Examining Accessibility of Services for Sexualized Violence: Understanding the Survivor's Experience

by

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Dalhousie University is located in Mi'Kma'ki,
The ancestral and unceded territory of the Mi'kmaq.
We are all Treaty people.

Table of Contents

Abstract

Sexualized violence has a profound impact on an individual's health and wellbeing, yet only a fraction of survivors seek support from formal services. Studies exploring survivor decision processes on accessing services and supports for sexualized violence are lacking. The purpose of this study was to understand the lived experience of survivors who attempted to access, accessed, or did not access services/supports for sexualized violence, within Halifax Regional Municipality in Nova Scotia. Qualitative interviews were conducted with 10 individuals, informed by feminist phenomenology. The following seven themes were discovered: Recognizing Sexualized Violence, Re-traumatizing Services, Supportive Service Experience, Ripple Effect, Gaps in Service and Education, Foundational Knowledge, and Trauma-informed Care. Participants shared their experiences and provided suggestions to improve care for survivors. This research highlighted the voices of survivors and recommendations have been made to use trauma-informed care and increase education to strengthen services and supports for survivors across multiple sectors.

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Finally, to all survivors: I believe you.

Chapter 1: Introduction

Statistics Canada has estimated 22 in every 1000 Canadians self-reported experiencing sexualized violence (Conroy & Cotter, 2017). In 2014, 633,000 individuals self-reported incidences of sexualized violence, in Canada (Perreault, 2015). It is difficult to determine the exact number of incidents of sexualized violence. Conroy and Cotter (2017) estimated that in Canada, approximately 7% of incidents of sexualized violence were reported to the police. When incidents of sexualized violence are not reported to healthcare professionals, or police, following an assault, preventative treatments for sexually transmitted infections or pregnancy, for example, are often delayed which can have serious impact on an individual's health and wellbeing. Pregnancy, sexually transmitted infections, physical injuries as well as the psychological effects of an assault can negatively impact one's health, requiring further lifelong treatment (Resnick et al., 2000).

There is limited research highlighting the lived experience of survivors of sexualized violence when accessing or attempting to access formal health-related supports/services. There is a lack of literature exploring how and why survivors decide to access or not access services and supports for sexualized violence. Current literature attempts to quantitatively determine the prevalence of sexualized violence and the frequency with which healthcare, social and police services for sexualized violence are accessed. There is also a gap in the research that focuses on understanding the lived experience of individuals accessing formal health-related supports/services for sexualized violence. Formal health-related supports/services for sexualized violence include Sexual Assault Nurse Examiners (SANE), counsellors, physicians, nurses, emergency

department and clinic staff. The Sexual Assault Nurse Examiner program currently is recognized as best practice in addressing sexualized violence (Mahon, 2016).

I worked as a Sexual Assault Nurse Examiner for over three years and have worked with a variety of clients. Throughout my experience as a SANE I was made aware of how prevalent sexualized violence has been in our society. Although we have seen over 100 clients each year through the SANE program at Avalon Sexual Assault Centre, which provides service to all of Halifax Regional Municipality (HRM) (Mahon, 2016), there are still many survivors who do not use services post sexualized violence. My work as a SANE piqued my interest in research; to gain more understanding of why people use or do not use services; and how current services for sexualized violence could be improved and made more accessible for survivors.

Given the geographic area that I covered with SANE, it became clear that further research was needed to build more timely and effective services for survivors living within HRM. Gaining a deeper understanding of the experience of survivors who have, and have not, accessed supports/services for sexualized violence (both formal/informal, and health-related/not health related) can help build knowledge regarding changes needed to improve current services within the community. Furthermore, by using a feminist approach and informed by interpretive phenomenology, this research intends to build further understanding regarding the lived experience of survivors navigating supports and services for sexualized violence. In addition, using this holistic understanding, my research intends to identify and promote ways to improve current formal health-related supports/services for sexualized violence, to best fit the needs of survivors.

This research study explored the following questions: (a)What was the lived experience of individuals who have contacted, attempted to access, accessed, or not accessed supports/services for sexualized violence, whether they were formal, informal, health-related or not?

(b)What formal health-related supports/services did survivors of sexualized violence contact, attempt to access, access, or did not access post sexualized violence, and why?

(c) What other supports/services, that may not have been formal or health-related, did survivors of sexualized violence contact, attempt to access, access, or did not access post sexualized violence, and why?

(d) What factors influenced a survivor's decision to access or not access health-related supports/services?

(e) What recommendations did survivors have regarding how health-related supports/services could be improved and made more accessible?

Literature Review

Sexualized violence has a profound influence on an individual's health and wellbeing, yet only a fraction of survivors seek assistance from formal services for sexualized violence (Bletzer & Koss, 2006). Sexual violence is defined by the World Health Organization [WHO] (2006) as:

> Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

While performing a review of the current literature on individuals accessing formal services post sexualized violence, several reoccurring themes arose: the prevalence of sexualized violence; the populations at increased risk for sexualized violence, and the detrimental effects that sexualized violence can have on an individual's health and wellbeing. Further research is required to gain a better understanding of survivors' lived experiences, specifically the intersectional experience of sexualized violence (Reeves & Stewart, 2015). Intersectional, or intersectionality, refers to the insight that demographic characteristics of an individual (race, class, gender, sexuality, ethnicity, nation, ability, and age) are not exclusive identities but operate as "reciprocally constructing phenomena" (Collins, 2015). In particular, there has been little research highlighting the experience of individuals who have suffered sexualized violence while making the decision regarding whether, or not, to seek out formal health-related supports/services for sexualized violence.

This literature review will provide the following information: a brief definition of the language surrounding sexualized violence; the language that will be used; highlight the populations who are at increased risk for having experienced sexualized violence; the personal and societal impacts of sexualized violence; and information regarding the Sexual Assault Nurse Examiner program locally, and throughout Canada and around the world. Finally, what is known about survivors' experiences of accessing services for sexualized violence will be discussed, as well as prosecution rates and outcomes of sexualized violence within the criminal justice system.

Terminology

Individuals Who Have Experienced Sexualized Violence

The terminology used to refer to individuals who have experienced sexualized violence is a highly debated topic. Labels such as "survivor" have often been used in an effort to empower individuals who have experienced sexualized violence, whereas labels such as "victim" can be seen as negative and have been thought to lead to poorer coping and health outcomes (Williamson & Serna, 2018). Some individuals who have experienced sexualized violence may not identify as a "survivor" throughout their healing journey and may prefer to use "victim". The labels that individuals who have experienced sexualized violence prefer to use is a personal decision. Both terms have been commonly used within the literature and these terms will be used interchangeably throughout this proposal, where appropriate, to provide clarity. The term "sexualized violence", as defined within the introduction of this literature review, will be used throughout. Acts of sexualized violence are rarely born from sexual desires or lust. Indeed, they are acts of overpowering and dominance. The term sexualized violence attempts to separate the

belief that these acts are *sexual* in nature and, instead, emphasizes that they are *violent acts* which have been sexualized.

Supports/Services

The terms "formal," "health-related" and "informal" supports/services will be used to refer to supports and services accessed by survivors of sexualized violence. *Formal* supports/services are provided in hospitals or through community organizations which are financially supported and dedicated to providing resources and care to survivors, usually provided by trained professionals and volunteers (Ullman & Filipas, 2001). *Health-related* supports/services are those supports and services which focus on the physical and mental health and well-being of an individual. *Formal health-related* supports/services for sexualized violence can include, for example: Sexual Assault Nurse Examiners (SANE), counsellors and mental health services, physicians, nurses, emergency department, clinic staff and community health centres. Other formal services, that are not health-related, include police and legal services. *Informal* supports include, for example, family, friends, online support forums, communities and groups, and peer support groups. For the purpose of this research, *formal health-related supports/services* will be the focus, although it is necessary to explore the entirety of survivors' experiences including other *formal* or *informal* forms of supports and services they may have used, as these experiences may have influenced their decision to access or not access formal health-related services.

Accessibility

This study explored the accessibility of formal supports/services for sexualized violence, and survivor's experiences accessing (using), attempting to access, or not

accessing these services. Penchansky and Thomas (1981) define "access" as a "concept representing the degree of fit between the clients and the system." They highlight five specific "dimensions of access": *availability, accessibility, accommodation, affordability,* and *acceptability*. *Availability* refers to whether the supply of existing services is adequate for the volume of potential clients. *Accessibility* refers to the "fit" between the location of the service and the location of the potential service-users, which encompasses aspects such as location, transportation, travel time, distance, and cost. *Accommodation* refers to the clients' "ability to accommodate" the way in which the service is delivered to clients, i.e., by appointment, walk-in, scheduling, hours of operation, telephone services, etc., and the clients' perception of their appropriateness." *Affordability* refers to the cost of the desired service and the client's ability and willingness to pay for said service, including insurance coverage and credit arrangements. *Acceptability* refers to the "fit" of client's attitudes with the specific characteristics of the service and service providers, such as: age, sex, ethnicity, religious affiliation, and the type of facility from which the service is provided and the neighbourhood in which it is located. Services and service providers may also have attitudes toward specific client characteristics which may make themselves more or less available to accommodate specific clients (Penchansky & Thomas, 1981).

Populations at Increased Risk

While individuals of any age, gender, ability, ethnicity, sexuality or religion can be a victim of sexualized violence, certain populations have been identified as being at increased risk for experiencing or having experienced sexualized violence (Conroy & Cotter, 2017). In Canada, the majority of incidents of sexualized violence (94%) involve

women as victims and are perpetrated by men. Perpetrators are often known to the victim as either a friend, acquaintance or neighbour (Conroy & Cotter, 2017).

Women

According to Statistics Canada, women were the victim in 87% of instances of sexualized violence in 2014. The rate of sexualized violence committed against Canadian women aged 15 to 24 years was considerably higher than any other age or gender group. According to Statistics Canada, in 2014, 41% of all reported cases of sexualized violence were reported by University and College students (Conroy & Cotter, 2017). Among all cases reported by students, 90% were committed against women (Conroy & Cotter, 2017). Rates of sexualized violence were approximately eight times higher among individuals who were single compared to those who were married or common-law. The rate of sexualized violence among single women was nine times higher than that of women who were married, common-law, or among single men (Conroy & Cotter, 2017).

The rate of sexualized violence among individuals with disabilities is approximately two times higher than individuals without disability. Women and individuals with mental disabilities are at particular risk for experiencing sexualized violence. The rate of sexualized violence among individuals with a mental disability is five times higher than that of individuals without disability (Conroy & Cotter, 2017). Alcohol consumption tendencies significantly increases the rate of sexualized violence among women (Howard et al., 2008). In Canada, the rates of sexualized violence are approximately three times higher among women who self-reported binge drinking within the last month, than those who did not (Conroy & Cotter, 2017). Conversely, individuals

who were under the influence at the time of their assault self-reported being less likely to report their victimization to the police (Monk & Jones, 2014).

Human Trafficking. Human trafficking involves the recruitment, transportation, transfer, harbouring or receipt of persons in order to exploit or facilitate the exploitation of that person into many different forms of labour including sexual exploitation (Cotter, 2020; WHO, 2012). Human trafficking is a global issue, but the range and severity is largely unknown due to the highly illegal and invisible nature of this crime (WHO, 2012). Data from reports to authorities largely suggest that human trafficking is predominantly a gendered crime. Women and children are more likely to be trafficked into the sex industry and as domestic servants (WHO, 2012). In Canada, 97% of police-reported human trafficking were women and girls, and 81% of persons accused of human trafficking since 2009 have been men (Cotter, 2020). Cotter (2020) identified that the majority of victims of human trafficking tend to come from marginalized or vulnerable populations. Nova Scotia recorded the highest rate of police reported incidents of human trafficking, per capita, from 2009-2018 (Cotter, 2020). Evidence gathered from police investigations within Canada and advocates suggest that Halifax is part of a route used to transport victims of human trafficking from Atlantic Canada to other larger Canadian cities (Cotter, 2020). Among incidents of human trafficking reported to the police, 44% involved other violations, two-thirds of which involved offences related to sexual services (Cotter, 2020). The vast majority of victims of human trafficking were lured or groomed by someone known to the victim, such as a friend or acquaintance and current or former intimate partner (Cotter, 2020). Victims of human trafficking can experience physical and mental side effects similar to those of sexualized violence, with trauma and

mental health concerns persisting much longer than that of physical side effects (WHO, 2012).

Individuals in Sex Trade

Individuals working in the sex trade are three times more likely to self-report experiencing sexualized violence than individuals who do not work in the sex trade (Hudson et al., 2010). Individuals who work in the sex trade are not only at increased risk for sexualized violence, they also are at increased risk for more violent assaults and more serious injury resulting from sexualized violence (Andermann, 2016).

From the limited research available, individuals who work in the sex trade experience marginalization when accessing services for sexualized violence (DuMont & McGregor, 2004). Marginalization is a process in which individuals, or communities, are "peripheralized on the basis of their identities, associations, experiences, and environments," (Dodgson & Struthers, 2005). Marginalization further includes a vulnerability due to genetic, social, cultural, and/or economic circumstances which can have profound effects on the delivery of healthcare services to individuals (Dodgson & Struthers, 2005). Individuals who work in the sex trade often do not report experiences of sexualized violence to the police for fear of criminal charges due to their work. They also often face judgement, blame, disrespect, and insensitivity toward the circumstances in which they have experienced sexualized violence, their work and their day-to-day lives. The misconception that individuals "choose" to work in the sex trade marginalizes these individuals and fails to see the conditions and contexts in which they are forced to live by society (DuMont & McGregor, 2004).

Individuals working in the sex trade often experience mental health concerns which can contribute to their marginalization as well as their hesitancy to access services for sexualized violence (DuMont & McGregor, 2004). Unfortunately, these individuals often experience sexualized violence multiple times in their lives, and some seek services, causing service providers to label them with judgmental labels such as "Frequent Flyer." From personal experience working with this population, this lack of understanding and empathy did not go unnoticed by these individuals.

Insecurely Housed and Unhoused Individuals

Individuals who are "insecurely housed" and "unhoused" include those who do not have reliable housing circumstances, such as individuals who live on the streets or rely on friends, "couch-surfing" situations and community shelters for housing. Researchers estimate as many as one third of women who are unhoused or insecurely housed have experienced sexualized violence (Hudson et al., 2010).

Insecurely housed and unhoused individuals share many challenges with individuals who work in the sex trade when accessing services for sexualized violence. Exposure to sexualized violence, as well as physical violence, among insecurely housed and unhoused individuals is often associated with poor general health, psychiatric co-morbidities such as post-traumatic stress disorder, depression and suicidal ideation (Hudson et al., 2010). Many of the women who engage in sex work, and who are insecurely housed or unhoused, are often escaping circumstances of intimate partner violence and have exhausted all social support avenues prior to resorting to these survival tactics. Similar to those working in the sex trade, insecurely housed and unhoused individuals are hesitant to report their victimization to the police due to previous negative

experiences with the criminal justice system and police themselves. A lack of empathy and compassion toward these individuals by police can cause fear and distrust within this population. Due to their low socioeconomic status, not having coverage for services such as medications, and blood work can prevent this population from receiving adequate care for sexualized violence (Hudson et al., 2010). Having transportation to a hospital as well as having access to a telephone, for example, are further barriers that this population faces when attempting to access services for sexualized violence (Mahon, 2016). A lack of access to a telephone prevents clients' follow-up from SANE and from scheduling, or inquiring about counselling services.

In my experience working with this population, their unsafe or insecure housing situation often contributes to their experience of sexualized violence. Some individuals may have chosen to forego safety in exchange for a place to sleep, forcing them into dangerous situations. Often, after these individuals have received their treatment, they return to these unsafe living situations where the perpetrator of their assault may reside.

2SLGBTQ+ Population

Members of the 2SLGBTQ+ population are more likely to self-report a history of sexualized violence than heterosexual individuals. Among the 2SLGBTQ+ population, transgender individuals report experiencing sexualized violence twice as frequently as cisgender individuals (Langenderfer-Magruder et al., 2016). Much like their heterosexual peers the victimization of individuals who identify as women is staggering, 46% of lesbian women and 75% of bi-sexual women self-report having experienced sexualized violence within their lifetime (Langenderfer-Magruder et al., 2016). Balsam and colleagues (2005) determined that, compared to the 2% of heterosexual men who report

having experienced sexualized violence, one in ten gay and bisexual men self-report having experienced sexualized violence. Much like the heterosexual and cisgender population, there is a severe under-reporting of victimization among 2SLGBTQ+ individuals (Langenderfer-Magruder et al., 2016). The true breadth and prevalence of sexualized violence among the 2SLGBTQ+ population is difficult to fully estimate, much like other populations, due to the shame, guilt and fear associated with disclosing sexualized violence (Todahl et al., 2009).

There are several misconceptions that healthcare providers and police may have surrounding sexualized violence, such as heterosexist assumptions about which genders experience sexualized violence (Todahl et al., 2009). These perceptions reduce the availability of services for sexualized violence to 2SLGBTQ+ individuals and subjects them to accusations and judgement when these services are sought. Assumptions that male identifying individuals do not experience sexualized violence or that those with a sexuality that is not heteronormative is abnormal, can cause 2SLGBTQ+ individuals to feel at fault, targeted and unsafe when accessing these services. Fear of having to disclose gender identity or sexual orientation and having it become the focus of the service interaction, or perceived cause of the assault, can cause 2SLGBTQ+ individuals not to seek necessary services for health and wellbeing, especially regarding sexualized violence. Exclusionary perceptions and beliefs further marginalize this population (Todahl et al., 2009).

Indigenous Populations

In Canada, members of the Indigenous population are three times more likely to self-report experiencing sexualized violence than non-Indigenous populations. Among all

reports of sexualized violence in which the survivors were Indigenous, 94% were women (Conroy & Cotter, 2017). In 2016/2017, under 5% of individuals presenting to the SANE program, within HRM, self-identified as Indigenous (J. Crowell, personal communication, November 2, 2018).

When compared with non-Indigenous, Indigenous populations have been found to suffer from poorer health, including lower life expectancy, elevated risk of chronic diseases (e.g., diabetes and obesity), higher rates of infectious diseases, and a higher prevalence of substance use and misuse, addiction, and suicide (Hajizadeh et al., 2018). Furthermore, they have been found to face higher rates of incarceration and victimization (Scrim, 2017) as well as higher rates of poverty, which directly influences an individual's health (Hajizadeh et al., 2018). These health disparities reflect years of inequities due to social, political, and economic disparities related to colonization (Adelson, 2005).

Canada's historical maltreatment and abuse of Indigenous populations has had serious ramifications on their health and wellbeing to this day. The Canadian government forcibly attempted to remove the unique and diverse cultures of Indigenous peoples through colonization, Residential Schooling, the "Sixties Scoop," and the loss of land, family, and language, (Truth and Reconciliation Commission, 2015). Brave Heart (1998) stated that although post-traumatic stress disorder (PTSD) may describe the manifestation of trauma in those it affects, the diagnosis was too narrow to describe the complex experiences of Indigenous populations; therefore, historical, and intergenerational trauma has more accurately acknowledged the cumulative trauma of the Indigenous populations. Intergenerational trauma is referred to, by Pearce and colleagues (2008) "as a collective emotional and psychological injury over the lifespan and across generations." Although

Canada has formally apologized for the enforcement of Residential Schooling and its treatment of Indigenous communities across the country, there are still harmful policies and biases which contribute to health and economic disparities among Indigenous populations today (Hajizadeh et al., 2018). The colonial legacy of abuse is also evident in the current prevalence of intimate partner violence against Indigenous women (Adelson, 2005). Due to the historical inequities that Indigenous populations face, they are often marginalized by mainstream services.

Indigenous women in Canada are four to five times more likely to experience intimate partner violence, including sexualized violence, than non-Indigenous women (Scrim, 2017). Scrim (2017) found that 25% to 50% of Indigenous women were survivors of child maltreatment, specifically sexual abuse. Brownridge and colleagues (2017) proposed that child maltreatment (including physical, sexual, mental abuse and neglect, as well as children witnessing forms of abuse in the household) was a predictive factor of intimate partner violence.

Survivors of sexualized violence struggle to form and maintain meaningful intimate partnerships and can have difficulties overall nurturing healthy relationships. Mental health concerns among survivors of sexualized violence include mood disorders, low self-worth, post-traumatic stress, and a variety of issues related to anxiety (Reeves & Stewart, 2015). The cyclical nature of abuse and family violence is a result of historical trauma (Scrim 2017; Truth and Reconciliation Commission, 2015). Although the prevalence of violence is high, intimate partner violence and sexualized violence are likely to go unreported to authorities. Within Indigenous populations, Scrim (2017) found that 74% of individuals who experience intimate partner violence, sexualized violence,

and family violence did not report their victimization to police. However, this study did not indicate whether healthcare services were accessed.

In 2014, Amnesty International, a human-rights organization, highlighted the disproportionate victimization of Indigenous women and girls in Canada. Not only were the incidences of violence amongst this population higher than other populations, but the severity of violence was also much higher (Amnesty International, 2014). The continued abuse of Indigenous populations is also exemplified in Canadian homicide rates. The national homicide rate of Indigenous women is seven times higher than that of non-Indigenous women (Amnesty International, 2014; Boyce, 2016; O'Donnell & Wallace, 2011).

Impact of Sexualized Violence

Self-reported data from the "2014 General Social Survey (GSS) on Canadians' Safety (Victimization)" found that only approximately 17% of individuals who self-reported having experienced sexualized violence sought "support-services" for their victimization. These "support services" included crisis centres or crisis lines, victim services, counsellors or psychologists, and community centres. Further, only approximately 6% of self-reported survivors of sexualized violence disclosed their victimization to a healthcare professional (doctor or nurse); yet approximately 64% disclosed their victimization to informal supports such as a friend or neighbour (Conroy & Cotter, 2017). These statistics indicate that survivors are more likely to disclose experiences of sexualized violence to a person trusted by that individual, than a trained professional in healthcare or the criminal justice system.

Individuals may face a number of physical, and mental health, concerns as a result of sexualized violence (Benoit et al., 2015). When survivors do not report or disclose their victimization, these health concerns remain unaddressed which can result in further traumatization and negative health consequences (Resnick et al., 2000). Physical health concerns resulting from sexualized violence may include: "assault related injuries, sexually transmitted infections (STIs), unwanted pregnancy, pelvic pain, vaginal bleeding or infection, urinary tract infections, gynecological problems, gastrointestinal disorders, a range of chronic pain disorders, and short-term and long-term sexual health problems" (Benoit et al., 2015). Due to their victimization, individuals who have experienced sexualized violence use more healthcare services throughout their lives (Benoit et al., 2015; Resnick et al., 2000).

Sexualized violence does not always result in serious physical injury; however, survivors of sexualized violence often experience a number of mental health concerns (Benoit et al., 2015). These mental health concerns include: depression, PTSD, sleep disruptions, somatic complaints, substance use and misuse, behavioural problems, suicidality (Krug et al., 2002) and anxiety (Eisenberg et al., 2016). From a survey study conducted on college campuses, survivors often experience anger, confusion, guilt, shock, stress, agitation, disbelief and fear following an assault (Eisenberg et al., 2016). Mental health concerns can lead to physical health concerns such as stress related illness, substance use and risk-taking behaviours. Survivors face challenges maintaining intimate relationships as well as relationships with family, friends, coworkers, and peers. As a result of these challenges, survivors are often isolated and have less social support, which can further negatively affect their mental health and wellbeing (Benoit et al., 2015).

Aside from the personal impact that sexualized violence has on an individual's health and wellbeing, sexualized violence can also have a serious impact on the economy. Although there have been no formal calculations of the economic impact of sexualized violence, using the methodology developed to measure the cost of intimate partner violence (Zhang et al., 2012), McInturff (2013) provides a rough estimate of the economic impact of sexualized violence. In Canada, the direct costs of sexualized violence are estimated to be between $546 million and $1.9 billion per year. This estimate does not include factors such as the costs of attempted, or completed, suicides as a result of experiencing sexualized violence. This cost is expected to increase each year. Based on this estimate, the cost is approximately $334 per person, each year, in Canada. This is comparable to the cost of smoking, in Canada, which is $541 per person, each year (McInturff, 2013).

Sexual Assault Nurse Examiner Program

Sexual Assault Nurse Examiners are specially trained nurses with expertise in forensic evidence collection and have specialized training in crisis intervention as well as in providing care in a confidential, non-judgmental environment (Mahon, 2016). The Sexual Assault Nurse Examiner Program model was developed to address the needs of survivors who were receiving inadequate treatment from physicians and nurses in hospital emergency departments. The first SANE program began in 1976 in Tennessee, USA (Girardin, 2005). Prior to the implementation of SANE programs, survivors often faced long wait times in emergency departments as physicians and nurses were unable to accommodate the lengthy forensic exam, DNA collection and interview process. Aside from lengthy wait times, survivors also experienced a lack of privacy during

examinations and were often required to receive examinations from male physicians, which contributed to a client's re-traumatization and "the second assault", described later in this literature review (Girardin, 2005). SANE services are predominantly provided in the hospital setting, including the emergency department, gynecology department, clinics affiliated with the hospital, or "self-standing" clinics (Girardin, 2005).

To receive SANE credentials, SANE trainees must undergo extensive training including over 40 hours of classroom and clinical education. The International Association of Forensic Nurses provide educational guidelines for SANE training. The educational requirements for SANE include a minimum of 40 hours of classroom education from an accredited provider and additional components such as simulated clinical experiences which are not included in the 40 hours of classroom education (International Association of Forensic Nurses, 2018). In addition to clinical and classroom education, SANE are required to complete a minimum of 10 speculum examinations supervised by a physician or nurse practitioner experienced in female genital exams, as well as an additional 40 hours of supervision and evaluation by a senior SANE (Mahon, 2016).

Within the Halifax Regional Municipality (HRM) the SANE program is community-based and delivered through a local not-for-profit organization, Avalon Sexual Assault Centre. The community-based model is in contrast to most programs nationally and internationally, which are provided in hospital emergency departments and clinic settings (Girardin, 2005). The Avalon SANE model is also unique in that two nurses are on-call 24 hours a day, at all times (Mahon, 2016), in contrast with other programs which typically have a single nurse response. Individuals of all genders and all

ages who have experienced sexualized violence can use SANE services for up to 7 days (170 hours) post assault. Services are provided to survivors in the emergency department of the four main hospitals in HRM, the IWK Health Centre, the QEII Health Sciences Centre, Dartmouth General Hospital, and the Cobequid Community Health Centre. The Avalon SANE program employs a full-time coordinator, administrative assistant and 15-18 contracted on-call registered nurses. Funding for the Avalon SANE program is provided by the Nova Scotia Department of Health and Wellness through the District Health Authority, and the IWK Health Centre for Women, Children and Families (Mahon, 2016).

SANE provides guidance to clients by highlighting community services such as counselling, and clinics necessary for follow-up care (Campbell et al., 2005). Services that SANE provides include physical assessment, STI prophylaxis, pregnancy risk assessment and prevention, a forensic exam (including DNA evidence collection), discussion of medical, legal and follow-up options, information for community support resources, and discussion of follow-up from the SANE. All services are provided from a client centred, trauma-informed approach, meaning that clients are in control of their care and may choose any number of services available to them. Elliott et al. (2005) define a "trauma-informed approach" as an understanding that all clients have experienced some form of trauma which affects their life and development, and that care should be sensitive to this, so as not to retraumatize these individuals. Witness testimony in a court of law may also be provided by SANE if a client decides to criminally pursue the perpetrator of the assault (Mahon, 2016).

Local, national, and international studies have identified the value of SANE in the healthcare setting, and the potential for a positive impact on the healing journey of a survivor of sexualized violence (Campbell et al., 2005; Mahon, 2016; Stermac et al., 2005). Although existing literature recognizes SANE as best practice in addressing sexualized violence, there is limited research highlighting the lived experiences of individuals accessing such services. In particular, there is limited research exploring the experiences of individuals accessing services from a unique community-based program, such as the Avalon Sexual Assault Centre SANE program.

Experiences Accessing Services

Healthcare Responses

There are a limited number of studies exploring the experience of survivors accessing formal health-related supports/services for sexualized violence. One Canadian study by DuMont and colleagues (2017) sought to compare the experiences of Indigenous and non-Indigenous women accessing specialized healthcare services for sexualized violence using a quantitative survey method to collect data immediately following the healthcare intervention. The study was limited in that the individuals agreeable to participate in the research were satisfied with the assistance and healthcare provided to them. As is the nature of survey studies, there was very little opportunity for participant elaboration regarding their experiences. In addition, the survey itself was not designed specifically for the Indigenous population nor did it touch on experiences unique to that population, such as perception of discrimination or stereotyping (DuMont, et al., 2017).

In another study, DuMont and colleagues (2003) used patient, perpetrator, and sexual assault characteristics to explore the probability that survivors would report their

assault to the police. Participant's information was gathered from emergency room documentation. From this exploration, DuMont and colleagues (2003) were unable to find statistically significant results to suggest the existence of predictive factors that influence a survivor's decision to report their assault. Some factors thought to influence underreporting included: self-blame, guilt, shame and embarrassment, helplessness, a desire to keep the assault private, helplessness, fear of retaliation from the perpetrator of the assault, and fear of not being believed as well as fear of judgement from peers. A visible physical injury and an excessive level of violence were the most convincing predictive factors for reporting victimization that DuMont and colleagues (2003) were able to determine. In this study, the intersectional influences of one's lived experience were not included in the list of factors that could potentially affect a survivor's decision to report an assault, or access services, post sexualized violence.

Stigmatization

Survivors often experience stigmatization when reporting or disclosing their victimization to peers and support services (Kennedy & Prock, 2018). "Rape mythology" and the perception of "real rape" and the "real victim" contribute to the stigmatization of survivors of sexualized violence (DuMont et al., 2003). DuMont and colleagues (2003) note that "rape mythology" often characterizes sexualized violence as "an act of violent, forceful penetration committed by a stranger during a blitz attack in a public, deserted place. The victim is portrayed as a morally upright white woman who is physically injured while resisting". These societal beliefs about sexualized violence influence a survivor's perception of self-worth following the assault. The fear of stigmatization, or anticipatory stigma, can play a role in whether survivors seek support services, and their

healing process following the assault. Fear of stigmatization often leads to survivors engaging in isolating and avoidance behaviours which further prevents survivors from seeking support services (Kennedy & Prock, 2018).

Re-victimization

Survivors often face discrimination, judgement and experience re-traumatization when attempting to access services for sexualized violence (Shaffer et al., 2018). A study by Campbell (2006) compared the first-hand experiences of survivors accessing medical and legal services for sexualized violence with the experience of the professionals providing these services. The study explored which services were offered to survivors and if service providers engaged in re-traumatizing, or "second assault," behaviours (Campbell, 2006). Campbell (2006) defined the "second assault" as "insensitive victim-blaming treatment," by the services designed to protect these survivors which exacerbate the trauma of the assault. Survivors and service providers were administered a verbal "checklist" style interview. This study found that service providers were unaware of the emotional response that survivors would have while accessing services and, therefore, were unaware of the harmful behaviours and tendencies in which they were engaging (Campbell, 2006).

In South Africa, Steinbrenner and colleagues (2017) conducted a phenomenological study exploring the experiences of six South African women accessing services for sexualized violence. Participants described experiencing re-traumatization when accessing services from police, medical staff (nurses) and when pursuing their assailant in court. These harmful interactions included being "laughed" at by police when reporting their victimization, not being provided with privacy during questioning,

receiving judgmental treatment from nurses, and being required to face their assailant in a court of law (Steinbrenner et al., 2017).

Rural and Remote Communities

Research on sexualized violence in rural communities has identified certain consistencies. Sexualized violence in rural communities is often perpetrated by someone known to the victim (e.g., acquaintance, peer, family, etc.) and is highly underreported. Due to the closeness of the community and its members, and therefore, the lack of anonymity among residents, survivors may be reluctant to seek services for sexualized violence. In addition, many rural communities often lack the proper services to address the needs of survivors of sexualized violence (Hankivsky & Cormier, 2009). Rubin (2008) identified barriers to providing services for sexualized violence in rural and remote communities across Nova Scotia and Canada. These barriers include:

> Insufficient funding for rural services, safety issues and 'burnout' of sexual assault workers, high staff turnover, public scrutiny/lack of anonymity (survivor's service use), retractions of sexual assault disclosures, lack of access to specialized treatment and diagnostic resources, lack of other specialized service providers, geographical isolation, limited telecommunications, turf wars and service provider resistance to change, problems with the criminal justice system, delayed court proceedings, ideological loneliness of some service providers, denial of existence of sexual assault by some service providers, denial of existence of sexual assault by community residents.

Hankivsky and Cormier (2009) emphasize the lack of appropriate healthcare services (e.g., those related to reproductive health, domestic violence, substance use and

sexually transmitted infections) and the difficulties accessing the limited services available to individuals living in rural and remote communities. Often, small communities do not have culturally appropriate interventions for sexualized violence and intimate partner violence. The familiarity of residents within rural communities can inhibit an individual's right to confidential reporting of sexualized violence (Rubin 2008).

Informal Supports

Informal supports include, for example, intimate partners, family, friends, coworkers, online support forums, communities and peer support groups. Conroy and Cotter (2017) noted that the majority of individuals who self-reported incidents of sexualized violence disclosed their victimization to a friend or neighbour, a fraction compared to those who reported their experience to the police or a healthcare provider. Milliken and colleagues (2016) note that informal supports such as friends, family and intimate partners can provide emotional and social support to survivors. Informal supports are also noted to have helped survivors access formal services and increased the probability that a survivor used those services, which can have a positive effect on their healing journey (Milliken et al., 2016). Starzynski and colleagues (2005) note that women have self-reported receiving more negative reactions from informal supports when disclosing experiences of sexualized violence compared to those disclosing non-sexual assaults. Furthermore, Starzynski and colleagues (2005) suggest that the negative reactions from informal supports associated with disclosures of sexualized violence, highlights the unique perspective regarding sexualized violence embedded within greater society.

Prosecution Rates of Adult Cases of Sexualized Violence

According to Statistics Canada in 2009-2014, 12% of incidents of sexualized violence reported to the police led to a criminal conviction. Of those incidents that led to criminal convictions, only 7% received a custody sentence (Rotenberg, 2017). The majority of cases of sexualized violence were perpetrated by someone who was known to the victim (87%); however, only 47% of cases in which the assailant was known to the victim proceeded through the criminal justice system. This is compared to the 64% of cases perpetrated by a stranger to the victim which proceeded through the criminal justice system (Rotenberg, 2017). Social media movements such as #MeToo have increased the number of police reported incidents of sexualized violence, yet there is no change in the proportion of cases which proceed through the criminal justice system, and ultimately result in conviction (Rotenberg & Cotter, 2018).

Greeson and colleagues (2008) produced a *Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System*. The goal of the toolkit, which was created and empirically validated, was to provide SANE programs with a step-by-step resource to determine if SANE had an impact on cases of sexualized violence in the criminal justice system, within their own community (Greeson et al., 2008). Greeson and colleagues (2008) intended to address a gap in literature surrounding the impact and effectiveness of SANE programs in the criminal justice system. The toolkit also provides information on how to understand and analyze the data collected. SANE programs can use the data to determine rates and frequencies of the level of progression that cases tend to reach within their community and determine areas of strength and weakness within their current program

(Campbell et al., 2014). Campbell and colleagues (2014) also recognize that given the limited research that exists surrounding this topic it may not reflect the impact of an individual SANE program within a community.

Campbell and colleagues (2012) retrospectively compared the rates of prosecution of adult cases of 'sexual assault' prior to the implementation of the SANE program (n=156) to the rates of prosecution of cases of 'sexual assault' following the implementation of SANE (n=137). The study was conducted using data from a town in a Midwestern State of USA. Campbell and colleagues (2012) found that the number of cases *not referred* to the police for prosecution decreased from 49% prior to the SANE program to 43% after the SANE program was implemented. The rate of guilty pleas, or trial convictions, *increased* from 24% of all cases prior to the SANE program to 29% after the implementation of the SANE program (Campbell et al., 2012). These results are in accordance with the hypothesis highlighted by Campbell and colleagues that the SANE program positively affected case progression outcomes within the criminal justice system (Campbell et al., 2012). This study collected retrospective data from 12 years (5 years prior to, and 7 years following, the implementation of the SANE program) (Campbell et al., 2012).

Valentine and colleagues (2016) used a tool developed by Greeson and colleagues in 2008, *Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System*. Valentine and colleagues (2016) conducted a retrospective study involving post-only data i.e., adult sexual assault cases following the implementation of the SANE program (n=270), spanning 9 years from 2003-2011 (Valentine et al., 2016). The toolkit recommended

excluding the data from the first full year that the SANE program was implemented, as the program was not fully established at that point. The post-only test method required researchers to compare the outcomes of adult cases of 'sexual assault' within the criminal justice system that had involved the SANE program, to two "other urban sites", which did not have SANE programs, to evaluate the program's impact (Valentine et al., 2016). Valentine and colleagues (2016) found that of the 9% of adult case of 'sexual assault' which had criminal charges filed, 6% were successfully prosecuted, which is less when compared to the two "other urban sites" without the SANE program, which found 9-15% of cases were prosecuted. Little information is provided regarding the comparison group, referred to as "other urban sites."

According to a report from Mahon (2016), the Avalon Sexual Assault Centre SANE program (Halifax, Nova Scotia) conducted a program evaluation, including a study on the outcomes of 'sexual assault' cases with SANE involvement, within HRM. The report found that the involvement of SANE in cases of sexualized violence did not significantly differ when compared to the rate of prosecution prior to the implementation of the SANE program in HRM (Mahon, 2016).

Conclusion

A review of the literature has highlighted the populations at increased risk for sexualized violence such as women, individuals working in sex trade, insecurely housed and unhoused individuals, 2SLGBTQ+ and Indigenous populations. This review of the literature also explored the formal health-related services for sexualized violence such as the Sexual Assault Nurse Examiner program, the limited qualitative research on the experiences of survivors accessing services for sexualized violence as well as the stigmatization and re-victimization they have faced. Much of the current literature available on sexualized violence quantitatively explores the prevalence of sexualized violence and the populations at increased risk of violence. However, there exists a gap in knowledge surrounding the lived experience of survivors who access healthcare services post sexualized violence, as well as factors which influence survivors to access, or not access, supports/services for sexualized violence, and their decision to access particular services (if any). There is also a gap in research from Canada, and within contexts as unique as the sexualized violence response within Nova Scotia (community based Sexual Assault Nurse Examiner programs with a two-nurse approach). Gagnon and colleagues (2018) called for further qualitative research with survivors of sexualized violence who have not disclosed their victimization to formal services, as these individuals may have specific recommendations to address barriers to accessing formal services for sexualized violence. By using a feminist lens with an interpretive phenomenological approach to gain the perspective of survivors, researchers can begin to address this gap and provide insight into how services can be enhanced.

Chapter 2: Methods

The following section will discuss the research objectives and questions, design, methodology, sampling, data collection, analysis, and ethical considerations of the research study.

Objectives

There were three general objectives of this research. Objective 1: To gain a deeper understanding of the lived experience of survivors of sexualized violence and the actions they took to seek assistance or not. Objective 2: Explore which supports/services survivors used (if any), how and why they came to the decision to use them. Objective 3: Determine, from the survivors' perspective, how they believe available supports/services could be improved and made more accessible, to better fit the needs of survivors, and how these suggestions can be applied to nursing and other formal health-related supports/services.

Research Questions

The specific study questions for this study included: (a)What was the lived experience of individuals who have contacted, attempted to access, accessed, or not accessed supports/services for sexualized violence, whether they were formal, informal, health-related or not? (b)What formal health-related supports/services did survivors of sexualized violence contact, attempt to access, access, or did not access post sexualized violence, and why? (c) What other supports/services, that may not have been formal or health-related, did survivors of sexualized violence contact, attempt to access, access, or did not access post sexualized violence, and why? (d) What factors influenced a survivor’s decision to access or not access health-related supports/services? (e) What

recommendations did survivors have regarding how health-related supports/services could be improved and made more accessible?

Methodology

For the purpose of this research, a feminist lens was applied to interpretive phenomenology, as the aim of this study was not to describe the survivors' experiences but to interpret the meaning of the survivors' experiences, the effect (if any) that support/services for sexualized violence had on their healing, and ways to improve supports/services.

Feminist Interpretive Phenomenology

Phenomenology is a qualitative research method as well as an expansive philosophical movement (Lopez & Willis, 2004). The modern day "founding father" of phenomenology, Edmund Husserl, a German philosopher, sought to investigate the absolute truth of human experience. This approach is now referred to as *descriptive phenomenology,* which seeks to describe the essence of experiences of the lived-world in which people are "detached subjects existing in a world of objects" (Dreyfus, 1987, as cited in Walters, 1995). The lived-world refers to the world as we experience it in the moment, prior to reflection (van Manen, 2016). Husserl sought to observe the lived experience objectively and proposed the concept of "bracketing," to enable the researcher to suspend judgment and biases and perform research free of influence of previous experiences (Creswell & Poth, 2018).

Martin Heidegger, a student of Edmund Husserl, rejected Husserl's use of bracketing and his view of humans as subjects in a world of objects, and proposed that "an understanding of the person cannot occur in isolation from the person's world"

(Dreyfus, 1987, as cited in Walters, 1995). Heidegger conceptualized "Dasein" as being the aspect of an individual which explores its own existence and state of "being" (van Manen, 2016). Heidegger emphasized that individuals' realities are influenced by the world in which they live, and that human reality cannot be objectified (Walters, 1995). This concept applies to participants as well as researchers (Lopez & Willis, 2004). This approach to phenomenology is referred to as *interpretive or hermeneutical phenomenology*. The focus of hermeneutic inquiry lies beyond the description or essence of an experience and seeks to clarify the meaning of these experiences. Meaning is not always known to the participant but can be found through the recounting of the experience (Lopez & Willis, 2004).

The concept of situated freedom is important to interpretive phenomenology. Situated freedom is an existential phenomenological concept that refers to the freedom that all individuals have to make choices; however, this freedom is incomplete. Individuals are constrained by the conditions of their day-to-day lives. Every individual has roles and responsibilities in their daily lives that make up their reality and produce meaning (Lopez & Willis, 2004).

Feminism is a lens which, when applied to phenomenology, allows us to understand women's orientation to the world (Goldberg et al., 2009). Sexualized violence can occur to any individual of any race, age, gender, sexual orientation and ability, yet it is predominantly and disproportionately a gendered crime (Mahon, 2016). The understanding of a woman is influenced by the woman's lived experience within the social contexts and the values that society has placed on her existence (Goldberg et al.,

2009). A feminist approach to research aims to "promote social change, respect, understand and empower women" (Campbell & Wasco, 2000).

The feminist lens also provides an epistemology which accepts an individual's experience as a legitimate knowledge source, which aligns well with the trauma-informed approach to care (Elliott et al., 2005) that I practice as a nurse. Feminism does not only concern itself with inequalities of the sexes, but with societal power imbalances, race, and class; and therefore, applies to all those who have been victims of sexualized violence (Campbell & Wasco, 2000). There are systemic power imbalances which survivors may encounter when attempting to access, or accessing, formal services for sexualized violence, such as the power of knowledge that a healthcare-provider may exude over their clients/patients (Koeck, 2014). These systemic power imbalances can influence a survivor's decision to access certain services, as well as their perception of their experience attempting to access, or accessing, a support or service (Health Council of Canada, 2012).

Existentials. van Manen (2016) highlights four pillars of interpretive phenomenology that are referred to as "existentials," which pervade the lived-world of every individual, regardless of their reality. They include *spatiality, temporality, corporeality,* and *relationality*. During the research process, these "existentials" can provide a guide for reflection (van Manen, 2016). These elements are often unconscious to the participant. A phenomenological approach to understanding the participants' lived experience provides an opportunity to unveil these "existentials" and gain insight into the emotional experience of the individual (Tembo, 2016).

van Manen (2016) refers to *spatiality* or lived space as "felt space." An individual exists physically in the world. The concept of *spatiality* refers to an individual's "situatedness." An individual's "situatedness" is not only about geographical location, but about the spaces that individuals occupy and how those spaces, in turn, influence individuals (van Manen, 2016). "...lived space is a category for inquiring into the ways we experience the affairs of our day-to-day existence; in addition, it helps us uncover more fundamental meaning dimensions of lived life" (van Manen, 2016, p.103). The formal services available for sexualized violence, specifically healthcare services, are predominantly delivered within clinical settings (emergency departments, blood collection clinics, doctors' clinics) which may be anxiety provoking to certain individuals and populations. A fear of these clinical settings may deter some individuals from accessing formal health-related supports/services or influence their experiences when accessing these supports/services.

Beings are subjected to the constraints of time and use time as a measurable structure. The concept of *temporality*, or lived time, refers to "awareness of time through the experience of being in time" (Mackey, 2004). Heidegger conceptualized *temporality* as the "ground for our awareness of existence," (Mackey, 2004) and acknowledged that past, present and future can be experienced together. *Temporality* also refers to the disruption that experiences can create in time. Experiences can alter an individual's future, or change perceptions of the past, as well as slow down, or speed up, how time is experienced in the present (Mackey, 2004). Past experiences stay with individuals as they move through time and influence their day-to-day existence (van Manen, 2016). Previous personal, or familial, experiences with formal service systems may influence an

individual's decision on whether, or not, they should access services post sexualized violence (Hudson et al., 2010). Those who have had previous negative experiences may distrust the formal services and may ultimately decide not to seek care post sexualized violence. Conversely, those with positive experiences may believe that they can use formal service systems for all their needs.

Corporeality, or lived body, refers to how we exist as bodies in the lived-world. Individuals move through, and interact with, the lived-world through their bodies (van Manen, 2016). Humans exist in, and with, the body; it is through the body that individuals are able to have human interaction with other individuals from within their own body (Tembo, 2016). One's perception of an individual's body can differ from others, depending on their feelings toward that individual (van Manen, 2016). Our bodies are tied to our individual lived-world. Merleau-Ponty (1962) states, "...our body is not primarily *in* space: it is *of* it" (p. 171). The mind and body cannot be separated, what affects the body affects the individual (Goldberg et al., 2009). It is common for those who experience sexualized violence to employ a variety of unconscious coping mechanisms to survive trauma, such as dissociation. Dissociation is a disruption in "the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (American Psychiatric Association, 2013) caused by traumatic events. Dissociation can cause a "separation" of mind and body, which contributes to a survivor's difficulty recalling events, or even consciously acknowledging that a traumatic event has occurred (American Psychiatric Association, 2013). This dissociation may contribute to a survivor's delay in caring for themselves physically and

mentally after an assault. Trauma can take time to process and during this time, a survivor may not access formal services.

Relationality, or lived-other, refers to the relations with other individuals in shared space within the lived-world. Lived-other is felt through the body, through physical contact and through perception of others and their body (van Manen, 2016). Previous experiences with formal services such as healthcare professionals can have a profound impact on whether individuals will access further formal services. Healthcare professionals who provide culturally appropriate and competent care to populations who have experienced marginalization may begin to build trust within the healthcare setting which may influence these populations to seek further services (Health Council of Canada, 2012).

Limitations of Phenomenology

As previously stated, interpretive phenomenology is not only a qualitative research method, but an expansive philosophical movement (Lopez & Willis, 2004). The existential nature of interpretive phenomenology has been viewed as a limitation to the methodology as it is too vast and philosophical to be "rigorous." However, interpretive phenomenology as a methodology provides researchers flexibility and creativity to use the words of the participants to inform the phenomenon under inquiry. This flexibility and creativity can be an asset when working with diverse and complex populations (Pringle et al., 2011). The use of small sample sizes in interpretive phenomenological studies often has been seen as a limitation of the methodology, as small sample sizes can lack diversity. Pringle and colleagues (2011) emphasize, however, that fewer participants can allow for richer and more in-depth analysis of the data.

Research Design

Sampling and Recruitment

Purposive sampling was used to attain a sample population of individuals who were survivors of sexualized violence and either have, attempted to, or have not, accessed formal health-related supports/services for sexualized violence. Dukes (1984) recommends a sample size between three and ten participants. For the purpose of this research, the goal was to interview eight to ten participants. Participant's experiences with other supports/services they may have accessed for sexualized violence *that may not be formal or health-related* were explored as they may have affected their decision to access, or not access, formal health-related supports/services. The participants were required to be 19 years of age or older, able to speak English, able to consent and self-identify as having experienced sexualized violence. Sexualized violence was defined by the participant. Biros (2018) highlighted that the ability to consent to participate in research is determined by an individual's decisional capacity. Decisional capacity regarding research is the ability of an individual to "understand and logically process the information that is necessary to make an informed decision regarding study participation," (Biros, 2018).

Recruitment included flyers around various institutions within HRM, including a university campus (Dalhousie University), Avalon Sexual Assault Centre, and other relevant community and healthcare services, such as walk-in clinics, as well as local community organizations (Halifax Public Libraries). MacWilliams and colleagues (2016) had success recruiting participants for research on a topic of similar sensitive and traumatic nature (women who had miscarried in emergency departments) by using social

media and other online classifieds (such as Facebook, Kijiji, Instagram and email forwarding). A Facebook group and Instagram page were created for the study, and recruitment material, including the study specific contact information, was posted. The majority of participants were recruited through these online methods.

Individuals who were interested in participating in the research contacted the researcher (using contact information solely designed for this study, provided on recruitment material, including a unique email address and a toll-free number that was created during the recruitment phase). The researcher addressed questions or concerns that the potential participant had regarding the study and verified that the participant was not a former client of the researcher. To identify past clients, the researcher notified potential participants of her name and role (Sexual Assault Nurse Examiner through Avalon Sexual Assault Centre) to determine if they were a past client by their name.

Data Collection

Interviews

Data on the experience of individuals who contacted, attempted to access, accessed, or did not access, formal health-related supports/services for sexualized violence were collected through individual, one-on-one, semi-structured interviews with open-ended questions, at a mutually agreeable time and private location. van Manen (2016) highlights two main functions of interviewing within phenomenology: (1) it provides a means to explore and gather experiential narrative data, which will provide a source to develop deeper understanding of a human phenomenon, and (2) it assists in developing a conversational relationship with the participant about the meaning of the phenomenon or experience. Semi-structured interviews and the use of open-ended

questions allows the researcher to guide the participants' reflections of an experience, and also allows for a conversational relationship between researcher and participant (van Manen, 2016).

In appreciation of participants donating their time and for their candidness in sharing their lived experience, participants were provided an honorarium in the form of a $25 gift card to Amazon or a local grocery store of their choice.

Reflexivity. As per Creswell and Poth, (2018), reflexivity is a way for researchers to position themselves within the research study. Positioning is based on the researcher's work experiences, cultural experiences, history and any biases, preferences and preconceptions that the researcher may have (Polit & Beck, 2017). I, the researcher, identify as a Caucasian cis-gendered woman. More specifically, I am a registered nurse who worked in specialized healthcare services for sexualized violence, as a Sexual Assault Nurse Examiner. These aspects provided me, the researcher, with assumptions of my own concerning the phenomenon of inquiry, which I identified prior to, and throughout, data collection. Written reflexive-comments were used throughout the research process to address any experience or observation that I had as a result of the research. This allowed me to be explicit about my "position" within the intended research (Creswell & Poth, 2018).

Data Storage

The interviews were transcribed verbatim from audio recordings. The audio recordings and transcribed interviews were saved electronically on a password protected USB drive. As per the recommendation of Creswell and Poth (2018) backup copies of the electronic data were made and the data were anonymized to protect the identity of

participants. The USB drive and participant ledger were then locked separately in filing cabinets in a locked office within the School of Nursing at Dalhousie University.

Data Analysis

In order to analyze the collected data, the researcher transcribed, verbatim, the recorded interviews herself to gain familiarity with the content. Thematic analysis was used to analyze the transcribed interviews. Thematic analysis is a flexible research tool used for "identifying, analysing and reporting" themes within qualitative data. (Braun & Clarke, 2006).

van Manen (2016) provides three approaches to isolating thematic statements when analyzing the transcribed data: "1. the wholistic or sententious approach; 2. the selective or highlighting approach; 3. the detailed or line-by-line approach" (p. 93). The wholistic or sententious approach included attempting to capture the concise meaning or main understanding of the text as a whole. The selective or highlighting approach involved reading a text multiple times in an attempt to highlight the statements or phrases that appear essential to describing the phenomenon of interest. Finally, the detailed or line-by-line approach required the researcher to examine every sentence of the text and attempt to isolate what each sentence revealed about the phenomenon (van Manen, 2016).

Braun and Clarke (2006) provide six steps to analyzing data using thematic analysis. The first step required the researcher to familiarize herself with the data collected. To familiarize herself with the data, the researcher collected the data herself (through face-to-face semi-structured interviews), listened and re-listened to the recorded interviews to transcribe them, verbatim, as well as by reading and re-reading the transcribed interviews. Once familiarized with the data, the researcher generated the

initial codes. After the initial coding, codes were sorted into potential themes and sub-themes. The fourth step involved reviewing and collating the potential themes and sub-themes. This step involved eliminating some themes which did not have enough data to support them, combining themes that may have initially appeared separate into coherent themes and isolating separate themes. Themes and sub-themes were then reviewed in relation to the entire data set to determine if they accurately reflected the meaning of the data as a whole. A thematic map was developed. Once a satisfactory thematic map was developed, the fifth step involved defining and naming the themes. Once the essence of each theme and sub-theme was accurately identified and named, the final report of the analysis was produced (Braun & Clarke, 2006).

The researcher collaborated and partnered with her supervisor and committee to ensure an accurate interpretation of the data. The researcher sent out two un-coded transcripts to committee members that they analyzed independently. Once completed, the researcher held a meeting with the committee and presented her analyses of the transcript followed by a discussion with members to find agreement on coding/themes.

Trustworthiness

Common criteria used to evaluate trustworthiness in qualitative research are credibility, dependability, and transferability (Ryan et al., 2007). To ensure credibility, the researcher used reflexive comments or notes immediately after interviewing participants, to ensure that biases and values were made known. The researcher returned to participants, who consented, with emerging themes during the interpretive analysis of the data, to ensure an accurate depiction of the participants' view of the phenomenon, known as *member checking*. *Member checking* is used to "validate, verify, or assess the

trustworthiness of qualitative results," (Birt et al., 2016). Dependability was established by clearly documenting, and recording, the design and decision-making process of the study, including the methods used. Transferability was established by providing rich detail and a deeper understanding of the lived experience of individuals who had contacted, attempted to access, accessed, or not accessed formal health-related supports/services post sexualized violence, which can in turn influence similar populations in similar settings (Ryan et al., 2007).

Ethics

Prior to beginning this study, permission was obtained from the Dalhousie Health Research Ethics Board, to perform the intended study. Informed consent was required from all participants. Informed consent included: the purpose of the study, as well as the risk and the benefits to participating in the study. Participants were given the option to withdraw from the study during any point of the recruitment and interview process and could remove their data up to one week following their interview. There were no direct benefits to participating in this study; however, participants contributed critical information to enhancing existing knowledge of this phenomenon. Participants may have benefitted from the chance to reflect on their experiences. There were no physical risks to participating in this study. Due to the sensitive and traumatic nature of the topic of inquiry, participants could have experienced some mental and emotional distress by sharing their experiences. Therefore, participants were reassured that they were able to stop the interview at any time and/or pause for breaks. The researcher also provided a list of mental health resources for participants. There has been research to suggest the therapeutic benefits of sharing traumatic experiences. If given a respectful and caring

environment, researchers can contribute to a survivor's healing journey by providing survivors with an opportunity to discuss their experiences (Snyder, 2016). The data collected has been reported accurately and honestly and without manipulation.

Chapter 3: Findings

In the following section a description of the participants has been provided and the five themes which emerged from the data were summarized.

The Participants

A total of 10 individuals participated in this study. Participants ranged in age from 19-60 years ($\overline{x} = 31$). Eight of the ten participants self-identified as women, two participants did not specify gender identity. Participants varied in a number of other demographics: their level of education (high school to post-secondary, the majority of participants had achieved post-secondary education); how soon after their experience of sexualized violence they attempted to, or accessed, services and support (five participants initially accessed services and support days following, five participants sought services and support for the first time years later); and the types of services (physical and mental health services, criminal justice system, university administrative justice) and supports (family, friends, or formal supports - for example, community organization) they accessed. As the interviews for data collection were conducted using a trauma informed approach, participants were not asked to describe or to provide any specific details about their experience of sexualized violence. Participants were free to share as much, or as little, of their experience with which they were comfortable. From the information provided, it was apparent that each participant's experience with sexualized violence was distinctly unique, and thus difficult to reduce into categories. Some notable variances in participants' experiences of sexualized violence included: whether perpetrators were unknown, or known, to the survivor (including intimate partner violence); and whether it was historic, or recent, trauma.

Within the past five years, all participants had accessed, or attempted to access, supports and services (in some cases, multiple services), within Halifax Regional Municipality (HRM), regarding an experience of sexualized violence. All the participants had experienced violence perpetrated by men. The formal services accessed by participants varied. Four of the ten participants accessed/attempted to access the police and other services within the criminal justice system. Two participants accessed services in the administrative justice system within their university. Five participants sought medical care through either Sexual Assault Nurse Examiners (SANE), physicians or physiotherapists. Nine of the participants sought mental health care and counselling through university, private or public sectors (including Avalon Sexual Assault Centre) and one participant used a shelter. All participants described using, or attempting to use, family and friends for support. One of the ten participants accessed an informal cultural support group, while another participant described using yoga and meditation as informal support, and another participant used online forums (Facebook Groups) as informal mental health support. Five of the ten participants voiced having had more than one experience of sexualized violence within their lives.

Two participants who volunteered for the study were known to the researcher through the Halifax community; therefore, guidance was sought through the Dalhousie Research Ethics board and permission to include the participants in the study was granted. To ensure the participant's comfort during the interview process and in participating in the research, the participants were provided the option to be interviewed by the researcher, or a classmate, Clare Heggie, who conducted similar qualitative research exploring the experience of women who sought supports and services for

sexualized violence in rural communities within Nova Scotia. One participant consented to be interviewed by Clare, while the other consented to be interviewed by the researcher. The same process of data collection and obtaining informed consent was followed for all participants, and Clare adhered to a confidentiality agreement.

Themes

In the following sections the five themes reflecting the experience of survivors using and/or attempting to use, support and services for an experience of sexualized violence has been described. Through these five themes, 14 subthemes emerged.

Themes and Sub-themes

Recognizing Sexualized Violence
- *Questioning Whether They Were Deserving of Support*
- *Mental Health Crisis*
- *Disclosure to Family and Friends*

Re-traumatizing Services
- *Neglect of Survivor's Needs*
- *"Culture Blind"*
- *Barriers to Access*

Supportive Service Experience
- *Trauma-Informed Healing*
- *Social Support*

Ripple Effects
- *Post-traumatic Growth*
- *Ongoing Effects of Trauma*

Gaps in Services and Education
- *Available Services*
- *Appropriate Training*
- *Sexual Health Education*
- *Justice Reform*

Recognizing Sexualized Violence

The theme *Recognizing Sexualized Violence* refers to the arduous process that the participants went through to acknowledge their experiences, and resulting trauma, as sexualized violence. This acknowledgement preceded the participants' decision to seek support from services for sexualized violence. Participants described struggling with their own shame, guilt and fear surrounding the experience of sexualized violence. Participants also described having limited knowledge and awareness about sexualized violence, and confusion regarding if what they had experienced was in fact, assault. This absence of awareness was often noted as a contributing factor as to why the participants did not immediately seek services related to sexualized violence. Each participant's recognition of their assault happened at different points in their healing journey. Participants noted a number of factors which contributed to their ability to recognize that their experience was sexualized violence. As a result, within this theme the following three sub-themes emerged: *Questioning Whether They Were Deserving of Support, Mental Health Crisis*, and *Disclosure to Family and Friends*.

Questioning Whether They Were Deserving of Support

Eight of the ten participants voiced feeling confused or questioned whether they were deserving of support from formal services. They noted feelings of fear, shame, self-doubt and a lack of awareness or knowledge related to sexualized violence in general. This lack of knowledge further contributed to the confusion about whether participants' experience of sexualized violence "fit" their perception of the criteria "needed" to access support from formal services for sexualized violence. For these individuals, their perception of whether they were deserving of support influenced *how* and *when* they

would seek services for their experience of sexualized violence. These complex feelings often influenced the trajectory of the participant's healing journey, and the services and support that they decided to use, or not use.

> So, even when it happened, I was like, well, I wasn't "raped" and that was kind of like the only thing that I thought was sexual assault, was only rape, but like you know, it was everything up until that. So, I thought, well that's not what sexual assault is, sexual assault is rape… and it's usually by a stranger. Like how could it be someone I know? Someone who I thought was my friend. So, then I just assumed for a long time I was like, well that's just my fault… I didn't do anything when it happened, cause I didn't know what to do and I didn't even know it was sexual assault, really. So, I just kind of blamed myself for it happening, which I know everybody does, but I think because I didn't even recognize that it was sexual assault, I didn't even think about using services. (Participant 3)

These feelings of guilt, confusion and self-doubt often persisted for participants even as they accessed supports and services for sexualized violence.

> I would always say to her [mental health therapist], 'I feel like I'm pretty good with my situation,' I was always pretty composed, or whatever. I had those feelings of being like 'I shouldn't even be here; I'm taking up someone else's space that could be way worse than me.' (Participant 8)

Mental Health Crisis

The subtheme mental health crisis refers to the notable deterioration in mental health that each participant experienced as a result of their trauma from sexualized violence. This "dysregulation" (as one participant referred to it) and crises ultimately pushed participants to seek services to address their trauma related to sexualized violence, in order to care for their mental health. Each participant varied in the timing of this deterioration in their mental health. Some participants suffered it immediately following their experience of sexualized violence. Other participants suffered the deterioration of their mental health after some time had passed from their assault which allowed them to recognize and acknowledge their trauma. Still other participants

attempted to deal with the trauma on their own which led to a deterioration in their mental health, and eventually pushed them to seek support and services for sexualized violence.

> I think, at the time, I just really needed support and kind of getting through the day-to-day stuff. I was feeling just so dysregulated and having to see this person [assailant] every week was so overwhelming that it was really helpful to have someone who I could talk to about that… and also kind of talk to… about what had happened because it wasn't something… like I had never accessed counselling services before that point. (Participant 2)

> I tell you, I never contemplated committing suicide, but it was just like, I was a wreck, you know, I was using alcohol and weed, … but I was using substance to just stay, you know, stay. (Participant 4)

One participant experienced a severe mental health crisis due to a lack of mental health support for their mental health in general, and trauma related to their experience of sexualized violence. As a result, this participant disclosed that they had attempted suicide.

> It was actually after a suicide attempt, when I got in contact with my therapist. (Participant 10)

Participants' mental health journey post sexualized violence did not appear linear. Participants voiced fluctuations in their mental health over a number of years. They also voiced experiencing ongoing mental health crisis and emotional dysregulation while accessing services for sexualized violence and working through their trauma.

> Yeah, at that time, it felt like pretty crisis… like I was really not doing well and felt like very unstable… and so she could tell obviously, as my psychologist… and so I kind of stopped making appointments, or cancelled appointments, and she ended up calling me and, just like, said 'What's up? You need to be here, why aren't you coming?' (Participant 9)

Disclosure to Family and Friends

The final subtheme, *Disclosure to Family and Friends*, described by all participants, reflects disclosing their experience of sexualized violence to family and/or friends who then played a critical role in validating their experience and ultimately influencing their decision to seek formal services for sexualized violence. Two of the ten participants attributed disclosing to family and friends and the resulting discussion as a catalyst for them to recognize and acknowledge that their experience was, in fact, sexualized violence. Discussing their experience with family and/or friends allowed the participants the opportunity for their feelings and experience to be *validated*, and also to *reframe* their perspective on the experience.

> So, I think it took me a really long time and it wasn't until I started talking to people or would let something slip about what happened and someone would be like 'wait, what?'… that I really started to kind of understand that this [experience of sexualized violence] wasn't normal. (Participant 2)

Five of the ten participants were encouraged to seek out support from formal services for sexualized violence by their family and friends following disclosure. These participants identified this encouragement as a factor contributing to their decision to access support for sexualized violence.

> So, I told him [husband] what happened, and he goes 'let's go there I want to see him, I want to go see him right now.' I'm like 'no, cause you're going to do something.' He said 'let me just figure out what to do.' …He said 'well let's go to the police,' I said 'no, I can't go'… and then my husband would ask me every few months, 'you ready to go yet?', 'No, I'm not ready to go yet,' 'Okay.' Every few months he would say, 'Do you want to go?' 'Nope.' I knew exactly what he was saying, he would just say 'you want to go?' …Then finally one day I just woke up and I said, 'you know what, let's do it, let's go.' (Participant 5)

> I actually called my boyfriend at the time, and he was so freaked out because he lived up here in, [town], and yeah, he said, 'you should call the police' and he said 'I'll do what I can and I'll come down' …and anyway, I reported it… (Participant 10)

Three of the ten participants voiced some fear of burdening their friends and family with their experience of sexualized violence and resulting trauma. They then used this fear as motivation to seek formal services and supports for sexualized violence to alleviate some of this perceived burden from their social supports.

> I think also it wasn't easy on my friends at that point… I was really struggling, and so having someone else that I could go to for support, that was like professional support, was helpful because then I didn't feel like… like, I felt like that would have taken pressure off of them [friends]… and also, I didn't feel like I was going to them all the time with this. (Participant 2)

Re-traumatizing Services

The theme *Re-traumatizing Services* describes the experience of participants who accessed support from services that were ill-equipped to care for survivors of sexualized violence. All participants described negative aspects of their experience using, or attempting to use, services regarding their experience of sexualized violence. Sexualized violence is undoubtedly a violating and traumatic experience, leaving survivors confused and vulnerable. Deciding to disclose, or report, their victimization to another individual required immense courage and emotional labour (Benoit et al., 2015). Participants voiced receiving insensitive treatment from formal services or supports which negatively affected their healing and influenced whether they would continue to seek formal support in the future. Within the theme *Re-traumatizing*, three sub themes emerged: *Neglect of Survivor's Needs, "Culture Blind"*, and *Barriers to Access*.

Neglect of Survivor's Needs

Nine of the ten participants described receiving treatment that reflected a level of service provider inexperience, lack of education, and/or attitudes and beliefs about sexualized violence that were insensitive and not trauma informed. Participants described

feeling violated and shamed for their experience of sexualized violence by service providers, which deepened their existing self-doubt and confusion regarding their trauma.

Participants reported that service providers who lacked appropriate training and awareness in sexualized violence, trauma or trauma-informed care often engaged in victim blaming behaviour. They badgered participants with inappropriate questions and sought gratuitous details about their experience of sexualized violence, which served to further re-traumatize participants.

> Her [therapist] responses to everything were really strong… She would kind of make comments like 'that's disgusting' or like 'can't believe he did that,' or stuff like that… And like, she would ask things in such a way that it just felt like she was judging me for what had happened… Like, I would have been 22 when I saw her but 17 when most of the assault took place… and like, she would be like 'but when he was doing that did you say no the whole time? Did you say no the whole time he was doing this?' To be honest, I really don't remember, but it felt really, yeah, just the way that she did that, I felt really violated by the questions that she was asking me, and I didn't feel like I had a choice as to whether or not I talked about certain things or not. (Participant 2)

> Yeah, so just again, it's kind of an attitude I think… and it's not that I'm looking for someone who I can hug and whatever, it's a therapist… I understand it's professional, but there is definite things that kind of piss me off… Like, there's a whole technicality for childhood sexual abuse, the person has to be at least four years older than you and like blah, blah, blah, … and it didn't fully coincide with that… So, she was like, 'technically it wasn't childhood sexual abuse.' …and I'm like 'well, technically then what the fuck was it?' …That's not helpful, why would you say that? Just shit like that… that's like invalidating, unhelpful, not relevant… like I understand that you kind of want me to look at it differently and say, not like, get stuck in the past. But let's call it what it is, like you know… that's not what the issue is. (Participant 6)

> Yeah, and like they [police] were questioning my character… anyway, my boyfriend at the time, they kept questioning if I wanted to 'try somebody new' and stuff… They kept trying to pin it on me, which was disgusting. I kept telling them 'no, no, no.'… Yeah, but that was their attitude, they just did not believe me. (Participant 10)

"Culture Blind"

The subtheme, *"Culture Blind,"* acknowledges the experience of the Indigenous and Black participants in this study, who noted a lack of cultural diversity in service providers as well as a lack of knowledge in diverse populations and their healing practices. These participants described receiving Euro-centric care that ignored their spiritual needs and healing. The implications of sexualized violence, in the context of different cultures, directly affects the trauma a survivor experiences, and how they may access support for sexualized violence and future needs (Benoit et al., 2015). Ignoring this aspect of a survivor's identity can contribute to their re-traumatization, as it can invalidate their experience, and the complexity of intergenerational trauma (Bletzer & Koss, 2006).

> I wouldn't say they were like culturally insensitive, maybe culture blind? I think being native has such a significant place if you're a woman experiencing violence, given all those impacts. Like when you do it's not just you, you remember your mom and your sister and all of that, so that's different for us. And sort of getting that, would be helpful. Yeah, I wouldn't say culturally insensitive, nobody blamed my violence on me being native, that didn't happen, but culture blind. (Participant 1)

The concept of "culture blind" was further observed by the Indigenous participants within the infrastructure and environment of where services and supports were offered in particular, hospital and clinical settings. Participants voiced that these spaces lacked the infrastructure to accommodate cultural healing practices, further stigmatizing individuals of different cultures.

> Or I find a lot of comfort in culturally relevant things, but there wasn't a native nurse, which like, those services are hard, and I get recruitment is hard and all of that, but like, I think that was sort of difficult for me when I was accessing that… It's always helpful when you see someone who can kind of contextualize, or like, understand how you're kind of experiencing it. So, like, yeah, I guess I didn't really have that. Or in the hospital there's no place to smudge in the ER. Which

> makes sense because of scents, but that's kind of really important to me, and I wanted to, but there wasn't the space for that, so I didn't. Yeah, that was kind of hard, I guess. (Participant 1)

> So, another pro with having someone who understands the culture… and that could also be a con too… because there's a lot of counsellors who don't know anything about our culture …and some of the places that, like, if [family member] wanted to smudge they can't do that at the hospital. They would have to go outside and do the smudging ceremony outside the hospital, so that could be kind of a pro and con. (Participant 5)

Barriers to Access

The third subtheme, *Barriers to Access*, reflects the experience shared by all participants of systemic, structural, and organizational barriers that limited the accessibility of supports and services for survivors of sexualized violence. All survivors acknowledged that once they had recognized their victimization as sexualized violence, there was the challenging task of seeking assistance for that experience, whether it was immediately following the assault, or years later.

A barrier that all participants described was the lack of availability, high cost and a long wait time to access existing support and services for both sexualized violence, and general mental health services. Participants described the emotional toll and vulnerability that it took to acknowledge needing, and actively seeking out, support for sexualized violence only to face limited availability of services, and long wait times for the services that were available. Participants noted the cyclical nature of long wait times as barriers that discouraged them from actively attempting to seek assistance from these services, which negatively affected their ability to work through their trauma.

> So, for me, it was always that, you know, you've got to wait a month or two months, and by the time it happens you've either swallowed it, you know… or you've decided this is too much, I can't go public with this. So, it's really a thing about time and not having enough resources out there. (Participant 4)

> So, I didn't find that there was a place that was accessible… the second that it was in my mind, I didn't find there was a place that I could go to right away… because all the mental health system resources, and stuff like that, it's like, if it's for sexual assault, if it wasn't something that happened right away, that happened that you were actively experiencing fresh trauma from… then I felt like they wouldn't take me as seriously. At the same time, you know, if I wanted to just go to a normal mental health practitioner then I would have to wait three to six months… and then, by then, maybe I would have forced myself to forget about it, or whatever, again. (Participant 7)

Further barriers to access identified by five of the ten participants included a lack of privacy, as well as a stigmatizing infrastructure and environment in which services and supports for sexualized violence were offered, which included hospital and clinic settings.

> Somewhere that's a little more private, I guess, initially, I think would be more helpful. You're so on edge already, the lights are harsh, it's always busy, that's really overwhelming… Or I found it to be really overwhelming, when I was already really overwhelmed… I think if I was aware of an alternative option, or like alternative space, or something, I probably would have tried to access that instead. (Participant 1)

> I didn't really like the way even the waiting room was set up, it just felt very strange because they …they kind of have two separate areas so that it's all one waiting room for all of the health services that are accessed there but depending on who you're seeing you sit on one side of the room or the other. But what it winds up being is that all of the people who are accessing mental health services sit on one side of the room and then the people who are accessing physical health services sit on the other, and there might be a little bit of cross over but that's very much kind of the breakdown. So, it just felt very public… (Participant 2)

Supportive Service Experience

The theme, *Supportive Service Experience,* reflects the supports, services, providers and their environment in which participants found support and healing. These experiences described services and providers who were compassionate, caring, knowledgeable and trauma-informed, which contributed to the healing and wellness of the participants. Participants also described services which were provided in welcoming

and relaxed environments with comfortable waiting areas, which helped to ease their anxiety when accessing these services and supports. Within the theme *Supportive Service Experience*, the following two sub themes emerged: *Trauma-Informed Healing* and *Social Support*.

Trauma-Informed Healing

The sub theme *Trauma-Informed Healing* refers to the experiences that each participant had with a service provider who they found to be supportive and aided them with their trauma. All participants described at least one experience of an interaction with a service provider who proved to be caring, validating, and forward thinking in their approach to service provision. These service providers had enough knowledge and empathy to provide trauma-informed care to survivors of sexualized violence and helped them to understand their experience and begin to process the resulting trauma. Furthermore, participants benefited from service providers who assisted them to engage in tangible coping methods to help them build resilience and skills to mitigate the trauma they had experienced. Seven of the ten participants who used private mental health therapists, noted these interactions to be the most positive, supportive, and healing interactions. These mental health practitioners were well equipped to care for survivors of sexualized violence by understanding, reassuring, and assisting them to gain meaning from their experiences of sexualized violence. Participants noted that the greatest impact on their healing involved the work done with their mental health counsellor. For all participants, supportive interactions with any service provider involved them acknowledging and validating the participant's experience of sexualized violence. Participants voiced the importance of having a positive relationship, or connection, with

their mental health service provider. They also noted valuing service providers who *listened* to the needs of the participant, were *client directed* with their care, and *acted as advocates* for survivors of sexualized violence. These service providers openly recognized to the participant any limitations to their knowledge and scope of practice and referred participants to appropriate additional services when necessary. These values align with principles of trauma-informed care, which aim to reduce the possibility of re-traumatization (Elliott et al., 2005). One participant, who was Indigenous, noted the importance of incorporating culturally relevant healing practices and having a mental health practitioner who was Indigenous, as it provided a level of context and understanding that was not always acknowledged in similar services.

> Just her [family physician] being there, just her being there, you know, she was there, it wasn't like she brushed me off, or anything. She was very there and very aware. (Participant 4)

> It was like extremely helpful, I don't know, maybe or maybe not lifesaving. She was great… I made a really good connection with her and felt very lucky and grateful… like the first person that I reached out to kind of privately, was a good experience… kind of after the few not great health experiences… Yeah, it was like a lot of work was done with my private psychologist. (Participant 9)

> They [SANE] made me feel safe. Like, they explained everything as they were doing it, like they didn't push me… Whenever I would start to break down, they would let me have my space and come back to it after I calmed down a bit… They were really patient with me, I remember that. (Participant 10)

Participants also noted service providers who appeared to have appropriate training and knowledge to support survivors of sexualized violence. Participants acknowledged that their provision of care was appropriate, and trauma informed.

> The nurse was awesome. She told me exactly what was going on, what she was going to do, what things were being used for… and I think was trying to give me a sense of control, which was, that was really helpful. Clearly, there's only so much you can do in that situation, you're still not really in control… but to have

> the option to say 'no,' or 'stop,' or 'why are you doing this?' …or whatever, like I felt comfortable doing that. (Participant 1)

> I felt that whatever training she had had, had been trauma informed, and that everything that she did was very respectful… and she didn't do anything without asking… and, you know, checked my comfort level all the time… and was like 'are you okay if I do this?' …you know, 'you can let me know if this is bothering you,' like 'we can stop at any time,' kind of thing. (Participant 3)

Participants also noted a sense of safety and comfort from the environment in which these services were offered. They described waiting areas that felt private, non-judgemental, and comfortable, which helped to ease their anxieties about seeking supports for their experience of sexualized violence. Participants felt safe and were able to engage with their service or support provider to conduct meaningful work on their healing journey.

Social Supports

The sub-theme *Social Supports* reflects the experience of all ten participants who sought support from family, friends, and/or community members (for example a community group) for an experience of sexualized violence. For the individuals in this study, their social supports were crucial in filling in the gap of care due to a lack of formal services and supports readily available, or long wait times, for survivors of sexualized violence. Support included providing informal guidance, care, and assistance to participants. Participants voiced disclosing their victimization at different periods in their healing journey, and as previously discussed, acknowledged that disclosing their victimization to family and friends acted as a catalyst that encouraged participants to seek support from formal services and supports.

Social supports which shared common understanding and lived experience of sexualized violence were identified by eight of the participants as a valuable support as

they were better able to relate to the participants. Participants also noted the devastating realization at how prevalent experiences of sexualized violence were among community members and within their social circles. The support received from social supports was notably more loving and caring than that from some formal services and supports, as social supports are more invested in the well-being of the participants.

> There's a women's, or fem identified folk group at the [local cultural community centre]… like it's not necessarily for survivors of sexualized violence or intimate partner violence necessarily, …unfortunately that's kind of the shared experience within our community. So that's kind of like a healing circle, I guess you might describe it. …So that was helpful and continues to be… But it's always simultaneously horrific and beautiful to have a shared community of these people that have had these similar experiences so we can relate to each other. (Participant 1)

> Even though, it was like really just friends, none of our experiences were the same, or even similar, but it's like 'this sucks for all of us, let's commiserate, let's talk shit, let's like get it all out.' (Participant 9)

For two of the ten participants who accessed group style counselling through their university, they greatly benefitted from the sense of community and understanding that the group provided. Group therapy settings provide survivors an opportunity to share, and validate, their experiences with individuals who can empathize, understand, and provide perspective (Coholic, et al., 2018). This shared understanding also can combat the sense of isolation that survivors of sexualized violence experience (Benoit et al., 2015).

> I think it was nice, because there was never any session where everybody sat down and talked about specifically what had happened… but I think bits and pieces would come out as people would share their stories. I think it was something that, I think, going into it I partly had my reservations just cause I didn't feel like my story was going to fit and, or be something that… yeah, fit in with what everybody else was going to… what everybody else's experiences would have been. But I think that hearing, or coming to kind of understand a bit more about what other people had gone through was helpful… and just giving me some context where I was… like, everybody's story is really different and so I think it made me feel more comfortable, not with what had happened… but just

> more comfortable with my story as being something that wasn't just completely like out there. (Participant 2)

Ripple Effect

The theme, *Ripple Effect*, describes the experience shared by all participants as they continue to process and learn to live with the ongoing effects of sexualized violence. The effects of sexualized violence are complex, and survivors often felt the effects in varying intensity throughout their life following their victimization. Participants acknowledged that their changed perspective influences how they engage in social interactions, navigate new and existing relationships, as well as cope with the demands of day-to-day life, as survivors of sexualized violence. Despite the tremendous hardships that these survivors had faced, they persevered and continue to seek support for their victimization. The theme, *Ripple Effect*, is divided into two subthemes: *Post Traumatic Growth* and *Ongoing Effects of Trauma*.

Post Traumatic Growth

All of the participants highlighted the actions they took for protection and self-care following a traumatic experience of sexualized violence. Participants advocated for themselves by seeking care that was most appropriate for their needs. Participants demonstrated their vulnerability by facing various experiences of re-traumatization when attempting to access support for their victimization but continued to persevere to address their needs. Participants advocated for themselves and for others, so that other survivors would not face the same re-traumatizing experience when attempting to seek help for their victimization. This provided the participants with a sense of control and allowed them to reclaim some of the power that was taken from them by their perpetrators of violence. For some participants, reclaiming power included determining and voicing

boundaries with service providers, educating themselves and others on sexualized violence and trauma, and reciprocity.

> I think it was just… the main thing was that first interaction where that particular counsellor really felt like the way to move forward was by me reporting what had happened… and I really didn't feel like that was something that I wanted to even kind of have on the table. But that was something I told the second counsellor, I was like 'I don't want to talk about this,' and she was like 'great we won't,' and we never brought it up again. (Participant 2)

In supporting other survivors, participants found meaning and purpose in their trauma, and worked to improve care for survivors, and the culture surrounding sexualized violence. Almost all of the participants voiced some desire to raise awareness and improve services and support for survivors of sexualized violence as a reason for participating in this study.

> You get a little bit of comfort knowing that you're not the only person that this has happened to… not comfort that it's happening to everyone… obviously that makes me angry and most other women angry… but that, you know, we've sort of all had this thing happen together and that almost makes me more motivated to do something about it. Knowing that it's so common and that it's become so normalized that it's pushed me to work in the area and be like 'why is this happening?' (Participant 3)

Ongoing Effects of Trauma

An experience of sexualized violence profoundly affects survivors' mental health and can make them feel isolated in their trauma. All participants voiced continuing to experience the effects of sexualized violence throughout their lives following the assault. All participants also voiced experiencing some judgement from service providers, or from within themselves regarding being unable to "move on" from the assault, as if it were an illness from which one could recover. All participants acknowledged that despite the services and supports that they may have accessed for an experience of sexualized violence; their healing journey did not end with those supports. Participants noted that

dealing with the resulting trauma is an ongoing journey, and something that they must work through for the rest of their lives. The effects of sexualized violence influenced how survivors accessed other healthcare services, navigated relationships with others as well as themselves, and their sense of security - both physical and emotional. Participants acknowledged that healing from trauma is a process and there are no set steps that an individual must follow; indeed, the process is different for every individual, and some may find healing in support while others may not.

> So, it was 'why are you coming in after so many years?' You know, 'this is already over and done with.' No, it's not over and done with. It's just beginning for me, it's part of my life story now, you know. (Participant 5)

> Yeah, there's no starting point, like you don't walk through a door being like okay, 'healing now please.' It's just constantly like no matter what you do, whether you're going in to get examined or you're going through the justice system, or you're going to therapy, or you're acknowledging that you were assaulted, it's still just forever ongoing. I guess that's acceptance over time of like how I think that's why I don't think the justice system per se gave me what I needed. It's been what I have done with it since, in that big way. (Participant 8)

Participants also acknowledged how overwhelming and mentally and physically draining seeking support through formal and informal services can be for survivors for an experience of sexualized violence. A negative experience can have a severe impact on a survivor's mental health, and ultimately on their healing journey (Elliott et al., 2005). Furthermore, seven of the ten participants who had negative experiences with service providers and services, identified feeling distrust for similar formal services, in particular the criminal justice system.

> And if a friend came to me and was like I've been thinking about going to the cops, I would have to very much have to check myself out to, to tell them don't do it. To really be mindful in like, letting someone else decide for themselves because I feel so strongly about my experience with that, yeah, I would not encourage people to do that. (Participant 1)

> I said, it took me seven years to walk into that police station and actually charge him, and I said, thinking that there was going to be something done about what happened. When nothing gets done, you lose hope in the system, right. You know, how do I, as a worker who works with [individuals] who've been assaulted, how do I go to them and say you need to report this, you need to get support, when there's not a whole lot of support. Like, I feel like I'm setting them up. (Participant 5)

Participants continue to face re-traumatization from media coverage of publicized cases of sexualized violence. One participant felt angry and discouraged by the lack of any consequences allotted to perpetrators of sexualized violence. This participant voiced feeling upset and having an "incomplete feeling" when perpetrators are not punished. Participants lacked a sense of closure as they did not know whether their perpetrators' actions were deemed severe enough to warrant formal legal consequences or were afraid that their experience would not be taken seriously by police, and therefore were hesitant to report their assault to the police. Six of the ten participants did not report their victimization to the police; however, four participants did.

> It's just, it's not fair. It's not fair at all but also you know, it does something to the victim to see the person still, you know, going free. Like, even though I don't think I would have wanted to take a criminal route with my assault, I definitely wish that I at least had the option, you know, that… in an ideal world he would be penalized for that and it would follow him for the rest of his life just like it'll follow me for the rest of my life, you know. Just like if someone broke into your house and stole your stuff, you would want your stuff back and you would want them to be punished, but it never ever happens. So, it's like an incomplete feeling, you know… Every week there's something in the news like 'oh this one didn't go through,' you know like all those taxi assault cases here… it's just like that to me is more retraumatizing than a pap smear, you know. Watching women constantly not being believed and like nothing, no outcome… (Participant 3)

All of the participants highlighted the need for ongoing consistent support for survivors of sexualized violence, in particular, mental health services such as counselling. Participants described requiring support in varying degrees throughout the years following their victimization. In most cases, expensive private counselling fees, limited

availability of public services and long and unpredictable wait times for mental health services prevented participants from receiving vital care.

Gaps in Services and Education

Through sharing their lived experience of attempting to access and accessing supports and services for sexualized violence, participants identified a number of gaps within existing available services. Gaps included systemic and organizational policies and principles which restrict, or limit access to services and support for sexualized violence, and mental health services in general. Gaps in services also included the lack of education and awareness surrounding sexualized violence and trauma for service providers as well as the public in general. The following sub themes emerged: *Available Services, Appropriate Training, Sexual Health Education* and *Justice Reform*.

Available Services

All of the participants voiced experiencing some difficulty accessing formal services and supports for sexualized violence due to the lack of sufficient numbers of available services. Participants noted that public supports and services for mental health needs were limited in the number of appointments offered to survivors. Participants acknowledged the need for long term mental health services to truly address the complexities of trauma resulting from sexualized violence, and the ongoing effects that remain with survivors years later.

> Cause one of my complaints was, when they first started to limit you to three sessions, I said 'how is a person supposed to get healing or get help only through three sessions?' …You just start, really exploring, you know, the trauma for the first three sessions… and then you slowly start, you know, opening up and seeing how you can branch out and how… you just start healing, doing a lot more in-depth therapy long term. (Participant 5)

Participants also noted disappointment in the lack of types of services and supports for sexualized violence. Seven of the ten participants noted that mental health support with group therapy options were something they truly desired but were unable to qualify for, or readily access.

> So, yeah, most of my help outside of that short bit of counselling, has been from Facebook, from a group of random strangers. I've actually even been thinking of doing, like starting like a peer support group at the library… and like, reaching out to like nurses or health professionals to have at least one or two on site… and have, like you know, AA style… everybody sits in a circle, everybody talks in, like, group therapy. That's basically like… it's almost like cognitive behavioural therapy… like get, everybody talking about things, relating experiences, realizing that no, this is not normal… but you're not alone in it. (Participant 7)

> I think, I don't know if this counts… I really… what I really wanted, and contacted [service] several times over the last 3/4/5 years, is their group therapy. However, it's not accessible if you're not a one-on-one therapy client with [service], and I wasn't willing to go back to [service] after my shitty experience. So, yeah, I didn't feel like that was accessible… even though that is really what I craved the most was a group therapy. I don't know, and I asked my private therapist if she knew of anything, and there really wasn't anything happening in the province. (Participant 9)

Participants identified a common thread among the gaps in services and support for sexualized violence; the need for additional funding. Participants proposed that the increased wait times, lack of available specific types of service, as well as limited availability of existing services and supports were all related to a lack of funding for general mental health supports and specialized services for sexualized violence.

> Better funding, I mean if they're still going… I think it's a lot to ask for mental health services to be free, I think we're a long way away from that… but you know bolstered funding for community services, [local services], any support for sexual and domestic violence… the prevalence is so, so high and folks are not always able to afford privatized services. I know [specialized public service for sexualized violence] has a huge waitlist and they're not taking new clients… they need so much money… they do really great work, so while I didn't use them personally, I know folks who have tried to use them, and they can't because they're so underfunded. (Participant 3)

Appropriate Training

All participants noted that even when supports and services for sexualized violence were available, the care provided was not necessarily sensitive nor trauma-informed, often retraumatizing survivors of sexualized violence. Participants advocated for providers to obtain additional training in trauma, sexualized violence and caring for diverse populations and cultures. This training is crucial for service providers within healthcare and justice systems; not only for those working in specialized services for sexualized violence, but for all staff and service providers within these systems.

> So yeah, I think definitely there's a piece there where it's like, the SANE nurse is awesome and compassionate and gets it, but everyone needs to be awesome and compassionate and getting it. (Participant 1)

> I shouldn't have to go there and make them believe me… it should be a pre-thing, like you go in, they believe you, they get it, and you start working on it. (Participant 6)

Participants also noted the critical need for service providers who are ready, and able, to meet the needs of survivors from diverse populations and cultures. Two participants who were Indigenous noted that having a service provider who is also Indigenous would increase their comfort and the probability of them seeking and using support and services for sexualized violence.

> So, yes, so I didn't go to [service], I thought that [service]… and this is just my own biases… I guess, where I wanted someone who understood the Indigenous ways… I wanted to go to someone who I know would understand that… because I find that there's not a lot of organizations that do support Indigenous people… they may say they do, but when they don't really know our community. So, I guess, especially with my role, I would end up probably educating them more, than they would be supporting me. So, yeah, I didn't want that, I wanted to be able to just get the support. (Participant 5)

One participant described initially seeking assistance from a healthcare provider who ultimately lacked knowledge in sexualized violence and provided them with

misinformation which delayed their access to appropriate healthcare. Due to this gap in knowledge, the participant developed serious physical health concerns related to the assault. The participant acknowledged that had this healthcare provider had appropriate training regarding sexualized violence, further distress and trauma could have been avoided.

Sexual Health Education

Nine of the ten participants identified that more education and awareness in general were needed surrounding sexualized violence and trauma itself. Participants recognized that the lack of education regarding sexual health in grade school, as well as in post-secondary education, put themselves, and others, at risk for victimization. Participants strongly noted that, had there been more sexual health education and opportunities to discuss sexualized violence throughout the education system, they may have been able to identify their victimization as sexualized violence more easily.

> So, I think that having that education for young people is really important, because if you don't know what it looks like… or if your perception of it is that sexual assault is just rape… and rape is just penile-vaginal sex… then you're missing so, so, so much. (Participant 2)

> You know, I think people think if you just don't talk about it, it's not going to happen… but by not talking about it you're just leaving mostly, …well, often women and girls… vulnerable to violence… and then they don't know what to do about it. (Participant 3)

> I feel like if that's there [general sexual health education] then it will drive into other places… if it's there, if it's permeating, it will rise up into the counselling… and into when people make decisions if they have that base. (Participant 6)

Participants also noted that education and awareness of available services is necessary not only for survivors, but also for support and service providers who may encounter survivors looking for guidance following an experience of sexualized violence.

Justice Reform

Seven of the ten participants identified the need for changes to the criminal and university administrative justice systems for instances of sexualized violence. They also noted their own hesitancy and experiences of re-traumatization when accessing services within these systems. Participants who accessed the police immediately following an experience of sexualized violence recalled being badgered by questions, feeling judged and shamed for their actions and not being believed. One participant reported their assault years after their experience of sexualized violence and had their report mislabelled resulting in no investigation into the assault.

> I think that the nurse was so compassionate that I was like, oh they [police] will be too. …I'm not sure if they were as abrasive as a normal cop would be, there was probably some degree of sensitivity, but I would never do that [report to police] again. It was awful. (Participant 1)

> I was there until 2 AM. So, it was like eight hours of questioning… The first police officer, she was really sweet, and she was the one who took me to the hospital… but the other four officers I saw were just really rude to me… and they didn't seem like they believed me… Yeah, I was in hysterics by the time I left. (Participant 10)

The university administrative justice system refers to the policy that universities have in order to field disclosures and reports of sexualized violence on campus, or off campus involving university-related programs, operations or activities, involving students, faculty and/or staff. Complainants can disclose or report their victimization to trained advisors working in the department designated with the administration of the policy. When complainants disclose their victimization, advisors work with the complainant to identify needs and inform of available services. To make a report, complainants work with advisors to prepare a written statement and the advisor will determine whether the report will be addressed through an investigative or non-

investigative stream using criteria defined by the policy makers and university. A report to the university does not automatically include a report to the police, complainants can also report their victimization to the police. Non-investigative stream involves no investigation into the claims of the complainant. The advisor consults with all parties to identify desired outcomes, which are often remedial, educational, and or restorative. The investigative stream involves providing the respondent (perpetrator) with the opportunity to respond to the complainant in writing and an investigation occurs, all parties and witnesses are interviewed, and a confidential report is submitted with the findings and whether the investigator has determined if the respondent has committed acts of sexualized violence against the complainant. Outcomes of the investigative stream include remedial, educational, restorative, or a referral to a disciplinary committee. Both complainant and respondent engage with the policy and are both provided support and resources.

One participant who reported their victimization to the police, went through the court process and ultimately their assailant was charged with assault, believed that their experience with the police and criminal justice system was unique. The participant acknowledged that the result of their experience was ultimately positive but would not recommend for other survivors to pursue support through the criminal justice system. This participant also noted that there was little privacy during the trial itself, the participant voiced feeling vulnerable and described an overwhelming "release" of emotion following their testimony and crying, in a crowded general waiting area.

> It's interesting because I'm not an advocate for people to go into the justice system. It's a little bit of both for me… because I would never say that it's an easy process or that it should be done. Just because I had a good experience and it worked out in the end for me, I would never push someone and be like 'you got to

> do it, you got to go,' …like it was difficult, and it was actually a rare case… and I know I'm privileged in that sense because I'm like presenting as you know, a pretty little white girl… So, it's like I'm from a middle-class family, I understand that there's elements of it that I feel… like, that I recognize that I got lucky, basically. Going through the system and being in that percentage that is a case that got proven guilty is so rare. (Participant 8)

Participants also noted that support for survivors who have reported their victimization to the police was limited and felt there was little concern for their wellbeing or mental health. Resources were offered initially upon reporting their victimization, but there was little attention paid to the need for ongoing support throughout the onerous process of the criminal justice system.

Another participant sought justice through an administrative justice process in their university but found that they had to advocate for their needs to be acknowledged and push for consequences for the assailant. The participant recalled feeling frustrated with the academic process and believed that the service providers did not prioritize the needs of the survivor, but those of the assailant.

> It shouldn't be that you report it, and then have to fight for it to be heard. The system should be there to hear you and fight for you… you know, it shouldn't be… I'm already trying to do all this other stuff; I shouldn't have to fight to get stuff done too. (Participant 6)

Conclusion

Each participant's experience navigating and seeking supports and services for sexualized violence within Halifax Regional Municipality was unique. Participants accessed a number of different formal and informal services in healthcare and justice systems, as well as through social supports. The participants shared common challenges when attempting to access these services and supports. Participants faced confusion and a lack of knowledge regarding what constituted sexualized violence itself, what services to look for, and actually finding available services. Participants also found that there were limited knowledgeable, safe, and readily available options for care. In addition, they voiced facing long wait times, limited scheduling availability and unsustainable fees for private services. Participants also expressed being re-traumatized when accessing support from services and providers who were not trauma-informed and who engaged in victim blaming and judgemental behaviour upon interaction. However, all participants voiced having at least one positive experience with a service provider who was sensitive, trauma-informed and understanding. Overwhelmingly, participants expressed wanting accessible, long-term, holistic mental health supports that were inexpensive, physically accessible, welcoming with a culturally inclusive environment, and involved knowledgeable, trauma-informed staff. Participants also shared a number of suggestions to improve current services including increasing funding, additional training for service providers in trauma and sexualized violence, as well as bolstering and improving the current sexual health education curriculum in grade schools as well as post-secondary education.

Member Checking

Member Checking was a process used in this study during the analysis of data to validate, verify, and/or assess the trustworthiness of the results (Birt et al., 2016). All of the participants consented to the member checking process during data collection, upon reviewing the consent for the study. Participants were contacted by email and provided a brief description of the themes and sub-themes to review, to ensure that their story was reflected within the findings. Three of the ten participants responded and affirmed that their story had been represented within the findings. Due to the sensitive nature of the topic of study the researcher used a trauma informed approach throughout data collection and the informed consent process. Participants were reminded at the time of the interview, and when contacted again by email for the member checking process, that this process was completely voluntary, and they could withdraw from this process at any time or choose to not respond to the email. The member checking process did not occur until one year after the interviews were conducted due to delays related to the COVID-19 pandemic. As discussed throughout this chapter, the emotional and psychological effects of sexualized violence can be felt long after the experience of victimization. Everyone's healing journey with trauma from sexualized violence is different, and some participants may not have wanted to re-visit this experience again, through reviewing the findings of this research and engaging with the researcher.

Chapter 4: Discussion

The purpose of this study was to gain a deeper understanding of the lived experience of individuals who have attempted to access, accessed, or not accessed supports and services for sexualized violence. This study aimed to answer the following research questions: (a)What was the lived experience of individuals who have contacted, attempted to access, accessed, or not accessed supports/services for sexualized violence, whether they were formal, informal, health-related or not? (b)What formal health-related supports/services did survivors of sexualized violence contact, attempt to access, access, or did not access post sexualized violence, and why? (c) What other supports/services, that may not have been formal or health-related, did survivors of sexualized violence contact, attempt to access, access, or did not access post sexualized violence, and why? (d) What factors influenced a survivor's decision to access or not access health-related supports/services? (e) What recommendations did survivors have regarding how health-related supports/services could be improved and made more accessible?

(a)What was the lived experience of individuals who have contacted, attempted to access, accessed, or not accessed supports/services for sexualized violence, whether they were formal, informal, health-related or not?

Much like a survivor's experience of sexualized violence, the experiences of participants who contacted and accessed supports and services for sexualized violence varied greatly. Some participants found healing and support while others did not. This is consistent with other research which highlights the experience of sexualized violence as unique; there is no universal experience. An individual's experience of sexualized violence is framed by the context of their day-to-day life (Bletzer & Koss, 2006).

Participants' experiences of seeking, and accessing, supports and services reflected their unique needs, perception of deservedness, and their knowledge surrounding sexualized violence itself. Although *the way* in which participants sought services varied, as well as *the types* of services and supports they attempted to access, there were some similarities in the challenges they faced when attempting to access services and supports. Participants voiced feeling shame, guilt, and self-blame, as well as confusion or a lack of knowledge regarding sexualized violence itself and fear of judgement from others. These sentiments are reflected within current literature regarding survivor's experiences seeking services for sexualized violence (Pemberton & Loeb, 2020; Sit & Stermac, 2021). These well-established findings within the literature demonstrate how society continues to perpetuate negative beliefs and stereotypes, versus acknowledging the harmful patriarchal society and gender imbalances that cultivate a culture in which sexualized violence can be blamed on the survivor (Pemberton & Loeb, 2020).

Participants in my study also struggled to identify and find appropriate services for their needs. Indeed, they found few services and supports that were knowledgeable, safe, and readily available options for care. They voiced facing long wait times, limited scheduling availability and unsustainable fees for private services. They also expressed feeling re-traumatized when accessing support from services and providers who were not trauma-informed, lacked sensitivity and understanding, and engaged in victim blaming and judgemental behaviour. Sit and Stermac (2021) also found that the women in their study struggled to find appropriate services and supports for their victimization, due to a lack of awareness and limited education of services available to them. In addition, the women in their study encountered service providers who prioritized their own interests

and neglected the needs of the survivor. These findings are also noted in a study exploring the experiences of women navigating supports and services for sexualized violence in rural Nova Scotia. Heggie (2020) noted that the women experienced re-traumatization when attempting to seek support from services that were insensitive, not trauma-informed and blamed the victim for their experience. Heggie (2020) also notes that the women in the study faced challenges in actually identifying and locating services and supports, as well as long wait times for limited specialized services for sexualized violence within their community.

However, all participants in my study voiced having at least one positive experience with a support or service. They found healing through a number of different types of supports and services, such as private, public and university counselling, group therapy, Sexual Assault Nurse Examiners (SANE), informal cultural support groups, and social support from community members, friends and family. These service and support providers were sensitive, caring, trauma-informed and understanding. Similarly, Campbell (2006) found that survivors' experiences seeking legal and medical services were more positive when given access to 'rape victim advocates' who supported the survivor by providing non-judgemental support, advocating for the survivor's needs with healthcare and legal service providers, and having knowledge and experience in working with victims of sexualized violence.

(b)What formal health-related supports/services did survivors of sexualized violence contact, attempt to access, access, or did not access post sexualized violence, and why?

The participants in this study sought care from a number of physical health services, for example, Sexual Assault Nurse Examiners (SANE), family physician, walk-in clinic, gynecologist, and physiotherapy. Participants noted seeking physical health services for several reasons – including, having concern for their physical wellbeing, not knowing what else to do and were seeking guidance, and to assist with chronic health issues – all of which were exacerbated by the trauma resulting from their experience of assault. All participants sought mental health care from counselling and therapy services such as private psychologists, public mental health services, university counselling services, and a local sexual assault centre. They sought these counselling and therapy services for a variety of reasons, predominantly due to mental health crisis, or declining mental health and wellness, including one participant who attempted suicide as a result of their experience of sexualized violence. Indeed, participants noted that the psychological side effects of sexualized violence persisted for years after their victimization. The concept of *temporality* provides further understanding into the nature of trauma from sexualized violence. *Temporality* emphasizes that past experiences can be felt tangibly in the present and affect day-to-day life (van Manen, 2016). The trauma resulting from sexualized violence is experienced long after victimization. These findings highlight the importance of ongoing mental health care for survivors, as research has found them to be at increased risk for developing posttraumatic stress disorder, depression, generalized anxiety disorder/anxiety disorders, substance use disorders, eating disorders, sleep disorders and suicide attempts (Pemberton and Loeb, 2020). Survivors in rural Nova Scotia also noted that long term trauma-informed mental health services are needed to care for the complex psychological effects of sexualized violence (Heggie, 2020).

(c) What other supports/services, that may not have been formal or health-related, did survivors of sexualized violence contact, attempt to access, access, or did not access post sexualized violence, and why?

Participants voiced using social supports such as family and/or friends as informal support. These social supports bridged a gap in care while participants sought out, or waited for, other formal supports and services. Participants also used informal supports such as a culturally specific support group at a local community centre, yoga, and online Facebook groups. These informal supports were caring and shared understanding with the participants through their own lived experience. These findings link to the literature noting that survivors often feel isolated due to their victimization; however, informal, and social supports have been found to provide a sense of understanding, while the community plays a key role in the healing process and in addressing survivor trauma (Benoit et al., 2015). These findings also coincide with the literature that highlights the importance of survivors utilizing both formal and informal supports and services throughout their healing journey (SAMHSA, 2014).

(d) What factors influenced a survivor's decision to access, or not access, health-related supports/services?

Participants identified a number of factors that influenced their decision to seek and access services and supports. They sought care from social supports such as family, friends, and community members due to a decline in their mental health, and in search of help to understand their victimization and why it happened. For most of their experiences, participants' social supports were caring, loving, and understanding. Participants voiced that social supports played crucial roles in recognizing their

victimization as sexualized violence and encouraging them to seek formal services for support. Through the validation of family and friends, participants deemed their experience of sexualized violence as being real and something that was worthy of care, compassion, and support.

Participants also noted seeking formal supports and services out of concern for their physical health and wellness and being referred to additional services by trusted service providers. The majority of participants sought care from formal health-related supports and services due to a sense of crisis, declining mental health, and not knowing how to navigate their way through their situation without support. These findings indicate the importance of education for *everyone* regarding the full meaning of sexualized violence to provide survivors with context and understanding regarding their victimization, and aid in their stabilizing mental health to avoid mental health crisis situations (Pemberton & Loeb, 2020; Sit & Stermac, 2021). Furthermore, these findings also highlight the need for education regarding services and supports for sexualized violence, to assist survivors in finding appropriate and timely support (Sit & Stermac, 2021).

Social movements such as the highly publicized #MeToo movement, raise awareness regarding the prevalence of sexualized violence within society and around the world, which can contribute to a shift in the culture, and normalize sharing and discussing experiences of sexualized violence and trauma (Williamson et al., 2020). These movements provide survivors with the opportunity to share their story and build connections with others who also have experienced sexualized violence (Williamson et al., 2020). Furthermore, normalizing the discussion and sharing of experiences regarding

trauma and sexualized violence can diminish feelings of self-blame, guilt, and shame, which survivors commonly experience, and encourage survivors to seek support for their victimization from formal supports and services for sexualized violence (Pemberton & Loeb, 2020; Williamson et al., 2020)

(e) What recommendations did survivors have regarding how health-related supports/services could be improved and made more accessible?

Participants identified a number of ways to improve accessibility not only to health-related supports and services, but also non-health related supports and services. Overwhelmingly, the participants voiced that comprehensive education and training for service providers regarding trauma, trauma-informed care, and sexualized violence would greatly improve accessibility of these services for survivors. The Indigenous participants also identified the need for culturally relevant healing practises and customs to be integrated within existing services and supports for diverse populations. Marsh and colleagues (2015) performed a literature review exploring how Western treatment methods and Indigenous healing practices could be blended to help in healing intergenerational trauma and substance use disorders among Indigenous populations. The authors observed in the literature that using traditional healing methods promoted empowerment and health for Indigenous communities as it further endorsed the reclamation of Indigenous identity and traditional culture. A holistic approach to healing is a core tenet of Indigenous worldviews of health and should be incorporated into formal healthcare services (Marsh et al., 2015). Reeves and Stewart (2015) conducted a qualitative study that explored the use of traditional Indigenous healing practices and Western mental health services for individuals recovering from trauma related to

sexualized violence. The participants were traditional healers or medicine people, counsellors, and elders who were employed at Anishnawbe Health Toronto. Participants highlighted the uniqueness of the blended approach, stating that survivors had the *option to choose* from a number of traditional healing and Western treatment alternatives. Participants also highlighted the importance of reconnecting to cultural identity as being essential to healing work for Indigenous populations in which colonization has disrupted "cultural integrity" for many communities and individuals (Reeves & Stewart, 2015). Reeves and Stewart (2015) further note the powerful importance of informing survivors of the intergenerational effects that colonialism has had on Indigenous communities.

The participants in my study identified that service providers with knowledge and experience in working with survivors, and who used a trauma-informed approach to care provided the most sensitive, compassionate, and understanding support. Participants further identified the need for additional funding for public services (such as mental health counselling, group therapy options and sexual assault centres) to increase their hours of availability, the number of service providers available for support, and their capacity to support survivors with historic trauma, as well as those with acute trauma. The participants recognized that the limited funding currently available for public supports and services critically affects their ability to provide care and creates wait lists, long wait times, and limits options for support. The literature also notes that organizations and policy makers who wish to improve the health and well-being of survivors of sexualized violence need to take action to improve policy and procedures that prioritize a trauma-informed philosophy to care, which includes appropriate funding for staff and services (Maguire & Taylor, 2019; SAMHSA, 2014). Further

recommendations to improve services and supports for survivors of sexualized violence are explored in the remainder of this chapter.

Foundational Knowledge

A crucial shared experience among participants was a pervasive feeling of confusion, shame, and having disbelief surrounding their assault. Some participants did not recognize that their experience was actually sexualized violence until years later. This delayed their ability to identify and address their own needs, and seek support and care for their victimization. Participants attributed this lack of awareness surrounding sexualized violence to limited knowledge regarding sexualized violence and sexual health in general, as well as limited knowledge regarding available services to provide care for those who have experienced sexualized violence. This finding is also reflected in a study investigating the experiences of women accessing services for sexualized violence who live in poverty (Sit & Stermac, 2021). The authors found that a number of the women interviewed lacked the language and knowledge surrounding sexual health and sexualized violence to identify their experience as an assault following their victimization, resulting in feelings of guilt, shame, and loss of control. The authors further noted that, due to this lack of information, women delayed seeking treatment for their experience of sexualized violence (Sit & Stermac, 2021). Survivors in rural Nova Scotia also noted that had education on sexualized violence and consent been provided to them at an earlier age, they may have identified their experience as sexualized violence, and been able to seek supports and services for their victimization sooner (Heggie, 2020).

Participants in my study called for bolstering and improvements to be made to the sexual health education curriculum throughout grade schools, as well as in post-

secondary education systems. One participant recalled that their sexual health education focused primarily on abstinence. Abstinence-only education promotes waiting to engage in sexual activity until marriage. Abstinence-only based programs do not provide information on deciding to and how to engage in safer sex behaviours which prevent health concerns such as pregnancy and STI/HIV. Such programs also further marginalize and isolate 2SLGBTQ+ children and youth (Fonner et al., 2014). In addition, abstinence-only programs have been found to be ineffective in delaying initiation of sexual intercourse, as well as in reducing the number of sexual partners or the frequency of sexual interactions (Fonner et al., 2014). Currently, the quality of sexual health education in Canada is dependent on provincial jurisdiction and can vary greatly across the country, and from classroom to classroom. There is no framework to evaluate sexual health curricula and no national standard to which provinces must adhere (Action Canada, 2020). Educators are often expected to provide sexual health education without support and with varying levels of comfort in the subject matter, further contributing to the inconsistencies in sexual health education (Action Canada, 2020). This leaves children and youth vulnerable to receive limited education that is heavily influenced by their educator's personal beliefs and attitudes regarding sexual health and sexuality. Education which often prioritizes heteronormative, cis, and able-bodied perspectives, further marginalizes disabled and 2SLGBTQ+ youth (Action Canada, 2020).

Comprehensive Sexuality Education

The United Nations Educational, Scientific and Cultural Organization (UNESCO) advocates for "comprehensive sexuality education" and provides *The International Technical Guidance on Sexuality Education* which outlines the highest standard of

sexuality education (UNESCO, 2018). Comprehensive sexuality education must be adopted into classrooms across Canada and a framework for evaluating the standard of sexuality education provided to children and youth must be established (Action Canada, 2020). Comprehensive sexuality education is defined by UNESCO (2018):

> Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to: realize their health, well-being, and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives.

Information provided in this guide was gathered from evidence-based research conducted in various countries worldwide and provides educators with guidance for developing informed, relevant, age-appropriate comprehensive sexuality education curricula. This guide provides objectives and information tailored to children and youth from 5 to 18+ years of age (UNESCO, 2018). UNESCO (2018) emphasizes that the guide can be adapted to incorporate local contexts and cultural considerations within education. Comprehensive sexuality education can be adapted for in-school use, as well as for non-formal and community-based settings (UNESCO, 2018). Evidence gathered to develop this guide highlights several outcomes from youth and children receiving comprehensive sexuality education such as delayed initiation of sexual intercourse, decreased sexual risk-taking, increased contraception and condom use, increased knowledge of sexuality, safer-sex behaviours, risks of pregnancy, HIV/STIs, and

improved attitudes related to sexual and reproductive health, such as attending to sexual health care, seeking and sustaining healthy relationships, and seeking consent (Action Canada, 2020; UNESCO, 2018). Providing high quality comprehensive sexuality education did not increase sexual activity or risk-taking behaviours, nor did it increase STI/HIV infection rates (UNESCO, 2018). Although findings demonstrate that improving sexual health and sexuality literacy improves attitudes related to sexual reproductive health which promote safer sex outcomes, seeking consent, and fostering healthy relationships, further research is needed to determine outcomes related to rates of sexualized violence (UNESCO, 2018).

The curriculum recommended in the guide highlights the serious risk to well-being that gender-based violence and gender inequality pose to society and recognizes that sexuality education including the social and emotional aspects of sexuality are key in preparing and empowering youth and children to make informed decisions regarding their relationships and sexuality (UNESCO, 2018). Comprehensive sexuality education provides space to explore diverse gender and sexuality perspectives and social contexts, taking a multifaceted approach to health education and promotion (UNESCO, 2018). de Beauvoir (2011) defines the belief that in society: "Humanity is male, and man defines woman, not in herself, but in relation to himself; she is not considered an autonomous being" (p. 26). This concept of "otherizing" diverse genders and feminine perspectives is pervasive within current society (Carpenter, 2018; Wingood & DiClemente, 2000). Indeed, sexual inequalities, gender and power imbalances are embedded at the societal level and within institutions such as justice, education and healthcare systems and are reflected within the state of current sexual health education within Canada, and

throughout the world (Richmond et al., 2013; Wingood & DiClemente, 2000). As previously discussed, current sexual health education often prioritizes heteronormative and cis perspectives of sexual health and sexuality. Diverse gender perspectives provide a holistic and complete representation of sexuality (UNESCO, 2018). Haberland and Rogow (2015) found that sexuality education programs which emphasized issues of gender and power improved reproductive and sexual health outcomes (such as positive effects on reducing unintended pregnancy and STI rates).

Consent education promotes bodily autonomy and empowers children and youth to define and respect their own personal boundaries, as well as to seek consent throughout interactions with other individuals (UNESCO, 2018). By providing this education to children and youth, societal norms can begin to shift and create a culture without shame regarding engaging in, or rejecting, consent for sexual activity at any point (UNESCO, 2018). Consent education has progressed from "no, means no" models, and now promotes requiring enthusiastic and affirmative consent, "only yes, means yes" (Beres, 2020). Consent education is a vital focus in sexualized violence prevention programming (Beres, 2020). Within the guide, consent education developed for children as young as 5-8 years of age primarily focuses on bodily autonomy, and the idea that every individual has 'body rights' (UNESCO, 2018). Consent education can begin in primary schools for children, ensuring attitudinal and behavioural change in adolescents, when youth are more likely to engage in sexual activity (WHO, 2009).

This guide to sexuality education should be adapted to local contexts and provided in schools as well as in community-based youth organizations throughout Canada, including Nova Scotia, as recommended by the United Nations. By utilizing this

established and reputable resource, educators would have a framework from which to develop comprehensive sexuality education programming based on current evidence and research, with clear positive outcomes (UNESCO, 2018). Although the ultimate goal is to eliminate sexualized violence altogether, the reality is that sexualized violence is an ongoing pervasive public health crisis, predominantly affecting women (WHO, 2006). By providing children and youth with comprehensive sexuality education, they are provided the literacy to recognize victimization, and take actions to assist themselves, and others, according to their needs (UNESCO, 2018). The researcher recommends that Nova Scotia school boards use broader resources for educating students, such as the guide provided by UNESCO, as it provides a more holistic lens of sexuality education.

The participants in my study believed that if children and youth were provided a foundational education in sexuality and sexualized violence, a generation of empathetic, knowledgeable and more trauma-informed members of society could be formed. These individuals would join the workforce better equipped to support potential disclosures of sexualized violence. Thus, creating a safer environment for survivors, regardless of which system from which they are seeking services (formal services) or supports (community organizations, family/friends). Furthermore, by providing children and youth with comprehensive sexuality education; societal beliefs, and the culture of perpetuating "rape myths" can be remedied: for example, harmful beliefs that sexualized violence only occurs to women by strangers; women "invite" sexualized violence by behaving or dressing in sexually suggestive manners; or that individuals working in the sex industry cannot be victims of sexualized violence. These harmful beliefs are so pervasive that they

have been shown to influence how police conduct investigations, make arrests and ultimately convict cases of sexualized violence within Canada (Benoit et al., 2015).

Intervention programs aim to support survivors in the aftermath of an incident of victimization. Programs such as *Supporting Survivors and Self* provides education to potential informal supports, such as friends, to increase positive reactions to disclosures of sexualized violence, and decrease negative, victim blaming reactions (Edwards & Ullman, 2018). Programs such as this are developed in an effort to decrease psychological distress and diminish self-blame in survivors who disclose their victimization. These programs also provide tools for peers to support each other and reduce feelings of isolation among survivors. Although programs such as *Supporting Survivors and Self* are predominantly delivered on university campuses (Edwards et al., 2021), a program could be adapted and embedded within a comprehensive sexuality education curriculum to be delivered in schools or community organizations for school aged children and youth. While more research is needed in relation to the effectiveness of these programs, and little is known about how they affect common outcomes of sexualized violence such as depression; preliminary data show that these programs may reduce self-blame and posttraumatic stress symptoms among survivors (Edwards et al., 2021).

Although the implications for comprehensive sexuality education are evident, education alone will not change the systemic issues of misogyny, gender and power imbalances prevalent within society that perpetuate a culture which allows sexualized violence to occur. In Canada, sexual health education and its implementation within school systems is politicized and often a part of many political agendas and platforms

among provincial and territorial governments (Robinson et al., 2019). Rayside (2014) notes hesitancy in implementing inclusive and progressive curricula such as comprehensive sexuality education, that potentially is due to the political influence of "religious traditionalists" or "religious conservatives" who oppose recognizing diverse sexualities and perspectives and "normalizing homosexuality." Although noted to be increasingly a minority in Canada, religious traditionalists have historically organized and protested school board policies which recognize, for example, sexual diversity (Rayside, 2014). Progressive frameworks and curricula such as comprehensive sexuality education may encounter similar hesitancy in Nova Scotia schools ultimately stifling furthering education of sexuality and sexualized violence. Advocacy to stress findings such as the detrimental effects regarding a lack of knowledge and education in sexual health and sexuality must be used to push school boards and policy makers to incorporate thorough and holistic comprehensive sexuality education for children and youth in schools throughout Nova Scotia.

Trauma-informed Care

The inclusion of posttraumatic stress disorder in the DSM is due, in part, to feminist therapists who were treating survivors of sexualized violence, intimate partner violence and childhood abuse (Brown, 2004). Brown (2004) highlights the efforts put forth by feminist therapists to challenge the misogynistic criteria of trauma within the DSM and identified interpersonal violence as a source of trauma. Feminist theory and a trauma-informed approach to care share core concepts and values, both are applicable in the practice of supporting survivors of sexualized violence as they provide epistemologies and theoretical frameworks with which service providers can base their

practice, rather than specific techniques (Brown, 2004; Pemberton & Loeb, 2020). Both feminist theory and trauma-informed care recognize the significant impact the systemic oppression of non-dominant populations can have and contribute to an individual's trauma (Brown, 2004). A trauma-informed approach acknowledges that every individual has experienced some form of trauma, recognizes the impact that trauma has on an individual's health and wellbeing, and actively seeks to prevent re-traumatization (Maguire & Taylor, 2019). As demonstrated by the results of this study, participants experienced re-traumatization through services and providers who were insensitive, invalidating and did not believe, or acknowledge, the gravity of their trauma or experience of sexualized violence. Participants voiced feeling supported by service providers who were non-judgemental, listened to and prioritized their needs, were understanding, and had experience supporting survivors of sexualized violence. These values align with trauma-informed care (Elliott et al., 2005). All participants voiced that simply having services and supports available for sexualized violence was not enough. Instead, service and support providers must be knowledgeable, understanding and ultimately able to provide trauma-informed care so as not to re-traumatize survivors. These traits were noted by participants who accessed services from Sexual Assault Nurse Examiners, in particular.

Principles of Trauma-informed Care

Adopting a trauma-informed approach requires ongoing attentiveness and willingness to shift the culture within an organization, in hopes of promoting a shift in culture on a societal level. Sexualized violence disproportionately affects women compared to men. These acts result from ongoing power and gender inequities within

society (Brown, 2004). The Substance Abuse and Mental Health Services Administration (SAMHSA) provides six key principles to trauma-informed care which services can embed within their current structure to adopt trauma-informed practice. These principles provide a guide for organizations to adapt trauma-informed philosophy and practice to their unique setting, rather than providing concrete steps or a checklist that must be followed. The six principles include 1. Safety; 2. Trustworthiness & Transparency; 3. Peer Support; 4. Collaboration and Mutuality; 5. Empowerment, Voice and Choice; and 6. Cultural, Historical and Gender Issues (SAMHSA, 2014). Pemberton and Loeb (2020), note that many of the core concepts of feminist theory are reflected within SAMHSA's six principles to trauma-informed care.

Safety. The first principle, *Safety*, highlights the need to create a sense of physical and emotional safety for survivors and for the staff within the organization (SAMHSA, 2014). The participants in my study voiced feelings of re-traumatization when accessing services that were provided in stigmatizing environments, and highlighted interactions in which they felt judged, badgered, and encountered victim-blaming behaviour. These experiences jeopardized the participant's sense of safety and negatively affected their mental health and healing journey. The concept of relationality provides further understanding on the detrimental effects that these negative interactions can have on survivors. Relationality, or lived-other, again, refers to the relations that individuals have with others in shared space (van Manen, 2016). van Manen (2016), describes relationality as being felt through the body, through physical contact and through perceptions of others and their body. When survivors encounter service providers who engage in insensitive victim-blaming behaviour, they embody those judgements which contribute to re-

traumatization, and affect their sense of self-worth. As emphasized by some of the participants in my study, it can result in hesitation to seek further support for their victimization. The embodiment of these judgements and the impact it can have on a survivor's sense of self emphasizes the notion that what affects the *body* also affects the *individual* (Goldberg et al., 2009) highlighted within the concept of *corporeality*. *Corporeality* emphasizes that the mind and body cannot be separated (Goldberg et al., 2009). Pemberton and Loeb (2020) advocate for service providers to educate their clients regarding the impact that trauma has on an individual's emotional, mental, neurobiological, and social functioning. The authors also promote working with clients to increase safer and healthier coping skills to manage mental health concerns which can be exacerbated by trauma. By normalizing and providing clarity surrounding the survivor's experiences, they can build self-compassion and contextualize their emotions and reactions which can improve mental stability and contribute to their sense of safety (Pemberton & Loeb, 2020). Feminist theory aligns with these concepts and seeks to assist survivors to build understanding of their situation and contextualize their victimization within the framework of a patriarchal society (Brown, 2004). Service providers should also inquire into their client's environmental safety, such as situations of intimate partner violence, and if necessary, assist survivors in locating appropriate resources and developing a safety plan (Pemberton & Loeb, 2020).

Trustworthiness and Transparency. The second principle, *Trustworthiness and Transparency*, refers to the need for organizations to conduct services, develop policy and procedures while maintaining transparency with their staff, clients and the public in order to build and maintain trust (SAMHSA, 2014). Due to their victimization feelings of

shame and fear of judgement, survivors may have difficulty trusting others, including support and service providers (Pemberton & Loeb, 2020). Several participants in my study voiced negative experiences in which they were unable to trust certain services, and service providers; in particular, those participants who reported their victimization to the police. These negative experiences led to a general distrust of the police for these participants.

Service providers need to work to build trust with their clients by maintaining transparency throughout service provision. To provide trauma-informed care, options and expectations for care should be clearly presented to clients with opportunity to address questions or concerns. Prioritizing transparency of the service provision process creates a more egalitarian relationship between service provider and client, and aids to build trust, these concepts align with feminist theory (Pemberton & Loeb, 2020). Trust can also be established in tandem with the first principle, *Safety*, by providing survivors with compassion, non-judgemental care, as well as validating and believing their experiences (Pemberton & Loeb, 2020).

These principles should be implemented within organizations that provide services and supports to survivors, including within justice and healthcare systems. Currently in Nova Scotia, within the province wide health authority, Nova Scotia Health (NSH), there is no framework for incorporating trauma-informed care into current practice. Anecdotally, as an employee working in mental health within NSH, there was no training, online or in person, regarding trauma-informed care. The trauma-informed care education I received was through the specialized training with the SANE program, through Avalon Sexual Assault Centre.

Peer Support. The third principle, *Peer support*, is crucial to the healing process when utilizing a trauma-informed approach. Peer support aids survivors in building trust, and community, while encouraging them to collaborate with others who share the lived experience of sexualized violence (SAMHSA, 2014).

Overwhelmingly, participants in my study called for more peer support opportunities and felt their healing journey was negatively affected by the lack of peer support available within Halifax Regional Municipality. Peer support provides survivors with the opportunity to create a network of support within the community and combat feelings of isolation which survivors often experience following victimization. It also provides survivors with the opportunity to gain perspective, understanding and validation from others who have similar lived experience (Pemberton & Loeb, 2020). Pemberton and Loeb (2020) note that feminist theory aims to normalize the process of sharing of human experiences through the sharing of trauma in peer support settings, thus creating social change dispelling common myths related to sexualized violence.

The participants in this study highlighted the importance of informal social supports, such as family and friends, who also had experienced sexualized violence, in their healing journey and in influencing their decision regarding whether, or not, to seek formal supports and services for their victimization. Participants also voiced a desire to start their own peer support group, called for less "specialization" in the treatment of sexualized violence, and more readily accessible, informal supports, such as group therapy and peer support group options. Increasing awareness and offering programs such as *Supporting Survivors and Self*, previously discussed in this chapter, may increase the number of positive informal supports for survivors (Edwards et al., 2021).

Peer supports have been used in a number of healthcare settings for various health concerns, such as mental health (Walker & Bryant, 2013). Mental health peer support workers have been found to act as role models who build connection with clients in recovery, and aid in destigmatizing mental illness. Peer support is mutually beneficial and can be therapeutic for both peer support workers and their clients (Walker & Bryant, 2013). Gregory and colleagues (2021) recommend that more research is needed into the use of peer support with survivors of trauma such as sexualized violence. The authors noted that although survivors reported a desire for the use of peer and group support, organizations were cautious due to the lack of training and education that peer supports have in trauma, despite their lived experience (Gregory et al., 2021). In contrast, Walker and Bryant (2013) argue that while some training can be beneficial to peer support workers; professionalization of the role can interfere with the unique perspective and advantage of peer support. There are a number of methods and programs for training peer support workers. They include teaching how to build meaningful connections with individuals and develop therapeutic relationships; how to provide and accept differing perspectives and "worldviews" as well as how these influence an individual's experience; along with learning how to navigate and facilitate the co-learning process and how to define and work toward goals (Ley et al., 2010).

One participant used online resources, such as Facebook Groups, for informal support. A concern noted by this participant and echoed within the literature by Webber and Moors (2015), was that there is greater risk of misinformation to be provided to survivors seeking support through unregulated channels. At the same time, Webber and Moors (2015) also note additional benefits of survivors when using online support such

as increased feelings of safety due to anonymity, social connectedness, the cathartic act of writing about their experience of trauma as well as the accessibility of online options. Online options for therapy have become more readily available and regularly used in recent years, as well as in part due to the COVID-19 pandemic. In an effort to maintain social distancing and ease the strain on the healthcare system, therapists and their clients have moved to videoconferencing platforms for therapy sessions (Békés & Doorn, 2020). Well established peer support groups, such as Alcoholics Anonymous, provide peer support groups online, as well as in person (Sanger et al., 2019). Similar formats could be adopted for survivors of sexualized violence. Online access to peer and group support as well as mental health counselling in general, allow survivors an easily accessible option. Further implications for use of online support include the ability for survivors living rurally, or in resource sparce areas, and saving in travel costs and time (Békés & Doorn, 2020).

Collaboration and Mutuality. As previously discussed, acts of sexualized violence are not about sexual desire or lust, they are violent acts of dominance and asserting power over an individual. A trauma-informed approach to care aims to empower clients by working collaboratively, and providing them with options to best address their needs, in an effort to restore a sense of control over their body (Elliott et al., 2005). There exists a power imbalance in the client-service-provider relationship, including that of client and healthcare professional. This power imbalance often occurs due to the perceived elitism associated with professions in the healthcare system, as well as the knowledge that they possess from extensive education (McQueen, 2000).

The fourth principle, *Collaboration and Mutuality*, promotes partnering with survivors to level this power imbalance and to empower survivors to share in the decision-making process regarding their care (Pemberton & Loeb, 2020). This principle of collaboration and mutuality not only involves the relationship between service provider and client, but the relationship among organizational staff as well (SAMHSA, 2014). Partnering with survivors in the decision-making process builds confidence as well as provides a space for them to discuss and question the service process and their experiences (Pemberton & Loeb, 2020). This concept is noted in feminist theory, again, as it aims to create egalitarian relationships between service provider and client (Pemberton & Loeb, 2020). The participants in this study noted positive experiences with service providers who presented them with clear information regarding their options of care, and respected the decision they made. These positive experiences included services such as SANE and some private psychologists accessed by the participants, both of whom had knowledge in trauma or trauma-informed care.

Empowerment, Voice and Choice. The fifth principle, *Empowerment, Voice and Choice*, involves using and building upon the strengths and experiences of survivors, service providers and organizational staff. The service provided should center around the needs of the client, and service providers should promote and celebrate self-advocacy. Survivors have a wealth of knowledge and strengths from their lived experience, the principle of *Empowerment, Voice and Choice*, recognizes and incorporates input based on lived experience into policy and procedure (SAMHSA, 2014). Organizations should amplify the voices of survivors and, through their lived knowledge and experience, advocate for changes to better suit the needs and healing of survivors of sexualized

violence. Feminist theories also aim to empower survivors and assist them in identifying their strengths and drawing attention to power and gender inequities within society, and how they may have affected them in relation to their trauma (Permberton & Loeb, 2020). Many feminist therapist's treatments focus on empowering survivors and assisting them to view their experience of sexualized violence within a greater societal context (Brown, 2004).

Cultural, Historical and Gender Issues. The final principle, *Cultural, Historical and Gender Issues*, which emphasizes the need for organizations to reject cultural stereotypes and prejudices, such as those regarding race, ethnicity, sexuality, gender, age, religion, ability, level of education, and socioeconomic status, etc. Organizations which provide services to the public must accommodate the diverse public which it serves (SAMHSA, 2014). Incorporating services for diverse genders, cultures and ethnicities within policies and procedures attempts to address the effects of intersectionality that result in the disproportionate victimization of women and populations who have been marginalized (Pemberton & Loeb, 2020). Survivors are not only victims of sexualized violence, or one exclusive identity, they are complex individuals with diverse needs based on the context of their lived world (Collins, 2015). A trauma-informed approach to care ensures that the individual's holistic needs and healing are met (SAMHSA, 2014).

The Indigenous and Black participants in this study emphasized the need for inclusive, culturally competent and culturally safe services for survivors of sexualized violence. The concept of *spatiality* refers to an individual's "situatedness", not only geographically, but the spaces they occupy and how those spaces, in turn, influence individuals (van Manen, 2016). Spatiality provides further understanding of how the

context of our lives and the societal groups in which we belong affect our ability to deal with trauma, such as sexualized violence. The concept of spatiality parallels that of a "feminist consciousness". A common goal among feminist therapists when treating survivors of sexualized violence, or those who have experienced trauma, is to awaken a "feminist consciousness" within their client (Richmond et al., 2013). A "feminist consciousness" is defined by Brown (2004) as an "awareness that one's own suffering arises not from individual deficits but rather from the ways in which one has been systemically invalidated, excluded, and silenced because of one's status as a member of a nondominant group in the culture." Survivors who develop a feminist consciousness can shift harmful internal beliefs - such as blame, guilt, shame - and acknowledge the impact that gender issues have had on the collective society and how they contributed to their victimization (Richmond et al., 2013). This both enlightens survivors to the ways in which society has contributed to their oppression, through sexism and discrimination, and empowers them to critically examine their resilience and develop skills to identify, and mitigate, opportunities for further discrimination (Richmond et al., 2013).

By further exploring the feminist consciousness and the concept of spatiality, organizations can shift the predominant patriarchal culture which has dominated the structure of our society since it was founded and continues to perpetuate the subordination of women and marginalized populations (Lerner, 1993). Lerner (1993) describes the deeply embedded patriarchal systems which pre-date the formation of Western civilization and emerged as "the dominant form of societal order," in which women's rights are subordinate to that of men. Constructs which, as previously discussed, distinguish male as the norm and female as deviant or other (de Beauvoir,

2011; Lerner, 1993). Organizations that wish to adopt a trauma-informed philosophy must bring awareness to these constructs within their own systems and develop procedure and policies which actively combat these societal beliefs (SAMHSA, 2014).

Colonial history has disrupted the organic transmission of cultural knowledge and methodologies among members of Indigenous communities. Due to this disruption, Indigenous researchers and scholars have recognized that for Indigenous worldviews to thrive, cultural knowledge must "live" in many environments, including Western education and research (Kovach, 2010). Aspects of Indigenous worldviews of health include a balance among mental, physical, emotional, and spiritual aspects of the self. Many Indigenous healers use a variety of methods to attempt to promote balance among these aspects of the self, such as counselling, prayer, visualization, special breathing, discussing dreams and visions, talking circles to promote healing through storytelling, "speaking from the heart" and community integration (Reeves & Stewart, 2015). These methods are utilized in culturally specific healthcare services for Indigenous populations (Reeves & Stewart, 2015). The medicine wheel is often incorporated into traditional healing practices, and acts as a guide for creating balanced relationships with people and with the natural world. The understanding of the Cree medicine wheel is similar to the understanding within other cultures and is widely used. Nabigon and Wenger-Nabigon (2012) provide an explanation of the Cree understanding of the medicine wheel:

> The four quadrants of the medicine wheel cover four aspects of human life – feelings (vision), relationships (time), respect (cognition), and caring (action, physical, spiritual), around the core "fire" of the person, or what is considered the central location of healing in the heart.

The Indigenous participants in this study called for services and service providers to acknowledge *intersectionality* within their victimization and sought care that could engage with this perspective. Organizations that wish to provide trauma-informed services need to prioritize the diverse need for flexibility in their provision of services, and the ability to accommodate diverse healing practices, and ultimately provide a more holistic approach (SAMHSA, 2014). Efforts should be made not only to improve cultural competency and safety of staff, but to actively seek out staff from diverse cultures, in order to benefit from staff with a variety of experiences and perspectives.

Implementing Trauma-informed Care

A trauma-informed philosophy recognizes that all services and service providers may encounter individuals who have experienced sexualized violence, and other forms of trauma, despite not being a specialized service for sexualized violence (Maguire & Taylor, 2019). Ensuring that individuals who are providing support and services to the public have comprehensive trauma-informed training and education can equip them with the tools to support survivors regardless of the person to whom their disclosure of victimization is made. Schimmels and Cunningham (2021) found that healthcare providers who did not have trauma-informed training, lacked confidence when addressing trauma related issues, and developed avoidant practice habits regarding the topic of trauma. One participant in my study described an experience of a mental health counsellor who would not discuss their experience of sexualized violence with them, despite the participant voicing their victimization as a reason for seeking counselling. Heggie (2020) also highlighted the experience shared by women seeking mental health support for sexualized violence in rural Nova Scotia, who encountered counsellors and

therapists who would not address their experience of sexualized violence, and instead focused on other aspects of their mental health. This avoidant behaviour often ignored the root cause of some of their resulting mental health issues (Heggie, 2020).

Nurses often act as advocates on behalf of their patients regarding broader societal issues (Canadian Nurses Association, 2017). Education regarding trauma and trauma-informed care are infrequently included in nursing school curricula (Schimmels & Cunningham, 2021). Nurses can implement a trauma-informed approach into their individual practice, contributing to improved patient care, climate, and education for patients (Schimmels & Cunningham, 2021). To fully operationalize the trauma-informed care philosophy, organizations that provide services to the public (in particular, health care, policing agencies, education systems, etc.) not only must provide education and training in trauma-informed care for its staff, but also must provide ongoing resources (such as funding for ongoing professional development and education) for service and support providers. An organization with a trauma-informed care philosophy concretely written into its policies, protocols and mission can ensure the longevity of service provision for survivors by preventing burnout in service providers, and providing staff with the knowledge to safely care for survivors and to guide the practice and procedures of the organization (Maguire & Taylor, 2019; SAMHSA, 2014).

Wachter and colleagues (2020) define burnout as "feelings of depersonalization, exhaustion, and difficulties doing one's job effectively, and is often associated with a very high workload or a non-supportive work environment." Those who are exposed to the trauma of others through their occupation may also be more likely to experience "vicarious trauma" (also known as "secondary trauma") which can involve disruption in

sleep, intrusive thoughts or they may avoid any reminders of their client's experiences. Those working with survivors of sexualized violence are at risk for experiencing burnout or vicarious trauma (Wachter et al., 2020). Factors which contribute to burnout and vicarious trauma include a lack of self-care, excess work stressors, personal experiences of trauma, and a lack of job satisfaction (Wachter et al., 2020). Organizational factors such as limited resources, racism, bias, lack of control, excessive caseloads, poor supervision, in addition to a lack of support from superiors, as well as lacking experience in the field and younger age also contribute to burnout and vicarious trauma. Burnout and vicarious trauma in service providers can affect the delivery of service and could ultimately contribute to negative service experience for survivors (Wachter et al., 2020). Indeed, Wachter and colleagues (2020) highlight the importance of organizations incorporating self-care and coping-related activities into practice to prevent burnout and vicarious trauma. A key component of a trauma-informed philosophy in any workplace includes personal, and professional, self-care for workers, as they may have their own trauma history, and again, are susceptible to experiencing vicarious trauma when working with clients (Salloum et al., 2019). Human resources within organizations must adopt a trauma-informed approach and provide opportunities for staff for ongoing training in trauma and peer support (SAMHSA, 2014). Salloum and colleagues (2019) highlight key aspects of implementing a trauma-informed approach which include collaboration among workers, a sense of safety, and on-going trainings and development for employees.

In addition, SAMHSA provide guidance on implementing a trauma-informed approach within public institutions and services sectors. SAMHSA (2014) highlights ten implementation domains, some of which have been discussed above, they include: 1.

Governance and leadership, 2. Policy, 3. Physical environment, 4. Engagement and involvement, 5. Cross sector collaboration, 6. Screening, assessment, treatment services, 7. Training and workforce development, 8. Progress monitoring and quality assurance, 9. Financing, 10. Evaluation. These implementation domains are designed in conjunction with the systematic alignment of the six key principles of trauma-informed care, previously discussed in this chapter. These domains highlight the responsibility of organizations to invest in implementing and sustaining a trauma-informed approach, as well as incorporating the knowledge from the lived experience of the clients to whom they provide service. Furthermore, the environment of the organization must promote physical and psychological safety and engage in collaboration with clients, family, as well as staff. Collaboration must extend across sectors with a shared understanding of the principles of a trauma-informed approach, to best meet the multiple needs of service users. Service providers should be trained in, and use, evidence-based interventions, that are culturally appropriate and trauma-informed. When service providers are unable to meet the client's needs, they must facilitate referral to appropriate trauma-informed resources. Organizations must continue to reassess and re-evaluate adherence to trauma-informed principles throughout interventions and establish measures to evaluate implementation and effectiveness of the trauma-informed approach, using trauma-informed research tools. The implementation of a trauma-informed philosophy is beneficial to both clients and staff across multiple sectors, including those who do not specifically provide service to survivors of sexualized violence; however, it is crucial to train those who most often encounter survivors of sexualized violence, such as those working in healthcare and the criminal justice systems (Maguire & Taylor, 2019).

Avalon Sexual Assault Centre (Avalon) is the only organization specializing in care for survivors of sexualized violence in Halifax Regional Municipality. Avalon is a feminist organization that aims to provide trauma-informed care to survivors of sexualized violence through publicly funded counselling, Sexual Assault Nurse Examiner Program and prevention, intervention and awareness programs with the community. In April 2019, Avalon closed their wait list for counselling to new clients due to high demand, a wait time of up to two years to receive mental health support, as well as overwhelmed staff (Avalon Sexual Assault Centre, 2020). Many participants voiced wanting to access counselling services through Avalon, but did not attempt, or were unable to, due to the long wait for care. Additional funding is needed to increase Avalon's capacity for care, to hire and train additional therapists and counsellors to care for the survivors on their existing waitlist and to re-open their waitlist to new clients (Avalon Sexual Assault Centre, 2020). Additional funding is also needed to ensure that mental health counsellors and therapists within the public health and university systems as well as private psychologists are trained in trauma-informed care. This would lessen the burden of demand on specialized services for sexualized violence such as Avalon and would provide survivors with more options to receive knowledgeable, trauma-informed care (SAMHSA, 2014).

Policing Agencies

Particular attention must be drawn to the policing agencies (municipal police and RCMP) within the criminal justice system. The majority of participants in my study who reported to the police voiced experiencing victim-blaming treatment, disbelief and intrusive and insensitive questioning that demonstrated a lack of knowledge about trauma

and sexualized violence in general. The participants voiced feeling re-traumatized and that their mental health had been negatively affected through their interactions with the police. These findings are consistent with the concept of the "second assault" (Campbell, 2006). Experiences of the "second assault" or secondary victimization can occur when survivors encounter victim-blaming and judgemental attitudes from service and support providers regarding their victimization; exacerbating the resulting trauma from their assault (Campbell, 2006). The second assault is attributed to increased rates of physical and mental health concerns which negatively affect a survivor's healing journey, and contribute to reluctancy to seek further support for their victimization, and are often noted to be linked to survivor interactions with the police (Kennedy & Prock, 2018).

Survivors' feelings of hesitancy and a reluctancy to report an assault to the police is not unsubstantiated. Indeed, in Canada, from 2009-2014, only 12% of reported incidents of sexualized violence led to a criminal conviction (Rotenberg, 2017). In addition, cases of sexualized violence experience high rates of attrition within the criminal justice system (Quinlan, 2016). Prior to cases of sexualized violence reaching a conviction through a court of law, the police may dismiss reports of sexualized violence as 'unfounded'. The Royal Canadian Mounted Police (RCMP) define 'unfounded' as "after a police investigation, it is concluded that no violation of the law took place or was attempted" (RCMP, 2017). In 2016, the RCMP reviewed all cases that were deemed 'unfounded' and noted that 57% of unfounded cases had been misclassified (RCMP, 2017). Based on this review, the RCMP consulted stakeholders and law enforcement agencies to generate recommendations and develop a guide for investigating incidences of sexualized violence. Victim services professionals and victim/community advocates

across Canada were consulted for their expertise resulting in four areas of focus being identified as needing changes: police training and awareness, investigative accountability, victim support and public education and communication (RCMP, 2017).

The Canadian Association of Chiefs of Police (CACP) also provide a framework for responding and investigating reports of sexualized violence to be adapted by municipal police agencies throughout Canada (CACP, 2019). Both the RCMP guide and the CACP framework highlight the importance of a trauma-informed approach to investigating and questioning survivors, educating staff and the public on sexualized violence, as well as trauma and the way it can present in survivors, and the importance of partnering with, and using, specialized and community resources to best support survivors (CACP, 2019; RCMP, 2017).

Though the reports from the RCMP and CACP recognize the difficulty that survivors may experience when deciding and attempting to report their victimization to the police, there is little acknowledgement of the detrimental role that the criminal justice system has had in perpetuating "rape myths" and contributing to a culture of power and gender imbalance (Quinlan, 2016). Trauma-informed training must be prioritized for all staff in police and RCMP agencies and cannot only be reserved for specialized teams designated to investigate sexualized violence as that neglects the officers, or staff, who may have first contact with a survivor attempting to report their victimization. Marquis suggests that both police and the public view the powers of the police as open-ended; the mere presence of an officer can be profoundly influential for an individual (as cited in Schneiderman & Macleod, 1994). The police and RCMP workforce are traditional and male-dominated occupations (Marquis, as cited in Schneiderman & Macleod, 1994).

Thorough systematic changes within police and RCMP agencies are necessary to rectify power imbalances which dominate the criminal justice system and society in general, and to promote gender equality - not only in personnel, but also within policy and law (SAMHSA, 2014). Agencies within the criminal justice system must acknowledge their contribution to perpetuating a culture of disbelief in survivors, misinformation surrounding sexualized violence, and an acceptance of gender-based violence within society. Adopting a trauma-informed approach within police agencies is crucial for the safety of all survivors (SAMHSA, 2014).

Chapter 5: Conclusion

In this study, participants described the experience of deciding to seek assistance for their victimization, often facing a decline in mental health and dysregulation in their day-to-day lives. Participants voiced experiences of attempting to locate and navigate limited services and supports for sexualized violence, encountering limited availability, long wait times, stigmatizing environments, and service providers ill-equipped to care for the diverse needs and trauma of survivors of sexualized violence. Participants also highlighted the important role that friends, family and intimate partners played in supporting them when formal services and supports were not readily accessible. Participants in this study displayed their strength, resilience, and advocacy by sharing their experiences and made thoughtful suggestions for how to improve current services and supports to improve safety and accessibility for themselves, and all survivors. Finally, participants stressed the characteristics of the services and supports and their providers who aided them in their healing journey. Through conversations with the participants, a number of changes that are needed to provide survivors with safe and accessible supports and services became evident, these included ongoing mental health support for survivors, comprehensive sexuality education for children and youth and prioritizing the implementation of trauma-informed care across multiple sectors.

Survivors embody the effects of trauma resulting from an experience of sexualized violence, which can disrupt their sense of time, resulting in trauma from the past being felt as tangibly as if it were in the present (Edwards et al., 2021). Findings from this study demonstrate the ongoing effects of trauma felt by all participants. All participants voiced experiencing ongoing psychological and emotional effects resulting

from their assault, which continue to be felt long after victimization. This study highlights the need for long-term holistic, culturally relevant, trauma-informed mental health support for survivors of sexualized violence. There is a need for a variety of readily available options in mental health services and supports, including peer support, group therapy and affordable private counselling.

Prior to seeking services and supports for sexualized violence, survivors must first acknowledge that they have experienced sexualized violence. The participants' stories reflected a lack of overall sexual health literacy and drew connections between a lack of awareness regarding sexualized violence to that of limited sexual health education. Comprehensive sexuality education provides children and youth with insight into the complex aspects of sexual health including interpersonal relationships, physical and mental health. Through comprehensive sexuality education, educators can facilitate and normalize having conversations related to consent, nurturing healthy relationships and sexualized violence. Further research is needed to establish a framework for comprehensive sexuality education within Canada. Providing educators with a national standard with which they must adhere will ensure consistent education is provided to children and youth throughout Canada.

Throughout the retelling of all the participants' experiences, it became abundantly clear that the implementation of trauma-informed philosophy across multiple sectors is imperative to the health and wellbeing of survivors of sexualized violence. Survivors are being subjected to further trauma through systems that are inadvertently neglecting their needs by not providing appropriate education and training to their staff and service providers. Although there are implications for utilizing a trauma-informed philosophy in

any workplace setting, the systems which most frequently interact with, and intend to assist, survivors must be prioritized, in particular the healthcare and criminal justice systems. By utilizing a trauma-informed approach, survivors' voices and experiences are recognized as valuable knowledge, and collaboration among services and service users can improve and develop services and supports that prioritize the diverse needs of survivors of sexualized violence. A trauma-informed philosophy not only benefits an organization's clients, but it ensures that staff and service providers are provided the appropriate tools to optimally care for clients, as well as themselves. Research into the implementation of a trauma-informed philosophy across multiple sectors is needed to gauge willingness amongst services and providers, level of current knowledge regarding trauma and trauma-informed care, as well to identify any barriers within current systems that may threaten the success of this approach.

Finally, this study aimed to better understand the lived experience of *any* individual who attempted to use, used or did not use services and supports for an experience of sexualized violence. The lived experience of specific populations (diverse sexuality, ethnicity, ability, etc.) is likely to vary greatly, and their unique perspective may identify additional recommendations to improve accessibility of services and supports for diverse populations. Further research into the unique experience of diverse populations is needed.

Knowledge Translation

Participants were asked during the informed consent process whether they wished to receive an update regarding the final results of the study in the form of a community report and had the opportunity to provide an email address. This community report will

be plain-language and will be made available to the general public. The community report also will be provided to Avalon Sexual Assault Centre, to be made available to their clients and staff. A report will also be made for the Nova Scotia Department of Justice to be shared with local policing agencies (Halifax Regional Police and RCMP), Department of Education and Early Childhood Development, and Nova Scotia Department of Health and Wellness. A report will also be shared with Dalhousie University Student Health and Wellness Services, and the counselling services they provide. Findings will be presented locally to the Sexual Assault Nurse Examiner program at Avalon Sexual Assault Centre. The reports will be tailored to each department to highlight the most pertinent and relevant findings and recommendations to the service provided. The results of the study also will be available to fellow researchers and academics through publication in a relevant scholarly journal.

Limitations

As this research used a trauma-informed approach, participants were encouraged to provide as much, or as little, information regarding their particular circumstances as they desired. Given this approach, interview questions focused on the participant's experience in general, providing opportunity for the participant to elaborate without being intrusive. As a result, sexuality as well as gender identity, were not specifically discussed. However, it is known that members of 2SLGBTQ+ and transgender populations are at increased risk of experiencing sexualized violence (Langenderfer-Magruder et al., 2016). In addition, due to their marginalization, their experience attempting to access, and accessing, supports and services for sexualized violence may vary greatly from other populations. Therefore, further research into their specific perspective is necessary to

improve accessibility of supports and services for sexualized violence for all survivors. The majority of participants in this study self-identified as women (eight out of ten) while two participants did not specify gender identity. There were no male-identifying participants recruited for this study, this unique perspective is missing. The gender demographics of the study participants are consistent with the literature and what is known regarding sexualized violence, in that women are at increased risk for experiencing sexualized violence (Conroy & Cotter, 2017) and was expected. However, the literature also identifies that individuals of any age, gender, ability, ethnicity, sexuality or religion can be a victim of sexualized violence (Conroy & Cotter, 2017). Further research is needed surrounding the perspective of diverse populations, and their experiences attempting to and accessing services and supports for sexualized violence.

Conclusion

Sexualized violence remains an ongoing public health crisis in Canada, the long-term effects of which strain our already overwhelmed healthcare systems. This study has provided insight into the lived experience of survivors who have navigated supports and services for sexualized violence within Halifax Regional Municipality. Participants in this study shed light on challenges shared by many yet rarely discussed openly. The stigma associated with experiencing sexualized violence can often leave survivors feeling alone, fearful and confused about where to seek assistance. Through the retelling of their experiences, the survivors in this study displayed great strength and should be commended for their contribution to this research. Participants provided a number of helpful suggestions to improve the service experience for survivors accessing supports in the future. The participants also recognized that supporting survivors and preventing re-traumatization is part of a larger cultural shift that involves the education, criminal justice as well as healthcare systems. These system changes have the potential to change the way in which we perceive and care for survivors of sexualized violence.

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Appendix A: Recruitment Material

Poster

Instagram Post

Caption:
We are looking for individuals who have used, attempted to use, or not used supports and services for any experience of sexualized violence.
Sexualized violence is any act of violence, physical or psychological, carried out through sexual means or by targeting sexuality. This can include, for example, sexual assault, sexual exploitation, sexual harassment, stalking, indecent exposure, voyeurism, and any unwanted sexualized attention such as catcalls, persistent or aggressive come-ons, sexist remarks or jokes.
We are looking for participants who are at least 19 years of age and older, of any gender identity, have used, attempted to use or not used supports and services for sexualized violence within the last 5 years, and able to speak about their experiences in English.
Services and supports might include, for example: Sexual Assault Nurse Examiners (SANE), counsellors and mental health services, physicians, nurses, hospitals, walk-in and medical clinics, community health centres, support groups, family and friends, online forums, healing circles.
Participation will include one individual interview with the researcher that will last no longer than two hours. Interviews will be confidential/private and will take place in a mutually agreeable private location and time.
You will be given $25 gift card for your time and for participating in this study.
For more information, or if you have any questions, please respond to this ad or contact:
Nora Conboy BScN, RN, MScN (c) Sexual Assault Nurse Examiner “email” “phone number”

Email, Kijiji and Facebook Advertisement

Recruitment poster accompanied by the following caption:

PARTICIPANTS NEEDED!
We are looking for individuals who have used, attempted to use, or not used supports and services for any experience of sexualized violence.
We are looking for participants who:

- are at least 19 years of age or older,
- of any gender identity,
- have used, attempted to use or not used supports and services for sexualized violence within the last 5 years,
- are able to speak about their experiences in English.

Participation will include:
- One individual interview with the researcher that will last no longer than two hours.
- Interviews will be confidential and will take place in a mutually agreeable private location and time.
You will be given $25 gift card for your time and for participating in this study.
For more information, or if you have any questions, please respond to this ad or contact:
Nora Conboy BScN, RN, MScN (c) Sexual Assault Nurse Examiner “email” “phone number”

Appendix B: Consent Form

Project title: Examining Accessibility of Services for Sexualized Violence: Understanding the Survivor's Experience

Lead researcher: Nora Conboy, BScN RN, Sexual Assault Nurse Examiner, Master of Science in Nursing Student, Dalhousie University, nora.conboy@dal.ca

Research Supervisor: Dr. Jean Hughes, Professor, School of Nursing, Dalhousie University, jean.hughes@dal.ca

Introduction

My name is Nora Conboy, I am a Registered Nurse and a Sexual Assault Nurse Examiner through Avalon Sexual Assault Centre. Currently, I am a graduate student at Dalhousie University completing my Master of Science in Nursing. I would like to invite you to participate in the study I am conducting as part of my Graduate studies.

Your participation in this study is completely voluntary. You will not be forced into participating in this study, there will be no penalty if you decide to stop participating at any time, and you may withdraw from the study during the recruitment and interview process or up to a week (seven days) following the interview. The information below will describe what is involved in the research, what you will be asked to do, any benefits, risks, inconvenience or discomfort that you might experience. Please direct any questions you may have to me or my thesis supervisor, Dr. Jean Hughes (jean.hughes@dal.ca).

Purpose and Outline of the Research Study

The purpose of this research is to explore the lived experiences of ten (10) individuals 19 years of age and older, who have used, attempted to use, or not used supports and services for sexualized violence. I am looking to interview you about your experiences attempting to use, using, or not using supports and services for sexualized violence. I am also looking to understand which supports and services were used and why, challenges you may have experienced when attempting to use them, and how these current supports/services could be improved. A deeper understanding of the experience of individuals who have used, attempted to use or not used supports and services for sexualized violence can inform ways in which they can be made more accessible, safe and equitable for survivors. The interview will last no longer than two (2) hours.

During the interview, I will be asking you to answer questions, in as much detail as possible, regarding these topics. If you would like to be contacted about the results of the study, through a report, please check yes at the bottom of the consent form and provide your contact information.

Study Design and Participation

The study design involves one interview lasting no longer than two hours with 8-10 individuals who have used, attempted to use, or have not used, supports and services for sexualized violence, within the past five years. Participation in this study is voluntary.

Interviews will be in person or by phone and scheduled at a mutually agreeable time and place between the researcher and participant. In-person interviews will take place in a private room in a public building (e.g. community room in local grocery store, library, community center). Participants will be given a $25.00 gift for their contribution to the research.

Once interviews are analyzed, I would like to contact you again to ensure that I understood our conversation and to ensure that your experience is represented correctly. This is a process called "member checking." This is optional, you do not have to agree to the member checking process to participate in the study. If you agree to be contacted again, by me, to review my understanding of our interview, please check "yes" at the bottom of this consent form and provide the best way to contact you (e.g. by phone call, text, or email). Contact will end between you and I, Nora Conboy, once the member checking process is complete, unless you consent to receiving the final report. If you do not agree to participate in the member checking process, contact will end after the interview.

Who Can Take Part in the Research Study?

You are invited to participate in this research study if you:

1. Are 19 years of age or older.
2. Are of any gender identity.
3. Have used, attempted to use, or not used, supports or services for sexualized violence within the last five years.
4. Are able to have a conversation in English.
5. Agreed to be interviewed and audio recorded for up to two hours.

Who Conducts This Research?

I, Nora Conboy will be the primary researcher for this study. All interviews will be conducted by myself, or my classmate, Clare Heggie, a Master of Arts candidate in Health Promotions at Dalhousie University. This study is approved by the Dalhousie University Research Ethics Review Board and my thesis committee which includes, Dr. Jean Hughes, RN, PhD (supervisor), Dr. Megan Aston, RN, PhD, and Dr. Lois Jackson, PhD.

Possible Benefits, Risks and Discomforts

There are no direct benefits to participating in this study, indirectly you may benefit from a chance to reflect on your own experiences. In addition, this study, including your invaluable participation and contribution, will help us further understand the experience of survivors and improve current supports/services for sexualized violence.

There are some risks in participating in this interview. The possible harms of participation include emotional discomfort resulting from sharing negative experiences, due to the sensitive topic of research. Should you feel uncomfortable, remember that you can choose to: a) not answer a question or engage in discussion, b) take a break, at any point during the interview or c) stop the interview at any time and withdraw from

participating in the interview and in the study. A list of mental health resources for support will be provided to you.

Again, your participation is completely voluntary, and you can decide not to answer a particular question, or to stop participating. You can withdraw from the study any time during the recruitment and interview process and have your interview deleted up to one week (seven days) following the interview. There are no consequences to withdrawing from the study, you can keep the $25 gift card if you decide to stop participating during or after the interview. If you decide to withdraw from the study at the end of the interview, or up to a week after the interview, all information prior to this point will be destroyed (any notes, and audio-recording, contact information, etc.).

Compensation / Reimbursement
To thank you for your time, you will be given a $25 gift card to a local grocery store or Amazon. The gift card will be given to you at the beginning of the interview, there will be no penalty if you do not complete the interview, or to withdrawing from the study.

Confidentiality:
Your participation in this study and all your responses during the interview will be kept confidential. Your name, or other personally identifying information will not be used in any written reports, publications or presentations of this study. For ease of reading, fake names (or pseudonyms) will be used in any presentations, publications or reports. Direct quotes may be used but, again, will not be connected to your name - only fake names will be used. Audio recordings will be transcribed verbatim one week after the interview and will be checked for accuracy. Once interview transcripts are checked for accuracy, audio-recordings will be deleted. Interview transcripts, research notes and audio recordings will be kept in a locked cabinet at Dalhousie University for five years, then destroyed. Only myself and my supervisor will have access to this cabinet. All electronic data will be kept on encrypted USB drives.

The information obtained in this study will be strictly confidential unless required by law or professional obligations. If you inform me about abuse or neglect of anyone age 18 or younger, I am required by law to contact authorities. If I notice that you are at an immediate risk of harming yourself or other people, I am required by my professional code of ethics to seek assistance.

If I am required to disclose information about you, I will attempt to inform you.

Questions
If you have any questions regarding this study, please do not hesitate to contact me, Nora Conboy, at nora.conboy@dal.ca, or my thesis supervisor, Dr. Jean Hughes, at jean.hughes@dal.ca. If you have any concerns or if you have any questions about research in general, you may also contact Research ethics, Dalhousie University at (902) 494-3423, or email: ethics@dal.ca.

I would like to thank you for having the courage to come forward with information about your lived experience of having used, attempting to use, or not used, supports and services for sexualized violence, and considering participating in this research. Your contribution is invaluable.

Consent Form Signature Page

"Examining Accessibility of Services for Sexualized Violence: Understanding the Survivor's Experience"

Please check "**Yes**" or "**No**" to the following questions. **Please note, to participate in this interview you must Check "Yes."** A copy of this consent form will be provided to you for your records.

Do you agree for the researcher to audio-record the interview process?

Yes _____ No_____

Do you agree for the researcher to use your direct quotes from the interview process, knowing that only fake names will be used (no real names will be used) in written reports of this study?

Yes_____ No_____

I have read the above document regarding the study "Examining Accessibility of Services for Sexualized Violence: Understanding the Survivor's Experience." I have been given the opportunity to discuss the above information. All my questions have been answered satisfactorily and I consent to take part in this research study. I understand that my participation is voluntary, and I can withdraw from the interview process at any time.

_____ _____

Signature of Participant **Date/Time**

I have explained the above document and the requirements of this study including the consent process. I judge the above individual understands the study requirements and understands that this study is voluntary and that they are able to withdrawal at any time during the interview process.

_____ _____

Signature of Principal Investigator **Date/Time**

Do you agree to be contacted to participate in the "Member Checking" process?

Yes_____ **No**_____

Phone Number (text) or Email Address:

_____

Would you like to receive a summary of the results of the study?

If yes, please provide an Email Address:

_____

Verbal Signature Page Script

The date is _____. I have verbally reviewed the consent form with the participant and believe that they understand the consent process. They have been given the opportunity to discuss it and their questions have been answered. They have been informed that participation is voluntary and that they have the freedom to not answer any question and/or withdraw from the interview at any time during the interview, and up to a week after the interview. I have explained that this interview will be audio-recorded for ease of data analysis. They understand that they are not being asked to give up any of their rights. They understand that the information will be kept confidential within the limits of the law. They also understand that direct quotes may be used, knowing that no personally identifiable information will be used. They understand that they may receive a copy of this signed and dated consent form via email, if they request one. I have told them about the Member Checking process, and they can leave contact information if they agree to participate in it, knowing that it is completely voluntary and that they do not have to participate in Member Checking to participate in the interview. I have told them that there will be a summary report available to them at the end of the study, if they would like one. Furthermore, they understand they can contact the research ethics boards with questions or concerns.

Participant # _____
Email address for gift card honorarium _____

_____	_____	_____
Researcher name	**Signature**	**Date**

Contact information if participant agrees to participate in "Member Checking" process:

_____

Email address if participant would like summary of the results of the study:

_____

Appendix C: Interview Guide

Preamble: Thank you for taking the time to come and talk with me. I appreciate that it is not easy to come to this interview and speak to someone you don't know. Everyone's experiences and needs after experiencing sexualized violence are very different, there is no right or wrong way to seek, or not seek, support or services for sexualized violence, and there are no right or wrong answers in this interview. I am interested in learning about your perceptions and experiences with formal health-related supports/services for sexualized violence, and the factors which contributed to you deciding to use, attempt to use, or not use, these supports/services. Formal supports/services are provided in hospital, through community health centers, or community organizations which are financially supported and dedicated to providing resources and care to survivors, usually provided by trained professionals and volunteers. Formal health-related supports/services for sexualized violence can include for example: Sexual Assault Nurse Examiners (SANE), counsellors and mental health services, physicians, nurses, emergency department staff, clinic staff and community health centers. I am interested in hearing about supports/services that you wanted to use and tried to use, whether you actually used them or not and why, the things that helped, and the challenges you faced when doing so. I am also interested in other supports and services - either formal, health-related, or informal and not health-related, that you may have sought support from, that may have affected your experience. Informal supports/services can include, for example, family, friends, online forums and peer support groups.

General

1. "Can you tell me about your experience using, attempting to use, or not using formal health-related supports/services for sexualized violence?"

If formal health-related supports/services were used…

2. "If supports/services were used, which ones did you use?"
3. "Can you help me to understand why and how you decided to use each of the supports or services (if more than one was used)?"

   Prompts: "Tell me about each experience… What was it like? How did the experience make you feel?" (using empathy to note the emotions)
4. "Can you tell me what you found positive, or helpful, when using each support/service? What did you find negative, or unhelpful, when using each support/service?"

   Prompts: "Do you feel the service was easy to use or accessible? Was it easy to contact? Help me to understand how the service/support providers engaged with you? Were they supportive/respectful? Did they listen? Did they complement your strengths in seeking help? How did they help?"

5. "Help me to understand your overall experience with using each support/service. Do you believe that your needs were met by each support/service? If so how? …and if not, why?"

   Prompts: "Do you feel like your physical and social and emotional needs were met? Do you feel you received the help you were looking for? Did any of the services or supports connect you with additional resources or supports?"

6. "What suggestions do you have regarding how these supports, or services, and their access could be improved to better support survivors?"

   Prompts: Location, timing, availability, attitudes/manners of support/service providers/ways of engaging with survivors…

If formal health-related supports/services were attempted or NOT used…

7. "Was there a support/service you may have wanted to use, or attempted to use, if so which service?"
8. "Can you help me to understand what you think might have prevented you from using supports/services?"
9. "Were your needs met in another way? Can you tell me about the experience?"
10. "What suggestions do you have regarding how these supports, or services, and their access could be improved to better support survivors?"

    Prompts: Location, timing, availability, attitudes/manners of support/service providers…

General

11. "Were there any other services or supports, that may not have been formal and/or health-related, that you used or attempted to use – for example: legal services or police, online forums or peer support groups? If so, what were they, and how did they help, or not help?"

    Prompts: "Can you tell me how you decided to access each of the supports or services (if more than one was accessed)? Tell me about each experience… What was it like? How did the experience make you feel?" (using empathy to note the emotions) Can you tell me what you found positive, or helpful, when accessing each support/service? What did you find negative, or unhelpful, when accessing each support/service? Do you feel the support was easy to use or accessible? Was it easy to contact? How did you feel service/support providers engaged with you? Were they supportive/respectful? Did they listen? How did they help?"

12. Were there any other social supports, that you used or attempted to use – for example: friends, family, peers, or colleagues? If so, what were they, and how did they help, or not help?"

    Prompts: "Can you tell me how you decided to access each of the supports (if more than one was accessed)? Tell me about each experience… What was it like? How did the experience make you feel?" (using empathy to note the emotions) Can you tell me what you found positive, or helpful, when accessing each support/service? What did you find negative, or unhelpful, when accessing each support/service?

13. "Can you tell me what other supports and services you believe are needed for survivors that currently may not be available or may not exist, or ways existing supports/services need to change to better assist survivors?"

Closing: I would like to thank you again for having the courage to come to talk with me today. What you have shared will help build understanding about what services and supports are important, and ways they could be assisted to improve.

Appendix D: Resources for Participants

Avalon Sexual Assault Centre
•Avalon Sexual Assault Centre is a not-for-profit organization whose staff respond to sexualized violence and abuse and offer support, counselling, education, immediate medical care (SANE) forensic evaluation, leadership and advocacy.
•When you call, Avalon's Intake and Initial Response and Support Counsellor will work with you and provide sexualized violence information, support and referral to available counselling services.
•Dial 902-422-4240
•avaloncentre.ca

811
•Health information and services
•A registered nurse is available 24 hours a day, 365 days a year to provide you advice, information and reassurance concerning all kinds of general health issues and questions, including sexual violence.
•Service available in English, and French (interpretation services are available in over 100 languages).
•Dial 8-1-1

211
•Community and social services referral, available 24 hours a day, 365 days a year
•Available in multiple languages
•Dial 2-1-1
•ns.211.ca

Independent Legal Advice for Sexual Assault Survivors Program -2-1-1
•This program provides up to 4 hours of free, independent legal advice for sexual assault survivors who are 16 years of age and older. (Not required to report to police or take legal action by accessing this service).
•Registration is done through an independent agency, 211 Nova Scotia. Dial 2-1-1 for intake.
•https://novascotia.ca/sexualassaultlegaladvice/

The Sexual Assault and Harassment Phone Line
•Phone and web counselling.
•Offers non-judgemental, active listening and support to anyone who has experienced or has been affected by sexualized violence.
•Service available by phone from 12pm -12am, 7 days a week.
•The phone line is operated by Dalhousie Student Union.
•Dial 1-902-425-1066

Kids Help Line
•Free, non-judgmental, confidential and anonymous support for people 20 years of age and under.
•24 hours a day, 365 days a year.
•Live online chat with a counsellor from 7pm –3am, Wednesday-Sunday.
•Dial 1-800-668-6868
•https://www.kidshelpphone.ca/Teens/Home.aspx

BroTalk
•Counselling and information for teen males (and those who identify as male)
•Phone or chat support.
•Phone -24/7; Chat Wednesday 7pm –3am
•Dial 1-866-393-5933
•http://brotalk.ca/about

Transition House Association of Nova Scotia
•24/7 support line
•Emotional support and referrals for women who have been abused
•Dial 1-800-563-1945

Victim Services Emotional Support
•Emotional support for victims of sexual violence
•No police involvement is necessary in order to get support
•Monday-Friday, 8am-4pm, based on Halifax
•Dial 1-902-490-5300

Mental Health Mobile Crisis Team
•Intervention and short-term crisis management for children, youth and adults experiencing a mental health crisis.
•Telephone support across the province, 24/7.
•Mobile response in most communities in Halifax Regional Municipality, 1pm-1am.
•Dial 1-888-429-8167

Trans Life Line
•Peer support hot
•Trans led peer support offering direct service, material support, advocacy and education
•Available 11am-5am AST
•General inquiries 1-510-771-1417 or contact@translifeline.org
•Dial 1-877-330-6366

If participant is attending a local university…

Dalhousie University Student Health & Wellness Centre
•Offers students primary and mental health services to promote and enhance students' health.
•Counselling and psychiatry services are available by appointment and by walk-in.
•Dial 902-494-2171
•Same day counselling, online booking: https://booking.medeohealth.com/dalhousie-student-health-services

Saint Mary's University Counselling Centre
• Provides free and confidential personal and academic counselling and peer support services, by appointment, to Saint Mary's University students.
•Dial 902-420-5615

Mount Saint Vincent University Counselling Service
•Free personal and academic counselling services for Mount Saint Vincent University students.
•Contact Mathew, the Counselling Intern to book an intake appointment by calling 902-457-6567 or emailing counselling@msvu.ca

Appendix E: Participant Screening Questions

My name is Nora Conboy, I am the principal researcher for the study "Examining Accessibility of Services for Sexualized Violence: Understanding the Survivor's Experience" and a student in the Master of Science in Nursing program at Dalhousie University. Thank you for your interest in participating in this study. I have a couple questions to determine if you are eligible to participate in this study.

Are you 19 years of age or older? Yes/No

Have you contacted, used or attempted to use services or supports (whether they were used or not) in response to experiencing sexualized violence within the past five years? These could be either formal supports or services (e.g. health services) or informal (e.g. family, friends, peer support groups) Yes/No

If participant answers no to either questions:

Thank you for your interest. Unfortunately, you are not eligible to participate in this study because (reason). I very much appreciate your expressed interest and taking the time to contact me. It took great courage for you reach out.

If participant answers yes to the previous questions:

I am also a registered nurse working as a Sexual Assault Nurse Examiner through Avalon Sexual Assault Centre. Have you used the Sexual Assault Nurse Examiner (SANE) program through Avalon Sexual Assault Centre since September 2017? Yes/No

If the participant answers no:

Thank you for your interest, you are eligible to participate in this study. Would you like to schedule an interview?

If yes… do you remember the name of the nurses who met with you?

If the participant identifies the researcher as the SANE nurses who met with them:

Thank you for your interest. Unfortunately, you are not eligible to participate in this study as I do not want to place you in a situation where you might think you cannot speak freely about your experiences using the service, as well it may, inadvertently, be distressing for us to meet again. I appreciate you contacting me, and again, thank you for expressing interest in this study. It took great courage for you reach out.

If the participant does not identify the researcher as the SANE nurses who met with them:

Thank you for your interest, you are eligible to participate in this study. Would you like to schedule an interview?

If participants are unable to remember or is unsure of the SANE nurses who met with them:

Thank you for your interest, you are eligible to participate in this study; however, there is a risk that I could be one of the nurses who met with you. Some individuals may think they cannot speak freely about their experiences or may, inadvertently, experience discomfort, when meeting with a healthcare provider who has previously cared for them. This is a sensitive topic and I do not wish for our meeting, or the interview, to cause further distress or discomfort. With that in consideration, and the possible risk of this additional discomfort, you are eligible to participate in this study if you wish to do so, would you like to go forward and schedule an interview?

Appendix F: Letter of Support

AVALON
SEXUAL ASSAULT CENTRE

1526 Dresden Row, 4th Floor • Halifax, NS • B3J 3K3
P: (902) 422-4240 • **E:** info@avaloncentre.ca
SANE Program Business **P:** (902) 422-6503
W: www.avaloncentre.ca

October 29, 2019
Dalhousie University Research Ethics Board
Halifax, Nova Scotia
To Whom it May Concern,

On behalf of Avalon Sexual Assault Centre, this letter is in support of Nora Conboy, BScN, RN, and her research study "Examining Accessibility of Services for Sexualized Violence: Understanding the Survivor's Experience" in fulfillment of the requirements for the Master of Science in Nursing Program at Dalhousie University. Nora is a Registered Nurse who has worked in the Sexual Assault Nurse Examiner program at Avalon Sexual Assault Centre since September 2017.

For over 30 years, Avalon Sexual Assault Centre has been a leader in raising awareness and supporting those who have experienced sexualized violence, holding sexual perpetrators accountable, as well as advocating and influencing social and systemic change. Avalon offers a number of services for those affected by sexualized violence including advocacy, counselling, education, immediate healthcare through the Sexual Assault Nurse Examiner program and activism.

Sexualized violence is a serious public health and human rights issue with both short and long-term effects on an individual's physical and mental health and wellbeing. The recent increase in demand of services highlights the need to optimize limited resources to best support those affected by sexualized violence. Avalon recognizes the need for further research surrounding sexualized violence and the experiences of those affected by sexualized violence. Furthermore, Avalon supports the need for feminist research exploring these issues. Nora's proposed research study intends to use a feminist lens to explore and further understand survivor's experiences navigating and accessing services for sexualized violence, aspects which align with the philosophy and approach to care of Avalon as an organization. This research provides a voice to survivors to speak of their own experiences and provide suggestions as to how services and supports can be enhanced to better fit their needs.

We recognize the need and strongly endorse the objectives of this study. The methodology is appropriate, and we believe the graduate student capable of successfully completing the study. We support her proposal and look forward to seeing the results of her research.

Respectfully yours,

Jackie Stevens
Executive Director

Appendix G: Confidentiality Agreement

This agreement is between:
Nora Conboy, BScN, RN, MScN (c) Sexual Assault Nurse Examiner and Clare Heggie, MA (c) in Health Promotion

For Project Title: Examining Accessibility of Services for Sexualized Violence: Understanding the Survivor's Experience
REB File Number: 2019-4967

Summary of job description/service provision: Confidentially and respectfully conduct qualitative interviews for the purpose of data collection.

I agree to:

1. keep all the research information shared with me confidential. I will not discuss or share the research information with anyone other than with the Researcher(s) or others identified by the Researcher(s).

2. keep all research information secure while it is in my possession.

3. return all research information to the Researcher(s) when I have completed the research tasks or upon request, whichever is earlier.

4. destroy all research information regarding this research project that is not returnable to the Researcher(s) after consulting with the Researcher(s).

5. comply with the instructions of the Researcher(s) about requirements to physically and/or electronically secure records (including password protection, file/folder encryption, and/or use of secure electronic transfer of records through file sharing, use of virtual private networks, etc.).

6. not allow any personally identifiable information to which I have access to be accessible from outside Canada (unless specifically instructed otherwise in writing by the Researcher(s)).

Research staff:

_____	_____	_____
(Print Name)	(Signature)	(Date)

I agree to:

1. Provide detailed direction and instruction on my expectations for maintaining the confidentiality of research information so that Clare Heggie can comply with the above terms.

2. Provide oversight and support to Clare Heggie in ensuring confidentiality is maintained in accordance with the Tri Council Policy Statement Ethical Conduct for Research Involving Humans and consistent with the Dalhousie University Policy on the Ethical Conduct of Research Involving Humans.

Researcher(s):

_____	_____	_____
(Print Name)	(Signature)	(Date)