're going to have to go to the sexual health centre. Go to sexual health and get it done. I really just don't want to go. I don't want to go…I just didn't want to get undressed. I didn't want to expose myself to strangers again** 59. **Straight away, they say "did you report it? Are you going to report it? Do you want to report it? Do you know the way in which you could?" I know all the ways in which I could, but I just like, I couldn't do it, because if you do that, then everyone has to know. Like nothing would come of it anyway; there would be no evidence** 60. **but she's so fast at doing things, like she'll make a decision instantly and it's like: hang on, if things had had been a bit slower, something else might have made a bit more sense. If I think she had tried to slow it all down, then it would have made a bit more sense. She was like: "right, we've got to do this; we've got to do that… I've got to do this…" I didn't have a chance to ask questions, like… Well now what's going to happen? It was just pretty much: you need to report it to the police** 61. **She knew that something was wrong and she basically told me to make an appointment, so she was all like kind of… Made me do it. Erm… I think she helped kind of formulate a… Not a plan, but like a "you need to do this first off; you need to go and do this"**	24. Lack of engagement with support services as was reported on her behalf by family member. Didn't feel ready mentally to be prepared for police involvement or reporting at the time, no choice given 25. Relieved at someone taking charge and not having to make decision 26. Feeling of being pushed into accessing services elevates anxiety on what will happen next 27. Worried that reporting it will mean lack of confidentiality, people will find out what happened 28. Resigned to the thought that no evidence means nothing will happen once the assault is reported 29. Process moved so fast there was a lack of time to make or contribute to decisions 30. Someone else taking charge helped formulate a plan of what happens next, when maybe this decision making was too much
62. **Daunting** **63. Really daunting. Scary**	31. Disclosure felt daunting and scary. Frightened/fear.

64. **But he had children as well and if something happened, then obviously it's something that would be taken very seriously. Will come of it, whether it goes to court or it doesn't; something will come of it and then I didn't want people to find out.**	32. Concern about the impact on assailant and his family made reporting a difficult decision
65. ..**but I didn't want anything to come of it because of that [him having a family]"**	
66. **Like say if I did say something, I didn't want anybody to think that I'd slept with a 40-year-old. But like that's what he would do; he'd just tell everybody that I'd slept with him**	33. Worried reporting it would mean people would find out and not believe it was an assault. That it was consensual and would be judging her
67. **I just really wasn't prepared for it and I didn't know whether or not I could refuse. Yeah, I didn't know whether I could refuse to disclose to the nurse and just say "look, I'm not very comfortable; I've gone through a… I thought this was part of the process".**	34. Did not feel informed about the process. Thought she couldn't say no throughout process. Phrasing of questions did not leave room for an open/optional answer
68. **But I think the phrasing of "are you going to be alright with that?" Is different to "You don't need to answer if you don't want to". cos I thought: this has to be done.**	
69. **It's really strange**.	
70. **I was just a little bit on edge, this was stuff that I've only ever told like closest friends before and I'm going to have to tell it to a complete stranger**,	35. Not wanting to show upset or emotion in front of stranger
71. **I'm very very very guarded**… **I'm worried in case I end up crying or something like this, like in front of a stranger, Like I would be feeling too exposed.**	
72. **which for me was upsetting**, **I felt guilty and ashamed of what had happened,**	36. Feelings of guilt and being ashamed made emotional health worse
73. **Terrified.**	
74. **Yeah. Very tough.**	
75. **Like it just all hit me, really. It was very emotional and I couldn't stop crying and I was with her for quite a long time**	
76. **I felt sick. I just felt really sick**, **I didn't know what was going to happen**	37. Anxiety of not knowing what would happen next manifested as physical symptoms – sick.
77. **there is elements in your life that you do change; like I don't drink an awful lot now**.	
78. **Absolute relief. Like, weight off my shoulders, but also just then really horrible, because I thought I'm actually going to have to do something about this now.**	38. Realisation and relief of someone else knowing and that something might be done/support given
79. …**it would ruin many other people's lives other than just mine.**	
80. **I didn't speak for like half an hour, 'cos I just, like, physically find it hard to say things out loud**	
81. **I was really anxious and really like… Planning what I was going to say and how I was going to say it and like, you know when it's going like over and over and over in your head?**	
82. **Yeah, just massive anxiety**. **Holding back tears or fighting off tears continuously.**	39. Concern about not knowing the the impact on other people
83. **I was like: well I might not go. That walk was kind of like: right, you're going. If you're going to turn back, this is the time to do it now**.	
84. **I'm sitting there, thinking: I'm going to have to say this out loud to someone.** Like, **can they tell that I've been crying**?	40. Anxiety of planning what to say when reporting it, repeating in mind. This causes anxiety and makes survivor want to not report
85. **And then that's kind of like… Goes on to the bigger thing of: do you want people to know? Will people know? How many people are you going to tell? If it is real…?**	

86. I just… Felt so disgusting. Erm… So low… Erm, my anxiety was all over the place. Erm,. I didn't know how to tell them or anything like that. 87. Angry. Like nobody believed me. I didn't want to walk out of there and then possibly do something, like harmful… Somebody needs to help me before I get to that point 88. But then I didn't want to go home. I didn't want to have to face anyone. I just wanted to be by myself. I didn't want to talk to anybody else. Erm, it was just like I was trapped, not knowing what to do. I was confused. 89. I didn't want to see anyone. I thought: they all know what's happened. They're judging me and I just wanted to get out.	41. Feelings of concern about reporting then manifest into anxiety about who will find out 42. Not knowing if they are believed, making them feel judged by nurse
90. I had a reaction to it where I just completely switched off, I didn't really get that much of an emotion… Then I just felt… Emotionally, I felt nothing 91. I never really had much [emotion] to it, but I couldn't tell you what it was like afterwards, 'cos I thought I just switched off completely 92. I could talk about it fine and not get any emotions from it, but then there's other days where something will trigger… I can't get in his [my boyfriend's] courtesy car because it's the same car that he had… 93. It made me feel more dirty than I felt before 94. It was strange. I was told: you know, you do realise what you're actually saying here. Like it's quite extreme. 95. Because I was talking like as if I was talking about the weather. Like, just very sort of like, matter of fact. 96. I was just totally disconnected from what I was saying and it took a long time before I could actually like, admit to myself that it happened. 97. Like I'd told the odd close friend, but not really anyone professional before and it was just strange to kind of like say it out loud to somebody, like as if it was going on record. 98. At the time, I had thought: Oh, like I'm totally over this; like I got over it really fast and all this stuff. Like I realised later on that actually I wasn't over it and I was just hiding it. Like, it all kind of came out later on, that actually like, I wasn't okay and I'd just been kind of pushing it down on the inside, I don't really need to talk about this; 99. … I just thought… well I've never needed to tell anyone. if I'd needed to tell someone, it would have been like, years ago. 100. But it was good to kind of like get it out. You know? 101. like realising that I hadn't actually given myself a chance to feel sorry for myself about what happened	43. Emotionally shutting down. Feeling nothing 44. Shutting down emotions to self protect 45. Unexpected things trigger memories and cause emotions to return 46. Disconnected from emotions as a self-protection and the nurse emphasising the importance of the disclosure 47. Repressed emotions over a period of time to cope, then the feeling of relief once she disclosed to a nurse (first hcp). Realising she could feel emotional about what had happened – permission giving

102. …it was like the realisation that I am worth something. I'm allowed to feel sorry for myself. 103. Just sort of like: aah, what's going to come out here? Am I going to cry, or like what's going to happen here 104. I'm just going to tell her this. She's heard stuff like this before; it'll be fine. 105. she's the one who picked up on: actually, you're not showing your emotions here; you're not connecting with what you're saying at all, you know, 106. I was in my house and I just broke down and cried. And it was the first time I'd ever actually come to terms with it. 107. I did feel like a weight had been lifted. A little bit, like just a feeling of like relief a little bit. Yeah. Just sort of like: I feel better now; I'm going to go and have a good day. 108. And I felt ashamed and guilty when I was disclosing everything 109. I kind of buried it away. I hadn't gone in to disclose at all, but it was just thought discussion that things… 110. Helped me realise that it was rape that had happened and that it wasn't just my… Confusion 111. I just remember, kind of feeling… Quite supported 112. It just came out. It was one of those really… Erm, unexpected things… 113. I think it was affecting my behaviour because I didn't feel that it had been acknowledged in any way … So I'd begun drinking and I think it was actually kind of through that 114. I felt really really uncomfortable, I think the last thing you want to do is have another physical examination. 115. have to go back again and again and again and it was just reliving the trauma, you know. 116. so I went back once and it was like reliving the trauma, but disclosing to a nurse, I felt for my own particular case, it was just… It was really traumatic. 'Cos I hadn't articulated… It had only been two weeks. I hadn't articulated it and got it all together in my head. 117. The longest Metro journey ever. It was just really really upsetting. Really slow walking across the road. 118. You're reliving that all the time… one little Groundhog Day of what's happened during your rape and what's happened afterwards. 119. And you were left in like a no-man's land, it seemed like we had an appointment every day for a fortnight, I mean, I was exhausted with the amount of appointments that there was. Absolutely exhausted 120. I sort of knew that what had happened wasn't quite right, but I'd sort of shrugged it off and never really done anything about it and then my friend who was from social work had had a talk from Rape Crisis here and she basically said to me: she was like "Look, what happened to	48. feeling of shame and guilt when disclosing and not getting words out 49. suppressed emotion about assault, seeing the nurse gave permission to acknowledge and recognise how it had impacted behaviour 50. feeling uncomfortable with process, having to re-disclose with every appointment was like re-living the trauma 51. the process of follow up care was repetitive and exhausting to have to re-live the trauma

you wasn't right; you didn't consent to that; you didn't have capacity to consent to that. Like, I needed to hear it from someone who actually knows about it, to sort of say "yes or no". Erm, and I got myself in a bit of a state about it 121. It's a bit of like an overwhelming relief, 'cos that made it real… 122. Which I think is what I'd been trying to put off, 'cos it was like maybe two years before 123. Erm, terrifying, 'cos I was very emotional anyway… I didn't want to tell her; I just wanted to… Not that I didn't want to tell her… I just… I hadn't really processed what had happened myself to even tell her that I didn't really understand what had happened, so for me, it was like… 124. So for me to have broken down, it was quite… I felt like I was very vulnerable anyway 125. Just felt sick the entire time. 126. I didn't tell anyone for… About eight or nine months and my mental health deteriorated quite significantly and erm… I just nearly did something very stupid and I thought: I can't do it, I can't do it.. 127. I just was in a horrific state at the time; I was very depressed 128. I told her. But she was like the only person I talked to for I think about two years.	52. needed someone to say – this has happened to you, before acknowledging it. Permission giving 53. relief at being supported because it made it real 54. Terrified at disclosing as had not processed what happened herself. Felt vulnerable emotionally and manifested physical symptoms – sick /crying
129. I didn't really know what to expect. you'd never think that they'd actually have to video 130. Because you'd had to relay it so many times. Then I had to tell them again, so they could write down exactly what I'd said, because I'd relayed it so many times… It was a little bit intimidating, 'cos she was like asking questions that like, implied that they were going to trick you. But it ended up making me thinking: oh, have I answered that right or wrong…? 131. But it was quite scary, because when I told the police originally, I was more intimidated there, because it was like completely one-on-one. And she didn't look away; she just stared completely whilst asking questions and writing down… That was when I felt the worst I think when I was in that room 132. so we had to wait for all these people'cos it was in the morning; we'd had to wait for the nurse to reply, 'cos she was on call 133. So they didn't tell me anything about a camera or anything until we got there. 134. She didn't really show much emotion. 135. But she was very, like… Straight faced and very serious. 136. She did treat it like she sees it all the time. 137. … I remember that. And erm… She wasn't really… If like, it came for me to speak…She was like… Asking more questions and… Loads more questions and she didn't really give me much time… She was really nice, but she wasn't very… It wasn't very person-centred and she just… I could have been anybody, really. 138. It made me feel more dirty than I felt before	55. Procedure after reporting was unclear and not explained. The unknown 56. Repetitive and intimidating questioning made it like you were not believe. 57. Didn't feel emotion from the nurse. Felt like she just sees this all the time 58. The nurse was asking questions but didn't give her time to answer them, didn't feel she was listening and made her feel worse 59. Felt as though the nurse was not supportive however, showing empathy towards the nurse as the nurse had been called out in

139. I feel like she maybe wasn't the best nurse. But **I can understand as well, 'cos it was like three o'clock in the morning, so they'd probably just dragged her out of bed,** 'cos she was on call. **She was probably thinking: Oh, I've got out of bed for this** **140. She was just very very very like, sympathetic, like just very nice** 141. **she never like, kind of tried to coax anything out of me**. 142. **at first, I thought: Just tell me your name; I don't know who you are or what your role is.** 143. **accepting and quite motherly and she was nice**. 144. … **Caring, the whole time**. **I felt quite reassured by it** 145. **I had to disclose everything again to this man, who I wasn't sure what his exact role was, he used certain words like "were you active or passive", which I didn't know what they meant…** 146. **So I had to say "pardon? What does that mean?" I felt a bit stupid really** 147. **I guess sort or medical in a way. It sounded quite intrusive, like… he then went on to say "did you penetrate or were you penetrated?" and again, it sounded very, erm, specific. As if it was like… I'd done a bad thing and I felt a bit, erm… I felt very… Erm, on the spot and being questioned for what happened**. 148. **Someone knocked and came in, the first time it was… The nurse said "yeah, come in" and I thought: you know, who's this? This is a private conversation. I'm disclosing stuff that's very sensitive and I'm scared about.** 149. **Well each time, I just… I felt more ashamed and disappointed with myself**. **Females were nice and very like motherly, but then the male at the end, it felt more… Erm, it was less sort of compassionate and more… Not like a telling off, but you know, "you must have safe sex" and this… "You can't allow this to happen again, because it's obviously…" He just had a different manner. And I don't know if it was because it was a male to male thing**. **Don't know. It was the third time; it felt a bit more intrusive talking to a man. I don't know if that was because of the subject and the content of the talk or, erm… But three times is quite…Excessive.** 150. **partially ashamed of what I'd done and being judged for, you know, 'is this what gay men are assumed to do'**. 151. **I think it felt like she was on my side.** 152. **So almost it felt like she was going to help me get some help.** 153. **She was kind of like 'motherly' really, in a sense**. 154. **Throw away your kind of pre-conceived notions of what you think a sexual assault victim is like, because that's not what we're like.** 155. **"So can you tell me what happened?" And I thought it was really… 'Cos the police were involved at this point and I just didn't want to go through it again; that was my feeling**. **why am I going through it with you? I've already disclosed to the police**	the early hours of the morning to come and see the survivor. 60. No introduction, name given by the nurse. This increased anxiety 61. The nurse being caring (being believed) was seen as motherly, this was reassuring. 62. Having to disclosure the assault to 3 people in one visit was emotionally difficult 63. Feeling the nurse believed them made them feel more positive about getting help. 'motherly' nature 64. Repetitive disclosure causing emotional distress 65. Didn't accept that she had been assaulted until she was told by nurse. Almost like permission giving

156. The impression I got was that the nurse didn't feel very comfortable. I mean, she was lovely. But didn't feel very comfortable 157. **And I felt really really uncomfortable as well, because after everything that I'd gone through, I think the last thing you want to do is have another physical examination**. 158. **Because it was literally the last place on earth I wanted to be because it meant that I was reliving what had happened; it was three (nurses) in total that I saw that day.** 159. **It was like "yes. That is a sexual assault. You did not have the capacity to consent" and it was quite like… Straight. Which I think is what I needed to hear. It was kind of like my moment of realisation that I knew that she was going to say that that was what it was and… Yeah. It was instant. And I kind of said to her, like… You know… "It kind of wasn't really real 'til you said that"** 160. **Kind of relieved because I'd finally got it off my chest and someone had, like confirmed it, I'm always going to be someone that that happened to and somehow would have to deal with that and… Now that it's not just in my head, like, it's an actual real thing someone of like a professional level, they knew about it and confirmed it**. 161. **I just kind of remember her looking sad for us. And I don't really like pity very much. I don't deal well with people like, feeling sorry for us.** 162. **I didn't feel like I was wasting anyone's time. she made me feel like I was doing the right thing by speaking to someone about it.** 163. **Erm, it was firstly to GP and then to a nurse, because the GP kind of just went… "I cannot deal with this". Erm, and it left me a in a bit of a situation.** 164. **but yeah, the GP was kind of… "I cannot… I cannot… I don't know how to help you", so…** 165. **Erm, and I just as soon as I could see that she almost felt uncomfortable, I kind of then didn't feel comfortable being there any more…And felt like I shouldn't have said anything.** 166. **That was her response. And I wasn't looking for her to tell me to go to the police; I was looking for, er… For… I don't know. A bit more of a sympathetic**. 167. **If she obviously didn't feel comfortable talking to me about it, there was no offer of where I could go to speak to someone…** 168. **I thought, going to a female nurse, it would have been received differently. That it was the first… I think the first… I think that affected me was the fact that it wasn't received the way I feel like it should have been. The fact that she handled it badly and then, because she was female, there was no empathy at all.** 169. **You assume that like a maternal instinct [of the nurse you tell]** 170. **Even if she couldn't deal with it herself, point me in the right direction who could and I just… I think, 'cos I got none of that**,	66. Was supported and believed, this makes survivors feel like they made the right decision to disclose 67. The response of the nurse indicated she was uncomfortable, this made the survivor regret disclosure and feel judged 68. Was expecting sympathy and maternal instinct as the nurse was female but felt let down by lack of support/ belief.

Nurses Significant descriptive statements (188) **(colours represent the different participants)**	Formulated general meanings units **(these numbers are used in cross reference for findings chapter)** (75)
1. **'I literally had my hand on the door to go and it [the disclosure] just started coming out'** 2. **'It was in her late teens, she was now in her twenties…. She had disclosed it to her family but they had closed ranks and didn't do anything about it, it was probably that generation where you didn't, you know, it was like, you don't talk about it.'** 3. **'She'd obviously never had any support of counselling, she'd just bottled it up'** 4. **'she had disclosed it, and we had to go to the police'.** 5. **'she has disclosed it [in the past] and it wasn't impacted upon, it was kind of well…ignored maybe a little bit'** 6. **'there is a sense of 'this is just what we have to do [call police when safeguarding issues]'.** 7. **'Sometimes as a nurse you kind of get quite exacerbated and exhausted by it because you're thinking, yeah, but now I've got all of this to do as well. But the fact someone has actually got or made a decision to inform you is really quiet a privilege'** 8. **'It took a long time to get that confidence and trust'** 9. **'I could see a lot of feelings of low self-esteem and low self-worth'** 10. **'You're actually the one person that's spent some time getting to know me'** 11. **'there's an individual who's trusted you** 12. **'somehow policies take over, its very… tick, tick, tick. We lose the individual.** 13. **You know, I can't remember if we asked permission – if she wanted this reported to the police** 14. **I can't remember whether we persuaded or whether** 15. **'I would have remembered having to persuade her, 'cos I remember other people who I have to persuade to get sort of the police and things, so I don't think we had to persuade her; I think she wanted them.** 16. **'are you alright, I'm not sure you look alright, or like yourself' and she said after a bit of hesitation 'no, I'm not' and looked really upset** 17. **So we went and sat down in a private room, put a notice on the door** 18. **I said I don't want you to tell me anything you don't want to talk about but I'm concerned about you** being on the shift when you look so upset'. **And she said ' I do want to tell you**	1. The disclosure came at the end of the session. The supportive nature of the session had encouraged disclosure as she had previously disclosed and had a negative experience which cause on-going barriers to disclosure 2. The need to follow guidance and policy dictates what happens next however, the nurse is aware the individual gets lost in this 3. The nurse experiences mental exhaustion when considering the impact the disclosure will have on her workload 4. The unique bond the nurse has with the patient encouraged disclosure 5. When a person disclosed assault, the nurse sees it as their role to try to persuade the survivor to report to the police. At times this is done despite the survivors wishes. 6. The nurse often uses her observation and communication skills to recognise there was something wrong with the survivor prior to disclosure 7. Using communication skills to recognise a private area to talk was needed

actually' and I said ' ok' and she just said ' I've been raped at the weekend' [silence for 3-4 seconds] **19. then just reminded her that perhaps because of the disclosure I would be, I might feel that I need to take this out and further, erm.. if it was something perhaps to do with the law, and you know perhaps consider involving the police** 20. **they are based in an educational setting and obviously in this role, but obviously RNT, so you're still a registrant and you're still abiding by the code** 21. **in the middle of a seminar, completely unconnected to anything to do with sexual health, nothing to do with safeguarding, an entirely what seemed to be a disconnected, unconnected subject, in the middle of that room,** **22. "I… I… Well I've been raped" and that brought the whole room to a grinding halt** **23. it was out with anything that you could have even predicted could have come to the surface, it was completely unexpected for everybody in the room including me** **24. that was a very unexpected and actually quite explosive one and very powerful disclosure** 25. **So it's very rare that I'm sitting talking to somebody who is kind of say, speaking to us about something else and then, for whatever reason, they kind of come out and disclose a sexual assault totally out of the blue like historical disclosures.** 26. **You know? Kind of massively massively historical. And that's usually being discussed within the context of something absolutely nothing to do with that, yet somehow the direction of the conversation ends up where they feel it's pertinent to kind of tell you that that's happened to them.** 27. **they're coming out with "well, I was assaulted", you know, yeah, that type of thing can kind of come out in that and, you know, nothing to do with why they're there in the first place,** 28. **it has occasionally come up within the domestic violence – we ask about domestic violence within there, but we don't specifically ask about sexual assault within the nurses' consultation,** 29. **We don't ask that specifically (sexual assault experience)** 30. **has come out within that discussion as a disclosure that I wasn't expecting,** 31. **I want to help this person, but I do sometimes think: this is going to be difficult, so I need to like, be mentally ready to have that difficult conversation… You're in the middle of doing something down here (the senior staff office) and you're asked suddenly to go into, you know, something that's going to be challenging.** 32. **erm, you know, just mentally reminding myself all of the things that I need to address on behalf of, you know, the patient.**	8. Warning the survivor on role boundaries before disclosure took place 9. Nurse used communication skills to manage an unexpected public disclosure that may have been triggering for other people 10. The disclosure was unexpected and not in context of conversation 11. The nurses don't specifically ask about sexual violence, but disclosures can happen when the conversation opens up around a similar context or where SV may happen – such as domestic violence 12. The nature of the topic means nurses often have to mentally prepare themselves to explore.

33. **You know, like if it's after five O'clock, sometimes you do feel a bit more heart sink, what services are out there? What am I going to do if I have to make a referral?**	
34. Sometimes there is a sense of something there' **35. 'sort of probe a little bit more to get more information** 36. '**So with one of them particularly**, **well she wasn't coping very well'** 37. **you just knew there was something underneath'** 38. '**There was something that was a bit deeper'** 39. '**I couldn't crack it, for want of a better word'** 40. '**I just knew there was something'** 41. '**We'd get on to similar subjects and she'd get me off it quite quickly**. **You know, typical blocking'** 42. '**There's something going on there'** 43. **those missing bits were impacting where we were now'** 44. '**She'd either block me or deflect me onto something else'** **45. 'I knew it, I knew there was something'** 46. … **I knew there was something'** 47. **I knew there was something**, **I've cracked it'**. 48. **quite a disempowered patient**. **She was disenfranchised, socially disempowered'** 49. '**you get very skilled at picking up the ques'** 50. **empathy kicks in straight away, how on earth must this poor girl be feeling'** 51. **I go into mam mode straight away'** **52. just a very very young girl and I just felt so sad for her and I just wanted to comfort her and I think typically as a mam and a nurse a hug just makes…' 'but, I can't put any of my evidence onto her because it could interfere with the police investigations'** 53. **I don't feel I can do my job properly when I can't do that, to offer comfort and support to somebody**. **it's like a denial, it's part of my job**, and **I feel sad because most if the time that's, that's what I feel that these girls really want and need, just somebody to hug them, you're going to be OK** and **I feel denied of that part of my job, it's, I don't like it'** **54. the most important thing those girls need then is sympathy**, **I think they need to be comforted and reassured that they are then safe'** 55. **Because if you've always looked at the subjects of her essays, it was always to do with GU stuff and fertility and contraception and… And it wasn't 'til latterly did she make that disclosure, she said that she wanted to work in sexual health. I kept thinking: I wonder if… That's part of the healing process.**	13. Nurses using communication skills to identify potential psychological distress or those that need emotional support 14. Nurses use their intuition and other communication skills to be aware of when to explore an issue further 15. Being aware that people disclosing need extra emotional support to feel able to talk about it 16. Empathy contributes to communication skills when nurses are receiving disclosures 17. Nurses believe that having a maternal instinct emphasises care given in this situation 18. Being tactile with patients that are distressed contributes to what nurses seen as supportive responses 19. Once a patient has made a disclosure, their previous behaviour and actions become easier to understand

56. ‘I don’t want to say the wrong thing’ 57. ‘**But you just worry about saying something wrong and then then closing up’** **58. ‘the majority of people are alright, because you do prepare them [to ask about SA]’ ‘but some people come in and despite telling them that [we’re going to ask some personal questions] in the beginning, they appear quite offended by the question’** 59. ‘**am I telling them everything they need to know? Am I giving them the right information Am I scaring them off?’** 60. **you do worry that you have missed something’** 61. ‘**a bit panicked that you might have missed something’** 62. ‘**if its disclosed unintentionally it makes me feel less nervous’** **63. ‘I can’t stop thinking about it, because it does, it makes you feel sick’** **64. ‘I don’t think it goes away [the worry]. Talking about it makes you feel better but you can’t get rid of it’** **65.** ‘**you then start panicking you have done everything like: oh my god, have I missed anything? Did I tell her about this? Did I give the information about this? Did I offer that?** **66.** ‘erm, **it [my voice] seems to be different, I don’t know why but it’s different with every patient’ ‘I seem to ask if there’s any violence in the relationship or if they’re frightened by anyone quieter’** 67. ‘**erm, if the patient is louder I seem to ask more confidently’** 68. ‘**it’s almost like I’m a little bit nervous to ask that question** **69. It makes me a little bit anxious if I know they’re coming in for that reason’** 70. ‘**I actually feel quite nervous [when receiving a disclosure]’** 71. ‘**I think I almost try a little too hard and that gets me more anxious’** **72. ‘it [rape] makes you feel angry that its happened. It makes you feel really really angry’** 73. ‘**just generally quite sad about the whole thing, and it does play on your mind because its upsetting’** 74. **you think. How are they like that and I’m so mmmm angry and upset but they’re the ones that have been through it and they’re just so calm. It’s quite upsetting’** 75. **then it was a bit like, blooming heck, this is awful. You know, what do I do? She’s given me all of this information, but what do I do with it and where do I go with this?’** 76. **Yep, I’ve opened Pandora’s box. Where do I go now? And how do I deal with this?’** 77. ‘**where do we go from all of this’** 78. ‘**I’m a health professional, I’m supposed to help her but what do I do? that was really quite scary as well, the reality of it and the fact it was quite a privilege’** **79. ‘I wasn’t quite sure what to do with it’**	20. Nurses feel a sense of responsibility for saying the right thing in response to a disclosure. The concern is that the survivor won’t talk further. 21. The nurses worry that they have gave the patient all the right information and options following disclosure. 22. This is a topic that nurses don’t forget easily. They continue to remember and reflect on this type of consultation for months and even years. 23. Verbal communication changes depending on the questions asked. When asking sensitive questions their voice becomes quieter 24. Sexual violence disclosure makes nurses anxious 25. Nurses feel anger on behalf of the patient after they have disclosed rape 26. Worry that they won’t know what to do with the information given. Feeling responsible for holding the information 27. Nurses feel torn between the compassionate desire to help the patient make their own decision against whether the sexual assault needs reporting or policy to be followed - responsibilities blurred so they look for guidance to instruct

80. **you have a responsibility of what you do with that information'** **81. Where do I go now? Do we go that way, do we go this way, do we just leave it open? It was really… And then you just start to question your own skills'** 82. 'you know, your head starts spinning' 83. **I don't think there was a policy that covered it'** **84. because I get clinical supervision, which is always a godsend in terms of my role because that allowed me, allowed me to go back and say 'what do I do with this' and he was able to pull it apart from my point of view'** 85. 'A level of responsibility that someone has actually trusted you to disclose that, now what do you do with that [information].' **86. you kind of feel privileged that someone trusts you enough to disclose that. But then you feel a bit awful that you've got 2 police guys knocking at the door'.** 87. **it was just sad really'** **88. 'As a nurse you want to go help and support people, but sometimes there's only so much you can do'** 89. 'actually, you walk out the door you just think, actually have I changed anything? Have I made anything better?' **90. ' I felt nervous about going back in, because it was a bit like the elephant in the room'** 91. **'it was always a strained relationship because she always used to have HCPs in. It was almost like 'yeah, you're another one, you are going to sit here and disappear again', that relationship we had, well I don't think it ever seemed as good'** 92. **when you hear the girls trying to relay what has happened, it's very upsetting, to, you know, because again they're very often very young girls and they've got alcohol on board'** 93. 'it's just so frustrating to think that, they're just not taking enough care of themselves, they'll go out, they'll have so much to drink and they're not in full control of what they're doing and it's worrying' 94. 'it's upsetting to hear what some girls have experienced. 95. 'It's difficult, I do often go away and think ' Dear me' you know it's just empathy, empathy just kicks in. What must that have felt like, to go through that experience?' 96. 'You very quickly learn that you move from one experience to the next' 97. 'You've got to learn very quickly how to keep your emotions in check. It's afterwards, it's sometimes when you're driving home in the car when it comes back to you and you think 'I wonder how that girls getting on' and then you do, you think about, again you reflect on what they've told you and its sad isn't it?' 98. **And then you just click in to… I need to remember everything, 'cos I need to write this down; I need to help her.**	28. In order for nurses to manage the anxiety that comes with sexual assault disclosures they benefit from clinical supervision to reflect on their management 29. The is a level of guilt when a disclosure has resulted in police being called when the survivor may not have wanted this 30. Anxiety that continuing the relationship, once you have reported the assault to the police, without the patient's consent, can be detrimental. 31. Nurses feel sad that 'girls' are experiencing this and believe alcohol is a contributing factor 32. Listening to experiences of sexual assault and rape can be very emotionally distressing to nurses. 33. Whilst empathy is felt, there is a need to keep emotions compartmentalised during the consultation, so the main focus is the service user and their experience 34. Once a shift is finished the emotion of what has been disclosed stays with the nurse 35. A nurses main priority is to help the individual, to be her advocate 36. Receiving and managing these disclosures can be emotionally distressing

99. remember a lot of the stuff and then write it down later, 'cos you can't just leave somebody when all of this is coming out. 100. it was quite upsetting, quite distressing. You know? I just wanted to do the best for her and you don't know what's the best 101. 'cos I'm her advocate; I'm allowing the police to do this, but what's the best for her 102. just really just horrible. It was just horrible. 103. you feel: oh, god, I've got this to do, I've got that to do and what have you? Erm… But your priority is your patient. That comes with experience. Very much with experience 104. I need to, everything else is switched off and I'm very good at switching off 105. but then it was like reality sets in and I think: you've just… That reflection of: oh my god. All of that's just happened; she's told me all of this 106. Nurses are very good at processing things later; you don't process at the time because if you processed at the time, you wouldn't be able to do what you had to do 107. So if you processed at the time, I wouldn't have been able to let the pathologist do all the things, because she'd been through enough 108. It was quite a shock when it happened because, it was out of the blue and completely unexpected. 109. Just didn't want her to feel stressed, well she looked stressed, take her away to somewhere a little more peaceful and calmer. 110. I felt sick, I felt really sorry for her 111. I just remember feeling sick inside and thinking 'wow' 112. considering how long ago it was, just how vivid it is 113. Oh, I still think about that one regularly. 114. That one still sort of hangs around a little bit. 115. I always feel very sorry… A lot of sorrow for them. I think that's the main thing 116. I just think… It just must have been horrendous for them. Absolutely horrendous. 117. What a horrible thing to happen to somebody. to go through that and experience those feelings and emotions. It must just be awful. Like beyond awful. 118. I always think and hope that I've made it as easy as possible for them. Whatever they've had to do; whatever they've had to answer, be asked about, talk about…. I just hope that we've made it as comfortable and as stress free as we can possibly make it for that…. That's what I always think about. No matter what they've told us or what's happened to them, I'm always quite conscious about that when they go. Did I do that enough? I always ask myself that. Did I do that enough? Kind of, did I… Was there at any	37. Being able to switch off emotions to deal with the management some cases is essential to get through them 38. Disclosures are often unexpected 39. The experience and memory of receiving a rape and/or sexual assault disclosure stays with nurses for months and years after the case 40. Feeling sick when receiving disclosures, physical manifestation of emotions 41. Feeling sorry for them. Empathy. 42. The desire to make the experience of disclosure as easy as possible 43. Nurses feel anxiety that they managed the disclosure correctly 44. Receiving disclosures of SA and rape and be highly stressful 45. After receiving a disclosure there is often a need to see support from senior colleagues.

point where I could have upset this person more than, you know… Whether that was inadvertently I always think about, when they've gone. Every single time. 119. I used to feel highly, highly stressed when I had to go and speak to somebody [senior] about a sexual assault. Highly stressed. 120. Yeah. I find it highly highly stressful. Definitely 121. It's just awful. It's… I can't… It still stresses me to death to this day. I don't think it will ever not stress me to death. It's a really, really awkward uncomfortable situation to be in. 122. It can be a bit heart sink. 'Cos you think: right, we've got a much longer consultation and it's going to be more complicated now in many ways 123. Occasionally, they stay on my mind. if it wasn't straightforward, maybe something had happened, or if I felt I could have done something better, it would stay on my mind.	46. There is an awareness that the consultation will last longer than standard and will be more complicated. This causes anxiety 47. The nurse will often reflect on the disclosure consultation and be anxious that they have not manages it right, or could have done something better
124. Room is sort of, almost semi set up' 125. 'you could fully set it up before they come in, but I don't know if that's a good thing' 126. 'so it's [the consultation room] quite clinical looking' 127. 'It is quite clinical' 128. 'some people [other clinical staff] get all their swabs out ready, erm I don't always because I worry it might frighten them off' 129. 'I don't want them to see that [clinical equipment] and then get spooked and disappear' 130. 'Leave them [the clinical equipment] in a trolley, you can prepare them [service users] better… I think if they saw that, that might, might frighten them a bit' 131. 'I used to like seeing people in their homes because I used to think 'it's their environment' and they feel more in control. But whereas in hospital its more about, I suppose we have the power' 132. 'Seeing patients at home I used to find you got a lot more from that interaction, You just picked up that vibe.' 133. 'the hospital environment is more artificial' 'I personally don't think I would have elicited that information [has the discussion been in a clinical environment]' 134. 'maybe again if you're in your own home you feel more safe' 135. ' 'So the patient would first of all have to self-present to the department, book themselves in to create an account within the department so they're verbalising to the receptionist'	48. There is an awareness that the clinical environment can be intimidating to some of these patients. 49. Depending on the role of the nurse, it can be better to see the patients in their own environment in order to remove the power imbalance 50. In the home environment you can use more skills to pick up on potential issues. 51. There is an awareness that patients are often pre-disclosing to reception staff in busy areas, to make sure they see the right practitioner. However, there is no

136. ‘people might not realise they're well within their rights to say 'Actually I’d rather not talk about that here' or 'I would want to wait and speak about it in private' So potentially there's other people overhearing what could be said’ 137. ‘But it's still not in an enclosed room, it's behind a curtain, So it's still not private enough. If someone did though say something's happened to them, or if they are having like a PV bleed for example, any sort of intimate personal problem, we would always say 'right we need to go to a different area and we would take them to a confidential kind of, where a confidential conversation could take place. ‘it will always be in a private room where there's a door, where it can be closed so only the people in that room can hear what's being said’ 138. So we’re in a room, erm, a private room; there was no curtains, it was a room that shut, so it was completely private 139. So we explained that we had to preserve things, but we wanted to look after her as well, so there’s things that we had to do. Erm, phone the police and they came very quickly; they were really good 140. So if I’d have been anywhere near, then that could have skewed lots of things, ‘cos of there was cross-contamination, all that sort of thing 141. Quite relaxed [the tone of the room]. Not sort of like… So not unprofessional, but like not really strictly professional sort of stuff. Just a nurturing sort of thing, really. ‘Cos I think, you know, she’d been through a pretty horrific ordeal, so it wasn’t just sexual assault 142. as soon as she disclosed, the minimum amount of people went in, so we kept it to a minimum 143. Yes, it was off the ward [the room I took her to]. Because even on the ward if you put don’t enter on the door people did feel they could just knock and come in, so we just removed ourselves 144. that we could sit down and wouldn’t be disturbed 145. it was just a more comfortable environment than, you know… but I think it was probably trying to remove the power thing. 146. They’re a lot smaller. I think, I guess ‘cosier’ might be the kind of better word. Erm, they don’t have any clinical equipment in them whatsoever. With kind of comfortable chairs and the chairs are kind of arranged in kind of more of an adjacent way, 147. It is literally just… You know, kind of chairs, comfy chairs, kind of you know… A couple of serene pictures. Small, erm, tissues to the ready and it’s just… Yeah, it’s just more like, just a very informal room as opposed to… You know, you go in and like I say,	confidentiality with this. The nurses are aware of this, no changes are made to ease this process. 52. The nurse called the police to come straight after disclosure 53. They try to keep the atmosphere as relaxed as possible 54. There is an awareness that confidentially is key in facilitating disclosures of SA&R 55. There is an awareness that an informal counselling style room rather than a clinical room can aid in facilitating effective communication during a SA&R disclosure.

there's a lot of clinical equipment, bins, trolleys, beds, overhead lights. It's just very very different. 148. **but rather than sit at the computer and kind of tap and not look at them and kind of look at the screen and not look at them, I'll usually get a paper copy of the template and have it on a kind of clipboard, just either on my knee or next to us, 'cos I can kind of… I can make notes quite easily without kind of… Breaking eye contact – It tries to be a bit more of a normal conversation.** 149. **It's obviously a difficult disclosure; it's a difficult conversation. It's not going to be easy or straightforward and I guess… It's about making the patient more… Erm, or the woman, man, more comfortable and more able to go into the detail that they need to without being in a clinical environment.** **150. but they all have low sofas. Erm, and they're kind of set up so that you're sitting on an angle to the client and erm, you've got no computer between you** 151. **I personally think that kind of discussion is better done without constantly referring to a keyboard, because the person, you know, they're in the moment, aren't they? They're offloading they might be feeling quite stressed about what they're saying when they see it going into a computer; they feel like they've maybe lost a bit more control than just someone who is actively looking at them and intermittently making notes. Being able to listen actively, reflect conversations back, summarise conversations…** 152. **So I think it's about giving the person to talk about this really difficult situation and giving them permission requires the right environment and the right communication skills.**	56. Nurses believe that the consultation will be managed more effectively if there is a comfortable environment 57. There is a belief that the computer can cause a barrier in the consultation 58. Permission giving (to disclosure) is best facilitated in the right environment, this being a comfortable relaxed space
153. '**My main experience from having actual dealings with girls where they have suggested [rape]'** 154. '**Girls who had been out drinking with their friends'** 155. **'They come into us after being separated from their friends and then alleging that something has happened to them** 156. '**She'd alleged she had been raped, quite nasty as well because she had some injuries'** 157. '**so typically if a girl makes a suggestion that they've been in any sort of sexual assault we would send them directly there [sexual assault referral centre] and to the police'**	59. there is a use of the word 'girls' to describe survivors of SA and rape. This gives a very specific impression of who the nurses think are survivors of SA&R are 60. nurses associate sexual assault and rape with injuries

158. **'I find now a lot of girls where they've had a lot of alcohol to drink and they'll allege that things have happened and then they've maybe panicked or typically girls who are in relationships and then they'll backtrack and retract that nothings actually happened** 159. **'by the time the alcohol's stared to wear off their system and I think the information, they've absorbed it for themselves and then they'll come out and say 'I actually just want to go home, I don't think anything happened to me at all'** **160. 'it's a very sensitive issue and you know, a lot of genuine cases where we do see where girls have had things happen to them you know and they're very distressed and it's not pleasant is it'** **161. 'it can be made worse by the fact they've got alcohol on board usually, I've not dealt with a girl yet who hasn't had alcohol on board where this has allegedly happened'** **162. I guess when you're talking about reporting to the police with a patient. Again, it's trying to strike that balance between encouragement and you don't want to… You don't want them to feel pressured into it. You know, like they somehow have to be the person to fight the fight for everybody else who's ever been assaulted** 163. **I'm quite conscious just to make it sound like I'm just giving them information [about police reporting]; not selling it as some kind of like, personal crusade**. **164. Just a bit perplexed by. I want to know what in their head made them think that that was a… Safe situation? You know when somebody tells you something and you just think: God, I'd never do that. Or: I'd never put myself in that situation. How did you find yourself exactly in the mind set that you thought that that wouldn't be… Wouldn't be… Risky, I suppose.** 165. **and I was just perplexed… couldn't understand why somebody would do that…'Cos in my head, oh God, that feels so dangerous. Such a dangerous thing to do, to go off driving with somebody that you don't…** 166. **As a mother of three teenage girls, I think it does, because you become a little bit… Well a lot more conscious really of the potential for danger when they're out and about, especially alcohol, which always seems to be a part of… Or frequently is involved with assault and so I think it heightens your awareness of the dangers and when you're putting yourself at risk… Maybe not putting yourself at risk, but… You know… Just trying to sort of advise my girls to think about safety when they go on nights out in town. You know, all this sort of stuff about having enough money for a taxi and not leaving their friends and having their keys. Not travelling in taxis alone. That sort of thing. So I think I'm probably a little bit more aware than maybe…**	61. nurses often link distressed presentation with 'genuine' rape cases 62. nurses believe alcohol plays a large part in experiences of rape and sexual assault 63. some areas will immediately refer 'girls' to SARCs if there is any suggestion of rape or sexual assault 64. There is a belief, in some clinical areas, that when alcohol wears of the 'girl' will backtrack as they panicked into the accusation and then retract their accusation 65. Nurses do not want to pressurise patients into reporting but do want to encourage it. Striking the balance can be difficult 66. Lack of understanding as to why the individual would put themselves in a presumed dangerous environment 'not taking care of themselves'

167. 'My experience [of disclosures] of the people I see, they are either in a relationship with them [perpetrator] or it's been someone they know 'I'd like to think I have built up a relationship therefore that's why they have chosen to disclose it to me' **168. 'you then decide whether you then refer them elsewhere', based on what they want to do, because obviously you can't force anyone to do anything whether it was months ago, year or weeks. It has to be their decision' 'I give them information and then it's their choice, so I act upon what they want me to do'** **169. 'unfortunately, when the police came she wouldn't speak. but I felt better because I did what I was supposed to do'** 170. 'you leave it with her in the hope that she see's sense and goes to the police' **171. the ones we see we tend to pass on to our health advisors. We pass them [survivors] on to discuss giving them Hep B and further services. I get frustrated because I feel like I have built up that relationship. Why can't I see them through to the end. Instead, I have the trust of them and then I am passing them on to someone else, to then pass them on to someone else'** 172. 'We need quality and quantity don't we, we need all of the information together. So it's asking a lot of questions and again, I feel that because that's the job we have to do' 173. 'Well I ask the patient, have they reported to the police already and we give them the option do you want to report this to the police' 'so I would ask their consent, do they want me to ring the police? Do you want to ring the police yourself?' 174. 'it's less intimidating when it's only one female member of staff who is speaking to the patient. A lot of the time our registrars are male doctors and you're always very aware of that, how are they going to respond when we've potentially got a male doctor and they might be thinking, they're going to want to look at me' 175. And **the people who come to us and they haven't reported it, it's… You normally can't persuade them to report it, I would say** 176. **Sometimes it can take up to an hour, by which time the person they were originally booked in with has had to move on to the other patients and they're kind of… It's going to put their clinic behind. So sometimes there has to be a reshuffling and they end up seeing somebody else. Lack of continuity** 177. **Safeguarding for the patient, really, in case, you know, if it's someone that they know, are they going back to a situation that's going to be dangerous for them?** Erm, and **how are we going to make that patient safe? And how are we…? You know, after five O'clock on a Friday, what are we going to do to ensure that everything is done for this person that needs to be done?**	67. Some nurses are aware that a patient may not want to speak to the police but call them anyway as it makes them feel like they have done the right job. 68. It is frustrating for nurses that there is, at time, disjointed care with often numerous other staff involved. 69. Nurses believe they are giving the patient options as to whether they want to contact the police however, at times these are not options and cleverly worded questions 'so I would ask their consent, do they want me to ring the police? Do you want to ring the police yourself?' 70. There is a level of persuasion in most areas, by most nurses, to get the survivor to report the assault to the police 71. Due to the nature of certain clinics there is a lack of continuity of staff for survivors 72. The importance of safeguarding an individual can be very stressful for nurses 73. There is an awareness that cases are complex however, also an awareness that there are other patients waiting to be seen 74. Documentation is a very important element of management for nurses when considering the legal implications

178. **You know, you've got a room full of patients and you haven't got the time to ring other services and you're thinking: can I leave this 'til the next day? Can I pick it up tomorrow? All of that sort of thing.** 179. **You're talking about, you know, something obviously really difficult; it's a serious situation. I mean, the documentation itself, around sexual assault does have to be erm, very accurate, contemporaneous, in case it did become… I mean all documentation should be. But in those particular cases, you're thinking about documentation as well, because**… 180. **I think is it a concern that your documentation is accurate** **181. I suppose if it did become a legal case and the police… You know, it goes to court and then they ask for the notes. 'Cos that does happen.** 182. **I wanted to reflect on how I'd managed it, I would take it to supervision, clinical supervision**. **183. My clinical supervision comes from my manager, so I could take it there.** 184.	75. Supervision is used if a nurse feels they need to explore particular cases they have managed, this often has to be asked for - however this is often with managers and the power issues with thinking they may have not quite managed correctly.

Appendix 12: Formulated general meaning units converted into themes for both participant groups

Divided by themes and sub themes identified (in no particular order).

Survivors formulated meaning units into themes:

Theme 1: Unpreparedness	Subthemes:
• Not being believed can lead to feelings of regret, regret for attending and regret at disclosing • Because of the dismissive reaction of the nurse, feelings of embarrassment and being ashamed of the situation caused survivor to shut down and decide to not make any further disclosures • Disclosure felt daunting and scary. Frightened/fear. • Not wanting to show upset or emotion in front of stranger • Anxiety of not knowing what would happen next manifested as physical symptoms – sick. • Realisation and relief of someone else knowing and that something might be done/support given • Anxiety of planning what to say when reporting it, repeating in mind. This causes anxiety and makes survivor want to not report	Attending to Unready Emotion validation

• Emotionally shutting down. Feeling nothing • Shutting down emotions to self protect • Unexpected things trigger memories and cause emotions to return • Disconnected from emotions as a self-protection and the nurse emphasising the importance of the disclosure • Repressed emotions over a period of time to cope, then the feeling of relief once she disclosed to a nurse (first hcp). Realising she could feel emotional about what had happened – permission giving • Suppressed emotion about assault, seeing the nurse gave permission to acknowledge and recognise how it had impacted behaviour • Feeling uncomfortable with process, having to re-disclose with every appointment was like re-living the trauma	

• The process of follow up care was repetitive and exhausting to have to re-live the trauma • Needed someone to say – this has happened to you, before acknowledging it. Permission giving • Relief at being supported because it made it real • Terrified at disclosing as had not processed what happened herself. Felt vulnerable emotionally and manifested physical symptoms – sick • Repetitive disclosure causing emotional distress • Having to disclosure the assault to 3 people in one visit was emotionally difficult • Didn't accept that she had been assaulted until she was told by nurse. Almost like permission giving	

Theme 2: Not knowing	Subthemes:

• The nurse suggesting she had given implied consent made her question what had happened. This leads to anxieties over what people will believe too. • Nurse using language that indicated the survivor has some responsibility in the assault increases self-doubt and regret at attending and disclosing • Disclosure being questioned makes survivors feel as though they're being judged as making 'silly choices' • Disclosure not being taken seriously, leads to feelings of being judged • If alcohol is involved then survivors feel as though the nurse focuses on this, meaning they have some responsibility towards the assault • Once rape/SA is mentioned survivor felt not listened too as the rape became the focus • Feelings of not being believed • Worried that someone was going to tell them that they were wrong, that they hadn't been assaulted or that it	Anticipation Relationship Finding Their voice Repetition Confidentiality Environment Belief Communication Being Silenced Feeling Safe

was their fault because of alcohol use • Survivors are worried that someone will recognise them in the waiting room • Worry that other people in the waiting room are judging them (in sexual health services) • Panic that you see someone you know leads to increased anxiety • Looking for a friendly face among staff moving around the clinic, worry about who they will see and if they will be nice • Not a welcoming reception when there is already worry about being there • Anxiety about what will happen next. Not knowing the process causes heightened anxiety • No knowledge on what will happen next • Not knowing if the person you see will be nice • Vivid lurid colours still resonate with negative memory	

• What's behind the closed door, what happens once you are called in? • General equipment can trigger a memory of attack 'rapeso', this was unexpected • The feeling of everything going in slow motion, journey to clinic, waiting room, walking to consultation room – the not knowledge what is going to happen– all heightens anxiety and can contribute to regret at attending • Journey to the service gives time for thoughts around what might happen. This increases anxiety • Lack of engagement with support services as was reported on her behalf by family member. Didn't feel ready mentally to be prepared for police involvement or reporting at the time, no choice given • Relieved at someone taking charge and not having to make decision • Feeling of being pushed into accessing services elevates anxiety on what will happen next	

• Worried that reporting it will mean lack of confidentiality, people will find out what happened • Resigned to the thought that no evidence means nothing will happen once the assault is reported • Process moved so fast there was a lack of time to make or contribute to decisions • Someone else taking charge helped formulate a plan of what happens next, when maybe this decision making was too much • Concern about the impact on assailant and his family made reporting a difficult decision • Worried reporting it would mean people would find out and not believe it was an assault. That it was consensual and would be judging her • Did not feel informed about the process. Thought she couldn't say no throughout process. Phrasing of questions did not leave room for an open/optional answer • Feelings of guilt and being ashamed made emotional health worse	

• Concern about not knowing the the impact on other people • Feelings of concern about reporting then manifest into anxiety about who will find out • Not knowing if they are believed, making them feel judged by nurse • feeling of shame and guilt when disclosing and not getting words out • Procedure after reporting was unclear and not explained. The unknown • Repetitive and intimidating questioning made it like you were not believe. • Didn't feel emotion from the nurse. Felt like she just sees this all the time • The nurse was asking questions but didn't give her time to answer them, didn't feel she was listening and made her feel worse • Felt as though the nurse was not supportive however, showing empathy towards the nurse as the nurse had been called out in the	

early hours of the morning to come and see the survivor. • No introduction, name given by the nurse. This increased anxiety • The nurse being caring (being believed) was seen as motherly, this was reassuring. • Having to disclosure the assault to 3 people in one visit was emotionally difficult • Feeling the nurse believed them made them feel more positive about getting help. 'motherly' nature • Was supported and believed, this makes survivors feel like they made the right decision to disclose • The response of the nurse indicated she was uncomfortable, this made the survivor regret disclosure and feel judged • Was expecting sympathy and maternal instinct as the nurse was female but felt let down by lack of support/ belief.	

Nurse Formulated Meaning Units Converted into Themes

2* The need to follow guidance and policy dictates what happens next however, the nurse is aware the individual gets lost in this. 5* When a person disclosed assault, the nurse sees it as their role to try to persuade the survivor to report to the police. At times this is done despite the survivors wishes. 8* Warning the survivor on role boundaries before disclosure took place. 28* Nurses feel torn between the compassionate desire to help the patient make their own decision against whether the sexual assault needs reporting to safeguarding or the police – role blurred boundaries. 30* The is a level of guilt when a disclosure has resulted in police being called when the survivor may not have wanted this. 54* The nurse called the police immediately. 66* some areas will immediately refer 'girls' to SARCs if there is any suggestion of rape or sexual assault. 68* Nurses do not want to pressurise patients into reporting but do want to encourage it. Striking the balance can be difficult. 71* Some nurses are aware that a patient may not want to speak to the police but call them anyway as it makes them feel like they have done the right job. 73* Nurses believe they are giving the patient options as to whether they want to contact the police however, at times these are not options and cleverly worded questions 'so I would ask their consent, do they want me to ring the police? Do you want to ring the police yourself?' 74* There is a level of persuasion in most areas, by most nurses, to get the survivor to report the assault to the police. 21* Nurses feel a sense of responsibility for saying the right thing in response to a disclosure. The concern is that the survivor won't talk further. 36* A nurse's main priority is to help the individual, to be her advocate. 31* Anxiety that continuing the relationship, once you have reported the assault to the police, without the patient's consent, can be detrimental. ***(14 formulated meanings)***	**Responsibility:** *The state or fact of having a duty to deal with something or of having control over someone* *Juxtaposition of duty of care and patient choice*
3* The nurse experiences mental exhaustion when considering the impact the disclosure will have on her workload. 12* The nature of the topic means nurses often have to mentally prepare themselves to explore. 22* The nurses worry that they have gave the patient all the right information and options following disclosure. 23* This is a topic that nurses don't forget easily. They continue to remember and reflect on this type of consultation for months and even years. 25* Sexual violence disclosure makes nurses anxious, no matter whether they knew the reason for attendance. 26* Nurses feel anger on behalf of the patient after they have disclosed rape. 27* Worry that you won't know what to do with the information given. 28* In order for nurses to manage the anxiety that comes with sexual assault disclosures they benefit from clinical supervision to reflect on their management. 33* Listening to experiences of sexual assault and rape can be very emotionally distressing to nurses. 34* Whilst empathy is felt, there is a need to keep emotions compartmentalised during the consultation, so the main focus is the service user and their experience. 35* Once a shift is finished the emotion of what has been disclosed stays with the nurse. 37* Receiving and managing these disclosures can be emotionally distressing. 38* Being able to switch off emotions to deal with the management some cases is essential to get through them. 40* The experience and memory of receiving a rape and/or sexual assault disclosure stays with nurses for months and years after the case. 41* Feeling sick when receiving disclosures, physical manifestation of emotions. 42*Feeling sorry for them. Empathy. 44* Nurses feel anxiety that they managed the disclosure correctly. 45* Receiving disclosures of SA and rape and be highly stressful. 46*After receiving a disclosure there is often a need to see support from senior colleagues. 47* There is an awareness that the consultation will last longer than standard and	**Emotion:** *a strong feeling deriving from one's circumstances, mood or relationship with others.* ***Emotive:*** *arousing or able to arouse intense feeling*

will be more complicated. This causes anxiety. 48* The nurse will often reflect on the disclosure consultation and be anxious that they have not manages it right or could have done something better. 49* The consultation will stay on nurse's minds, even over run into their private life. 55* They try to keep the atmosphere as relaxed as possible. 56* There is an awareness that confidentially is key in facilitating disclosures of SA&R. 76* The importance of safeguarding an individual can be very stressful for nurses. 79* Supervision is used if a nurse feels they need to explore particular cases they have managed, this often has to be asked for ***(26 formulated meanings)***	
7* Using communication skills to recognise a private area to talk was needed. 9* Nurse used communication skills to manage an unexpected public disclosure that may have been triggering for other people. 13* Managing disclosures becomes more difficult outside of 'normal' hours (evenings and weekends). 50* There is an awareness that the clinical environment can be intimidating to some of these patients. 51*Depending on the role of the nurse, it can be better to see the patients in their own environment in order to remove the power imbalance. 52* In the home environment you can use more skills to pick up on potential issues. 53* There is an awareness that patients are often pre-disclosing to reception staff in busy areas, to make sure they see the right practitioner. However, there is no confidentiality with this. The nurses are aware of this, no changes are made to ease this process. 57* There is an awareness that an informal counselling style room rather than a clinical room can aid in facilitating effective communication during a SA&R disclosure. 58*Nurses believe that the consultation will be managed more effectively if there is a comfortable environment. 59* There is a belief that the computer can cause a barrier in the consultation. 60* Permission giving (to disclosure) is best facilitated in the right environment, this being a comfortable relaxed space. 72* It is frustrating for nurses that there is, at time, disjointed care with often numerous other staff involved. 75* Due to the nature of certain clinics there is a lack of continuity of staff for survivors. 77* There is an awareness that cases are complex however, also an awareness that there are other patients waiting to be seen. 78* Documentation is a very important element of management for nurses when considering the legal implications ***(15 formulated meanings)*** 1* The disclosure came at the end of the session. The supportive nature of the session had encouraged disclosure as she had previously disclosed and had a negative experience which cause on-going barriers to disclosure. 4* The unique bond the nurse has with the patient encouraged disclosure. 6* The nurse often uses her observation and communication skills to recognise there was something wrong with the survivor prior to disclosure. 14* Nurses using communication skills to identify potential psychological distress or those that need emotional support. 15* Nurses use their intuition and other communication skills to be aware of when to explore an issue further. 16* Being aware that people managing or needing emotional support may need extra guidance to feel able to talk about it. 17* Empathy contributes to communication skills when nurses are receiving disclosures. 18* Nurses believe that having a maternal instinct emphasises care given in this situation. 24* Verbal communication changes depending on the questions asked. When asking sensitive questions their voice becomes quieter. 39* Disclosures are often unexpected 10* The disclosure was unexpected and not in context of conversation. 11* The nurses don't specifically ask about sexual violence, but disclosures can happen when the conversation opens up around a similar context or where SV may happen – such as domestic violence ***(12 formulated meanings)***	**Communication:** *the imparting or exchanging of information by speaking, writing or using some other medium*

32* Nurses feel sad that ‘girls’ are experiencing this and believe alcohol is a contributing factor. 61* there is a use of the word ‘girls’ to describe survivors of SA and rape. This gives a very specific impression of who the nurses think are survivors of SA&R are. 62* nurses associate sexual assault and rape with injuries or distressed behaviour. 63* nurses often link distressed presentation with ‘genuine’ rape cases. 64* nurses believe alcohol plays a large part in experiences of rape and sexual assault. 65* there is an association between survivors being distressed and ‘genuine’ cases of SA&R. 67* There is a belief, in some clinical areas, that when alcohol wears of the ‘girl’ will backtrack as they panicked into the accusation and then retract their accusation. 69* Confusion to why the individual would put themselves in a risky environment. 70* Lack if understanding as to why the individual would put themselves in a dangerous environment such as, ‘driving off in a car with someone you don’t know’ ***(9 formulated meanings)***	**Naivety:** lack of experience, wisdom, or judgement Or **Blaming:** *assign the responsibility for a bad or unfortunate situation or phenomenon to (someone or something)*

Appendix 13: Key principles of trauma informed care and practice

Taken from Sweeney *et al.,* (2016)

1. Recognition	Recognise the prevalence, signs and impacts of trauma. This is sometimes referred to as having a trauma lens. This should include routine enquiry about trauma, sensitively asked and appropriately timed. For individual survivors, recognition can create feelings of validation, safety and hope
2. Resist retraumatisation	Understand that operational practices, power differentials between staff and survivors, and many other features of psychiatric care can retraumatise survivors (and staff). Take steps to eliminate retraumatisation
3. Cultural, historical and gender contexts	Acknowledge community-specific trauma and its impacts. Ensure services are culturally and gender appropriate. Recognise the impact of intersectionalities, and the healing potential of communities and relationships
4. Trustworthiness and transparency	Services should ensure decisions taken (organisational and individual) are open and transparent, with the aim of building trust. This is essential to building relationships with trauma survivors who may have experienced secrecy and betrayal
5. Collaboration and mutuality	Understand the inherent power imbalance between staff and survivors, and ensure that relationships are based on mutuality, respect, trust, connection and hope. These are critical because abuse of power is typically at the heart of trauma experiences, often leading to feelings of disconnection and hopelessness, and because it is through relationships that healing can occur
6. Empowerment, choice and control	Adopt strengths based approaches, with survivors supported to take control of their lives and develop self-advocacy. This is vital as trauma experiences are often characterised by a lack of control with long-term feelings of disempowerment
7. Safety	Trauma engenders feelings of danger. Give priority to ensuring that everyone within a service feels, and is, emotionally and physically safe. This includes the feelings of safety engendered through choice and control, and cultural and gender awareness. Environments must be physically, psychologically, socially, morally and culturally safe
8. Survivor partnerships	Understand that peer support and the coproduction of services are integral to trauma-informed organisations. This is because the relationships involved in peer support and coproduction are based on mutuality and collaboration
9. Pathways to trauma-specific care	Survivors should be supported to access appropriate trauma-specific care, where this is desired. Such services should be provided by mental health services and be well resourced

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