

ACCESSING SEXUALIZED VIOLENCE SERVICES AND SUPPORTS:  
EXPLORING THE PERSPECTIVES OF WOMEN LIVING IN RURAL PLACES

by

Clare Heggie

Submitted in partial fulfillment of the requirements  
for a degree of Master of Arts

at

Dalhousie University  
Halifax, Nova Scotia

June 2020

© Copyright by Clare Heggie, 2020

## TABLE OF CONTENTS

<b>Abstract</b> .....	vi
<b>List of Abbreviations Used</b> .....	vii
<b>Acknowledgments</b> .....	viii
<b>Chapter 1: Introduction</b> .....	1
Background.....	1
Research problem.....	1
Context .....	2
Research purpose and questions.....	3
Significance .....	4
Chapter 1 Summary.....	4
<b>Chapter 2: Literature Review</b>	
What is sexualized violence? .....	5
What are services and supports?.....	6
Accessing sexualized violence services and supports.....	7
Living in a rural place.....	10
Conceptual frameworks.....	11
Critical Feminist Theory .....	11
Gender .....	14
Trauma and trauma informed practice .....	15
Chapter 2 Summary.....	17

<b>Chapter 3: Methodology</b> .....	19
Research reflexivity .....	19
Recruitment .....	20
Data Collection.....	21
Analysis .....	21
Ethics .....	23
Ethical principles of research.....	23
Ethics as an ongoing process .....	25
Consent .....	26
Participant Safety .....	27
Data Storage .....	28
Knowledge translation .....	28
Chapter 3 Summary.....	29
<b>Chapter 4: Results</b> .....	30
Introduction to participants .....	30
Overview of results and key themes .....	30
Theme 1: Socio-cultural context of accessing services and supports .....	31
Living in a rural place .....	32
Narratives and terminology surrounding sexualized violence.....	36
Theme 2: Process of navigation.....	39
Awareness, attempting to access, and decision making .....	39
Emotional burdens.....	44

Time, travel and economic burdens.....	45
Theme 3: Services and supports that women want to access.....	49
Long term, trauma informed mental health services .....	49
Peer support.....	52
Outreach and extended services .....	53
Education .....	55
Theme 4: Services and supports women accessed .....	56
Non-community based .....	57
Community-based .....	63
Peer support .....	65
Informal supports .....	67
Chapter 4 Summary.....	74
<b>Chapter 5: Discussion.....</b>	<b>75</b>
Summary of findings.....	75
Barriers and facilitators to access.....	76
Socio-cultural context.....	76
Community and non-community based.....	77
Health service navigation.....	80
Alternative supports .....	82
Peer support .....	82
Informal supports .....	83
Recommendations .....	85

Invest in community-based services .....	85
Adopt a trauma informed approach .....	86
Explore peer support and patient navigation programs .....	87
Shift narratives surrounding sexualized violence.....	87
Limitations .....	88
Recommendations for future research .....	90
Reflection .....	91
Conclusion .....	92
<b>References.....</b>	<b>93</b>
<b>Appendices .....</b>	<b>102</b>
Appendix A: Interview Guide.....	102
Appendix B: Recruitment Poster .....	105
Appendix C: Screening Document.....	106
Appendix D: Consent Form .....	107
Appendix E: Gift card and Honorarium Tracking Form .....	112
Appendix F: Resources for Participants.....	113
Appendix G: Dalhousie University REB Approval Letter .....	116

## **Abstract**

Many women face significant barriers accessing formal services and informal supports after experiencing sexualized violence, including victim blaming, stigma, and fear of a traumatic experience. There is little research, however, on the experiences of women living in rural places who are accessing sexualized violence services and supports. The purpose of this study was to understand the formal and informal services and supports women living in rural Nova Scotia (NS) wanted to access/accessed following an experience of sexualized violence, as well as services they think are needed. Qualitative interviews were conducted with 9 women. Data were analyzed using thematic analysis. Women shared experiences of navigating a fragmented system of services and supports and identified several barriers and facilitators to access. Women also made suggestions to improve access in rural places. Findings from this study will contribute to the existing literature and may inform future service and support development in rural places.

## **List of Abbreviations Used**

CADTH	Canadian Agency for Drugs and Technologies in Health
CAMH	Centre for Addiction and Mental Health
CBO	Community Based Organization
EMDR	Eye Movement Desensitization and Reprocessing
ER	Emergency Room
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, + (inclusive of other identities)
NS	Nova Scotia
NSHA	Nova Scotia Health Authority
PTSD	Post Traumatic Stress Disorder
SANE	Sexual Assault Nurse Examiner
TA	Thematic Analysis
TIP	Trauma Informed Practice
TCPS	Tri Council Policy Statement
WHO	World Health Organization

## Acknowledgments

First and foremost, I would like to thank the nine women who participated in this study. This project would not be possible without your contributions. Sharing these experiences is not easy. I feel very honored that you chose to share them with me, and I am in awe of your strength. In the short time we spent together, it was clear how passionate each of you are about supporting other survivors of violence and advocating for your communities.

I would also like to thank the staff of the women's resource centers, sexual assault centers and transition houses across Nova Scotia who assisted with the development and execution of this project. I am grateful for both your support of this project and the work you do in your communities, every day, to support women who have experienced violence.

Thank you to my supervisor, Dr. Lois Jackson, for your constant guidance and support through every step of this project. You have challenged me intellectually and supported my growth as a researcher, student and person. I greatly admire you and feel lucky to have been able to learn from you.

Thank you to my committee members, Dr. Audrey Steenbeek and Dr. Colleen MacQuarrie. I am very grateful for the support and thoughtful feedback you provided throughout this project. This work would not be what it is without your input and ideas.

**Funding Acknowledgement:** This study was supported by the Maritime SPOR Support Unit (MSSU), which receives financial support from the Canadian Institutes of Health Research (CIHR), the Nova Scotia Department of Health and Wellness, the New Brunswick Department of Health, the Nova Scotia Health Research Foundation (NSHRF), and the New Brunswick Health Research Foundation (NBHRF). The opinions, results and conclusions reported in this paper are those of the authors and are independent from the funding sources. No endorsement by the MSSU or the named funding partners is intended or should be inferred.



## **Chapter 1: Introduction**

### **Background**

It is estimated that one in three adult Canadian women will experience some form of sexualized violence in their lifetime (Statistics Canada, 2006). Sexualized violence is a broad term used to describe any physical or psychological violence that is carried out through sexual means. A broad definition highlights the diversity of ways in which women can experience and identify sexualized violence. Sexualized violence impacts everyone, but it disproportionately affects women. Sexualized violence impacts women of all ages, income levels and education levels (Status of Women Canada, 2015). Women in Canada who belong to vulnerable populations (e.g. racialized, low income) are more at risk for sexualized violence (2015). In response to an experience of sexualized violence, women face significant barriers accessing both formal services and informal supports. For this study, a formal service is any hospital or organization-based service that is funded and mandated to provide resources. In a rural area, this might include hospitals, clinics, women's centers and other related community-based organizations. For this study, an informal service or support is anything that exists outside of formal supports and could include friends, family, informal women's groups and online communities. These barriers to accessing formal services and informal supports include fear of victim blaming, stigma, and fear of a re-triggering or traumatic experience (Campbell et al., 2001; Logan et al., 2005).

### **Research problem**

Relatively little is known about the experiences of accessing services and supports among women living in a rural area who have experienced sexualized violence. Rural areas

generally lack the breadth of services available in urban areas (Logan et al., 2005). The services that do exist may be over-burdened in an effort to service a large geographical area and may come at a higher travel or time cost to women. Women may fear being seen accessing a sexualized violence related service. This fear may be exacerbated in rural communities due to communities being small and close-knit. Additionally, women in rural communities may have personal relationships with service providers. These barriers interact with and exacerbate the barriers previously listed (fear of victim blaming, stigma, fear of a traumatic or re-triggering experience).

### **Context**

This study focuses on access to services and supports in rural Nova Scotia. In Nova Scotia, 43 percent of the population lives in rural areas, compared to a national average of 19% (Statistics Canada, 2011). Rural communities in Nova Scotia are currently facing a range of demographic, economic and infrastructure challenges. Faced with aging populations, out-migration of youth and an overall economic decline, rural communities are experiencing declines in infrastructure and service provision, including health services. In 2017-18, all of the emergency departments operating at reduced hours (e.g. less than 24/7) were located in rural communities (Province of Nova Scotia, 2019). Nova Scotia as a whole is experiencing a family doctor shortage and this problem may be exacerbated in rural communities, as family doctors are concentrated in Halifax, which is the largest urban centre in the province (Doctors Nova Scotia, 2018). Nova Scotians experience other issues impacting health outcomes as well. The 2016 Canadian census found that Nova Scotia had the highest prevalence of low-income households in the country (compared to other provinces), with many predominantly rural counties displaying high low-income rates (Statistics Canada, 2016). A lack of reliable public transportation in rural

Nova Scotia exacerbates these province-wide problems as people living in rural places may lack the ability to access critical services (Canada Without Poverty, 2015). Many communities in rural Nova Scotia historically depended on resource extraction-based economies (e.g. coal, steel, fishing) (Gibson et al., 2015). Although some rural communities continue to see economic benefits from these industries, there tend to be fewer people directly employed (2015). As industry has waned or ceased completely, rural communities in Nova Scotia may be navigating job loss and/or new low pay work and the need to diversify economies. Industry closure also impacts the fabric of the community, causing “trauma of industrial closure” (Bennet, 2013) – the disruption and psychological damage that comes from the loss of community identity and associated social networks. These community context specific challenges suggest that women in rural Nova Scotia will face unique barriers to accessing services and support after experiencing sexualized violence.

### **Research purposes and questions.**

The purpose of this study is to explore and understand the experiences of women living in rural Nova Scotia who have experienced sexualized violence. The research questions are:

1. What formal services and informal supports do women who have experienced sexualized violence living in a rural area want to access, attempt to access, or access in response to sexualized violence and why?
2. What are the barriers and facilitators to accessing formal sexualized violence services and informal supports in a rural area?
3. What services and supports do women who have experienced sexualized violence think are needed in rural places?

## **Significance**

The results of this study make unique recommendations for future service and support development based on the experiences of women living in rural places who have experienced sexualized violence. This study will also bring greater awareness to the issue of sexualized violence in rural NS. There currently exists very little literature on the experiences of women living in rural places who have experienced sexualized violence. Due to the study's uniqueness, and the urgent need to respond to sexualized violence in our communities, it has potential for impact on the field of health research and the health of Nova Scotians. By giving women space to share their experiences, the results speak directly to what women living in rural NS feel they need to respond to, and heal from, sexualized violence. By identifying barriers to access, this study also makes recommendations on how to improve existing services or develop new services based on the needs of the unique population.

## **Chapter 1 Summary**

A number of barriers to accessing sexualized violence services and supports have been identified in the existing literature. Although living in a rural place is known to have an impact on service access and health outcomes in general, there has been little research on the experiences of women living in rural places who are accessing services or support after experiencing sexualized violence. This qualitative study explored the experiences of women living in a rural place in Nova Scotia who attempted to access or accessed services and supports after experiencing sexualized violence. The findings give insight into these experiences and makes recommendations to improve access.

## Chapter 2: Literature Review

### What is sexualized violence?

The World Health Organization (2006) defines sexualized violence as: “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work” (World Health Organization, 2006, 149). This definition demonstrates the diversity of types and experiences of sexualized violence. It also disputes the dominant narratives or “myths” of sexualized violence in so far as it acknowledges violence can happen in any setting and the perpetrator can have a variety of different relationships to the victim. Sexualized violence myths are pervasive ideas about what constitutes sexualized violence (and in opposition, what does not “count”) reinforced by social and institutional discourse (DuMont, 2017). Myths suggest that sexualized violence is often committed by someone unknown to the assailant, when in reality, the majority of sexualized violence is committed by someone known to the victim. In Canada, approximately 82% of perpetrators of sexualized violence are known to the victim (Statistics Canada, 2011).

In 2014, Statistics Canada released a report on characteristics of self-reported sexual assault in Canada. Of all self-reported sexual assaults, 87 percent were committed against women (Statistics Canada, 2014). There are a number of factors that make women more vulnerable to experiencing sexualized violence. Some of these statistics will be shared here in an attempt to illustrate that while all women are at risk of sexualized violence, women who belong to one or more vulnerable populations are more at risk. The report indicates that over half of all sexual assault incidents reported in 2014 were committed against women aged 15 to

24 (2014). Single women reported a rate of assault nine times higher than common law or married women. Indigenous women reported a rate of assault three times higher than non-Indigenous women. Women with disabilities (physical or mental) reported a rate of assault two times higher than women who do not have disabilities. Other risk factors for sexual assault included substance use, frequent evening activity (e.g. night class, night work, socializing) and sexual orientation.

### **What are services and supports?**

Booth & McLaughlin (2006) conceptualize three main factors that are associated with accessing services: the means to access services (e.g. transportation), socio-demographics that will influence access, and the perceived need of a service. It is important to understand what services are available and needed in any given community and what factors influence access of those services. A formal service is defined in the literature as a hospital or organization-based service that is funded and mandated to provide resources (Ullmann & Filipas, 2001). In a rural area, this might include hospitals, family practices, women's centers and other related community-based organizations.

Informal supports include friends, family, informal women's groups and online communities. Women may access other informal supports not listed here (Ullmann & Filipas, 2001). In 2014, Statistics Canada reported that victims tended to rely more heavily on informal supports than formal services: 64% of women said they talked to a friend, 41% said they spoke to a family member, and 24% said they spoke to a co-worker. In contrast, only 19% of women said they consulted any formal support service (Statistics Canada, 2014). Existing literature suggest that many women rely on family and friends for support (Milliken et al., 2016;

Starzynski et al., 2005; Ullman & Filipas, 2001). Other commonly reported informal supports are trauma informed yoga (Crews et al., 2016; Stevens & McLeod, 2019) and spirituality/meditation (Kane, 2006; Knapnik et al., 2008).

### **Accessing sexualized violence services and supports**

The majority of existing literature focuses on the experiences of urban women, although there are some studies exploring the experiences of rural women. Logan et al. (2005) conducted focus groups with both rural and urban women who identified as survivors of sexualized violence to identify key barriers to services and found that lack of awareness of services, bureaucracy, shame and blame, fear of community backlash and confidentiality concerns all acted as barriers to formal service access. Lack of awareness of services and bureaucracy (e.g. waitlists, multiple phone calls needed to access) made physical access to service difficult. Shame, blame, and fear of community backlash (e.g. community members isolating women who disclose violence) made women feel as though accessing services was not a viable option for them, even if they had a desire to access a service. While delivery of services is supposed to be confidential, women had concerns about confidentiality that prevented them from accessing a service (e.g. fear that staff would violate confidentiality).

Zweig et al. (2002) interviewed staff from programs serving women who have experienced sexualized violence. The main barriers identified to service delivery were lack of service provider education and lack of integrated services (e.g. having housing support workers or addiction counselors housed in the same center or easily referred). Lack of service provider education operates as a barrier insofar as staff did not feel equipped to handle disclosures of sexualized violence. While this study focuses on service access, not service delivery, lack of

service provider education and lack of integrated services could act as a barrier to access.

Many of the identified barriers to access (e.g. stigma, blame) can have a re-traumatizing impact on women accessing services. Campbell et al. (2001) call this re-traumatizing effect the ‘second rape’. ‘Second rape’, or secondary victimization, is described as: “...the victim blaming attitudes, behaviors, and practices engaged in by community service providers, which further the rape event, resulting in additional trauma for rape survivors.” (1240). Secondary victimization has negative mental and physical health consequences. Fear of secondary victimization may prevent survivors from seeking services. Secondary victimization theory acts as a framework for understanding barriers to access. It encompasses the identified barriers of blame, shame, lack of confidentiality, community backlash and stigma and presents these barriers as a traumatic experience for the woman who is seeking services, rather than isolated phenomena that do not interact.

Existing literature also identifies that characteristics of the experience of sexualized violence can predict the likelihood of a woman accessing services. Resnick et al. (2000) interviewed women who had recently experienced a rape event and found that 26% of participants received care (e.g. through a formal service) after the rape event. Sustaining a serious physical injury during the violence event was positively associated with receiving healthcare, while reported use of drugs or alcohol were negatively associated with receipt of care (2000). This supports the findings of other research studies that suggest that stigma and fear of victim blaming hinders access of care (Logan et al., 2005). Women may feel they are responsible for the violence that was committed against them due to intoxication or other ‘unhealthy’ behaviours. Women and health care providers may also be internalizing an idea of the ‘rape myth’. Heath et al. (2013) described the elements of the “classic rape” or “rape myth:



“abduction, the perpetrator being a stranger, severe force, and serious injury” (1066). Whatley (1996) found that third party observers (e.g. people who did not experience sexualized violence) are more likely to see the “classic rape” as a crime, and more likely to ascribe blame and responsibility to victims of sexualized violence outside of the “classic rape”. Resnick et al. (2000) also found that women assaulted by strangers were more likely to receive care than women assaulted by assailants known to them, although most sexual assaults are committed by someone known to the victim (Murphy et al., 2011), which suggests the rape myth is prevalent and impacts women’s ability to access services.

Research has also found that reporting the event to police increases likelihood of accessing supports (Resnick et al., 2000). Though receipt of care is positive, there are significant documented barriers to reporting a sexual assault, including shame, guilt, embarrassment, concerns about confidentiality, fear of not being believed and distrust in the police/justice system (Sable et al., 2006; Khan et al., 2018). As a result of these barriers, sexualized violence is underreported (Benoit et al., 2015). Women should have access to care regardless of decision to report.

Overall, there is an urgent need to improve access to sexualized violence services and supports. Women face multiple barriers accessing services. When they do access the services, they may have a negative and potentially very harmful experience. Pervasive myths about sexualized violence reinforce the barriers of stigma, blame and shame – perpetuating a negative cycle that results in health problems remaining untreated and many women feeling unsupported in the wake of a violent event.

## **Living in a rural place**

Rural areas are generally defined as communities smaller than, and significantly distant from, larger urban communities (Lutfiyya et al., 2012). According to Statistics Canada, 43% of Nova Scotia's population live in census rural areas, defined provincially as communities with a population of less than 1000 and outside of areas with at least 400 people per square kilometer. (Statistics Canada, 2011). Research suggests that living in a rural place has an impact on health outcomes. Living in a rural place often indicates poor service availability and a lack of transportation services (Smith et al., 2008), and may increase likelihood of depression and other health issues (Lutfiyya et al., 2012). Ability to access primary and secondary care in rural places may be limited, with communities lacking hospitals, clinics and/or family doctors (Higgs, 1999).

Existing literature tends to focus on the experiences of urban women more than the experiences of rural women. We can expect rural women to experience accessing services and supports differently due to the importance of community context, and further research is needed to understand those experiences. In research exploring characteristics of rural women who experience violence, Logan et al. (2003) state that rural women have less social support, less education, less income, worse overall health, and a greater likelihood of having a past of physical and/or sexual abuse. This research did not identify rural specific barriers to services but demonstrates a need for additional research on the barriers unique to women living in rural places. Peek-Asa et al. (2011) identify transportation as a major barrier for rural women seeking domestic violence related services. The distance rural women travelled to access services is often greater than the distance urban women travelled. Services often serve multiple counties and as a result, women living in rural places may have longer wait times for programs or continued care. Transportation may also be a barrier for urban women, but access to public

transit and services in walking distance may reduce the burden.

### **Conceptual frameworks**

Critical feminist theory and a critical understanding of gender will be used as a conceptual framework to understand the experience of accessing services and supports in a rural place after any experience of sexualized violence. Trauma theory or trauma informed practice theory will also be used to understand the process of accessing services.

**Critical feminist theory.** This study is rooted in critical feminist theory. Critical feminist theory allows for an in-depth analysis and discussion of the power relations embedded in the experience of accessing (or not) services and supports related to sexualized violence. To define critical feminist theory, Rhodes (1990) states that "...what distinguishes feminist critical theories from other analysis is both the focus on gender equality and the conviction that it cannot be obtained under existing ideological and institutional structures" (619). Rhodes further describes the shared "commitments" of critical feminist theorists as: centering gender in analysis, describing experiences in a way that corresponds to women's experiences and identifying change necessary for greater gender equality/equity and states "...these traditions share a common goal: to challenge existing distributions of power" (619).

Sexualized violence (and the marginalization of survivors of sexualized violence) is an example of an existing distribution of power. In a report on violence and health, the World Health Organization states that: "The underlying factors in many sexually violent acts are power and control, not, as is widely perceived, a craving for sex" (WHO, 2006, 9). Power may also be distributed unevenly through service access and service availability. Women's service access

will be impacted by policy and resource allocation decisions that are rooted in a patriarchal structure. These structural forces are controlled and moderated by the hierarchies and cultural attitudes towards women and violence against women. Critical feminist theory allows for the individual experiences of women to be placed in, and analyzed alongside, these dominant structural power structures and imbalances.

Sexualized violence functions on the normalcy of rape culture and the subjugation of women that is reinforced by dominant forces. Sexualized violence is fundamentally about relational power – not only between a victim and their assailant, but also between genders as dictated by the construction of the gender binary and its maintenance through patriarchal ideals. Accessing a service is also rooted in relational power (e.g. patient/provider). Metzl & Hansen (2014) call for a recognition of the structures that shape service access. They urge service providers and researchers to consider the impact of upstream decisions about resources and policy on patients.

Critical feminist theory allows for a nuanced understanding of the complex intersecting forces that exert control over women’s lives, and in the context of this study, the experiences of accessing services and supports after experiencing sexualized violence for women living in rural Nova Scotia. It is important to note that critical feminist theory has been criticized for centering gender while ignoring other factors such as race and class, as well as centering normative narratives of womanhood (Wing, 2003). More broadly, the “mainstream” feminist movement has been criticized for centering the concerns and achievements of white women and “...controlling the movement to facilitate entry into the capitalist heteropatriarchal power structure, seeking to become part of the same system they [feminists] decried as oppressive” (Brewer & Dundes, 2018, 50).

A number of scholars, such as bell hooks, Kimberlé Crenshaw, Angela Davis, Patricia Hill Collins, Barbara Smith and Sara Ahmed, have challenged “feminist theory” and made a call to action for critical feminist theory to consider the complex identities of women. In her book ‘Living a Feminist Life’ (2017), Sara Ahmed challenges the concept of any one essential feminist theory; she discusses at length how feminist theory is generated, how knowledge is produced, and how the word ‘theory’ carries capital and power. Ahmed’s scholarship is rooted in critical race theory and queer theory and posits that everyday life generates feminist theory, and there is great power in deciding where we find that feminism matters, for whom we find that feminism matters and what we deem as feminist theory. In other words, ascribing any one ideal of feminism or any singular understanding of gender to the experiences of women can recreate the same kind of power imbalance that feminist theory set out to dismantle. Ahmed’s understanding of theory informs this study as analysis was not undertaken with preconceived notions of how women might experience accessing services and supports. Rather, critical feminist theory was used to situate women’s unique experiences within a broader power structure, including structures of racial and economic inequality.

Ahmed demonstrates that feminist theory should be inseparable from other critical theories, and critical feminist theory should also be critical of feminist action that is concerned with success within an inequitable system and fails to acknowledge class and other identities. Acknowledging the necessity to survive current systems financially and otherwise, critical feminist theory should look at unjust structures and allow the imagination of a more just world. For example, a world without sexualized violence and rape culture, rather than a world where there are an abundance of services for victims/survivors. However, strong and

accessible services and supports are still needed urgently to both support women who have experienced violence and work to prevent future violence through education and empowerment of women (e.g. economic opportunities and housing).

**Gender.** Butler (1988) states that "... to be a woman is to have *become* a woman, to compel the body to become a cultural sign, to materialize oneself in obedience to an historically delimited possibility, and to do this as a sustained and repeated corporeal project" (Butler, 1988, 522). In other words, gender is socially constructed and consequently enacted and embodied on a daily basis. To *become* a woman is to be influenced by the gendered roles, norms and relations ascribed to women. Butler popularized the phrase 'gender trouble', referring to the constant performance of gender. Sara Ahmed puts forth the idea of feminist trouble: "... feminist trouble is trouble with women. When we refuse to be women, in the heteropatriarchal sense as beings for men, we become trouble, we get into trouble... we bring into our statements of intent and purpose the experience of what we come up against. It is the experience that allows us to articulate a *for*, a *for* that carries with it an experience of what we come up against". (Ahmed, 2017, 256). Conducting research on the experiences of accessing services and supports related to sexualized violence necessitates a nuanced understanding of gender, womanhood, the ways in which womanhood is embodied and enacted and the privileging of some experiences of womanhood over others.

This study aimed to explore and understand the experiences of women living in rural places who are accessing services and supports after any experienced sexualized violence. Women living in a rural place experience a unique construction and embodiment of gender and womanhood. The epistemological framework of this study is pro-survivor, pro-woman

and views women as the experts on their own lives and experiences of gender and violence. Ahmed critiques theoretical understandings of feminism that are separate from feminist practice; “living” one’s feminism. She states that “feminism is at stake in how we generate knowledge; in how we write, in who we cite... feminist theory is world making.” (14).

Drawing on the work of Ahmed and other feminist phenomenologists, this study is rooted in living a feminist practice. Grounding analysis in feminist scholarship does little to advance the project of feminism and equity for rurally based women if the voices of those women are not privileged, respected and honoured. Analysis cannot ignore the patriarchal forces of rape culture and violence that oppress women living in rural places; this research is inherently political. Doing feminist work in a good way involves “feminist trouble”, making patriarchal and other oppressive structures visible and known, rejecting the status quo and putting the voices of women first as the experts of their needs and wants, a role that may have been systematically denied to them throughout various service and support interactions. The methodology of this study aims to reflect this by elevating the voices of women living in rural places.

**Trauma and trauma informed practice.** Many of the services for women who have experienced sexualized violence are “trauma informed”. Understanding trauma and what makes a service trauma informed is important to understand women’s experiences of accessing services and supports after any experience of sexualized violence. The Centre for Addiction and Mental Health (CAMH) defines trauma as “the challenging emotional consequences that living through a distressing event can have for an individual.” (CAMH, n.d.) Traumatic or trauma causing events cannot be clearly defined as events and may be more or less traumatic for

different people. Historic trauma is trauma stemming from traumatic events early in life. Traumatic events also occur later in and throughout life, such as experiencing or witnessing violence, experiencing a serious accident or health problem or a sudden or unexpected loss. Living with trauma is common and widespread. Due to the complex and varied nature of trauma, gathering statistics on the number of people living with trauma is difficult. Van Ameringen et al. (2008) surveyed Canadians over the age of 18 and found that 76.1% of respondents reported exposure to at least one traumatic event that cause trauma and post-traumatic stress disorder (PTSD) like symptoms. The most common reported traumatic events were the sudden or unexpected death of a loved one, sexual assault, and seeing someone badly injured or killed. Trauma Informed Practice (TIP) is a framework for providing services that recognizes the prevalence of trauma and its impacts on the wellbeing of people and communities. TIP promotes physical, psychological and emotional safety and aims to create service/care environments that are safe, empowering and healing. TIP is a framework that was developed in healthcare and social work settings. Falot & Harris (2001) established the “five principles” of TIP. These principles are widely regarded as the foundation of TIP. The principles are:

- 1) Safety:** Creating spaces where clients feel culturally, emotionally and physically safe.
- 2) Transparency and Trustworthiness:** Providing clients with clear and accurate information about what is happening and what is likely to happen next.
- 3) Choice:** Respecting the client’s dignity and right to choice (including the right to say no to an intervention or treatment.)



**4) Collaboration and Mutuality:** Recognizing the role of the service provider and respecting that safety and healing will only happen in respectful, democratic relationships with shared decision making

**5) Empowerment:** Recognizing and fostering the client's strengths.

Many services and supports for women who have experienced sexualized violence are described as trauma informed, but women's experiences with these services and supports vary. These five principles provide a framework for understanding how trauma-informed (or not) the experience of accessing services and supports may be. A truly trauma informed approach will incorporate and actualize each principle (Safety, Transparency and Trustworthiness, Choice, Collaboration and Mutuality, Empowerment) from the beginning of any interaction and regardless of any prior knowledge of someone's history of traumatic events (Butler et al. 2011). These principles were referred to throughout the analysis process in order to understand how women's experiences accessing services and supports may have been helpful or harmful, and how services and supports could be more trauma-informed.

## **Chapter 2 Summary**

A review of existing literature identified several gaps. There is relatively little research on rural women's experience of accessing sexualized violence services and supports. Research focusing on the perspective of women who have experienced violence rather than the perspective of the provider is also lacking. The small body of literature on rural women's experiences focuses on characteristics of rural women who have experienced sexualized violence rather than their service access. Inferences about rural women's service access can be made from urban focused literature, but literature on rural women's health and rurality as a health determinant

suggests that at least some of the barriers may be different, such as community related confidentiality concerns, lack of services and transportation. Existing research identifies that services are under-utilized and that there are barriers to service access (Logan et al. 2005, Campbell et al. 2001), but does not explore the process of deciding what services to access (or not), nor does it explore the experience of accessing informal services and supports or identify what services and supports are most desired by women living in a rural area.

## Chapter 3: Methodology

### Researcher reflexivity

It is important to acknowledge my own position as a researcher as it influences all aspects of the research process. Like most people, I have had experiences navigating sexuality, sexual health and consent. These experiences and the experiences of others close to me have motivated many of my educational and advocacy pursuits. I was born in what could be considered a rural community in Nova Scotia, but I was raised in Halifax, an urban community. I have never accessed services and support in a rural community.

Several researchers have argued that the dichotomous understanding of a researcher as either an insider or an outsider to their study population/community is not useful in practice (McNess et al., 2015; Hellowell, 2006; Milligan, 2016). McNess et al. (2015) state that being an insider or an outsider "...has much to do with our own constantly evolving lives, academic scholarship, previous experiences and prior knowledge of the context to be researched," and "has much to do with how we each perceive the world and how we interpret what we see and experience." (311). As someone with both insider and outsider perspective, I was conscious of how these boundaries can shift during the research process. I shared my own background and interest in the research process in order to build trust with participants, but I did not assume participants would see me as an "insider".

Feminist research acknowledges that pure objectivity is not only impossible, but also undesirable to the research process (Gatenby & Humphries, 2000). So, I also acknowledge that my own experiences influenced the analysis. Feminist scholars engaged in participatory and community-based research and actions draw attention to the dilemma of

subjectivity/objectivity raised by both data collection and analysis. Gatenby & Humphries (2000) discuss the tensions they experienced situating themselves in their research on women and work: “We sense the tension in the possibilities for various roles we may undertake, as observers, supporters, listeners, advisors and so forth... Our own participation and disclosures vary, not only according to the practical realities of our lives, but also according the emotional realities of living with feminist ideals in a patriarchal world.” (98). Philip & Bell (2017) and Burgess-Proctor (2015) discuss the necessity of positionality in feminist research while addressing the tensions involved in navigating if and how to share your own experiences when the focus of the work is elevating the voices of previously silenced women. Sharing my own investment and interest in this research helped to build trust and demonstrate commitment to action. However, I also acknowledge that any experiences I have of accessing services (for example) are not representative of other women’s experiences.

## **Recruitment**

In qualitative research, the intent is to understand a particular context or phenomena in great depth, not achieve generalizability through a large sample size. Recruitment can be facilitated by the involvement of trusted community members or representatives (Jagosh et al, 2012). For this research, recruitment was accomplished through women’s centres and transition houses based in rural areas in Nova Scotia. Initial recruitment strategies included informing staff at these centres about the project so they could inform clients about the project directly as appropriate, and postering and recruiting through other relevant community organizations (e.g. libraries, community centers). Recruitment also took place on social media, by sharing relevant information via the Facebook, Twitter and Instagram accounts of women’s centres, transition

houses, and other relevant organizations.

Recruitment materials were directed to anyone who had experienced sexualized violence and attempted to access or accessed a service within the past two years, in order to speak to current policies and programs. Recruitment materials made it clear that the study would be asking questions about the formal service and informal support experience, not the experience of sexualized violence.

### **Data collection**

Data were collected through in-depth, one on one, semi-structured interviews. Participants were given the option of an in person or a telephone interview. Telephone interviews were presented as an option to reduce travel expenses for participants. Telephone interviews may also be more comfortable and confidential for the discussion of sensitive subject matters. 5 participants chose to have an in-person interview and 4 chose to have a telephone interview. In person interviews were conducted at a community partner site. If those centers were not convenient or comfortable locations for participants, the participant was able to select another location in the community (e.g. public library) (Creswell, 2013). Interview guides (Appendix A) were pre-tested with a woman with lived experience. Questions and probes were designed to speak to the experience of accessing services and supports in rural NS and to generate discussion on what services and supports are needed.

### **Analysis**

Thematic analysis (TA) is a theoretically flexible method for analyzing data that can be adapted to a variety of research questions and epistemological frameworks. Braun & Clarke

(2006) state that the theoretical freedom of thematic analysis makes it appropriate for research coming from different epistemologies and can yield complex data (2006). It is a method that is utilized for identifying, analyzing and reporting patterns that exist across a data set. It is appropriate for this research as it allows for the development of patterns that will help to explicate the experience of accessing services and support in rural Nova Scotia. It was used in conjunction with critical feminist theory. Braun & Clarke outline a six-step process to conducting TA. In the first step (1), the researcher familiarized herself with the research by transcribing the data, reading and re-reading the data and listening to the audio recordings. The researcher then generated the initial codes (2). Codes were then sorted into potential theme categories (3). Once candidate themes were developed and codes were appropriately sorted, themes were reviewed (4). This step involved reviewing first the themes and coded extracts to ensure they were coherent, then reviewing the themes in the context of the dataset to ensure all relevant concepts were captured. At this stage, once cohesiveness was established, a thematic map was developed. The thematic map was used to define and name themes (5). Once each theme was described in detail, the final analysis was written (6).

As stated above, this thematic analysis was conducted with a feminist lens that acknowledges that we cannot separate our experience of the world from our experience of gender. The experience of accessing services and supports for sexualized violence is not an abstract or apolitical event that exists outside of the construction and embodiment of gender. Jenkinson et al. (2017) adapted Braun & Clarke's process to a feminist research context by conducting two iterations of the thematic analysis process. The first iteration was descriptive, focusing on participants' experiences of accessing maternity care. This iteration "was not, however, intended to foreground the underlying values, attitudes and behaviours that influence

the provision of [maternity care] in such situations.” The second iteration was undertaken using a ‘feminist lens’ and focused on participants’ broader comments about accessing or not accessing care, and allowed for issues of power, dominance and gender to come to the foreground (2017). In the final report, the themes were discussed together. They state the value of this phased thematic analysis lies in its ability to generate complex data that speaks to power hierarchies and its ability to “recover and value women’s stories” (3). Additionally, applying a feminist lens to thematic analysis recognizes that women’s stories are not “mere anecdotes” (3), meaning that themes do not exist in isolation of the oppression of women. The experiences of accessing services does not exist separate from gendered violence and patriarchal subjugation of women and adapting TA to a feminist context allowed this to be substantiated through complex data that can inform change about service and support delivery. Spencer et al. (2017) and Toffoletti & Thorpe (2018) conducted a similar feminist thematic analysis, analyzing women’s decisions not to report sexual assault and female athletes’ self-image, respectively. By applying a feminist lens to the processes of code and theme identification, themes exist in a wider context of critical feminist theory.

## **Ethics**

**Ethical principles of research.** The Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS) is the guiding policy for ethical research on human subjects in Canada. The policy is based on the concept of ‘respect for human dignity’ which “requires that research involving humans be conducted in a manner that is sensitive to the inherent worth of all human beings and the respect and consideration that they are due” (Canadian Institutes of Health Research, 2018). The TCPS expresses respect for human dignity through three principles:

Respect for Persons, Concern for Welfare and Justice (Canadian Institutes of Health Research, 2018). Respect for persons involves respecting and protecting human subject's autonomy. Autonomy can be respected through processes of seeking free, informed and ongoing consent. The choice to participate in research should be informed, meaning participants should have a full understanding of the research purpose, what will be asked of them during the research process and any foreseeable risks and/or benefits to participation in research (2018).

Concern for welfare is expressed by researchers protecting the welfare of participants by ensuring they are not exposed to unnecessary risk. This is particularly relevant when doing research on a marginalized population such as women who live in a rural place and have survived sexualized violence. The welfare of both the individual and the population/community should be promoted. Confidentiality is critical to ensure that the welfare of the population and/or participant is not impacted by stigmatization or discrimination stemming from participation in the research process (2010). Wide knowledge of participation in the research process could out women's identity as survivors of sexualized violence and could pose a threat to their welfare. This knowledge was limited at the data collection stage by providing a confidential space for in person interviews, and at the analysis stage by de-identifying all data.

Potentially inequitable power differentials may exist in the researcher/participant relationship. Traditional research paradigms create a "researcher-subject" dichotomy that may other the participant and further entrench the inherent power dynamic (Beckman, 2014). The researcher can make efforts to remove power imbalances and create a non- hierarchical interview experience by working to remove the perception of her as an expert; rather, both the researcher and the participant are only experts on their lived experiences. In this study, I



aimed to do this through sharing my own interest in the subject matter and maintaining a conversational, non-intimidating interviewing style.

Clarke (2006) warns that there are also ethical considerations that go along with the non-hierarchical, conversational interview style prevalent in feminist research, as participants may begin to see the interviewer as a friend and disclose information they may regret sharing later. With this in mind, I acknowledged that the researcher-participant power imbalance can never be fully eradicated, and the rapport established should remain professional so as to not mislead the participant, especially given the sensitive subject matter of this study.

**Ethics as an ongoing process.** Ramcharan & Cutcliffe (2001) suggest that qualitative health research necessitates an ethics as process model in which “the research process should be sustained as with any other human interaction with good intention, in such a way as to respect and not to undermine the person emotionally, socially or physically; the time-limited researcher/participant relationship should be managed, as should withdrawal from the field; the balance of participants’ personal contribution against both the personal and wider benefits of the work should be made clear on a repeated basis...and an ‘audit trail’ should be created by the researcher as a record of their work.” An ethics as process model is especially appropriate given the sensitive nature of the research. In this study, efforts to view ethics as an ongoing process were made by prioritizing participants wellbeing over data collection and conducting interviews at a pace deemed appropriate for the subject matter and participant safety and comfort, as well as maintaining availability for follow-up. Research results will be shared with participants who expressed an interest in receiving results as soon as they are available (e.g. after thesis defense).

**Consent.** Free and informed consent was obtained from all participants prior to the interview. In accordance with Article 3.2 of the TCPS, participants were provided with all information necessary to make an informed choice about participation. When participants made initial contact with the researcher (e.g. responded to recruitment materials), all relevant information on the study (research purpose, research questions, what will be asked of them during the research process, potential risks and benefits) was provided. At the time of the interview, the material and the accompanying consent form was reviewed by the interviewer. Any questions the participants had were answered. The participants were informed that they could withdraw at any point and their withdrawal would have no impact on receipt of honorarium. Additionally, participants were informed that their participation had no impact on their ability to access any services they discuss in the interview (e.g. speaking positively or negatively about a local service). Article 3.12 of the TCPS states that consent will be documented either by a signed consent form or in some other form of documentation that is deemed an appropriate means of consent. In the event that participants are uncomfortable with written consent (e.g. discomfort signing their name), the TCPS states that verbal agreement and documentation of verbal agreement (researcher signs consent form) is appropriate. This procedure of verbal consent was followed as participants had the option for a phone interview. After participants consented to participation, the honorarium was distributed as to ensure participants they could withdraw at any time and would still have received the honorarium. At in person interviews, a \$20 cash honorarium was provided. At telephone interviews, a \$20 Amazon gift card was sent via email. Participants were informed in the consent process that if they chose a telephone interview, they would need to provide an email address to receive the honorarium. Once the participant completed the interview, they had up to two weeks to withdraw from the study. After two

weeks, the data was a part of the data set and had no identifiable information attached to it. No participants withdrew from the study. All identifiable information (e.g. names, specific references to time or place) was deleted in the transcription process. Participants were given the choice if they would like direct quotes from their interview to be used in the consent process and were informed that these quotes could be identified by participant number or place of interview (e.g. Antigonish) as appropriate. This study was reviewed and approved by the Dalhousie Research Ethics Board.

**Participant safety.** This study did not ask any questions about the experience of sexualized violence, however I acknowledged that the interview process likely brought up memories of violence. The questions focused on the experience of accessing services. However, the process of seeking services could be as traumatic as the experience of the violence itself. I acknowledged that discussing accessing services and discussing memories associated with sexualized violence may be very challenging and potentially bring up past trauma. This was addressed in several ways. First, it was made clear that participants could stop the interview at any time. Stopping the interview had no bearing on the participant receiving an honorarium. The participant was informed that they could stop the interview entirely or stop for a break. Secondly, procedures were put in place in the event of the participant needing support post interview. In the in-person interviews, interview times were attempted to be arranged so that a support staff could provide brief post interview support, however this was not always possible, as some participants preferred to meet at another location more convenient to them. A list of resources and community supports was distributed at the end of each interview to participants who wanted the resource. The resource list could also be shared electronically with participants who had a phone

interview, although no participants requested an electronic list. Additionally, I made myself available via email or telephone should the participant have follow up questions and/or need referrals to additional support. Ellsberg & Heise (2005) published a guidebook to researching violence against women. They caution that participants should never feel obligated to share personal or individual details about violence or abuse. This guide was referred to throughout the data collection process to ensure maximum safety of participants. The researcher also completed the NS Sexual Violence Strategy training on Supporting Survivors of Sexual Violence. This was important because it prepared the researcher to better listen and respond to participant's disclosures of sexualized violence.

**Data Storage.** Each participant had the choice of being audio recorded or having notes taken. One participant chose to have notes taken. Audio tapes were transferred to a password protected hard drive and then deleted from the recording device. The recordings were then transcribed by the researcher at Dalhousie. Personally identifying information (e.g. names, specific dates and times) was not transcribed. Transcription files were stored on two password protected hard drives. The audio recording was deleted once transcription was completed and checked for accuracy. Data and consent forms will be retained for five years post first publication, at Dalhousie University, in the event of questions about analysis or interpretation. All data and consent forms will be destroyed after that period.

### **Knowledge translation**

Results will be shared through a community report directed at community members, including women who have experienced sexualized violence and supporters of people who have

experienced sexualized violence, service providers and local stakeholders (e.g. women's centre staff members, local therapists and sexual assault nurse examiners). Sharing this knowledge with the community is important to both support local stakeholders in improving access to services and to educate the community on the challenges women who have experienced sexualized violence face and how response can be improved at a community level. Results will also be shared as a thesis, in a peer-reviewed publication and at a relevant national conference. Sharing this knowledge with the academic community is important to bridge the existing gap in knowledge, foster collaboration between other researchers addressing these issues and encourage future research on issue of sexualized violence and service access in rural NS and rural areas in general.

### **Chapter 3 Summary**

This qualitative study was developed with attention to the sensitive nature of the research questions. Ethical considerations to protect participant safety were taken into consideration at every stage of the methodology. Semi-structured interviews were used in an effort to maintain a conversational, non-hierarchical interview process. Data was analyzed using a process of "feminist thematic analysis" in order to ground results in feminist theory. Knowledge translation strategies aim to share results with rural communities (including service providers and local stakeholders) and the academic community.

## **Chapter 4: Results**

### **Introduction to participants**

A total of nine participants were interviewed as a part of this study. All participants identified as women and identified as living in, and attempting to access or having accessed services in, a rural place. Socio-demographic information on age and county were collected as part of the interview. Participants ranged in age from 21 – 50 and represented 7 different counties. It should be noted that while socio-demographic information was collected on the county participants live in, many participants had attempted to access or accessed services from a number of different counties. Information on other identities (e.g. race, sexual orientation) was not collected, although some participants disclosed this information during the interview as it related to their experience of accessing services and supports. One of the participants was personally known to me. When this woman volunteered, I offered to have somebody else conduct her interview, but she preferred to be interviewed by me. This was also discussed with the Dalhousie Research Ethics Office to ensure that the participants confidentiality and rights would be protected.

### **Overview of results and key themes**

Four key themes were identified through analysis of the data: (1) Socio-cultural context, (2) Process of navigating services, (3) Services and supports that women accessed and (4) Services and supports that women wanted to access. The socio-cultural context of service access includes the two subthemes of living in a rural place and dominant narratives around sexualized violence. These contextual factors influence the experiences of accessing services and supports in a rural place after experiencing sexualized violence and provide context to the rest of the key

themes discussed here. Women identified significant challenges to navigating services. In this section, the process of navigation refers to the process of identifying, attempting to access, and making decisions about one or more services and supports. During that process of navigation, women reported emotional duress, time and travel burdens (e.g. waitlists and driving to other counties to access services) and in several cases, economic challenges related to lost work and housing issues. Women accessed services and supports throughout this process of navigation. Women may have accessed a service at the beginning of the process (e.g. visited an ER or walk-in clinic looking for resources) and/or accessed a service only after making several attempts to access throughout the process of navigation (e.g. connected with a therapist after being placed on a wait list for several months). All of the services and supports that women accessed will be identified as community based, non-community based, or informal. Women also identified what services and supports they would have liked to access and/or made suggestions about what they think should be in place in their community. Recommendations for what services and supports women think are needed in their community and/or in rural communities in general can be drawn from these suggestions.

### **Theme 1: Socio-cultural context of accessing services and supports**

The process of seeking services and supports is not a neutral experience separate from the place and time that women exist in. Women's experiences seeking services and supports was influenced by both the cultural context of both women's local communities and the broader discourse and narratives around sexualized violence and women in general. Women spoke about a number of barriers or challenges to accessing services in a rural place, including a lack of anonymity, issues related to confidentiality, a culture of silence related to sexualized violence

and a limited number of services.

**Living in a rural place.** Living in small (and in some cases isolated) communities influenced the access of services and supports in a variety of ways. For example, a lack of anonymity and dealing with service providers that are sometimes known through family or friendship networks to the person accessing services. On a positive note, several women also identified feeling a strong sense of community and reported that the love and appreciation for the rural community they lived in compensated for their frustrations with the lack of services and/or supports available to them in their community. Several women had moved to a bigger town/city but eventually moved back due to the sense of community. One woman identified a tension between the strong sense of community she felt living in a rural place and her frustration with how under serviced the area is:

*“I loved living there but when I was going through, I guess like realizing the trauma that I had gone through and realizing that there were no supports for me, that’s when I felt especially isolated. And kind of resentful at the same time. Feeling like the community wasn’t doing as much about sexual assault. So, it was pretty emotional to have this place that you love so much, and you feel so connected to and also feel really isolated and feel resentful towards this system you’re kind of stuck in.” (P7)*

Concerns about breach of confidentiality made when accessing services was difficult for some of the women, with some reporting fears of being seen accessing services. One woman reported feeling nervous that somebody would see her entering a service:



*“I would always be nervous when I was going in. I’d be nervous about bumping into somebody I knew if I was leaving. I’d have to really make sure I looked like I wasn’t crying. I would be embarrassed if someone were to see me. There’s definitely some specific issues that you run into when you are living in a rural community as opposed to when you’re living in a more urban community.” (P8)*

Women also reported personal relationships with service providers that made it difficult to access services. One woman had a family connection to the only therapist available in her town, which made her uncomfortable when she was discussing her experiences of sexualized violence. Another woman reported being friends with an intake worker, putting her in the position of having to disclose violence to someone she would not have otherwise disclosed to:

*“Because it was a small town, when I went to the [service] the woman working at the front desk was one of my co-workers. So, it was a little uncomfortable because of that. Not because I thought she would say or do anything awful but it’s weird having to disclose that you need these resources to someone that I wouldn’t normally have told. As a small town it’s also like you can’t escape people and walking down the road you have to say hi to everyone and everything. (P6)*

Several women felt that there was a pervasive culture of silence around sexualized violence in their community, which influenced their ability to access services. Women were aware that sexualized violence was happening in their community, but rarely heard about it,

making them anxious and uneasy seeking services and sharing their experience, as one woman explained:

*“I feel like there weren’t so many stories about sexual assault. Maybe there was like one popping up every year.” (P8)*

It is important to note that the research questions did not ask participants to make any comparisons between rural and urban settings, and results do not draw any comparisons or distinctions between the two. One woman who had also lived in an urban community did identify, however, that she felt violence against women and sexualized violence was much more “out in the open” in urban communities. Another woman identified that being in the town where she had experienced sexualized violence made it difficult to feel ready to seek services or supports because there were constant reminders or triggers of what had happened. This experience may be shared by women regardless of living in a rural or urban community, but this woman did feel that being in a small place amplified the feeling, as there was no “escape”.

Being in a rural area also made the process of navigating services difficult in a practical sense of having very few services available. Several women stated plainly that there were no services to access in their community. Other women reported that while there were general primary care services, there were no specialized options (e.g. trauma therapy, support groups). Women also reported that there was no immediate support. Services had limited hours and women could not access services or supports after hours or on weekends. One woman explained

how there were no services at all in her community and that calling the police in an emergency situation was the only means of getting mental health support:

*“So [community] there’s nothing here. If you need to talk to somebody right now, there is absolutely no help. You could not talk to anybody right now. If you needed to talk to somebody right now. Right? And even if you were suicidal, the only way you’re going to get to talk to somebody is if the police come escort you to the hospital.” (P1)*

Many of the women spoke about their experiences of various barriers to services, but at the same time, there were comments about living in a rural place as a facilitator to access. For one woman, living in a rural area was a facilitator because knowing service providers helped her to get appointments. According to this woman:

*“Because she [provider] knew who I was, she wasn’t sure when the appointment was going to be, but she ended up being able to figure out how to get me in later that day. Because I think she could tell how in distress I was. So, she ended up actually calling me. Again, because we were friends. She was able to call me in bring me in.” (P6)*

Another woman discussed how the support she received from community members removed barriers to service access she was experiencing when she lost her mode of transportation to services:

*“I had car trouble. Every single one of them emailed me to say, can I give you a ride? All of them were really wonderful. Just to have community and how meaningful it was to me to be around a group of women.” (P9)*

**Narratives and terminology surrounding sexualized violence.** Dominant narratives related to sexualized violence influenced women’s ability to feel comfortable accessing services.

Narratives include terminology, ideas about who perpetrates sexualized violence and what “counts” as sexualized violence, media narratives and general stigma. The term sexualized violence has been used throughout this thesis, and in the research and interview questions, because it encompasses a range of different experiences. However, several women reported that they did not feel the term was an accurate way to describe their experiences. Women used a variety of terms to refer to their experiences, including non-consensual sexual experience, sexual assault, rape and date rape. One woman indicated that she thought of her experience as a non-consensual sexual experience and “it wasn’t overly violent”. She did not feel “sexualized violence” services fit with her experience. She indicated feeling “guilty” about using services that were for women who had experienced sexualized violence and that she did not access resources that she needed because of how she understood her experience. According to this woman:

*“I had a hard time feeling like I was entitled to any of the resources that were around. Because it’s always about sexualized violence and that wasn’t exactly how I would have labelled my own experience. It felt like this asymmetry between the two, I guess. And part of it was that I still felt a little guilty around the level of severity of my incident and I felt that there were a lot of other women that were more deserving of those resources. And I*

*think I just carried that guilt and didn't want to seek out the resources that I needed because of that. All of the other resources seemed to be about sexualized violence and I was super uncomfortable with that label.” (P6)*

Other women identified a similar guilt about whether their experience of sexualized violence “counted”; feeling that the violence they experienced may not have been serious enough to warrant seeking services. One woman described feeling guilty learning about an experience another woman in her community had. She felt that she was not deserving of the services she was attempting to access because her experience was not as explicitly violent as others, although she explained that she still knew she should be able to access services:

*“I was like it's okay, I know that my issues aren't maybe as intense as other people, but it doesn't mean that I shouldn't be doing this. It doesn't really matter what happened or what the situation was. It matters how you feel about it and what it is doing to you. Like, if you're able to manage it. That's a very natural feeling to have. This woman was [other experience of violence]. That's crazy. Nothing like that has ever happened to me. I don't feel like I deserve to be taking up this space. But, you know, that's not how it is.” (P9)*

One participant reported that she had trouble accessing services because the perpetrator of violence against her was female. She went to an ER seeking services, but because her experience did not align with the doctor's expectation of who perpetrates violence (e.g. male perpetrator), she was not taken seriously and was not provided with any resources or medical attention:

*“I guess just to stress the point that regardless of where the violence is coming from it should be taken seriously. Like, whether the perpetrator is male or female or whatever. Any of the above. It should be taken just as seriously.” (P7)*

Narratives about sexualized violence can also be perpetuated by the media. One woman was accessing services at the same time that the Jian Ghomeshi case was frequently in the news. Ghomeshi, a prominent Canadian celebrity and radio host, was charged with four counts of sexual assault in 2014. All charges were dropped or withdrawn in 2016. The charges and trials were front page news from 2014-2016. Narratives about the case perpetuated by the media and online/comments and discussion (e.g. the women accusing him were sexually promiscuous and therefore not trustworthy; he was talented and intelligent and therefore was not capable of violence) trickled down into her community, as she explains:

*“When I had been realizing all of this stuff, Jian Ghomeshi was happening. The micro-aggressions I would hear would be like “trigger warning” or “Oh, I just got raped by that exam....” I hear that and it was just like someone stabbed me in the chest. It was so painful. I felt like yelling at that person. But they wouldn’t get it.” (P8)*

She explained that this atmosphere made her more hesitant and scared to access services, as she felt people in her community in general did not take sexualized violence seriously. Another woman said that seeing coverage of high-profile court cases discouraged her from accessing any services, not because of the media discourse, but because of the outcome of the court cases:

*“I heard about how the court system treats women. So, I’m scared they’ll just say oh no, whatever.” (P2)*

## **Theme 2: Process of Navigation**

Women spoke about having to “navigate” services with little or no support. They sometimes experienced significant burdens (e.g. emotional, economic) as they navigated different services. This navigation process included identifying what services were available to them, expending considerable time and work in attempting to access services (e.g. phoning, wait times, travelling, asking for referrals) and decision making between different, potentially undesirable services. Women described the process of navigating services as being influenced by the socio-cultural contexts described in Theme 1 and as being incredibly difficult. The process of navigating services was time consuming, emotionally taxing, and in some cases, economically taxing, with women losing work or housing. The economic and emotional burdens of navigating services were off-loaded onto the women, with some reporting re-traumatizing experiences attempting to access some kind of service or support. Several women reported “giving up” or “settling” for an undesirable or unhelpful service because of the stress of attempting to navigate services.

**Awareness, attempting to access, and decision making.** Every woman spoke at length about the difficulty they experienced identifying what services they were able to access and navigating the process of accessing the service. Women living in rural places have limited options, and they bear the complicated and sometimes re-traumatizing responsibility of making decisions about what services to access and how to access them. Options available to women

included public mental health services, hospital services and, in cases where available, community-based organizations (e.g. women's centres, sexual assault centres). Women in rural areas must navigate and make decisions based on what is available to them. For example, some women only have access to the ER or a walk-in clinic. This is not the service they want to access, but they may choose to access that service rather than travel a long distance to access a more desirable, designated sexualized violence service (e.g. women's center). Women bear the responsibility of identifying what services are available to them (and what those services can offer), attempting to access those services (e.g. phoning, experiencing wait times) and making an informed decision to the best of their ability.

Women reported that they knew little about available services after their experience(s) of sexualized violence and they believe that many women in their community do not know about the services that are available to them. Many women found it difficult to find information about what services were available to them, and only found out about services through friends or "by chance". In cases where they were aware of some services, they did not know what the services would provide. Women did not know where to begin accessing services after experiencing sexualized violence. One woman explained that a period of several months passed between experiencing sexualized violence and making any attempt to seek services, because she had no awareness of any existing services. She reported being surprised to learn that there was in fact a women's centre providing sexualized violence related services:

*"I didn't even know that [women's centre] existed and I've been living down here for a long time. And I only heard about it after, you know, like a couple months. After talking*



*about my issues I had a friend down here say, like, do you know about [women's center], they offer free counselling. I was like, what? I had no idea. I don't know exactly where I would have found out about it other than word of mouth. I don't doubt for a second that there's a lot of people who don't know that the center exists. A lot of them could benefit from it. I was surprised that it existed." (P9)*

Many women reached out to professionals in order to learn what services were available to them in their communities. The first point of contact with service access was often a walk-in clinic, family doctor, or in some cases, an emergency room at a hospital. Women expressed frustration that they were not referred to any additional services or given resources (e.g. web resources, help line to phone) by these service providers. Many felt that these services were not equipped to handle their situation and had little to no awareness of the other services and supports that they could refer women to, and so the women bore the responsibility of trying to navigate services to find what might be useful to them. Several women had frustrating experiences attempting to get connected to services and support through family doctors or walk-in clinics. Women expressed feelings of helplessness when they had reached out to a service in order to receive direction in accessing services (e.g. went to a walk-in clinic or ER hoping to be referred to a sexualized violence specific service) only to be offered nothing. This is exemplified in one woman's experience going to a walk-in clinic to ask the doctor what services or supports she could contact to get help dealing with her experience of sexualized violence. He did not refer her to the free trauma informed counselling that existed in her community. She eventually did access counselling, but expressed frustration that she was not immediately referred to this service, which could have prevented several months of un-managed anxiety and feelings of

depression. She describes her experience with the doctor, after waiting approximately 6 hours in the walk-in clinic waiting room:

*“The doctor there was this male doctor. He had no idea of what was going on. He basically was expecting me to come in with some kind of cold or something. He was just kind of helpless. It was not good at all. I don’t think doctors are really trained very much on how to deal with traumatic, emotional experiences He basically recommended me to the public mental health services. He was like you’re going to have to wait forever. And then he recommended me to a private therapist. But there was no mention of [community based organization].” (P9)*

Another woman echoed a similar feeling about her service provider by stating that “he had no idea of what was going on” in her own experience going to an ER:

*“It just seemed like they didn’t really know what to do with me. It didn’t seem typical of what they normally experienced in the ER.” (P7)*

Women reported feelings of “desperation” e.g. that they felt they would have to resort “extreme” measures in order to access services. Several women felt that the only way to access any kind of mental health supports in their community was to report being suicidal, and that this was unfair because they were still suffering whether or not they were experiencing suicidal ideations. One woman felt that she was being punished for “surviving” in the sense that because she was functioning well on the surface (working, in a successful marriage, parenting), she was not

deemed as deserving of supports, although she was experiencing significant symptoms of post-traumatic stress disorder. Another woman considered pursuing a court case against the person who had assaulted her because she was desperate for some kind of support and thought that being involved in the justice system may open up new avenues to access services. She had prior experience with the justice system and did not want to pursue a case, but felt desperate, as she explains:

*“I was to the point where I was like, do I go and charge this guy? I was like I am not going through all that again. Because I know what the interrogation is like. Been there, done that.” (P1)*

In the process of identifying and attempting to access services, women often had to make decisions about what services they would focus on attempting to access. Women described being presented with two or three options, none of which were ideal, and having to make a calculated decision on which service would be the most effective. In the absence of an ideal and easily accessible service, this decision could be difficult to make as women tried to piece together the best option for themselves. This difficult decision-making process is exemplified by one woman’s experience of having two options: a lengthy wait list for publicly funded trauma therapy, or no wait list for short term counselling through her university. Although she would have preferred to access trauma therapy, and knew that the university counselling would be focused on school related stress and career planning, she felt that receiving support right away was the priority, and so she chose to receive short term counselling:

*“I didn’t know what existed. I just knew, okay these are my only two options. I guess I’ll just do this and then maybe I won’t need this. I had definitely vocalized that I needed*

*more and I just never got it.” (P8)*

**Emotional burdens.** Women experienced significant emotional burdens in the process of navigating services. In the process of navigating services, women may be required to re-tell the story of their trauma repeatedly, which can be re-traumatizing and cause distress. Women felt that services and/or service providers could be better coordinating between each other (e.g. when making a referral, a provider could inform another provider of the woman’s experience with the woman’s consent) and did not think it was fair that the responsibility was placed on the woman. Several women reported that this expectation to re-tell a traumatic event and consequently “re-live” it repeatedly prevented them from continuing to attempt to access services. One woman reported feeling “passed around” by service providers. The expectation that she would continue to re-tell her story to new providers eventually prevented her from continuing to seek resources, as she explains:

*“... in trying to find mental health resources I was still like I don’t really want to be passed around and I don’t really want to have to inform and re-tell the story of every past trauma that I’ve had to every human being that I encounter.” (P6)*

Along with the emotional stress that comes with “re-living” the experience, women reported that they were usually unsure of how people would react to their disclosure of sexualized violence, making re-telling their story a fearful experience. Several women reported that although some family members reacted negatively to their story (e.g. victim blaming, not believing them), they generally felt they could predict friends and family’s reactions, as well as justify negative reactions in the context of their family and friends not wanting to believe or accept that

something bad had happened to their loved one. On the other hand, they felt that it was very difficult to predict how a service provider (who may be complete stranger to the woman) would react, and that a professional responding negatively could be a more emotionally distressing experience than a family or friend reacting negatively due to the power imbalance and your reliance on the provider for help. One woman who had seen a number of health care professionals over the course of attempting to access services described the fear and uncertainty she felt before each appointment, wondering how the provider would treat her. She reported always hoping that she would be referred to a service she had already accessed:

*“I always hope they refer me somewhere I’ve already been. I always hate starting at a new place. You kind of always have to tell your story over and over again. It’s hard. It’s never easy.” (P5)*

**Time, travel and economic burdens.** All women reported some experience with a wait list. Reported wait times ranged from three weeks to a year. One woman was still on a wait list for a publicly funded therapist at the time of the interview; she had been on the wait list for a year and not been followed up with during that time. Some women were so discouraged by the wait list that they chose to seek other services:

*“I think because I was so discouraged by that [waitlist] I didn’t even put my name on the waitlist. I was just like, okay well screw you guys. Not helpful.” (P8)*

In one case, a woman was able to move up the wait list, but reported that she had to go to an “extreme” that shouldn’t be necessary to access basic services:

*“I was on a waitlist for six months. I was told because I wasn’t suicidal and I’m not going to harm anyone, I am not a threat. I am not... basically I wasn’t important. That’s what I said to her. I said I feel like my case isn’t important enough to see somebody. And I also said to her that it was bullshit. Because why is this fair? I’ve been dealing with this for like 30 years. And you’re telling me that I’m not important enough because I’m not suicidal. If anything, I’m like surviving here. You know what I mean? It’s like if you’re not suicidal they’re not going to help you. They almost want you to be suicidal to get the help. I lived with this for 30 something years. How is this fair that you’re telling me I have to wait another six months now that I’m looking for help? I have to wait another six months? And she got me in. I think it was a month or two. But I mean I had to go to that extreme. I had to push for it. If I wasn’t pushing for it, I would have to wait for six months.” (P1)*

In cases where there was not a service to access, some women had to travel to nearby towns. Travel requirements ranged. Two women reported the need to travel but felt that it was manageable given supports in place (bus tickets and cab money provided by the service they were accessing). For other women, travel was a major barrier to accessing services. Two women reported travelling an hour or more for services. In these situations, having a vehicle was necessary. With the exception of two women, no women reported having any access to reliable

public transport. One woman explained the complicated travel arrangements she had to make in order to access services:

*“The closest place would be [small town 15 minutes away] So in [small town] basically you would have the clinic that’s there now. At one point I did actually, when I needed to emergency see somebody, I did travel to [small town an hour away]. So, I would travel an hour away to talk to someone. Then I did the referrals to mental health. And then I travelled to [other town an hour away] because they were the only ones I could get in to see quick. The travel was crazy. If you don’t travel or if you’re in [small town 15 minutes away] you’re stuck. If you need to get to the hospital to see a counsellor, in [town an hour away], you have no way to get there.” (P1)*

Some other economic burdens associated with the process of navigating services were reported.

One woman had to move suddenly in order to be safe from the person who had assaulted her.

While the economic burdens from the sudden move were a result of the violence committed against her, not the accessing of services, she reported that the emergency housing she was provided with through a provincial housing authority was also not safe. She felt that there should be more housing supports integrated into other services. At the time of the interview, she was in the process of navigating multiple health services and non-profit organizations in an attempt to get some support with finding safe housing, describing the process as frustrating:

*“They pretty much say oh here you go. And left me alone. I’ve been fighting since I got in here to get out because it’s not good for me. And that’s a problem I’m having right now that nobody can help me with. I’m stuck. And that’s not fair. But it is what it is. (P3)*

Another woman had to leave her main employment because she had experienced sexualized violence in the workplace. She reported that service providers seemed ill equipped to handle her specific situation, where she wanted to both access services and receive some support leaving her job and/or receiving unemployment income supports. In her experience going to a doctor to ask for help going on medical stress leave, she reported that she did not feel supported and that the doctor did not seem to recognize the distress she was in:

*“I had to get a doctor’s note for my stress leave because the first doctor I saw only signed me off for a month. So, I had to go to my family doctor to get this form signed. She was just like, alright, this form is \$11, what are your symptoms, just like so brutal. They’re not very supportive. Those are sometimes the people that you’re at your last rope trying to reach out to. It’s really important for doctors to recognize that. Like, okay, this is not something that I just need to treat and send a prescription off. This is something that requires a little more care. I’m sure there are lots of doctors who are caring. But, there’s lots of doctors who aren’t.” (P9)*



### **Theme 3: Services and supports that women want to access**

Women were asked to identify what services and supports they would have liked to access after experiencing sexualized violence. All of the women had a clear idea of what service or combination of services they would have liked to access. Women did not speak to informal supports as something they “wanted” to access, rather, they identified that they had accessed a range of informal supports already, but the focus of their needs and ideal services were formal services.

**Long term, trauma informed mental health services.** All women expressed that the service they most wanted to access was long- term mental health support (e.g. counselling, therapy). Women wanted to access long term services that were specific to sexual trauma, or at the very least, coming from a trauma informed perspective. Their conceptualization of what a trauma informed approach would look like also included an understanding of the long-term nature of trauma. Women identified that they wanted to access services without a timeline or set end date (e.g. therapy sessions that last until you are comfortable stopping, rather than 6 sessions). They felt that linear journey to healing or better health did not make sense with how they understood trauma to affect them and their daily lives.

*“To have those people but then to also not expect someone to be better after a short period of time. Because I’ve found with, especially sexual violence and trauma, it’s a lifelong challenge after you’ve been affected by it. So, something that’s more... a support that’s more long term. Yeah, maybe you have so many sessions but then they’re always available.” (P7)*

Women also expressed a desire for a holistic approach to trauma informed practice. In Fallot and Harris’ (2001) five principles of a trauma informed approach, creating safety includes

considering details such as physical space and providing clear and transparent information, even when discussing seemingly mundane or unrelated to trauma details. One participant gave an example of the way that organizations could better conduct intake as a way to create more safety:

*“Waitlists are going to happen unfortunately because the government does not give us enough money to do the work we need to do. But even just little trauma informed things when you’re talking on the phone. Like “Oh I’m so sorry, we’re full right now,” and at least get the persons’ name, their contact information. Offer them a crisis line if they need it. Not just say “No sorry we’re full, try calling in three weeks.” That’s not okay when you’re talking to someone who has experienced something awful. So, I think there are little tiny ways to be more trauma informed.” (P8)*

This woman gave another example of the physical space where she accessed counselling, and made expressed that the space was not trauma informed:

*“...you walk into a waiting room which was very small. And to the left, like right beside the receptionist’s desk, was the office. I was always really aware of that because I didn’t want people to hear me. There wasn’t a radio on that would block anything. Even the way it was designed, it was just not trauma informed. There was absolutely nothing trauma informed about the whole experience, even down to the layout.” (P8).*

In general, women wanted services and supports that understood the all-consuming nature of trauma and respected its severity, even if women were “coping” in a functional sense. One

participant described the ever-present nature of her trauma:

*“I describe as a tumour that’s inoperable on my brain. The trauma is just there and it’s just hard.” (P2)*

Women also expressed a desire for less of a “one size fits all” approach to therapy or mental health supports. Rural places may have a limited number of options of mental health professionals (if any), so women lack the ability to make informed choices about their own care (e.g. different specialties). One woman, for example, had a positive experience with eye movement desensitization and responsiveness (EMDR) and was frustrated that she was not able to access anyone trained in EMDR in her community:

*“...I needed someone who specialized in EMDR and the closest place I could go was [town and hour and a half away]. And then when I started looking through Mental Health and I was looking for someone who specialized in EMDR I found out they are all just starting to take their training. So, I’m like, good! So, there will be more. But EMDR has to be done carefully. I would be nervous seeing someone from Mental Health because they try to get you in and out. If you don’t do EMDR slow, you can retraumatize the client. And that’s one thing that worries me about Mental Health using that. That they would be really quick doing it. But I don’t know because I’m not using their services anymore. I don’t know what they would be like. I think EMDR is definitely something that needs to be more out there. People need to learn about EMDR and see somebody that does do that training.” (P1)*

**Peer support.** Women also identified wanting to access peer support. Some women did access peer support and felt that peer support should be expanded upon and/or more formalized (e.g. a peer support group with a trained health professional facilitator). Peer support is defined broadly as “what we do when we recognise our shared experiences of disadvantage and distress, make an inter-personal connection on that basis, and come together to support and learn from each other.” (Gillard, 2019) Peer workers are people with lived experience of a particular health issue who are trained to provide support and care within a designated scope of practice (Gagne et al., 2018). Peer workers are common in substance use and mental health fields, but there are few examples in the literature of a peer worker/support model for survivors of sexualized violence. Women felt that peers or women with similar experiences would be more understanding and would be able to validate their experiences of sexualized violence. Several women reported feeling “alone” after experiencing sexualized violence, and they felt that having had access to peer support would have lessened that feeling. Two women reported that they specifically felt alone and isolated because they were living in a rural place, and that connecting with other women in the community would have been a huge help, as this woman explains:

*“I do believe that [peer group] would have been helpful. So, I didn’t feel so alone. This isn’t the first time I’ve been through something like this. It’s not that it’s less hard but I’ve been there before. But it is hard every time.” (P3)*

Women also felt that accessing support through peers would lessen some of the anxiety and fear of disclosing sexualized violence and fearing being disbelieved or stigmatized. One woman explained that she would trust a peer worker more than any formal service provider:

*“I think it’s a great idea to have a peer worker here who has experienced these issues. I think that’s the greatest person to get because they know what it’s like. They live it everyday. So, they would know how to, you know, direct somebody else to services or whatever. I think that people do feel comfortable that they’re not alone and these people can relate to them if they’ve gone through similar, you know, situations in their lives too. I would trust somebody more with lived experience than without. One hundred percent.”*

*P5*

**Outreach and extended services.** Several women reported that they wanted to access outreach or mobile services. This was particularly important for women who did not have a community-based organization (e.g. women’s center or sexual assault center) in their community. In the absence of a designated sexualized violence service or women’s centre, they felt that outreach or mobile services would be useful. Women reported not having a car, not having gas money and/or needing childcare as reasons why travelling to another community was not an option for them, and why they wanted to access a satellite or mobile service. Suggestions included having a women’s center in a nearby town provide services on a weekly basis or having services in other communities provide gas money and childcare compensation.

In addition to a desire for more geographically accessible services, women reported wanting more extended hours or “on-call” support. It is important to note that several of the communities where participants live now have a Sexual Assault Nurse Examiner (SANE) program, which provides on-call medical attention and information about resources up to five days following a sexual assault. Not all of these communities had a SANE program at the time

that women were seeking services. Some of the “on-call” services that women would have liked to access (e.g. one woman said she wanted to get a “rape test” but wasn’t sure how) would now be accessible through the SANE program, although women living far from the nearest hospital providing SANE services may still be isolated. Additionally, the SANE program provides immediate response, medical attention and support. It is not intended to provide long-term support and/or support to victims of historic trauma. Women also reported a need for on-call or after hours support for women who may be dealing with historic trauma or dealing with a past incident, such as an evening drop in center or a hotline to call for support. One woman identified a perceived gap in her community, which had a small women’s center and a transition house. While the women’s center was there for support during limited hours, and the transition house was there to support crisis situations or abuse that was “happening right then and there”, there were no options for somebody who was not dealing with current sexual abuse or intimate partner violence and not in “crisis” (e.g. in danger or at a risk to harm herself or others). She suggested an evening drop-in group at the women’s center or clinic but reported that she eventually started to see a private counsellor. There were other reasons for her decision to pay for a private counsellor (no wait list, more specialized approaches), but one reason was her need to have support after hours that she could not get elsewhere:

*“...if you need to see somebody, you know at 8 o clock at night, good luck. Because you can’t speak to your counsellor. Whereas with me at least where I’m now private if I have an issue, I send an email. If I need to talk to her she is there ready to talk to me. You know what I mean? That’s the big difference there. There’s nobody around 24/7. When people need help, it’s usually after hours or the weekend. When people need help. Unless*

*they're abused now, and the person was charged now. But if it's something that's old. There's all these abuse victims that are in their 30s and 40s and 50s that need help and don't know what is available to them for the help.” (P1)*

**Education.** Several women wanted to access education on consent and sexualized violence. This is not necessarily something they wanted to access after experiencing sexualized violence; in most cases women would have liked to access it early in their lives (e.g. in the school system). In one example of this, a woman had difficulty accepting that the violence that had happened to her was not her fault until her counsellor gave her some resources on consent:

*“We didn't get educated on consent in high school and I didn't know until my counsellor gave me a sheet on it that silence is not consent” (P2)*

She felt that had she received this information earlier in her life, rather than once she was accessing services after experiencing sexualized violence, some of the intense feelings of guilt and shame she had experienced would have been alleviated. Other women who reported wanting more education also expressed a regret that they were not more aware of consent prior to experiencing sexualized violence. Several women reported that it took them a long time after experiencing sexualized violence to understand it as such and felt that education could have shortened that process and allowed them to start seeking services sooner. One woman described this as being “blinded by ignorance”:

*“I didn’t feel like my public education addressed the idea of consent. At all. If you’re not brought up being aware that everyone has the right to their own personal space, then how can you know? Kind of like blinded by ignorance... there were a lot of instances where I was assaulted or bullied or what have you and didn’t even realize that it was wrong. I knew that it hurt but I didn’t realize that someone was doing something illegal per se.” (P7)*

Another woman described this as the “normalization” of sexualized violence and felt that education directed to women at an early age would have helped her move past that and understand experiences she had as violent:

*“There’s a lot of young women who would benefit from having guidance at a young age...It [experience of violence] made me think about how much I have let go or let slide with how men have treated me. I had no guidance whatsoever. No one ever gave me any information on sex or anything. There was no support at all.” (P9)*

#### **Theme 4: Services and supports women accessed**

In general, women had positive experiences with community-based services and negative experiences with non-community-based services. Women reported several negative experiences with non-community based services (police, publicly funded mental health support, hospital services) including negative attitudes of service providers (e.g. victim blaming, judgmental) and an inability for the services to properly deal with sexualized violence (e.g. focusing on other health issues, services unaware of other resources for women who had experienced sexualized



violence). Several women articulated their experience with non-community based services as explicitly “not trauma informed”. In contrast, community-based services (women’s centers and sexual assault centers) were described as “trauma informed”. Women reported positive experiences including positive attitudes of providers at the community-based services (e.g. nonjudgmental, supportive, kind) and the ability of the service to provide resources and support directly related to sexualized violence. There were exceptions to this generalization, however in most cases the negative experiences with community-based services were related to wait list or capacity constraints, rather than the staff or programs of the service.

**Non-community based.** Several women reported interactions with the police and/or justice system. One woman had a positive experience receiving funding through the justice system, although she noted that the funds were not well advertised. She also felt that receiving these funds should not be contingent on having someone charged (e.g. there should be additional funding and resources for victims who either do not want to pursue a court case or do not have a successful court case) Two women had experience with the police. One woman was supported by her (community-based) counsellor to make a statement to the police several months after experiencing sexualized violence and felt positive about the experience because of the support of her counsellor. One woman went to the police immediately after the experience and had a re-traumatizing and negative experience. She requested a female officer and was denied, which she explains made her feel unsafe and uncomfortable:

*“I went there and I asked for a female and they said they didn’t have any on staff. When I called originally and said I wanted to report they told me they did. But when I got there,*

*there wasn't one. And I got a guy, for one. And I didn't feel comfortable telling him what happened to me, but I did. All he told me was that the interview was being videotaped and it was just him in there with me. By myself with a man. After what I went through, that's not right." (P3)*

The officer who took her statement actively blamed her for what had happened, making her feel worse:

*"And he said to me at the end of it are you sure you didn't get your period and pull your pants down? That's what he said to me. For anyone to go there and tell them that and get "Are you sure?". Uh, yeah. I'm pretty sure I didn't do that, thanks. It irritated me. It made me feel angry. It made me feel like they didn't care. That I was lying. So, I didn't really go any further after that with trying to get this person charged. I don't even know who did it. I don't want to be talked to like that. You know, that is a horrible thing to have to go talk about. And then when you get asked are you sure this is what happened. I didn't do this to myself, so? It made me feel worse." (P3)*

This woman also reported that she was not offered any health services by anyone in the police department, adding to the negative and uncaring attitude displayed by the police:

*"I wasn't even offered services, that's the worst part. The cops didn't say anything. I got nothing. Maybe it's just that particular officer, I don't know. I got nothing from that. I went home and walked home crying alone. That's what I did. That's horrible. They didn't*

*give me any information. They didn't even tell me about the sexual assault center. They treated me like they didn't even care what I had to say. And that was awful. I hope another woman does not have to go through that. It is re-traumatizing. It makes you feel worse. It's really, really hard to get help in the first place. Anything like that. When you feel like you're just being treated like you're nothing it's not a fun feeling. Or they don't believe you. It feels like nobody really cares. And what happened to you was brutal and wrong and against the law." (P3)*

Women experienced similar negative and harmful attitudes from staff and providers while accessing non-community based (e.g. hospital based) health services. Several women reported that the therapists provided to them through public mental health services were not able to provide them adequate support for dealing with their experience(s) of sexualized violence. Women reported feeling blamed and judged for what had happened to them, and felt that although these health professionals (therapists, counsellors) were trained to treat trauma, they seemed uncomfortable with discussing and treating trauma stemming from sexualized violence. Several women explicitly named the experience of accessing mental health supports as traumatizing or re-victimizing.

This feeling was exemplified by one woman who had been seeing a therapist prior to experiencing sexualized violence and experienced a change in the quality of the service she was being provided once she disclosed the experience of sexualized violence. She reported that he was able to talk about the "family trauma" she had originally sought out support for, but was not supportive or caring when she disclosed her experience of sexualized violence:

*“I told him what happened and I think almost exactly after I told him what happened he received a phone call and proceeded to answer it. Which would happen quite often in our appointments. He was okay with the family trauma stuff that I was talking to him about. But when I had to talk to him about the sexual violence and stuff that was awful.” (P6)*

This woman reported several traumatizing experiences with this provider, who she felt was not trained to address sexualized violence with a trauma informed lens. In one example, she expressed hurt that a friend of hers had displayed victim blaming attitudes when she told her friend what had happened to her, and her therapist mirrored the same victim blaming sentiment immediately after:

*“I told him about how I ended up telling my friend what had happened to me and my friend kept saying something like “Well what would you do differently next time” because that’s her response when bad things happen. Like you can only control yourself. I’m like, no, in this instance, there wasn’t much I could have done differently. This was not a me thing to control. And I said that to this therapist, and he said, literally right after I told him that I didn’t like that my friend said that, he said “Well what would you do differently next time?”. I was like, okay! Then later on he said something like that I made myself open to the experience and stuff.” (P6)*

Another common experience was therapists and other mental health professionals not focusing on the experience of sexualized violence and the resulting trauma. Women reported accessing services explicitly to “heal” from the experience(s) of sexualized violence, but several women

found that the service they were provided ended up focusing on other stressors, goal setting, career planning and school, as one woman explains:

*“She didn’t focus on the things that I wanted to talk about and vent out and get out. She just focused on me graduating and travelling and not the traumatic events that happened. So, I was just like no, I don’t want to go further with this therapist. And so then after that I just kind of gave up on any sort of support. Therapy, anything.” (P2)*

Another woman reported feeling satisfied with the support she received at the time, which focused on setting goals and career planning. She felt that focusing on her future did “get her through it”, however, looking back on the experience at the time of the interview, she realized that the complex trauma was never really addressed:

*“She directed my pain into, like “Okay, well what do you want to do with your life?”. She kind of ignored that I was going through a trauma and kind of tried to redirect it into a goal-oriented strengths-based thing. Like, what I wanted to do with my life. Which was kind of interesting, because at the time, that’s definitely what got me through it. Re-focusing on myself. You have to figure out what you want to do with your life. But, I just feel like now that I’m reflecting on it, she didn’t actually focus so much on the sexual assault. And maybe that’s because it wasn’t her background at all. We ended up doing like, career tests and personality tests. Which had nothing to do with my sexual assault so it’s kind of funny to think about now. It wasn’t focused on the trauma at all.” (P8)*

Another woman reported that her therapist focused on everyday stress related to work and family, but she could identify that the stress was related to the experience of sexualized violence. The connection between the trauma and the day to day stress was not addressed in therapy:

*“I don’t even think I spoke with them about the sexual abuse. It was just like, everyday stress. But I was stressed out because of the sexual abuse. And so, even with them, you talk through it but to me I found it didn’t really help” (P1)*

In one case, a woman was referred to a talk therapy group for LGBTQ+ young adults, because she had disclosed her identity as queer while accessing services. She reported that the experience of sexualized violence “never came up” and the focus was on LGBTQ+ identity and living in a rural place as an LGBTQ+ person. She did find some aspects of the support generally helpful (e.g. having someone to talk to, meeting other LGBTQ+ people in the community), however said it was not at all what she was looking for, and felt that she was referred there because it was all that was available in her rural and relatively remote community.

One woman reported a positive experience with a doctor at a hospital-based services but identified it as an “exception to the rule”. Her experience demonstrates the value of a trauma informed approach:

*“I’ll tell you one thing that actually just changed my whole outlook and gave me a lot more hope was when that doctor told me, “Wow. This is what trauma does. I’m so sad to see this right now.” Like, no doctor has ever said that. They say “Oh, she’s here again.”. Which is not nice. But that gave me hope.” (P5)*

She reported that having her trauma acknowledged in that way motivated her to seek out other community-based resources and advocate for herself with other providers:

*“I thought, you know what, let’s try and stay away from the hospital. Let’s try and find some resources outside of the hospital. And it’s actually pushed me forward too to stand up more for my rights and not just let everything steam roll over me. We don’t think we’re worth it. People who’ve been traumatized. But we are worth it. We’re human beings and we are worth it. And I don’t want to suffer anymore. So, I’m doing the things that I know will help me take care of me and move forward from there. Because you know what? Life is so short.” (P5)*

**Community based.** Women reported mainly positive experiences accessing services through community-based organizations (e.g. women’s centers and sexual assault centers). This was due in large part to positive attitudes of staff and providers of the community-based organizations. Women reported feeling safe and described staff attitudes as non-judgmental, supportive, friendly and kind. Women also felt that community-based services were “easy” compared to accessing non community-based services. This reported ease had several meanings for the women. Several women felt that community-based services were straight-forward about what their services were and what they could provide, including what they could not provide and what their wait times were like. Women who reported this appreciated the transparency and felt more comfortable going to therapy or other appointments with an awareness of what to expect. One woman expressed that her lack of formal education had made accessing services (related to

sexualized violence and other wise) difficult. She felt that the staff at the community-based service made an effort to be clear and straight-forward about what they could provide:

*“When they referred me to this person at [CBO] that’s when my whole world opened up. They’re very friendly out there. They’re really good. They explain things if you don’t understand it. You know, I left home when I was 14. So, I didn’t get the education my kids did. So, yeah, like when you don’t understand something they’re very good at explaining it. (P5)*

Another reported “easy” aspect of community-based services was that the environment (e.g. going to a women’s center rather than a hospital) was comfortable and removed some of the fear that comes with disclosing and discussing sexualized violence. Women who had accessed services at women’s centers reported that the explicitly feminist mission and values of the centers made them comfortable and made talking about their experiences of violence “easy” because they could anticipate that the staff and providers would respond in a supportive and validating way. This validation and acceptance was important for several women, with some reporting that it “saved their life”, and/or attributing their positive current situation to the community-based organization:

*“I’m doing a lot better now. It’s positive. It really is. I don’t know what I would have done without my trauma therapist from [CBO] last year.” (P3)*



Several women explicitly praised their local women's center staff and asked for more funding for their local women's center when discussing the service they had accessed, which could be a testament to the value they see in the services the centers have provided to them and their community.

Women did report some negative experiences accessing community-based services. One woman reported that a lengthy wait list prevented her from accessing a community-based service. Another woman reported having to go to several intake appointments with different staff before being able to access a service. Although she was ultimately satisfied with the care she received, and praised the attitudes of the staff, she expressed frustration that the process was not more organized.

**Peer support.** Several women accessed peer support. Peer support is distinct from the informal support of friends and family as it involves some kind of training or formalized delivery. Women reported accessing peer support through either trained peers or a support group facilitated by a health professional. Women who accessed peer support felt an added level of comfort, validation and respect and felt that they could "be themselves". One woman who had accessed a trained peer worker felt that she had to put on a different persona when accessing services provided by professionals. In contrast, she described peer support as comfortable and non-judgmental because she knew that she had shared experiences with the peer:

*"We [peer worker and participant] share a lot more things because we were perpetrated also. When I was younger. Then when I was older, raped also. So, I don't know. I feel more comfortable around people that can understand. Because then I feel like I have to*

*put on this kind of persona of who I'm not. And that doesn't feel comfortable to me. You know, if I was in crisis, I wouldn't call the crisis line. That's just not helpful. A peer or friend, yeah. I'd call them before I'd go to the hospital." P5*

Several other women also reported the value of getting support from somebody with a shared experience of sexualized violence. One woman described peers as “lifting each other up” and felt that it was “less pressure” than one on one therapy because peers would also share their experience. She also felt that accessing peer support removed some of the power imbalance present in a formal therapeutic relationship (noting that this group did have a volunteer facilitator with some training):

*“[Peer support] is nice because it's real people with real issues without any money involved. There's no like, I'm paying you big money, help me. I'm a human being. You're struggling and I'm struggling. Let's listen to each other and help each other get through this. It was really helpful to have someone there to kind of guide it. But we would always go around in a circle and talk about an experience. She was really good at just letting the conversation flow.” (P9)*

All women who had accessed peer supports found accessing peer supports helpful, however, they noted the limitations of peer support, which included an inability for peer support to provide them with clinical or medical care, as one woman described:

*“It was helpful. You could really tell that they cared... But it’s just not helpful in that it wouldn’t lead to any type of diagnosis or like medical professional recommendation. Or prescribing of something. Or anything longer.” (P7)*

Some women had suggestions for ways to close the gap between peer support and formal services, such as hospital-based services hiring and training peers who could provide support and offering a facilitated peer support group as an alternative to trauma informed therapy for women who would be more comfortable accessing support that way. These suggestions focused on “formalizing” peer support in order to increase peer’s capacity to make referrals or connections to formal services, while still having programs delivered by peers.

**Informal supports.** Women accessed a variety of informal supports after experiencing sexualized violence, such as friends and family, spirituality and advocacy. In general, women felt positively about accessing informal supports, but reported that they could not replace formal services insofar as they could not provide long term professional care. There were other limits to informal supports as well. All women reported relying on friends and/or family/chosen family in some capacity. In many cases, friends and family were able to provide support. Women felt that people who loved them wanted to support and care for them. At the same time, many women (including women who felt positively about the support family and friends had given them) reported complicated experiences relying on friends and family for support. Family and friends’ ability to provide support was limited by their own experiences and biases, their capacity to provide support and by women’s desire to “protect” their family and friends from their suffering. Women felt hesitant telling some family and friends, particularly parents, because they didn’t

want to burden or “worry” them. They felt that knowing the violence they had gone through would hurt their family and friends. In some cases, women reported being dismissed or disbelieved by friends and family initially, but eventually receiving support after their friends and family had worked through their own immediate reactions. Some women reported that their friends were not able to provide support because they had their own experiences of sexualized violence. One woman explained her experience looking to a friend living in a rural community for support, and how her friend’s capacity to support was limited by her own experiences:

*“...it was such a bad experience. And I probably should have anticipated that. The person that I told was actually from a rural community too. She was a very close friend and she still is. And she kind of like ignored it. Minimized it. Wasn’t supportive, wasn’t open to hearing my story. Just kind of brushed it off. I only came to learn a few years ago that she had actually also been someone who had experienced sexualized violence and she just wasn’t ready to hear my story. That was at first super hard on our friendship because I thought she just didn’t want to hear it. But it was because she had also experienced something like that.” (P8)*

Women reported participating in advocacy (e.g. volunteering, activism) as an informal support. Not all women used the word advocacy. Some women did, and expressed it explicitly, as did one woman who described getting involved in activism and advocacy related to sexualized violence as a “huge” part of her “healing journey:

*“I think a lot of survivors kind of move that way towards advocacy and just how powerful resiliency can be when it turns into social action. It took me a few years to get into that. I think that’s been a huge part of my healing journey. I’m definitely more vocal about my experiences now. I think a lot of women who experience sexualized violence, or anybody can find moving into more advocacy or working in a community that’s also experienced it can be really powerful and therapeutic.” P8*

Other women did not use the word “advocacy”, but they described a range of experiences of helping other women in their community and/or raising awareness. One woman ran an online group for women in her community where she shared daily affirmations and other content she thought might be useful, such as a videos or articles about recovering from trauma. Women in the group had given her lots of positive feedback about how much the group had helped them. She acknowledged that it could not replace professional help, but could provide support for women in the moment who may not have a professional to call:

*“I have a Facebook group...I would never say no don’t go get professional help. Do the two things together. Because they compliment each other. So, when you’re going through an anxiety attack and you don’t know what’s going on, that means you can do that [use the Facebook group]. If you need somebody, they’re there. Like okay, so you’re having a panic attack. Try this. Or try some breathing exercises. Or here, go to youtube and do this quick meditation. It’s just like that. And I’m trying to promote that in the area. Even if it helps just that one person.” P1*

Another example of advocacy reported was participating in this research study. One woman described her advocacy as pursuing opportunities to speak about her experiences, citing responding to the recruitment poster for this study as an example. She reported that the benefit was two-fold – it helped her to talk about her experiences, and she felt it would help other women to continue to share their experiences. Pursuing a career related to supporting women who have experienced sexualized violence was discussed by several women, with the same “two-fold” benefit reported (e.g. helping other women would also help their own healing journey). Two women were actively working and/or studying to work in a related field and one younger woman expressed hopes to eventually study to become a counsellor for women who had survived sexualized violence.

Women also found ways to use their experiences of accessing services to help other women who had experienced violence and were trying to access services in their community. Women saw this as a support because it helped them to feel that both their experiences of sexualized violence and their experiences accessing services could be channeled into something positive and productive. One woman created a resource “file”, with details about each service she had accessed in her community. She described how creating and sharing the file helped her own growth and made her own process of healing “a lot easier”:

*“I’m actually glad that I have been trying to access supports because it really helps me support others too. I’ve been researching some different places when I’m at home and I write them down just in case. I’ve got this little file, so like if you need this help you go here. One of my friends needed – she has no doctor. Somebody who’s suffering from abuse who’s 30 needs a doctor. She’s having a difficult time. I told her you can self-refer*

*at [clinic] and they will set up an appointment with you and say everything. Don't hold anything back. They will know best how to help you if you're not holding anything back. This has been my life. This is what I've been able to get help with and this is what I haven't been able to get help with. It helped my own growth. Yeah, one hundred percent. We all learn from each other, right? When you're helping someone who has similar life experiences to you then it's a lot easier to be honest."* P5

In another example, a woman informed the community-based organization in her community about negative experiences she had with local hospital-based services, as she describes:

*"I also told [service provider] about how my therapist at the hospital hadn't been incredible. And I told her that not because I wanted to call this guy out but because I thought that the [CBO] in general should know so that they know not to send people his way. Because I didn't feel comfortable enough having a conversation about it with him. So, I ended up talking to her about it instead. So that was super helpful and it made me feel good. I was never able to confront the dude that did this to me, but it felt good to do something that felt productive."* P6

Women also shared other "unconventional" informal supports that they accessed after experiencing sexualized violence. While these supports may not have directly addressed or related to the experience of sexualized violence, women identified them as supports that played a big role in healing. Some commonly reported supports were a connection to or practice of spirituality, meditation and yoga or other forms of exercise. Other supports reported were tarot

cards, volunteering for a local political party, making art and music, and reading books about consent and feminist theory. Several women expressed a hope that formal services might integrate these kinds of supports into their programming. Women acknowledged that, on their own, these supports were not adequate, but that formal services might benefit from taking a more “holistic approach” to wellness and incorporating other support (e.g. offering a trauma informed yoga program to complement therapy).

A common thread among reported “unconventional” supports was the ability of these supports to provide women a sense of autonomy and control that was violated when they experienced sexualized violence. Through meditation, or playing music, or exercising, women felt that they were in control of their body and their emotions. This feeling was best described by a woman who reported getting a tattoo as a helpful informal support. She described how the tattoo artist asked for permission each time the artist touched her and clearly described where she was going to touch her and what the touch would feel like (e.g. “It’s going to be this area on your leg that I will touch. You’ll feel certain tugging or pulling motions like this.”). Once permission was given, the artist continually checked in, and after she took a break, the artist did not assume permission was still given, and again explained where and how she would touch her and asked for permission to do so. Her tattoo artist modelled asking for consent, and in doing so, empowered her to feel in control of her body. She describes the impact of this experience:

*“I felt so seen and so understood and I felt so empowered in those moments. I think I ended up crying while the tattoo was happening, but it wasn’t because I was in pain at all it was because I genuinely felt so good. You are having an experience where you realize that you’re allowed to have, and you should have someone asking for consent at every*



*moment of touching your body. You should feel comfortable asking for those things. She made me realize that through that process. I was practicing things like consent in a way that I wouldn't normally be able to. Just because you know there are so many social pressures and expectations when you're in very serious positions in life.” (P6)*

She acknowledged that getting a tattoo was an unconventional support, and not a support that would benefit all women. However, she felt that the value of the experience that came from having a space to practice consent and control over her body, and that these spaces could be cultivated in both community and non-community based services, as she explains:

*“I know that [getting a tattoo] is a very niche and particular way of doing it. But I think having experiences like that where you can have some type of safe space where you practice consent or you show people how much control they have or are allowed to have over their own body is an empowering thing. I don't know how you would go about doing that other than tattoo which, again, is not the best way. But maybe having stuff available like that would be good.” (P6)*

This sentiment was reported by other women, who felt that while yoga (for example) may not appeal to all women, having space to reclaim control over their body was important to them, and the idea of having activities that encouraged autonomy delivered in a safe space could be applied to both community and non-community led programs.

## **Chapter 4 Summary**

Women shared experiences of navigating a fragmented and complicated system of health and social services. This process of navigating and accessing services was influenced by women's local community context as well as the broader discourse surrounding sexualized violence. While access to non-community based services was generally poor, women shared some positive experiences accessing community based services such as a women's centers and sexual assault centers. Women also shared their experiences accessing informal supports. Women displayed strength and resiliency in their efforts to find and create spaces for support, in many cases becoming an advocate for other women in their community in the process. Women shared a number of suggestions to improve access in their communities, many of which focused on adopting a holistic, trauma-informed approach to care.

## Chapter 5: Discussion

### Summary of findings

The purpose of this research was to understand what services and supports women who have experienced sexualized violence in a rural place want to access, attempt to access or have accessed, what barriers and facilitators to access women experience, and what services and supports are needed in rural places to respond to sexualized violence. Generally, women wanted and attempted to access long term mental health services and supports, including peer support. Many of the barriers to access women reported aligned with the existing literature. The main barriers to accessing services and support identified in the existing literature were stigma, fear of victim blaming or re-triggering or traumatic experience, lack of awareness of services and “bureaucracy” related barriers (e.g. waitlists, multiple phone calls needed to access) (Logan et al., 2003; Logan et al., 2005; Campbell et al., 2001). All of these barriers were reported in some way by the women who participated in this research. Reported barriers and facilitators were consistent with barriers and facilitators in the existing literature (Logan et al., 2003; Logan et al., 2005; Campbell et al., 200; Zweig et al. 2002), however there were several potentially unique findings relating to the socio-cultural context of access as a barrier, the difference in access experience between community and non-community-based services, and the difficulty of navigating services. Additionally, women reported a number of suggestions for what is needed in rural places to respond to sexualized violence that are potentially unique. This chapter will discuss these findings and their significance for health promotion.

## **Barriers and facilitators to access**

**Socio-cultural context.** Results suggest that the socio-cultural context in which women are accessing services can act as a barrier or a facilitator. This includes both dominant, macro level narratives about sexualized violence and local, micro level attitudes towards sexualized violence. Resnick et al. (2000) found that women were more likely to access services if the assailant was not known to them, if they reported the incident to the police and/or they were not using drugs or alcohol at the time of the experience of sexualized violence. This aligns with this study's findings that narratives surrounding sexualized violence and the perpetuation of the 'rape myth' can act as barriers to access. These pervasive ideas about what sexualized violence is and isn't have been referred to as the "rape myth" in sexualized violence literature. Heath et al. (2013) described the elements of the "classic rape" or "rape myth: "abduction, the perpetrator being a stranger, severe force, and serious injury" (1066). Whatley (1996) found that third party observers (e.g. people who have not experienced violence) are more likely to see the "classic rape" as a crime, and more likely to ascribe blame and responsibility to victims of sexualized violence outside of the "classic rape". Although all widely available statistics on sexualized violence point to perpetrators most often being known to the victim, women's reported discomfort with terminology, feelings of being undeserving of services, and comparing their experiences of violence to other "more severe" experiences suggest that internalization or acceptance of the "classic rape" myth is a barrier to service access.

This discomfort with terminology is consistent with Logan et al.'s (2005) findings that some women felt that terms such as 'trauma' and 'crisis' did not align with their experience of sexualized violence. This made women unsure which services they could access. Logan et al. also found that women felt guilt about the relative perceived severity of their experience of

violence and were not sure if they “deserved” to access services, which was reported by several women in this study. Interestingly, although Logan et al.’s study interviewed both rural and urban women, only urban women reported these narrative/’rape myth’ related barriers. Rural women reported community stigma and people in the community not talking about sexualized violence as context-related barriers, both of which are consistent with findings of this study. Logan et al. state that “...differences in barriers to service utilization that were mentioned only in rural areas and some that were mentioned only in urban areas may suggest that community context is important to consider in understanding barriers to service use.” (610). Results of this study are consistent with this recommendation, but suggest that broader cultural narratives surrounding sexualized violence will interact with rural, community context.

**Community and non-community based.** A unique finding of this study was how barriers and facilitators were experienced differently between community based and non-community-based services. All of the barriers identified in the existing literature were reported by women who participated in this study, particularly stigma, fear of victim blaming and fear of a re-triggering or traumatic experience, lack of awareness of services and “bureaucracy” related issues (e.g. wait list, needing to call multiple times to access a service). Existing literature primarily focuses on women who had accessed one service (e.g. all participants accessed the same clinic) or women who had primarily accessed formal services (e.g. hospital, clinic, police). One study (Campbell et al. 2001) interviewed women who had accessed one or more of five service “systems”: legal, medical, mental health, rape crisis centers and religious communities. They found that women who accessed rape crisis centers (defined as a designated, community-based service providing education, referrals, and advocacy), mental health professionals and/or religious communities did

not report as many gaps (e.g. providing information and resources, follow-up care) in service delivery as women accessing medical services (e.g. hospital). Women also ranked their service contact experience on a scale ranging from “very hurtful” to “very healing”. Women overwhelming reported their contact with rape crisis centers, mental health professionals and religious communities as very healing, while about half of women who accessed medical or legal systems reported that contact as healing, the other half reporting it as hurtful. (1250). Campbell et al.’s finding that women have more “healing” or positive experiences with community-based services is consistent with the findings of this study, however, women interviewed for this study did not report consistently positive experiences with mental health professionals. Positive experiences were only reported with community based mental health professionals, a distinction that Campbell et al.’s findings do not make.

Although the existing literature does suggest a distinction between community based and non-community-based services, the findings of this study make the distinction very clear and provide detail about what makes women’s experiences with community-based services positive. Because this study recruited women who had accessed or attempted to access any service or support after any experience of sexualized violence, women spoke to a range of services. Many women attempted to access both community and non-community-based services. Generally, women experienced many barriers when accessing non-community-based services. The most common barriers experienced were fear of a negative experience (e.g. fear of not being believed or being blamed for the experience of violence), lack of services, lack of awareness of services, wait lists and negative staff/provider attitudes. These barriers align with barriers identified in the existing literature. Women experienced very few barriers to access when accessing community-

based services. All of the reported barriers to accessing a community-based service were related to wait list/program capacity or travel (e.g. the community-based service was not in the woman's home community). Women also reported a lack of awareness as a barrier, although when discussing CBOs, they were referring to a general lack of awareness (e.g. did not know the center was in their community) rather than a lack of transparency on the part of the service (e.g. service does not make women aware of what they can offer them), which was experienced with non-community based services. Women reported several facilitators to access community-based services, namely positive staff attitudes (e.g. non-judgemental and supportive) and a general trauma informed and individualized approach to services.

These results suggest that community-based services remove or mitigate some of the barriers commonly experienced by women accessing non-community-based services by virtue of their model of service delivery. All of the community-based services women reported accessing have an explicitly feminist mission and/or value statement that recognizes women as experts on their own lives and centers clients' experiences and wishes. They also have designated sexualized violence services. Women did not report any barriers to accessing community-based services related to stigma, victim blaming or a fear of a re-triggering or traumatic experience. They reported the opposite – that they felt validated and heard and that they did not experience fear or anxiety accessing the service because they could anticipate a positive reaction. These results suggest that women are more comfortable accessing services after any experience of sexualized violence from a community-based service that is designated to deal with sexualized violence, or is at least a designated women's centre, and that the most commonly reported barriers in existing literature can be mitigated by focusing on community-based services. This

highlights the value and importance of these services. Investing in community-based modes of service delivery could potentially reduce barriers to access.

Women reported several barriers specific to living in a rural place, including a lack of services to access, travel of up to two hours to access services, and non-community-based service providers in their community not being equipped or trained to deal with sexualized violence. Considering these barriers, community-based services may be especially important to improve access in rural areas. Women who lived in communities with community-based services generally felt that accessing a community-based service removed some of these barriers, although there were still issues with waitlists. Women in communities without a community-based service expressed a desire to access such a service, reporting feeling alone or isolated. In general, these results suggest that these community-based services are not “add on” or additional specialized services; rather they can remove barriers to access and provide women with the service they are ideally able to access.

### **Health service navigation**

Health care or health service navigation is a field that is growing in response to increasingly fragmented health care models. Health navigation or “patient navigation” programs aim to reduce barriers to accessing health care such as lack of awareness of services, low levels of health literacy, logistical barriers (e.g. transportation), and difficulty negotiating/maintaining relationships with providers. (Carter et al. 2018; Dohan & Schrag, 2005). Health service navigation emerged in cancer care and has since expanded to a number of areas of healthcare that involve “complex” clients/patients, or patients whose health care and social support needs are



complex enough to span multiple fragmented services. In a scoping review of 34 papers that included a navigation program involving both the health care system and community-based services, Carter et al. (2018) reported a range of “complex” patient health issues, the most common being chronic disease and mental health and addictions. There were no examples of survivors of sexualized violence as a patient population identified in this study or elsewhere in the existing literature. There is one example of a navigation program for survivors of intimate partner violence (IPV) in the existing literature (Kramer et al., 2012). Women experiencing IPV may also experience sexualized violence, and vice versa, but the two populations may have different service needs.

A significant and potentially unique finding of this study was the difficulty women have navigating services. Women’s experiences would suggest that they can be considered “complex” patients: every woman interviewed expressed a desire or need to access a range of services, including mental health counselling, medical attention, peer support, police, justice system, education, housing support and employment supports. Women’s experiences also suggest that they experienced barriers identified by the health care navigation literature. Almost all of the barriers listed above (lack of awareness of services, logistical barriers such as transportation, and difficulty negotiating/maintaining relationships with providers) were reported by women. A low level of health literacy was the only barrier not reported by these women, although women did report difficulty understanding what each service could provide them. Many women shared experiences of clinical or non-community-based services having little to no awareness of what community resources were available to women, including having a doctor tell a woman to pay for a therapist when there was a free, trauma-informed sexualized violence therapy in her community. Some of women’s experiences highlight service navigation issues unique to this

“patient” population, such as a lack of coordination between police, justice services and health services and a requirement to re-tell the story of their experience of sexualized violence. Women found both of these experiences distressing and re-traumatizing.

Navigating services also took an economic toll on women. Logan et al. (2005) reported that rural women were more likely to experience lack of personal resources (e.g. income, housing and transportation) as a barrier to services than urban women. This study cannot draw any comparisons between rural and urban women’s experiences; however, women did report trouble accessing both housing and employment supports. They also reported childcare and gas costs as barriers to accessing services. These findings suggest that women who have experienced sexualized violence are complex patients who are bearing the emotional toll and economic costs of navigating a fragmented health care and social support system. A patient navigation program could benefit women who have experienced sexualized violence. According to Wells et al, (2018), patient navigators services can include making arrangements (e.g. arrange child care), making referrals to services (e.g. refer to counseling), provide treatment support (e.g. provide support during treatment related decision making), care coordination (e.g. attend appointments) and basic navigation (e.g. identify patient needs).

### **Alternative supports**

**Peer support.** Women generally reported wanting to access peer support. There is limited discussion in the existing literature on peer support for women who have experienced sexualized violence. Logan et al. (2005) reported that women listed peer support as one of their suggestions for future service development. The Canadian Agency for Drugs and Technologies in Health (CADTH) conducted a systematic review in order to identify any examples of peer support

programs for adults who experienced sexualized violence and establish evidence-based guidelines for such programs, but they found no relevant publications after screening literature (CADTH, 2017). Although peer support programs have been adopted in other fields, such as mental health and addictions (Tracy & Wallace, 2016), there seems to be relatively few established programs in the field of sexualized violence. Despite this, several women in this study did access peer support in their community. They felt that speaking to someone with lived experience was helpful. They described feeling validated, supported and comfortable. Although some women expressed that they were more comfortable speaking to a peer than a ‘professional’, women also felt that the value of peer support could be limited by its capacity to refer to clinical/professional services (e.g. referrals, prescriptions, diagnosis). This implied that there is a desire for peer support to be delivered in partnership with a formal service. These insights are a potentially unique finding of this study.

**Informal supports.** Women reported accessing a range of informal supports. All women reported accessing family and friends for some support, which is consistent with existing literature (Milliken et al. 2016; Starzynski et al., 2005; Ullman & Filipas, 2001). Existing literature also supports the finding that women had both positive and negative experiences accessing support through family and friends. A number of other informal supports were reported, including advocacy, spirituality/meditation, exercise, and receiving a tattoo. Some of the informal supports women reported are consistent with the literature. There are several studies on yoga/other forms of exercise (Crews et al., 2016; Stevens & McLeod, 2019) and spirituality/meditation (Kane, 2006; Knapnik et al., 2008) as informal supports. Existing literature also discusses the history of getting tattoos as a mode of self-empowerment and bodily

control, although these articles do not focus on women who have experienced violence specifically (Atkinson, 2002; Leader, 2016; Struebel & Jones, 2017). While these supports were consistent with the existing literature, a potentially unique finding from this study was a desire to have these supports integrated into formal services. Women reported that these supports were beneficial and may be filling a gap in their rural community (e.g. no women's center). They also expressed a desire for formal services to take a more "holistic" and "collaborative" approach by incorporating informal supports into their programs.

Women who experienced sexualized violence participating in advocacy as a support is also a potentially unique finding. Rath (2001) interviewed rape crisis center volunteers and found that several women were motivated to volunteer by their own experiences of sexualized violence. These women felt that volunteering was part of their own healing process. Hargrave et al. (2006) similarly found that volunteers with victim support groups often had their own history of sexual trauma. This is consistent with findings from this study. Several women reported volunteering and/or pursuing a career in supporting survivors in sexualized violence as part of their own process of accessing support. Women also reported modes of advocacy that are not presented in existing literature, including maintaining a 'file' of local services and resources to share, participating in research, running an online group for survivors, writing about sexualized violence and reporting poor service experiences to local advocates. There is existing evidence that participation in advocacy has a positive impact on general well-being (Brown et al., 2012; Klar & Kasser, 2009), although this research tends to focus on more traditional volunteerism. The experiences women reported suggest that women engage in advocacy in more diverse and occasionally grassroots ways than volunteering with established organizations.

## **Recommendations**

**Invest in community-based services.** Women overwhelmingly prefer to access services through a community-based organization. Further, they prefer to access services from an explicitly feminist and/or women centered service. Women reported some access of public, non-community based mental health supports but were not satisfied with their experiences. The first recommendation of this study is to meaningfully invest in community-based services, specifically women's centers and sexual assault centers. Although no women reported accessing transition houses, these community services are also important resources for women who have experienced and/or are currently experiencing violence. Investing in community-based organizations capacity to provide trauma informed therapy (including via mobile or satellite offices) would mitigate the main identified barriers to access. The 2008 report "Suffering in Silence: An Assessment of the Need for a Comprehensive Response to Sexual Assault in Nova Scotia" (Rubin, 2008) states that: "The current mental health services delivery model is ill-matched to the needs of sexual assault survivors. Best outcomes are achieved through delivery of specialized, holistic, survivor-centred therapy by community-based agencies" (31) and that "...community-based women's organizations, due to their relationships of trust with survivors, as well as their expertise, structure and philosophies of service, are well suited to provide survivor-centred care." (33). This research strongly supports these findings. Recommendations can also be made for public mental health services to remove barriers to access; however, women's experiences suggest that they prefer to access community-based services and that the community-based organizations mitigate the reported barriers. Therefore, this study recommends a meaningful investment in community-based organizations above other strategies. This investment would ideally involve an increase in sustainable funding, but it should also involve a

broader, long-term, strategic investment in these services as an integral part of our healthcare system.

**Adopt a trauma informed approach.** As noted above, recommendations can be made to improve public mental health services. However, as “Suffering in Silence” also reports, there are immutable aspects of the public mental health care system in Nova Scotia that prevent it from fully adopting a holistic, collaborative and trauma-informed approach, such as non-open ended session duration (e.g. 6 sessions maximum) (Rubin, 2008). Additionally, research findings from this study suggest that women who were provided a “trauma informed” therapist through the public health care system had negative and re-traumatizing experiences. Just as the public health care system may be incompatible with the needs of women who have experienced sexualized violence, professionals working within that system and within “traditional” patient/provider frameworks may be unable or unwilling to provide collaborative and empowering trauma-informed therapy. While a comprehensive evaluation of the public mental health care system’s ability to provide trauma informed therapy could be useful for program improvement, increasing capacity of community based organizations is again a main recommendation. Community based organizations’ inability to provide women the care they wanted was not due to a fundamental incompatibility, but due to wait-list constraints and/or the physical location of the service. Increasing capacity for organizations to take on additional clients and provide mobile/outreach services where needed may be a more effective route to increasing trauma informed care in rural NS.

**Explore peer support and patient navigation programs.** Peer support and peer navigation services are desired by women and may be especially important in rural places, which women described as having fractured health care and social support systems. Peers provide safe and validating support that women cannot access through a professional who may lack lived experience of sexualized violence. Women also expressed a desire for peer support to be more “formalized” in that they hoped to be able to get referrals to or be connected to formal services. While some women reported accessing peer support in their communities, there does not appear to be any patient navigation programs for women who have experienced sexualized violence in Nova Scotia. This research demonstrates that women who have experienced sexualized violence living in rural places are complex “patients” for whom navigating services and supports is emotionally and economically taxing. While a patient navigation program may be useful for all women who have experienced sexualized violence, province wide, women living in rural places face a highly fragmented system and face unique challenges to accessing services, such as extensive travel. Further study is needed to establish the best practices for establishing a patient navigation program in rural Nova Scotia. It may be relevant that in other fields, many patient navigators are also peers (e.g. have lived experience in the patient population they are supporting). There may be potential for the peer support women reported accessing or wanting to access to also provide support during the process of navigation.

**Shift narratives surrounding sexualized violence.** In their communities, women reported that they experienced an internalization or acceptance of the “classic rape” myth, a culture of silence surrounding sexualized violence and a broad normalization of sexualized violence that made identifying harm difficult. Critical feminist theory holds that dominant power structures will

impact individual experiences. The experiences women shared support this. Alongside investing in community-based services and exploring new services and supports, continued work needs to be done to shift narratives surrounding sexualized violence and address the socio-cultural factors that impact women's experiences accessing services and supports in their community. Some strategies that women suggested included having more community dialogues about sexualized violence (including an explanation and discussion of the term 'sexualized violence') and integrating topics such as consent and sexualized violence into public education systems. In addition to taking these steps to shift narratives surrounding sexualized violence, communities, organizations and providers should work to address structural factors that may impact women's ability to access services and supports, such as access to transportation, housing and childcare. Recognizing that the experience of accessing services and supports exists within a larger structure of inequity will allow for more impactful change.

### **Limitations**

There were several limitations to this study, mainly related to the study sample. I initially aimed to recruit 10-12 women however recruitment was challenging. The final study sample (n=9) was slightly smaller than the recruitment goal. Participants were diverse in age, but other aspects of the study sample may be homogenous. Because I did not collect demographic data on the race or sexual orientation of participants, I cannot speak to the range of identities represented in the sample. One participant disclosed her identity as queer during the course of the interview. No participants disclosed any racial identity. As noted in Chapter 2, women who belong to one or more vulnerable populations are at a greater risk of experiencing sexualized violence. Women who belong to one or more vulnerable populations also experience additional and unique barriers



to accessing services. In Nova Scotia, the service access experiences of African Nova Scotian and Mi'kmaq women have been systematically erased and further marginalized. The Creating Communities of Care Project, which spoke to African Nova Scotian and Indigenous women in Nova Scotia who have experienced violence, reported that, "The survivors consulted for this project emphasized their reluctance to access mainstream services for women in their position, recounting how they had been subject to racist remarks and practices by staff and residents when "forced" to use these services. They repeated that they felt unwelcome and unheard in these spaces which they saw as being designed by privileged women who did not understand their plight" (Creating Communities of Care Project, n.d.). This study does not speak to these experiences. General recommendations made by this research should be not seen as a "one size fits all" approach for all women who have experienced violence. Women who belong to one or more vulnerable populations, particularly African Nova Scotian and Indigenous women, should be given opportunities to share their experiences and meaningfully participate in and guide research.

Another study sample related limitation was the range of counties represented in the study sample. Although participants represented only 7 out of 18 counties, there were participants from each of the 4 Nova Scotia Health Authority (NSHA) management zones, and women spoke to a range of communities. That being said, there were areas of the province that no participants lived in or had accessed services in such as Cumberland County. While results speak to rural Nova Scotia as a whole, it is important to note that access varies across the province and between communities. Any recommendation from this study should be considered in the context of the local community before being implemented.

Additionally, only women who accessed or attempted to access a service or support were recruited, which could be seen as a limitation since women who did not access any services were excluded. Women who did not attempt to access services may have valuable insight to contribute on why they chose not to, or were unable to, access services and supports.

### **Recommendations for future research**

Based on the findings of this study, several areas for future research can be identified. The possibility of a patient navigation program for women who have experienced sexualized violence should be explored. Further research is also needed on modes of peer support delivery for women who have experienced sexualized violence in order to understand best practices for ‘formalizing’ peer support without losing the value of accessing support outside of the formal health care system. Additionally, it would be useful to explore the perspective of service providers and/or key stakeholders working in a rural area. Providers and stakeholders may be able to speak more broadly to programs and policies that act as barriers to access. This perspective would complement the findings of this study and further inform recommendations to improve services and supports going forward. In general, future research should aim to remove some of the limitations of this study by recruiting a diverse participant sample, including recruiting participants from each county and/or NSHA zone.

## **Reflection**

I was motivated to pursue this research by an awareness of the many barriers to accessing sexualized violence services and supports in rural areas. This understanding came from both existing literature and discussions with service providers and community members. My interest in focusing on rural communities in Nova Scotia was not solely motivated by barrier focused literature and stories. I have a love and admiration for rural Nova Scotian communities and the incredible strength they display. Often, discussion of rural Nova Scotia (and rural communities in general) is deficit based, and while it is important to understand the disparity and challenges facing rural Nova Scotia, this research only strengthened my belief that rural communities are vibrant, supportive and resilient. This research also strengthened my belief that the solutions to rural issues should come from rural voices and expertise. I hope that women living in rural places, both community-based providers and women who have experienced violence, continue to be meaningfully consulted and valued. I also know that grassroots change and action will continue to happen at a community level, whether or not rural communities are invited to be meaningfully involved in policy and program conversations and provincial and federal levels. Although many of the findings of this study were incredibly troubling and discouraging, I was continually uplifted and inspired by participants' advocacy and efforts to create local systems of support and care. I was also encouraged by participants' stories of positive experiences with community-based organizations and peers. This work has oriented me as a researcher, advocate and future health promotion professional in that I hope my role can be to support and facilitate this community-based work.

## **Conclusion**

This study aimed to explore and understand the experiences of women accessing sexualized violence services and supports in a rural place. Women navigated a fractured and complex health and social support system that was impacted by both their local community context and broader discourses surrounding sexualized violence. Although women reported a number of barriers to accessing services and supports, women also reported positive experiences with community-based organizations and presented a number of suggestions to provide collaborative and trauma-informed care in their communities. Women living in rural places have unique experiences, voices and expertise, and should be involved in future service and support development. The strength and resiliency women (and the community organizations serving them) displayed in both accessing services and supports and providing support to women around them should be recognized and celebrated.

## References

- Ahmed, S. (2017). *Living a feminist life*. Duke University Press
- Atkinson, M. (2002). Pretty in Ink: Conformity, resistance, and negotiation in women's tattooing. *Sex Roles*, 47, 219-235.
- Beckman, L. J. (2014). Training in feminist research methodology: Doing research on the margins. *Women & Therapy*, 37(1-2), 164-177.
- Bennet, K. (2013). Women and economy: complex inequality in a post-industrial landscape. *Gender, Place & Culture*, 22(9), 1287-1304.
- Benoit, C., Shumka, L., Phillips, R., Kennedy, M. & L. Belle-Isle. (2015). *Issue Brief: Sexual Violence Against Women in Canada*. Status of Women Canada.
- Booth, B., McLaughlin, Y. (2006). Barriers to and Need for Alcohol Services for Women in Populations. *Alcoholism: Clinical and Experimental Research*, 24, 1267-1275.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3:2, 77-101
- Brewer, S. & Dundes, L. (2018). Concerned, meet terrified: Intersectional feminism and the Women's March. *Women's Studies International Forum*, 69, 49-55.
- Brown, K., Hoye, R., Nicholson, M. (2012). Self-Esteem, Self-Efficacy, and Social Connectedness as Mediators of the Relationship Between Volunteering and Well-Being. *Journal of social Service Research*, 38 (4), 468-483.
- Burgess-Proctor (2015). Methodological and ethical issues in feminist research with abused women: Reflections on participants' vulnerability and empowerment. *Women's Studies International Forum*, 48, 124-134.
- Butler, J. (1988). Performative acts and gender constitution: An essay in phenomenology and feminist theory. *Theatre Journal*, 40 (4), 519-531.

Butler, L. et al. (2011). Trauma-informed care and mental health. *Directions in Psychiatry*, 31, 197-210.

CAMH (n.d.) Trauma. Retrieved from: <https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/trauma>

CADTH (2017). *Peer support programs for adults who have experienced sexual assault, abuse, harassment, or misconduct: a review of clinical effectiveness and guidelines*.  
<https://cadth.ca/sites/default/files/pdf/htis/2017/RC0942%20-%20Peer%20Support%20-%20Final.pdf>

CAMH. (n.d.). Trauma. Retrieved December 12, 2019, from <https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/trauma>

Campbell, R., Wasco, S., Ahrens, C., Sefl, T., Barnes, H. (2001). Preventing the “Second Rape”: Rape Survivors’ Experiences With Community Service Providers. *Journal of Interpersonal Violence*, 16(12), 1239-1259.

Canada Without Poverty (2015). *Nova Scotia Poverty Progress Profile*.  
<https://www.cwp-csp.ca/resources/sites/default/files/resources/ProvincePovertyProfiles-NS.pdf>

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council, Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, December 2018.

Carter, N., Valaitis, R., Lam, A., Feather, J., Nicholl, J., Cleghorn, L. (2018). Navigation delivery models and roles of navigators in primary care: a scoping literature review. *BMC Health Services Research*, 18(1), 96.

Clarke, A. (2006). Qualitative interviewing: encountering ethical issues and challenges. *Nurse Researcher*, 13(4), 19-29.

Creating Communities of Care Project. (n.d.). Communities of Care. Retrieved January 4, 2020, from <https://creatingcommunities.ca/background/>

Cresswell, J. (2013). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*. SAGE Publications.

Crews, D., Stolz-Newton, M., Grant, N. (2016). The use of yoga to build self-compassion as a healing method for survivors of sexual violence. *Journal of Religion & Spirituality in Social Work*, 35(3), 139-156.

Doctors Nova Scotia (2018). *Healing Nova Scotia Part Two*. Retrieved from [https://doctorsns.com/sites/default/files/2018-07/next-steps/HealingNS2-2018\\_0.pdf](https://doctorsns.com/sites/default/files/2018-07/next-steps/HealingNS2-2018_0.pdf)

Dohan, D., & Schrag D. (2005). Using navigators to improve care of underserved patients: Current practices and approaches. *Cancer*, 104, 848–855.

DuMont, J., Woldeyohannes, M., Macdonald, S., Kosa, D., Turner, L. (2017). A comparison of intimate partner and other sexual assault survivors' use of different types of specialized hospital-based violence services. *BMC Women's Health*, 17, 59.

Ellsberg, M., Heise, L. (2005). *Researching violence against women: Practical guidelines for researchers and activists*. World Health Organization. <https://apps.who.int/iris/handle/10665/42966>

Fallot, R.D. & Harris, M. (2001). Using trauma theory to design service systems. San Francisco: Jossey-Bass.

Gagne, C., Finch, W., Myrick, K., Davis, L. (2018). Peer workers in the behavioral and integrated health workforce: Opportunities and future directions. *American Journal of Preventive Medicine*, 54(6), 258-266.

Gatenby, B., & Humphries, M. (2000). Feminist participatory research: Methodological and ethical issues. *Women's Studies International Forum*, 23 (1), 89-105.

Gibson, R., Fitzgibbons, J., Nunez, N. (2015). *State of Rural Canada Report: Nova Scotia*.

- Gillard, S. (2019). Peer support in mental health services: where is the research taking us, and do we want to go there? *Journal of Mental Health*, 28(4), 341-344.
- Hargrave, P., Scott, K., McDowall, J. (2006). To Resolve or Not to Resolve: Past Trauma and Secondary Traumatic Stress in Volunteer Crisis Workers. *Journal of Trauma Practice*, 5(2), 37-55.
- Heath, N., Lynch, S., Fritch, A., Wong, M. (2013). Rape Myth Acceptance Impacts the Reporting of Rape to the Police: A Study of Incarcerated Women. *Violence Against Women*, 19 (9), 1065-1078.
- Hellawell, D. (2006). Inside–out: analysis of the insider–outsider concept as a heuristic device to develop reflexivity in students doing qualitative research. *Teaching in Higher Education*, 11(4), 483-94.
- Higgs, G. (1999). Investigating trends in rural health outcomes: a research agenda. *Geoforum*, 30(3), 203-221.
- Jagosh J, Macaulay, AC, Pluye, P, Salsberg, J, Bush, PL, Henderson, J, Sirett, E, Wong G, Cargo, M, Herbert, CP, Seifer, SD, Green, LW, Greenhalgh, T. (2012). Uncovering the Benefits of Participatory Research: Implications of a Realist Review for Health Research and Practice, *Milbank Quarterly*. 90(2): 311-346.
- Jenkinson, B., Kruske, S., Kildea, S. (2017). The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis. *Midwifery*, 52, 1-10.
- Kane, K. (2006). The Phenomenology of Meditation for Female Survivors of Intimate Partner Violence. *Violence Against Women*, 12(5), 501-518.
- Khan, S., Hirsch, J., Wamboldt, A., Mellins, C. (2018) “I Didn’t Want To Be ‘That Girl’”: The Social Risks of Labeling, Telling, and Reporting Sexual Assault. *Sociological Science*, 5(19), 432-460.
- Klar, M., Kasser, T. (2009). Some benefits of being an activist: Measuring activism and its role in psychological well-being. *Political Psychology*, 30(5), 755–777.



- Knapnik, GP., Martsof, DS., Dracuker, CB. (2008). Being delivered: spirituality in survivors of sexual violence. *Issues in Mental Health Nursing*, 29(4), 335-350.
- Kramer, A., Nosbusch, JM., Rice, J. (2012). Safe mom, safe baby: a collaborative model of care for pregnant women experiencing intimate partner violence. *Journal of Perinatal & Neonatal Nursing*, 26(4), 307-318.
- Leader, K. (2016). On the book of my body: Women, power, and “tattoo culture”. *Feminist Formations*, 28(3), 174-195.
- Logan, T., Evans, L., Stevenson, E., Jordan, C. (2005). Barriers to Services for Rural and Urban Survivors of Rape. *Journal of Interpersonal Violence*. 20(5), 591-616.
- Logan, T., Walker, R., Cole, J., Ratliff, S., Leukefeld, C. (2003). Qualitative Differences Among Rural and Urban Intimate Violence Victimization Experiences and Consequences: A Pilot Study. *Journal of Family Violence*, 18(2), 83-92.
- Lutfiyya, M., McCullough, J., Haller, I., Waring, S., Bianco, J., Lipsky, M. (2012). Rurality as a Root or Fundamental Social Determinant of Health. *Disease-a-Month*, 11, 620-628.
- Metzel, J.M. & Hansen, H. (2014). Structural competency: theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, 103, 126-133.
- McNess, E., Arthur, L., Crossley, M. (2013). ‘Ethnographic dazzle’ and the construction of the ‘Other’: revisiting dimensions of insider and outsider research for international and comparative education. *Compare*, 45(2) – 295-316.
- Milligan, L. (2016). Insider-outsider-inbetween? Researcher positioning, participative methods and cross-cultural educational research. *Compare*, 46(2), 235-50.
- Milliken, J., Paul, LA., Sasson, S., Porter, A., Hasulube, J. (2016). Sexual Assault Disclosure Recipients' Experiences: Emotional Distress and Changes in the Relationship With the Victim. *Violence & Victims*, 31(3), 457-70.

- Murphy, S., Potter, S., Pierce-Weeks, J., Stapleton, J., Wiesen-Martin, D. (2011). An examination of SANE data: Clinical considerations based on victim–assailant relationship. *Journal of Forensic Nursing*, 7(3), 147-144.
- Peek-Asa, C., Wallis, A., Harland, K., Beyere, K., Dickey, P., Saftlas, A. (2011). Rural Disparity in Domestic Violence Prevalence and Access to Resources. *Journal of Women's Health*, 20(11), 127-141.
- Philip, G., Bell, L. (2017). Thinking critically about rapport and collusion in feminist research: relationships, contexts and ethical practice. *Women's Studies International Forum*, 61(1), 71-74.
- Province of Nova Scotia (2019). *Annual Accountability Report on Emergency Departments*. Retrieved from [https://novascotia.ca/dhw/publications/Emergency\\_Departments\\_Report\\_2019.pdf](https://novascotia.ca/dhw/publications/Emergency_Departments_Report_2019.pdf)
- Ramcharan, P., Cutcliffe, JR. (2001). Judging the ethics of qualitative research: considering the "ethics as process" model. *Health & Social Care in the Community*, 9(6), 359-66.
- Rath, J. (2007). Training to be a volunteer Rape Crisis counselor: a qualitative study of women's experiences. *British Journal of Guidance & Counseling*, 36(1), 19-32.
- Resnick, H., Holmes, M., Kilpatrick, D., Clum, G., Acierno, R., Best, C., Saunders, B. (2000). Predictors of Post-Rape Medical Care in a National Sample of Women. *American Journal of Preventative Medicine*. 19 (4), 214-219.
- Rhodes, D. (1990). Feminist critical theories. *Stanford Law Review*, 42 (3), 617-638.
- Rhodes, T. (2002). The 'risk environment': a framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, 13 (2), 85-94.
- Rubin, P. (2008). *SUFFERING IN SILENCE: An Assessment of the Need for a Comprehensive Response to Sexual Assault in Nova Scotia*. Nova Scotia Sexual Assault Services Planning Group. [https://novascotia.ca/coms/svs/docs/SufferinginSilence\\_2008.pdf](https://novascotia.ca/coms/svs/docs/SufferinginSilence_2008.pdf).

- Sable, M., Danis, F., Mauzy, D., Gallagher, S. (2006). Barriers to Reporting Sexual Assault for Women and Men: Perspectives of College Students. *Journal of American College Health*. 55 (3), 157-162.
- Smith, K., Humphreys, J., Wilson, M. (2008). Addressing the health disadvantage of rural populations: How does epidemiological evidence inform rural health policies and research? *The Australian Journal of Rural Health*, 16, 56-66.
- Starzynski, L., Ullman, S., Filipas, H., Townsend, S. (2005). Correlates of women's sexual assault disclosure to informal and formal support sources. *Violence and Victims*, 20 (147), 417-32.
- Statistics Canada. (2006). Measuring Violence Against Women: Trends 2006. Retrieved from <https://www150.statcan.gc.ca/n1/pub/85-570-x/2006001/findings-resultats/4144393-eng.htm>
- Statistics Canada. (2011). NHS Profile, 2011. Retrieved from <https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E>
- Statistics Canada. (2016). Income Highlights Tables, 2016 Census. Retrieved from: <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/inc-rev/Table.cfm?Lang=Eng&T=301&S=99&O=A>
- Statistics Canada (2014). *Self-reported sexual assault in Canada, 2014*. Ottawa, Ontario: Canadian Centre for Justice Statistics
- Status of Women Canada (2015). *Issue Brief: Sexual Violence Against Women in Canada*. Ottawa, Ontario: Federal-Provincial-Territorial Senior Officials for the Status of Women.
- Stevens, K., McLeod, J. (2018). Yoga as an adjunct to trauma-focused counselling for survivors of sexual violence: a qualitative study. *British Journal of Guidance & Counselling*, 47(6), 682-697.

- Strubel, J., Jones, D. (2017). Painted Bodies: Representing the Self and Reclaiming the Body through Tattoos. *The Journal of Popular Culture*, 50(6), 1230-1253.
- Spencer, C., Mallory, A., Toews, M., Stith, S., Wood, L. (2017). Why Sexual Assault Survivors Do Not Report to Universities: A Feminist Analysis. *Family Relations: Interdisciplinary Journal of Applied Family Science*, 66, 166-179.
- Toffoletti, K., Thorpe, H. (2018). Female athletes' self-representation on social media: A feminist analysis of neoliberal marketing strategies in "economies of visibility". *Feminism & Psychology*, 28 (1), 11-31.
- Tracy, K., Wallace, S. (2016). Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation*, 7, 143-154.
- Ullman, S., Filipas, H. (2001). Correlates of Formal and Informal Support Seeking in Sexual Assault Victims. *Journal of Interpersonal Violence*, 16 (10), 1028-1047.
- Ullman, S., Filipas, H. (2001). Predictors of PTSD Symptom Severity and Social Reactions in Sexual Assault Victims. *Journal of Traumatic Stress*, 14 (2), 369-390.
- Van Ameringen, M., Mancini, C., Patterson, B., Boyle, MH. (2008). Post-traumatic stress disorder in Canada. *CNS Neuroscience & Therapeutics*, 14(3), 171-181.
- Wells, KJ., Battaglia, TA., Dudley, DJ., Garcia, R., Greene, A., Calhoun, E., Mandelblatt, JS., Paskett, ED., Raich, PC. (2008). Patient navigation: state of the art or is it science? *Cancer*, 113(8), 1999-2010.
- Whatley, M. (1996). Victim characteristics influencing attributions of responsibility to rape victims: A meta-analysis. *Aggressions and Violent Behavior*, 1(2), 81-95.
- Wing, A. (2003). *Critical Race Feminism: A Reader*. NYU Press.
- World Health Organization (2006). Sexual violence. *Violence and injury prevention*. Retrieved from: [https://www.who.int/violence\\_injury\\_prevention/violence/global\\_campaign/en/chap6.pdf](https://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf)

Zweig, J., Schlichter, K., Burt, M. (2002). Assisting Women Victims of Violence Who Experience Multiple Barriers to Services. *Violence Against Women*, 8 (2), 162-180.

## APPENDIX A: INTERVIEW GUIDE

### Interview Guide

**Preamble:** I would like to know about your experiences accessing formal services and informal supports in your community for women who have experienced sexualized violence. By formal services, I mean any service that is funded and mandated to provide services, such as the hospital, clinic, the women's resource center or victim services. By informal support, I mean anything outside of that, such as an informal women's meet up, talking to a friend or family member, online forums, etc. I am interested in what services you wanted to access, attempted to access or accessed and the barriers and/or facilitators you experienced. I am also interested in what services and supports you think are needed in rural places for women who have experienced sexualized violence. There are no right or wrong answers.

I'll start with some general questions. How long have you lived in this community?

Can you tell me a little bit about the community that you live in?

E.g. size, what services are available, sense of community, satisfaction with community

### Formal services

I'll start by asking you to talk about formal services. Can you tell me a little about your experiences accessing formal services after experiencing sexualized violence?

Were you aware of any formal services that were available to you? If so, can you tell me which ones you wanted to access and why?

*If service was accessed....*

Why did you access this service?

Can you tell me anything that was helpful when accessing the service?

E.g. awareness of service, easy to get in to service (no waitlist), location of service, transport to service, website clear and easy to understand

Can you tell me anything that was not helpful when accessing the service?

E.g. location of service inaccessible, not easy to find information about the service,

*If service was not accessed ...*

What kept you from accessing the service?

E.g. attempted but could not get in, fear of being seen, fear of stigma, did not want to access

Can you tell me anything that prevented you from accessing the service if you attempted to?

E.g. unaware that service exist, couldn't drive to service, fear of being seen accessing a service

Is there anything else you'd like to add about accessing a formal service in your community that we didn't cover?

### **Informal supports**

Now I'll ask you a bit about informal supports. Can you tell me a little about your experiences accessing informal supports after experiencing sexualized violence?

Were you aware of any informal supports available to you? If so, which did you want to access and why?

*If accessed ...*

Why did you access this support?

Can you tell me a little about what was helpful when accessing the support?

E.g. talking to someone known and trusted, location

Can you tell me anything that was not helpful when accessing the support?

E.g. discomfort disclosing personal information, didn't have awareness

*If not accessed...*

What kept you from accessing informal supports?

E.g. fear of stigma or victim blaming, prefer to keep private

Can you tell me anything that prevented you from accessing support if you attempted?

E.g. didn't know who to talk to, support person not receptive, supports did not know how to respond

Is there anything else you'd like to add about accessing informal supports that you'd like to add that we didn't cover?

### **General**

Can you tell me about what services and supports you think are needed in your community?

*Probes: Is there anything that would have been helpful to you after experiencing sexualized violence that you could not find or access?*

*Are there services and supports you would like to exist?*

**Demographic Information**

**Age range (circle one):** 18-24    25-29    30-34    35-39    40-44    45-49  
50 – 54    55-59    60+

**County:**



# Are you a woman who has accessed or attempted to access a service or support after any experience of sexualized violence?

Do you live in a rural place in Nova Scotia?

In the past 5 years, have you attempted to access or accessed a service or support after any experience of sexualized violence?

We want to hear about your experiences accessing (or not) services and supports.

---

**Sexualized violence** can be any physical or psychological violence carried out through sexual means, including but not limited to: attempt to obtain sex using threats or coercion, unwanted comments or advances, and assault

**Services** include hospitals, clinics, women's centres, family practices. **Supports** include talking to friends or family, online or in person support groups

---

Want to participate or have more questions? Email [Clare.heggie@dal.ca](mailto:Clare.heggie@dal.ca) or call 1-844-502-2631

You will receive \$20 as a thank you.

The interview will be confidential. We do not want your name.



## APPENDIX C: SCREENING DOCUMENT

### Project title: **Accessing sexualized violence services and supports: Exploring the perspectives of women living in rural places**

Thank you for your interest in this study. I'd like to ask you some questions to make sure you are eligible to participate in this study. If you're eligible we can schedule an interview time and date.

1. Are you 18 years of age or older? (Yes/No)
2. Have you attempted to access or accessed a formal service (e.g. hospital, clinic, family practice, women's resource centre) and/or informal support (e.g. talking to a friend or family member, online communities, informal women's support group) in response to experiencing sexualized violence in the past five years? (Yes/No)
3. Do you live in a rural place in Nova Scotia? (Yes/No)

*If you want to have a telephone interview ...*

Do you have access to a phone and a private space to complete the interview? (Yes/No)

Do you have access to an email address to receive the gift card honorarium? (Yes/No)

#### **If participant answers No to any questions:**

Thank you for your interest. Unfortunately, you are not eligible to participate in this study because [reason] but thank you again for expressing interest.

#### **If participant answers Yes to all question:**

Thank you for your interest, you are eligible to participate in this study. Would you like to schedule a phone or in person interview? Would you like a phone or email reminder the day before your interview?

Participant First Name \_\_\_\_\_

Participant # \_\_\_\_\_

Telephone or In person interview \_\_\_\_\_

Location \_\_\_\_\_

Time and Day \_\_\_\_\_

Phone number \_\_\_\_\_

Email address \_\_\_\_\_

## APPENDIX D: CONSENT FORM



### CONSENT FORM

**Project title: Accessing sexualized violence services and supports: Exploring the perspectives of women living in rural places**

**Lead researcher:** Clare Heggie, Health Promotion (MA Student), Dalhousie University, clare.heggie@dal.ca

#### **Other researchers**

Dr. Lois Jackson (Student supervisor), Health Promotion, Dalhousie University, Lois.jackson@dal.ca

#### **Introduction**

We invite you to take part in a research study being conducted by me, Clare Heggie, a student at Dalhousie, as part of my Master's in Health Promotion. Taking part in this research is **entirely your choice and completely voluntary**. The information below tells you about the study, what you will be asked to do and the risks and benefits of taking part. Ask as many question as you like. If you have additional questions about the study you can contact me at: clare.heggie@dal.ca

#### **Purpose and Outline of the Research Study**

The purpose of this study is to understand your experiences of accessing or attempting to access services and supports after any experience of sexualized violence. Sexualized violence refers to any physical or psychological violence carried out by sexual means, including but not limited to: unwanted sexual advances and comments, coercion, attempt to obtain a sexual act using coercion or threats, and sexual assault. You will be asked about what services or supports you wanted to access, if you accessed them, and what was helpful or not helpful in accessing the services or supports. We hope to speak to 10-12 women about their experiences.

#### **Who Can Take Part in the Research Study**

You can take part in this study if you identify as a woman, are over the age of 18, and have accessed or attempted to access a service and/or support after any experience of sexualized violence in the last approximately 5 years in a rural place in Nova Scotia. You will have the option of having a face to face interview or a telephone interview. If you choose to do a

telephone interview, you must have access to a phone number in a private space in order to complete the interview and access to a private email address in order to receive the gift card honorarium.

### **What You Will Be Asked to Do**

You will be asked to share your experiences of attempting to access or accessing formal services and/or informal supports in the past 5 years within a rural place in Nova Scotia after any experience of sexualized violence. You will have the option of having the interview take place in person or over the phone. If you choose to have a face to face interview, it can take place at a safe community space, such as a women's centre. If that location is not suitable for you, another confidential and convenient space will be chosen that allows for the interview to take place during the day. The interview will be held at a time that is convenient for both you and me.

You will be asked to review this consent form with me, the interviewer, to make sure you understand it, and to give your verbal consent to voluntarily participate. We will keep a record of your verbal consent but only as a participant number – not your name. If you are completing a telephone interview, we will also ask for a personal email address in order for me to provide you with the gift card honorarium. You will be given the choice of having your interview audio recorded or having me, the interviewer, record answers or notes by hand. The interview should not take more than 50-60 minutes.

### **Possible Benefits, Risks and Discomforts**

**Benefits:** Participating in the study will not benefit you directly but the research may learn things that could improve access to services and supports for women living in a rural area who have experienced sexualized violence.

**Risks:** You may feel experience negative feelings or discomfort while answering some of the questions. You are free to skip over any questions you do not wish to answer, take a break mid-interview or end the interview at any time. It is up to you how many questions you answer or not and we can stop at any time. If you experience distress or discomfort, the interviewer (Clare Heggie) can provide you with names and numbers of resources in the community that you can access after the interview.

**If you disclose any information about current child abuse or an adult in need of protection we are required to contact the authorities and reveal your identity. This is a risk of participation.**

### **Compensation / Reimbursement**

To thank you for your time, we will give you \$20. If you have an in-person interview, you will receive this in cash. If you have an over the phone interview, you will receive this in the form of an e-gift certificate (e.g. \$20 to Amazon). You must have a personal email address in order to receive an electronic gift card honorarium.

You will get this money whether or not you complete some or any of the interview questions. You will receive the money after you have reviewed and understood the consent form.

#### **How your information will be protected:**

The audiotape or notes from your interview will be given a number, such as “Participant #1”. There will be no names attached to the audiotape or notes.

After you complete the interview, the audio recording will be saved on a password protected hard drive until the interview can be written out word for word. If you decide to have handwritten notes taken for your interview, they will be stored in a locked filing cabinet until they are typed out word by word. Any personally identifying information will not be written out (e.g. names of friends, place of work) Once interviews are typed out word for word, the audio recordings and notes will be destroyed. The electronic copies of the written out interviews will be stored on password protected hard drives, not a computer, in a locked filing cabinet. Members of the research team (listed on the first page) will have access to the data. After all the interviews have been analyzed, the typed out interviews and consent forms will be locked away at Dalhousie University for at least 5 years post publication in case there are any questions about the data analysis after presentations/publications. The name and record of personal email addresses collected to set up the interview will be destroyed. If you have a telephone interview and receive the honorarium gift card via email, a record of your email address will be kept for two months to ensure that there are no problems with you receiving the gift card. After the 2 months period, they will be destroyed.

Information that you provide to us will be kept private. The findings will be shared in my thesis, presentations, publications and community report. We will be very careful to only talk about group results so that no one will be identified. This means that ***you will not be personally identified in any way in our reports***. Also, we will use a participant number (not your name) in our written and computer records so that the information we have about you contains no names. You may be identified by age range and/or geographical county.

#### **If You Decide to Stop Participating**

You are free to stop the interview at any time. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can also decide for up to two weeks if you want us to remove your data. After that time, it will become impossible for us to remove it because we will already have included it as part of our study findings.

#### **How to Obtain Results**

Study results will be shared in a short summary report. You can obtain these results by including your contact information at the end of the signature page. This contact information will be stored on a password protected hard drive and destroyed once the report has been sent. The report will also be provided to local community organizations (e.g. Antigonish Women’s Resource Centre) to be shared with clients and community members. Results will be

available approximately 1-2 years from now.

**Questions**

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Clare Heggie at [Clare.heggie@dal.ca](mailto:Clare.heggie@dal.ca)) or Lois Jackson at (902) 494-1341 or [lois.jackson@dal.ca](mailto:lois.jackson@dal.ca) at any time with questions, comments, or concerns about the research study. We will also tell you if any new information comes up that could affect your decision to participate.

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: [ethics@dal.ca](mailto:ethics@dal.ca).

## Signature Page for Interviewer

**Project Title: Accessing sexualized violence services and supports: Exploring the perspectives of women living in rural places**

**Lead Researcher:** Clare Heggie, Dalhousie University, [Clare.heggie@dal.ca](mailto:Clare.heggie@dal.ca)

I have verbally reviewed the consent form with the participant and believe that they understand the consent process. They have been informed that they have the freedom to not answer any question and/or withdraw from the interview at any time. 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 understand that they may receive a copy of this signed and dated consent form via email, if they request one. They understand they can contact any of the research ethics boards with questions or concerns. I have answered any questions that they have, and have told them that there will be a summary report available to them at the end of the study, if they would like one.

Permission for audio taping during the interview (Circle one) : YES          NO

Permission for use of direct quotations (Circle one): YES          NO

**Participant #** \_\_\_\_\_

Email address for gift card honorarium if conducting interview over phone \_\_\_\_\_

\_\_\_\_\_  
**Researcher name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**If you would like to be contacted in 1-2 years with study results, please share the email you would like to be contacted at** \_\_\_\_\_

APPENDIX E: GIFT CARD AND HONORARIUM TRACKING FORM

**Project title: Accessing sexualized violence service and supports: Exploring the perspectives of women living in rural places**

**Researcher:** Clare Heggie, Health Promotion, Dalhousie, [Clare.heggie@dal.ca](mailto:Clare.heggie@dal.ca)

Participant # \_\_\_\_\_

Date honorarium was given or sent: \_\_\_\_\_

Type of honorarium (Cash or gift card): \_\_\_\_\_

Date gift card honorarium was received: \_\_\_\_\_

Researcher Giving Honorarium \_\_\_\_\_(Print)

\_\_\_\_\_ (Signature)



## APPENDIX F: RESOURCES FOR PARTICIPANTS

### ***Antigonish/Guysborough/Inverness/Richmond County:***

#### **Antigonish Women's Resource Centre:**

Call: 902-863-6221

Email: [info@awrcsasa.ca](mailto:info@awrcsasa.ca)

Visit: 9:00 – 4:30 Monday to Friday:

204 Kirk Place, 219 Main Street

Antigonish, Nova Scotia

#### **St.Fx Health and Counselling (for St.Fx students)**

Call: (902) 867-2263

Email: [idrouin@stfx.ca](mailto:idrouin@stfx.ca)

#### **St. Martha's Regional Hospital**

Call: (902) 867-4500

Visit: 25 Bay St, Antigonish, NS, 24 HR

#### **Antigonish After Hours Clinic**

Call: 902.735.4000

Visit: 40 Church St.,

Antigonish, Nova Scotia

#### **Strait Area Women's Place**

Call: 902-625-1614

Visit: 609 Church St., Port Hawkesbury, NS

#### **Leaside Society Transition House**

Call (24 hr): 902-625-2444

### ***Cape Breton Regional Municipality:***

#### **Every Woman's Centre**

Call: 902-567-1212

Visit: 21 Trinity Ave, Sydney, NS

#### **Cape Breton Regional Hospital**

Call: 902-564-5566

Visit: 1482 George St., Sydney, NS

#### **Jane Paul Indigenous Women's Resource Centre**

Call: 902-539-5890

Visit: 440 George St, Sydney, NS

***Pictou/Colchester/Cumberland Counties***

**Pictou County Centre for Sexual Health**

Call: 902-695-3366

Visit: 279 Foord Street, Stellarton, NS

**Pictou County Women's Resource and Sexual Assault Centre**

Call: (902) 755-4647

Visit: 503 South Frederick Street, New Glasgow

**Central Nova Women's Resource Centre**

Call: 902-895-4295

Visit: 82 Esplanade St, Truro

***Shelburne/Queens/Lunenburg Counties***

**Tri-County Women's Centre Shelburne Office**

Call: 902-875-4777

Visit: 25B King St, Shelburne

**Sexual Health Centre Lunenburg County**

Call: 902-527-2868

Visit: 109 Logan Rd Unit 2, Lunenburg

***Hants/Kings/Annapolis Counties***

**Survivors of Abuse Recovering (for adult survivors of child sexual abuse)**

Call: 902-679-7337

Visit: 32 Cornwallis St., Kentville

**Women's Place Resource Centre**

Call: 902-532-1898

Visit: 228 George St, Annapolis Royal

***Digby/Yarmouth Counties***

**Tri County Women's Centre Yarmouth Office**

Call: 902-742-0085

Visit: 12 Cumberland Street, Yarmouth

**Tri County Women's Centre Digby Office**

Call: 902-245-6866

Visit: 126 Water Street, Digby

***General resources:***

**Sexual Assault Nurse Examiner (SANE) Program**

Call: 1-877-880-SANE(7263) 24 HR toll free

**Mental Health Crisis Line:**

Call: 1-888-429-8167

**Nurse Telecare:**

Call: 811

**Independent Legal Advice for Sexual Assault Survivors Program:**

Call: Intake done through 211. Dial 211 and ask for the program.

**Sexual Assault and Harassment Phone Line:**

Call: 1-902-425-1066

**Victim Services Emotional Support:**

Call: 1-902- 490-5300

## APPENDIX G: Dalhousie REB Letter of Approval

5/8/2020

Mail - Clare Heggie - Outlook

### REB # 2019-4839 Letter of Approval

ethics@dal.ca <ethics@dal.ca>

Tue 7/2/2019 3:56 PM

To: Clare Heggie <Clare.Heggie@dal.ca>

Cc: Lois Jackson <Lois.Jackson@Dal.Ca>; Research Ethics Database <ethics@dal.ca>

\*\*\*This was sent from a no-reply address. To respond to this message, please reply directly to Research Ethics at ethics@dal.ca.



### Health Sciences Research Ethics Board Letter of Approval

July 02, 2019

Clare Heggie

Health\School of Health and Human Performance

Dear Clare,

**REB #:** 2019-4839

**Project Title:** Accessing sexualized violence services and supports. Exploring the perspectives of women living in rural places.

**Effective Date:** July 02, 2019

**Expiry Date:** July 02, 2020

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans*. This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,



Dr. Lori Weeks, Chair

---

#### Post REB Approval: On-going Responsibilities of Researchers

After receiving ethical approval for the conduct of research involving humans, there are several ongoing responsibilities that researchers must meet to remain in compliance with University and Tri-Council policies.

##### 1. Additional Research Ethics approval

Prior to conducting any research, researchers must ensure that all required research ethics approvals are secured (in addition to this one). This includes, but is not limited to, securing appropriate research ethics approvals from: other institutions with whom the PI is affiliated; the research institutions of research team