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THE INFLUENCE OF #METOO ON SEXUAL ASSAULT SURVIVORS' DECISION MAKING AND HEALTH BEHAVIORS: A QUALITATIVE INQUIRY

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Abstract

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Sexual assault is a national public health problem, yet there is a dearth of information about how and why survivors disclose and obtain post sexual assault healthcare in the era of social media campaigns. This study examined the influence of #MeToo on sexual assault survivors' decision-making post assault, including formal disclosures to health providers and formal health seeking behaviors. The research question is "what are the patterns of sexual assault survivors' disclosure and health seeking behaviors in the era of #MeToo?" A qualitative, exploratory descriptive study was undertaken to understand the influence of #MeToo on a survivor's decision to disclose sexual assault and obtain health care. With the use of online focus groups, 56 participants' stories were shared, and four salient themes emerged. These results were the first to provide insight into how an online social media movement (#MeToo) influenced offline health behaviors. The knowledge gained from this study advanced nursing science focused on the care of sexual assault survivors. Additionally, findings informed intervention strategies such as developing targeted public health campaigns that capitalize on online social movements to impact offline behaviors.

Keywords: sexual assault, social media, #metoo, post sexual assault health care, disclosure, forensic exam

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Chapter 1: Introduction

Statement of the Problem

Social engagement online has become a significant part of current culture and society. We have entered a new era where technology impacts our daily lives and our health (Mesko, 2013; Rideout & Fox, 2018; Tennant et al., 2015). At the tap of a screen, individuals can post ideas and opinions on a plethora of social media platforms such as Twitter, Facebook, and Instagram. These postings can reach millions of people in a short amount of time. This ability has transformative power – from igniting social movements, to connecting people around the globe, to rapidly disseminating information on any topic. Studying online social engagement (social media) and its impact on offline behavior is an emerging field of inquiry (Bravo, Bravo, Lygidakis & Vogele, 2019; Zhang & Centola, 2019) and should be of particular interest to nursing science.

The social media movement, hashtag 'MeToo' (#MeToo), began as a small grassroots campaign by activist Tarana Burke in 2006 to unite survivors of sexual assault (Guerra, 2017). Eleven years later, the phrase/hashtag became an international social media movement. In early October 2017, the *New York Times* covered Ashley Judd's rape allegations against Hollywood producer Harvey Weinstein (Kantor & Twohey, 2017). This was followed by a lengthy article in the *New Yorker* that told the stories of additional accusers of Weinstein's harassment and assaults (Farrow, 2017). Then, on the night of October 15th, actress Alyssa Milano responded to the allegations with Burke's phrase/hashtag on Twitter. Milano tweeted,

> Suggested by a friend: If all the women who have been sexually harassed or assaulted wrote 'me too' as a status, we might give people a sense of the magnitude of the problem. If you've been sexually harassed or assaulted write 'me too' as a reply to this

tweet (Zacharek, Dockterma & Edwards, 2017).

Within 8 hours over 30,000 people had used #MeToo on Twitter; within 24 hours more than 500,000 Twitter users and 4.7 million Facebook users had engaged in the #MeToo conversation, equaling over 12 million posts, comments, and reactions (D'Zurilla, 2017; France, 2017).

Despite the movement's social and cultural impact over the subsequent years (Almukhtar, Gold & Buchanan, 2018; Fortin, 2018; The New Yorker, 2018; Solani & Pundir, 2019; Zacharek et al., 2017), researchers have yet to uncover the impact #MeToo has had on offline health protective behaviors, such as disclosure of sexual assault to a health provider and/or receipt of health services post assault (either formal forensic post assault care and/or general care).

Many researchers have already examined sexual assault survivors' reasons for disclosure of sexual assault to both informal supports (friends/family) and formal supports (health care providers). Survivors are more likely to disclose to informal supports than formal supports, and rationale for non-disclosure include: stigma and victim-blaming, distrust in the legal system, fear of retribution, guilt and self-blame, trauma, downplaying the event to a misunderstanding, and history of past negative social reactions from disclosure (Johnstone, 2016; Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007; Krebs, Lindquist, Warner, Fisher, & Martin, 2007; Wilson & Miller, 2015). Despite barriers to disclosure, the sooner a survivor presents for health care services (formal post assault care and/or general post assault care), the better the health outcomes (Campbell et al., 2014; Fehler-Cabral, Campbell, & Patterson, 2011). This includes reduced symptoms of post-traumatic stress disorder (PTSD), quicker access to mental health resources, and faster emotional and physical recovery (Campbell et al., 2014; Fehler-Cabral et al., 2011; Crandall, & Helitzer, 2013).

Currently, we are unaware of the ways in which #MeToo has influenced survivors' formal disclosure or health seeking behaviors, particularly when public health campaigns did not capitalize on the movement to directly inform survivors of the importance of (1) seeking care to promote general health and healing, and (2) seeking time sensitive care for evidence collection, sexually transmitted infection (STI) prophylaxis, and emergency contraception.

Therefore, the purpose of this study was to examine the influence of #MeToo on sexual assault survivors' decision-making post assault, including formal disclosures to health providers and health seeking behaviors. The knowledge gained from this research will inform public health nurses' ability to (1) understand the impact of online social engagement on offline health behaviors, and (2) formulate campaign strategies that capitalize on social movements to disseminate targeted health messages which will ultimately impact individual and public health.

Significance of the Problem

National health problem. Sexual assault is a grave and persistent national and global problem. In the United States (U.S.), approximately 1 in 5 women, 1 in 30 men and 1 in 2 transgendered people will be victims of sexual assault in their lifetime (James et al., 2016; U.S. Department of Justice [DOJ], 2015). This equates to approximately half of a million sexual assault victims a year or an assault every 68 seconds (U.S. DOJ, 2020). Those that are most at risk for sexual assault include college women, immigrants, Native Americans, military veterans, those who identify as belonging to a sexual minority group, those with disabilities, and youth in the foster care system (National Sexual Violence Resource Center, 2015). The health outcomes of the victimizations are based on a variety of social and cultural factors including individual level factors, microsystem factors, meso/exosystem factors, macrosystem factors, and chronosystem factors (Campbell, Dworkin & Cabral, 2009).

The negative health outcomes of sexual assault are physical, emotional, and behavioral, and both short and long-term. They can include physical trauma, unwanted pregnancy, STIs, pelvic pain, and dyspareunia (Mark, Bitzker, Klapp, & Rauchfull, 2008; Campbell et al., 2009; Centers for Disease Control and Prevention [CDC], 2015). Victims of sexual assault are at an increased risk of substance abuse, depression, anxiety, relationship stress, avoidance of cervical cancer screening, PTSD and suicide (CDC, 2015; Weitlauf et al., 2008); up to 94% of sexual assault survivors will exhibit acute PTSD symptoms in the first 2 weeks following an assault (Riggs, Murdoch & Walsh, 1992).

Although survivors of sexual violence are at risk of facing a lifetime of negative health outcomes, the majority do not disclose their assault to formal supports, obtain forensic care, or seek any type of health care (Garcia-Morena, Jansen, Ellsberg, Heise, & Watts, 2006). Historically, the rates of disclosure to formal supports such as law enforcement and health care providers has been low, at approximately 15% (Fisher et al., 2003; Jones, Alexander, Wynn, Rossman, & Dunnuck, 2008; Wolitzky-Taylor et al., 2011). Less than one in five sexual assault survivors seek health care services post sexual assault (Zinzow, Resnick, Barr, Danielson, & Kilpatrick, 2012) and sought care is often delayed past the window of evidence collection (Du Mont & White, 2007; Resnick et al., 2000; Zinzow et al., 2012). However, disclosure to health care providers and receipt of health care services post sexual assault, especially by a specialized forensic nurse (sexual assault nurse examiner [SANE]), is known to facilitate physical and emotional healing (Campbell et al., 2014; Fehler-Cabral et al., 2011; Crandall & Helitzer, 2013).

Calls for researchers to examine ways to prevent and address sexual violence have been and continue to be a focused priority for over 20 years (United Nations, 1993). *Healthy People 2020* prioritized reducing sexual violence with this objective also contained in *Healthy People*

2030 (U.S. Office of Department of Disease Prevention and Health Promotion, 2014), and the United Nations' 2030 sustainable development goals include peace, justice, and gender equity free from sexual violence (Transforming Our World, n.d.). The World Health Organization's (WHO) *Global Plan of Action* is to strengthen the health system structures to reduce and eventually eliminate sexual violence (WHO, 2016). Additionally, the leader in forensic nursing, the International Association of Forensic Nurses (IAFN), published a call to action which stressed the critical need for survivors to have trauma-informed care post sexual assault (2018).

With the beginning of the #MeToo era in 2017, sexual violence became integrated into public discourse. The #MeToo movement has unified sexual assault survivors globally and has claimed media spotlight on sexual assault. Thus, it has become necessary to examine the possible offline health impact that social media movements, such as #MeToo, has had on sexual assault survivorship (Bravo et al., 2019).

Financial burden. The financial burden of sexual assault in the U.S. is high; it is estimated to be at least $41,000 per offense, an annual cost of $20 billion (McCollister, French & Fang, 2010). Sexual assaults may result in pregnancy; an estimated 2.4% to 5% of females in the U.S. become pregnant as a result of assault (Basile et al., 2018; Holmes, Resnick, Kilpatrick, & Best, 1996), which is estimated to cost the U.S. $21 billion annually (Monea & Thomas, 2011). The most common STIs acquired through sexual assault include trichomoniasis, gonorrhea, and chlamydia (Lamba & Murphy, 2000); the cost of which is about $16 billion annually (CDC, 2015; Owusu-Edusei et al., 2013; Sonfield & Kost, 2013). Despite the high economic burden, rate and incidence in the U.S., funding for sexual violence prevention is low compared to other public health concerns such as heart disease, diabetes, and HIV (Waechter & Ma, 2015). Additionally, funding for post-assault health care services and forensic services is also limited.

This lack of funding contributes to a lack of immediate STI and contraceptive prophylaxis, and a stark national backlog of collecting and processing sexual assault evidence collection kits (SAECKs or ‘rape kits’) (End the Backlog, 2019; U.S. Government Accountability Office, 2016).

Social media strategies for health campaigns are underutilized. Social media is a powerful, yet underutilized, tool in health promotion and disease prevention (Wakefield, Loken, & Hornik, 2010; Zhang & Centola, 2019). For example, numerous public health campaigns marketed via social media and focused on sexual health have demonstrated efficacy by reducing health disparities and promoting healthy behaviors (Grier & Bryant, 2005; Martinez-Donate et al., 2010; Plant et al., 2014; Stephens, Bernstein, McCright, & Klausner, 2010). National health promotion campaigns focused on HIV testing and prevention have shown to increase STI-related health-seeking behaviors (McFarlane et al., 2015). Mass media campaigns, such as those concerning tobacco products, physical activity, and road safety, have also shown strong evidence of health benefits by shaping health behaviors (Wakefield et al., 2010). The more the patient (consumer) is involved in the planning process of the media campaigns (aka community-based prevention marketing), the greater the behavior change potential (Grier & Bryant, 2005).

Although the majority of Americans (67%) agree that social media is important for creating sustained movements for social change (Anderson, Toor, Rainie & Smith, 2018), research on social media movements’ impact on health behavior is limited. Engaging with and connecting to social media movements is likely a promising new approach to health promotion (Bravo et al., 2019; Stephens et al., 2010; Zhang & Centola, 2019). Past social media movements have given clues into possible behavior change, such as the #BlackLivesMatter and the #ALSicebucketchallenge campaigns. For example, they both brought awareness/education to public health issues, and prompted people to act offline by donating money for treatment funds (ALS Association, n.d.) and racial justice (BlackLivesMatter, 2013).

Social media platforms provide ways to market preventative measures in health care, while also providing supportive spaces for users (Babatunde, 2018). Based on limited data, the #MeToo movement has offered an online network of social support for sexual assault survivors (Hosterman, Johnson, Stouffer & Herring, 2018). Researchers who examined online networks that provide safe and supportive spaces have documented that users often urge survivors to take some kind of offline action such as formal disclosure (Mendes, Ringrose & Keller, 2018; Moors & Webber, 2013). However, there is a dearth of understanding about how online social movements impact offline health and health seeking behaviors, particularly in the case of #MeToo. It is important to examine the influence of #MeToo on sexual assault survivors' experiences post assault, including motivations to seek post assault care and behaviors regarding disclosure to health care providers.

Purpose of Study and Study Aims

Since #MeToo began, an unprecedented number of survivors have reached out for support: from December 2017 to January 2018 there was a 110% increase in legal advocacy requests and a 43% increase for counseling services compared to the year prior (Atcheson, 2018). Additionally, there has been a significant rise in sexual assault legal service requests since October of 2017 across the nation (Jackson, 2018). A year after #MeToo began, the Ford and Kavanaugh hearing was televised; 201% more people reached out to the National Sexual Assault Hotline that day, which made it the busiest in their 24-year history (RAINN, 2018; Sacks, 2018). Disclosure has increased nationally, theoretically due to #MeToo (Morales, 2019).

The #MeToo movement has brought more attention to sexual violence and has reawakened the world to its prevalence (Bravo et al., 2019). It may also have staying power because it's resonating with survivors. It is crucial for nurse scientists to understand survivors' post assault behavior, given that there is evidence that this social media movement may be a critical paradigmatic shift in the sexual violence field. Thus, the purpose of this exploratory, descriptive qualitative study is to describe the extent to which the #MeToo movement has influenced both survivor's disclosure to a health provider and their health seeking behaviors post assault. The research question is "what are the patterns of sexual assault survivors' disclosure and health seeking behaviors in the era of #MeToo?" Study specific aims are to:

Aim 1: To explore #MeToo's influence on sexual assault survivors' decisions to disclose to a formal support (health provider).

Aim 2: To explore #MeToo's influence on sexual assault survivors' health seeking behaviors post assault, including: seeking forensic nursing care, care from another health provider, and the timeframe for care post assault.

Conclusion

This exploratory descriptive study aimed to understand the influence of #MeToo on a survivor's decision to disclose sexual assault (both to formal and informal supports) and obtain health care post assault (formal and/or general care). This study was the first to examine the influence of an online social media movement (#MeToo) on offline health behaviors. The knowledge gained from this study advances nursing science focused on the care of sexual assault survivors. Additionally, findings inform intervention strategies such as targeted public health campaigns that capitalize on online social movements to impact offline behaviors (in this case decision-making post sexual assault). As a strong collective, nurses and nurse scientists have an opportunity to support, build upon, and provide further health promotion interventions that capitalize on social media movements. This study provides the foundation for this effort by uncovering the impact of #MeToo on sexual assault survivors' health and health behaviors.

In the following chapter, the latest literature and the theoretical perspective that inform this work will be reviewed. Chapter three will detail the study design, research methodology, ethical considerations, analysis and rigor. Chapter four will describe research findings, while chapter five will discuss implications for future research, theory development, education, clinical practice and policy.

Standard Definitions and Assumptions Based on Existing Knowledge

Sexual Assault: Sexual assault is defined by the DOJ as any sexual contact or behavior void of the recipient's consent (2018). This may include rape, attempted rape, or unwanted sexual contact (U.S. DOJ, 2018).

Sexual Assault Nurse Examiner (SANE). SANEs are specially trained forensic nurses who are certified to provide trauma-informed-care and collect evidence from survivors of sexual assault (IAFN, 2018; U.S. DOJ, 2013). These forensic nurses are also referred to as sexual assault forensic examiners (SAFEs) in parts of the country (IAFN, 2018). Formal post sexual assault forensic care in the U.S. is primarily provided by SANEs (U.S. DOJ, 2017a).

Massachusetts Sexual Assault Forensic Examination Kit (MA-SAECK): The kit utilized by the SANE during formal post assault care. Often referred to as the 'rape kit.' Hereby referred to as the 'SAECK.'

Formal Post Sexual Assault Disclosure: The act of a survivor informing authorities such as health care providers (including SANEs), police, and/or counselors of the sexual assault (Ahrens et al., 2007; Ullman & Filipas, 2001). Reporting and disclosure are often used interchangeably in the literature. However, reporting also has the connotation of pursuing legal action starting with a police disclosure. This dissertation will only use the term ‘reporting’ if it’s a disclosure to police, and will use ‘disclosure’ if so to formal or informal supports.

Informal Supports: Friends or family members of the sexual assault survivor.

Informal Post Sexual Assault Disclosure: The act of a survivor informing friends or family members of the sexual assault (Ahrens et al., 2007; Ullman & Filipas, 2001).

Formal Supports: In this dissertation, we will be referring only to health care providers.

Formal Post Assault Care (FPAC): The formal post sexual assault forensic exam and is bound by timeframes for evidence collection. While there may not be a time limit for when a sexual assault may be disclosed, there *is* a time limit for forensic evidence collection – this window is small at only 120 hours (five days) post assault for vaginal penetration (U.S. DOJ, 2013). The window is even smaller for gathering evidence after an oral or anal assault (24 hours and 48 hours respectively), for starting HIV prophylaxis (72 hours), and for completing a toxicology screen (96 hours) (U.S. DOJ, 2013). The forensic exam plays an important step in the re-empowerment process as well as in the criminal justice system (Campbell et al., 2014; Fehler-Cabral et al., 2011). This formal post sexual assault care is provided under the framework of trauma-informed care (TIC). TIC is a framework for providing care during a SANE exam where there is an understanding on the part of the SANE that the sexual assault survivor has just experienced a traumatic event; the focus of the exam is thus on the survivor’s safety, comfort, and control (Butler, Critelli & Rinfrette, 2011). Additionally, the forensic exam is the important first step in the re-empowerment process as well as in the criminal justice system (Campbell et al., 2014; Fehler-Cabral et al., 2011), as it uses the model of trauma-informed care and the evidence serves as a tool for corroborating the patient's story and for linking the assailant to the crime (U.S. DOJ, 2017a).

General Post Assault Care (GPAC): This post sexual assault health care is not bound by timeframes and is performed by any primary or specialty health care provider. For example, the survivor may seek out routine health care and disclose a past sexual assault during that visit, weeks, months or even years after the sexual assault (Sutherland, Fontenot, & Fantasia, 2014). Health care providers are well-positioned to provide support to survivors and act as a gateway to referrals and resources such as psychological care and counseling, social work, and legal services (WHO, 2013).

Social Media: This term was coined in the 1990s, with the advent of AOL, an online chat service – it was deemed "a mashup of technology and communications and media" (Bercovici, 2010, para. 4). While not explicitly defined in the literature, three attributes are commonly agreed upon for what constitutes social media: (1) that it is web-based; (2) that it provides a means for individuals to connect and interact with content and other users; (3) it allows users to generate and distribute content on the respective platforms (Treem, Dailey, Pierce, & Biffl, 2016). Furthermore, there are different genres of communication within these social media communities (e.g. social networking site, blog, microblog) and differing platforms that facilitate these communication activities (e.g. Reddit, Facebook, Instagram, and Twitter) (Treem et al., 2016).

Social Marketing Campaigns: Public health marketing campaigns that have been designed and implemented via social media platforms, to promote socially and individually beneficial behavior change (Grier & Bryant, 2005)

Social Movements: Networks of flexible, informal interactions between individuals, groups and/or organizations that engage in and enable political or cultural discourse, and may spark rapid action on the basis of a shared collective identity (Bennett & Segerberg, 2012; Diani, 1992, 2000). With the help of social media, social movements are able to “organize across borders on a transnational level to build networks that overcome time/space constraints, potentially leading to a movement spill-over” (Cammaerts, 2015, p. 5)

Weak-Tie Networks: Interconnections between individuals within a social network that are anonymous and based on the ability for users to connect through experiences (Cammaerts, 2015). It is a way to easily share information and resources online without making lasting relationships (Cammaerts, 2015).

Chapter 2: Review of the Literature

Introduction

This research study aimed to explore the influence of social media movements on sexual assault disclosure and health behavior patterns, including seeking general post assault care (GPAC) or formal post assault care (FPAC). This chapter reviews the theoretical and philosophical underpinnings for this study, and provides a synthesized review of the literature including: (1) the influence of social media on health, (2) survivors' disclosure of sexual assault, and (3) survivors' health seeking behaviors post sexual assault. A review of the health risks of sexual assault is also included.

Theoretical Framework and Philosophical Underpinnings

Theory. Liang and colleagues' (2005) social ecological model for sexual assault disclosure is an integrated theory of help-seeking that considers a confluence of social and individual factors on help-seeking behavior for survivors of intimate partner violence. There are three aspects of help-seeking that may or may not happen in a specific order. One is defining and acknowledging that a sexual assault did in fact occur (Liang, Goodman, Tummala-Narra, & Weintraub, 2005), which may be influenced by cultural and social norms. The second is the act of help-seeking or disclosure, which may be wrought with its own set of barriers. The third are the outcomes of the disclosure or help-seeking (Liang et al., 2005). Overarching these three phases of behavior are both contextual or macro influences (such as rape myths, culture, and social climate) and individual or micro influences (such as demographics, social network, and resources) (Liang et al., 2005). This theory is reminiscent of Bronfenbrenner's ecological systems theory, wherein an individual (and hence their decisions) are shaped by a confluence of the micro, meso, exo and macrosystems of the individual (Bronfenbrenner, 1974, 1977). While the theory does not specifically speak to social media movements, social media movements and their influence could theoretically be found in both the macro system (influencing culture), but also micro with its network of weak-ties (see standard definitions). This study will give more insight as to how social media and social media movements can be integrated into this model. This theory is feminist in nature, and aligns well with the philosophical underpinnings of the study. This theory guided the qualitative semi-structured focus group script.

Philosophy. The feminist perspective will be used to examine survivors' sexual assault disclosure and health-seeking behavior in the era of #MeToo. Sexual assault is deeply rooted in power and control imbalances, and the voice of survivors have historically been silenced. Feminist philosophy provides insights into the power dynamics of relationships and the distribution of power amongst the population (Rogers, 2005). Through this feminist lens, the lived experience of women is paramount, and the goal is to unearth subjugated knowledge (Hesse-Biber & Griffen, 2015). Feminist philosophy allows researchers to examine health problems through a social justice lens, and in turn advocate for health equity (Falk-Rafael & Betker, 2012; Rogers, 2005) and contribute to social change (Reinharz, 1992). Feminist theory also attempts to transform power relations found within gender and societies (Reinharz, 1992), so the feminist lens is political, gendered, reflexive, as well as transformative (Gustafson, 2000). Lastly, the focus on feminism and social media is emerging as a transdisciplinary trend amongst national and global scientists (Turley & Fisher, 2018).

It is well-documented in the literature that there have been three waves of feminism – from the 1920s and the suffrage movement, to the 1960s of radical feminism and the sexual revolution, to the 1990s of postmodern feminism with a focus on queer theory and individual emancipation (Munroe, 2013). Anti-sexual violence activism was prevalent in each of these waves in different ways (Armstrong, Gleckman-Krut & Johnson, 2018). Yet there has been recent agreement among scholars that we have entered into a fourth wave of feminism, with the new age of technology and internet activism (Crossley, 2015; Fotopoulou, 2016; Guillard, 2016; Mendes et al., 2018; Munroe, 2013). 'Digital feminism' supersedes the historical female exclusion from the public sphere and participation in politics, and allows for quick 'calling out' or challenging of sexist or misogynistic remarks online (Mendes et al., 2018; Munroe, 2013).

Two situations, 27 years apart, show both similarities and differences among feminist waves. In 1991, Anita Hill appeared before Congress at the Supreme Court confirmation hearing of Clarence Thomas ("Finally, a proper hearing", 1991). Hill, a 35-year-old lawyer, testified that Thomas had sexually harassed her 10 years earlier (Bouchard & Taylor, 2018). Though credible and poised, she endured humiliation at the hands of male senators during her testimony (Bouchard & Taylor, 2018). In 2018, the testimony of Dr. Christine Blasey Ford at the Supreme Court confirmation hearing for Brett Kavanaugh took place. Ford accused him of sexually assaulting her in high school (Bouchard & Taylor, 2018). Mirroring Hill's experience, Ford too was subjected to fear and humiliation, though contrary to Hill's hearing, there was nonstop national media coverage of Ford's hearing through print, television, and over social media platforms. However, the hearings had an impact on fellow survivors during and post both Hill's and Ford's hearings (Koerth-Baker, 2018; Svokos, 2018). For example, after Hill's hearing, a large number of women entered into politics and were elected in record numbers, dubbing it the year of the woman (Bouchard & Taylor, 2018; Svokos, 2018). Digital feminism was evident immediately following Ford's hearing, as more than 3,000 people called the National Sexual Assault Hotline, making it the busiest the hotline has ever seen (Rape Abuse and Incest National Network [RAINN], 2018). In the first four days, the hotline saw a 338% increase in calls

(RAINN, 2018). That month, RAINN (2018) provided 28,509 survivors with services, averaging 950 each day, 10,000 more than the same month of the previous year. The impact of social media movements on offline health behavior is perhaps another part of this fourth, digital feminist wave to be discovered. This will be further explored.

Synthesized Review of the Literature: Methods

This review will provide a synthesis of the literature on the following topics: (1) social media's influence on health, (2) disclosure of sexual assault, and (3) health seeking behaviors post sexual assault. A review of health risks associated with sexual assault will also be provided. The following databases were searched: Google Scholar, PsycINFO, PubMed, the Cumulative Index of Nursing (CINAHL), ProQuest Sociology, and Women and Social Movements in the United States. For social media movements, search terms included #MeToo, social epidemiology, social media campaigns, social media movements, health, behavior, and feminism. For disclosure, search terms included sexual assault, sexual violence, rape, disclosure, and #MeToo. For health care, search terms included sexual assault, sexual violence, rape, medical services, nursing, health, health care, nursing, forensic exam, forensic nurse, and SANE. Only peer-reviewed articles written in English and published within the past two decades (2000) were considered eligible for review.

Synthesized Review of the Literature: Results

Social media's influence on health. Social media usage has grown exponentially in the past decade and a half and has become the standard means of social communication nationally and internationally (Baruah, 2012). For example, there are over 200 million active Twitter users per day around the world (@TwitterIR, 2021) generating conversations, making connections, and both dispersing and gleaning all types of information and news. Therefore, it is no surprise that the influence of social media on health is an emerging area of interest among health scientists. Thus, in this section of the review, the following areas in the literature are explored: 1) current social media use, 2) social media marketing and health behavior, 3) social media, movements, and offline behavior, and 4) social networks and health behavior.

Social media use. According to researchers from the Pew Research Center who examined social media use in the U.S. between 2017 and 2019, the vast majority of the public engaged with at least one social media platform, and often multiple times a day (Smith & Anderson, 2018). While 18 to 29-year-olds were the highest consumers of social media (88%, with 94% owning smartphones), this rate steadily declined as age increased (30-49 at 78%, 50-64 at 64%, and 65 and older at 37%) (Smith & Anderson, 2018). Facebook was the primary social media platform for most American adults (69%), though young adults (18-29) were especially high users of Snapchat (78%), Instagram (71%) and Twitter (45%) (Smith & Anderson, 2018). Most users visited these sites at least daily (Facebook 74%, Snapchat 63%, Instagram 60%) though more than half (51%) visited these sites multiple times a day (Smith & Anderson, 2018). Additionally, more than half of the young adult social media users (51%) said it would be hard to give up social media (Smith & Anderson, 2018).

Within the first 24 hours of the first #MeToo tweet in October of 2017, the hashtag was used 12 million times (Hosterman, Johnson, Stouffer & Herring, 2018). Within the first year, the hashtag was used over 19 million times on Twitter alone, with surges around events such as the Golden Globes (January 7th, 2018) and Les Moonves' resignation from CBS after allegations of sexual assault surfaced (September 9th, 2018) (Anderson & Toor, 2018). Twenty-nine percent of the hashtag posts had been in languages other than English (Anderson & Toor, 2018) and other hashtags had been born out of this movement such as #TimesUp, #WhyIDidntReport and

#BelieveSurvivors (Fortin, 2018; Solani & Pundir, 2019; TimesUp, 2018). The majority (65%) of social media users saw “a great deal” or “some” content on these platforms that related to #MeToo (Anderson & Toor, 2018, para. 6). Furthermore, the majority of Americans (67%) agreed that social media is important for creating sustained movements for social change (Anderson et al., 2018).

Trends from victim’s rights law centers and rape crisis centers showed that since #MeToo began, more survivors had been reaching out for counseling and legal support (Atcheson, 2018; Jackson, 2018). Anecdotally, #MeToo was influencing survivors’ decisions to seek out FPAC and disclose to both informal and formal supports (Southall, 2019).

Social media marketing and health behavior. Social media platforms provide supportive spaces for users as well as ways to market preventative measures in health care (Babatunde, 2018). For example, numerous public health campaigns marketed via social media have focused on sexual health, and have demonstrated efficacy by reducing health disparities and promoting healthy behaviors (Grier & Bryant, 2005; Martinez-Donate et al., 2010; Plant et al., 2014; Stephens et al., 2010). National health promotion campaigns focused on HIV testing and prevention, for example, have been shown to increase STI-related health-seeking behaviors (McFarlane et al., 2015). Mass media campaigns, such as those concerning the reduction of tobacco products, as well as promoting physical activity and road safety, have also shown strong evidence of health benefits by shaping health behaviors (Wakefield et al., 2010). Zhang and Li (2017) found that the spread of promotional messages through a social network could amplify the impact of offline, peer-to-peer social influence on health-promoting behavior change. Grier and Bryant (2005) concluded that the more the patient (consumer) is involved in the planning process of the media campaigns, the greater the behavior change potential. Thus, social media marketing has the potential to be an agent for both individual and community-level change. It may shape social norms by providing audiences with targeted health care information which may influence positive health behaviors (Wakefield et al., 2010).

Social media, movements, and offline behavior. Researchers have found that social media can play an active role in both establishing and legitimizing social movements (AlSayyad & Guvenc, 2015; Benski, Langman, Perugorría, & Tejerina, 2013), as the Internet has transformed the ability of online mobilization and cyberactivism (McCaughey & Ayers, 2003; Treem et al., 2016). Social media has contributed to the development of policies in the domains of science (Rotman et al., 2012) and government (Bertot, Jaeger & Grimes, 2010). Social media can help mobilize protests, organize uprisings, head policy change efforts, influence decision-making processes, and connect academics, advocates and activists around the world (Della Porta & Diani, 2006; Hick & McNutt, 2002; Mansoor, 2015). According to multiple researchers, social media has expanded from what was called collective action to what is now connective action, which may have more ability to influence change and behavior (Bennett & Segerberg, 2012; Leong, Pan, Bahri & Fauzi, 2019).

Social media has been a tool used to shape offline behavior in the field of public health and has been used to monitor the spread of epidemics and share timely, health-specific guidelines for consumers (Paul & Dredze, 2011). It has also been used to alert the public to critical information about natural disasters (Liu, Fraustino, & Jin, 2016) such as evacuation plans and safety tips (Treem et al., 2016). Researchers have documented that online communities provide valuable social support for users, such as parents (Duggan, Lenhart, Lampe & Ellison, 2015), as well as those experiencing illnesses such as eating disorders (Eichhorn, 2008) and breast cancer (Shaw, Hawkins, McTavish, Pingree & Gustafson, 2006). Raising money for public health causes, such as ALS, and mobilizing and attending anti-vaccination rallies are other ways online social media use can impact offline behavior (Kluger, 2019; Van Laer & Van Aelst, 2010).

Social networks and offline health behavior. Online social networks that focus on health fulfill a variety of functions that offline networks cannot. For example, social networks have the capacity to transcend geographic boundaries and maintain different levels of anonymity (DeAndrea, 2015). They also allow participants to connect with others who share similar characteristics and experiences (Chung, 2014; Naslund, Aschbrenner, Marsch, & Bartels, 2016; Tanis, 2008). Online social networks can also influence users' attitudes towards health behaviors such as smoking cessation and promoting regular exercise (Centola, 2013). Thus, online networks can be particularly useful for addressing behavior change topics that are associated with stigma or are sensitive, such as potential HIV diagnoses, using contraception, and smoking cessation (Zhang & Centola, 2019). While Centola (2013) found that online social support can help spread desirable offline behavior change, both Huang and colleagues (2014) and Nesi and colleagues (2017) found that exposure to online risk health behavior, such as drinking alcohol, among networked peers can influence adolescents' alcohol drinking behaviors. These studies are indicative of the power that online networks may have on offline behavior, be it positive or negative.

The #MeToo movement created a weak-tie social support network, wherein there is little effort on the survivor to disclose their assault to strangers, though there may be great emotional and informational support benefit (Centola, 2013; Hosterman et al., 2018). This is largely due to anonymity and access to a large group of people and resources who share a similar story of victimization (Hosterman et al., 2018). Thus, the #MeToo movement has offered an unprecedented network of support via social media to sexual assault survivors (Hosterman et al., 2018).

Strengths and weaknesses of existing data. The study of social media movements and their impact on health behavior is an emerging field, though what data we do have is promising. In addition to understanding that disclosing online during a movement like #MeToo may impact mental health, survivors often receive direct emotional support from other social media platform users (Hosterman et al., 2018); see the 'online disclosure' and 'positive reactions to disclosure' sections below). However, no researchers have examined the influence of #MeToo on other aspects of health and health behavior. Informational support is often given via social media (Hosterman et al., 2018) but there is limited research that examines whether those supports are utilized and/or how offline. According to experts in the field Zhang and Centola (2019), more research is needed to examine how online social networks impact offline health, as well as the effectiveness of social network interventions for improving health.

Implications. The extent and reach of online social movements are evident. However, its potential power associated with offline health behavior has yet to be determined. More knowledge concerning social media movements and subsequent offline action must be examined. For example, are those who are retweeting #MeToo and disclosing via social media seeking out in-person support and utilizing in-person health care services; how did that movement impact their offline behaviors?

Survivors' disclosure of sexual assault. According to Ullman (2010), survivors' disclosure of a sexual assault can be both political and personal. Disclosure can help to label the assault, is a way to resist rape culture and pursue justice, and it can help the survivor begin the recovery and healing process in the aftermath of the assault. However, disclosure is often a complex decision, influenced by a multitude of micro (e.g. peers and community) and macro level variables (legal system and social norms) (Liang et al., 2005). Furthermore, survivors may either face a social response to their disclosure that is trauma-informed, empowering and comforting *or* that is blaming and unsupportive (Ahrens et al., 2009; Ullman, 2010). A negative response to the disclosure can be re-triggering and re-traumatizing for the survivor (Borja, Callahan, & Long, 2006; DePrince & Gagnon, 2018). Thus, literature examining (1) informal versus formal support disclosure patterns, (2) online disclosure, (3) influences of non-disclosure versus disclosure, and (4) both positive and negative responses to the disclosure, is reviewed below. The strengths and weaknesses of the reviewed studies, as well as implications are examined.

Informal versus formal support disclosure patterns. There is ample literature concerning sexual assault survivors' disclosure patterns to both formal and informal supports. It is well-documented that female survivors most commonly disclose to informal supports, such as family, friends, and significant others, as opposed to formal supports, such as legal or health care providers (Ahrens et al., 2007; Campbell, Ahrens, Sefl, Wasco & Barnes, 2001; Campbell, 2008; Filipas & Ullman, 2001; Fisher, Daigle, Cullen, & Turner, 2003; Liang et al., 2005; Orchowski & Gidycz, 2012; Starzynski, Ullman, Filipas, & Townsend, 2005). Fifty-five percent or more of survivors eventually disclose their assaults to informal supports, though this may be months or years from the assault (Krebs et al., 2007, Lindquist et al., 2013; Littleton, 2010; Orchowski & Gidycz, 2012). Researchers who examined these experiences among college women (ages 18-24) reported that almost half of students had a friend or loved one tell them about their sexual assault experience (Orchowski & Gidycz, 2012; Paul, Kehn, Grey & Salapska-Gelleri, 2014).

Overall, the rates of disclosing to formal supports, such as legal authorities or health care providers, is low (Fisher et al., 2003; Jones et al., 2008; Kilpatrick, Resnick, Ruggiero, Conoscienti, & McCauley, 2007; Wolitzky-Taylor et al., 2011). In 2011, Wolitzky-Taylor and colleagues found that these rates have not changed since the early 1990s, remaining at around 15%. Both Aherns and colleagues (2009) and Littleton (2010) found the rates of disclosure to health care providers alone was about 10%. Furthermore, disclosure to health care providers is usually delayed past the evidence-collection window of five days (Du Mont & White, 2007; Resnick et al., 2000; Zinzow et al., 2012).

Online disclosure. There have been few researchers who have examined online disclosure and online sexual survivorship networks. It appears that sexual assault survivors often go online post assault in the hope of seeking clarity as well as gaining helpful feedback or advice (Andalibi, Haimson, De Choudhury, & Forte, 2016; Moors & Webber, 2013). Mendes and colleagues (2018) looked at the survivors' online disclosure using the hashtag #BeenRapedNeverReported that trended in 2016. Survivors felt a sense of solidarity and support from the 'favorites', 'retweets', or 'DMs' (direct messages) from strangers (Mendes et al., 2018). Support from social networks led survivors to understand sexual violence as a structural, rather than personal problem, and online disclosure often subsequently led to formal disclosures (Mendes et al., 2018). Over half of the online responses to a survivor urged some kind of action, with the majority advising a formal disclosure and some, an informal disclosure (Moors & Webber, 2013). However, it is unknown if the survivors actually took this advice. Moors and Webber (2013) also found that over half of the survivors who disclosed online had already tried finding help (both formal and informal) and had been unsuccessful. Reasons for disclosing online as opposed to formal or informal in-person supports were due to shame/guilt, loneliness, fear, and confusion (Moors & Webber, 2013). Bogen, Bleiweiss and Orchowski (2018) examined social reactions to online disclosure of sexual assault using the hashtag "#NotOk" and found that most reactions (67%) were positive and supportive. Often survivors were given helpful advice and encouragement from fellow survivors online, such as how to move forward with the assault from a legal perspective (Webber, 2014). Survivors felt empowered when their assault was acknowledged by others (Lokot, 2018; O'Neill, 2018), and positive social support is related to adaptive coping following a sexual assault (Littleton, 2010) and to decreased PTSD symptoms (Dworkin, Ojalehto, Bedard-Gilligan, Cadigan & Kaysen, 2017).

Influences of non-disclosure. There are many reasons cited in the literature why survivors may refrain from disclosing. These include but are not limited to: stigma and victim-blaming, distrust in the legal system, family concerns such as wanting to protect loved ones from the incident, fear of retribution, shame/guilt, concern over presumed lack of proof, and downplaying the event to a misunderstanding or it being "not a big deal" (Spencer, Mallory, Toews, Smith, & Wood, 2017, p. 171; Kilpatrick et al., 2007; Krebs et al., 2007; Wolitzky-Taylor et al., 2011). "Did not know how" was also cited by almost half of survivors (44%) for the reason why they did not disclose to formal supports (Wolitzky-Taylor et al., 2011, p. 817) but other researchers discovered that 19% of their participants cited "lack of information" (Spencer et al., 2017, p. 175). Tjaden and Thoennes (2006) reported anticipated negative social reactions as a factor for non-disclosure. Furthermore, Ahrens and colleagues (2007) and Ullman (2010) found that a history of past negative social reactions from disclosing a previous assault impacted future decisions not to disclose. The trauma from the sexual assault may be a deterrent for disclosing in of itself (Wilson & Miller, 2015), along with possible resulting fragmented and/or disorganized memory (DePrince & Gagnon, 2018). Low rates of disclosure may also be impacted by the survivors' awareness of low criminal conviction rates (Campbell et al., 2001), which is extremely low at 2% (U.S. DOJ, 2017b). Cultural beliefs and societal factors may hinder the acknowledgment of the victimization of survivors in some communities and subsequent disclosures (Ahrens et al., 2009; Liang et al. 2005; Lindhorst & Tajima 2008; Ullman, 2010). Johnstone (2016) reported self-blame, avoidance and dismissal as reasons why survivors do not disclose. The concept of hidden rape was first conceptualized by Koss (1985), which was further expanded upon two decades later; Wilson and Miller (2015) called it 'mislabeling rape' and 'unacknowledged rape' while Johnstone (2016) called it 'normalizing.'

The #WhyIDidntReport hashtag was first used September 21, 2018 in response to President Trump's Twitter backlash about Dr. Ford's hearing. On examination of the tweets, survivors most frequently cited hopelessness (30.9%) and fear (20.6%) for not having wanted to have previously disclosed, followed by shame (18.7%) and lack of information (8.6%) (Garrett & Hassan, 2019). These findings are similar to what Moors and Webber (2013) found for reasons to disclose online (see above) instead of to formal or informal supports.

It is clear, as evidenced above, that there are significant barriers survivors face when disclosing a sexual assault. However, this literature gives insight into where there may be opportunity to facilitate change, for example, providing education to the public about disclosing, and changing cultural beliefs such as victim-blaming.

Influences of disclosure. Overall, survivors may disclose to formal supports to prevent others from being victimized (38.2%), apprehend the assailant (12.2%), prevent further crime against themselves (10.9%), and/or receive medical care (3.9%) (Wolitzky-Taylor, 2011). Kilpatrick and colleagues (2007) found significant predictors of disclosing to formal supports were physical force, verbal threats, physical injury, perceived fear of death/injury during the assault, and concern about family knowing about the assault. However, similar to Wolitzky-Taylor (2011), the main reason for reporting was an altruistic one, to prevent crimes *against others* (Kilpatrick et al., 2007). Survivors chose to disclose to formal supports for both reassurance (Ahrens et al., 2007) and for STI prophylaxis (Sturza & Campbell, 2005). If the assault represented the stereotypical rape scenario, particularly a violent stranger as the perpetrator, the survivor was also more likely to disclose (Clay-Warner & McMahon-Howard, 2009; Kaukinen, 2004; Starzynski et al., 2005). This is indicative of rape myths holding steadfast in society (DePrince & Gagnon, 2018) and among survivors themselves. If survivors experienced a rape myth scenario, for example if their perpetrator was a violent stranger in a dark alleyway, it may be easier for the individual to label the assault, and may influence whether they are believed by formal and informal supports.

Historically, researchers documented that social expectations from informal supports (both due to advice as well as pressure to seek help) influenced help-seeking from formal supports (Feldman-Summers & Norris, 1984). Over two decades later, Kilpatrick and colleagues (2007) found similar results; more than half of victims were encouraged by informal supports, such as friends, to report the assault to legal authorities. Among adolescent survivors, Campbell and colleagues (2015) found three disclosure patterns: 1) friends the survivors told encouraged and assisted them to disclose to formal supports (voluntary disclosure), 2) friends they told in turn told adults about the assault, against the survivors' wishes, and the adults *made* the victims seek help (involuntary disclosure), and 3) survivors were unconscious at the time of the assault, and their friends disclosed and sought help on their behalf (situational disclosure). Only the first pattern was related to a sustained engagement with the post-assault care process (and the prosecution process in this study) as the survivors had complete control over their decision-making ability (Campbell et al., 2015)

Lastly, race/ethnicity and educational attainment have also been noted as predictors of disclosing to formal supports. Black and Hispanic women may be less likely to report than White women (Wolitzky-Taylor et al., 2011). Plus, women with higher educational attainment (a college degree) may also be less likely to report than those with lower levels of education (Wolitzky-Taylor et al., 2011). Black and Hispanic women may be less likely to disclose if they perceive they are less likely to be believed, or they do not trust the police or health care provider. Those with a college degree may be aware that there are systemic legal issues for sexual assault cases, and feel as though coming forward will not lead to justice.

Positive responses to disclosure. Multiple research teams have found that positive engagement and reactions at the time of disclosure have a positive effect on survivors (Borja et al., 2006; Mason, Ullman, Long, Long, & Startzynski, 2009; Orchowski & Gidycz, 2012; Ullman & Peter-Hagene, 2014). Mason and colleagues (2009) concluded that survivors who received higher levels of emotional and informational support from informal and formal supports alike reported fewer incidents of being re-victimized again that those who did not. Furthermore, positive responses to disclosure promoted healing and well-being (Orchowski & Gidycz, 2012), higher levels of self-efficacy in recovery (Borja et al., 2006), as well as healthier coping behaviors and fewer PTSD symptoms (Ullman & Peter-Hagene, 2014). Positive social reactions and support can buffer the negative effects of the assault, reduce self-blame, and provide useful resources (Kaukinen & DeMaris, 2009; Patterson, Greeson & Campbell, 2009).

Negative responses to disclosure. Conversely, negative responses to disclosure have a negative effect on health (Borja et al., 2006; Campbell, 2009; Mason et al., 2009; Orchowski &

Gidycz, 2012; Ullman, 2010; Ullman & Peter-Hagene, 2014). Blaming and trying to take control of the survivor's post-assault decision making ability contributed to the survivors suffering and/or exacerbated the survivor's distress and was re-traumatizing (Campbell, 2009; Orchowski & Gidycz, 2012). These negative responses also increased the survivor's PTSD symptoms as well as feelings of helplessness and self-blame (Borja et al, 2006; Ullman & Peter-Hagene, 2014). Overall these survivors had poorer mental health outcomes (Ullman, 2010). Negative social reactions may make the survivor question the legitimacy of the sexual assault (Ahrens, 2006) and are associated with higher risk of re-victimization (Mason et al., 2009).

Strengths and weaknesses of existing data. There is little precision and uniformity among studies looking at disclosure. Inconsistencies were evident in defining disclosure or reporting, to who disclosed the assault, the timeframe for disclosure, and to whom the assault was disclosed. These nuanced differences make it challenging to come to conclusions even among national data, and to synthesize it in the context of formal and informal disclosures. Additionally, all but one of the studies reviewed gathered data before the #MeToo movement even began, thus limiting what we know about disclosure patterns in this current culture. Furthermore, although Garrett and Hassan (2019) were the first who looked at survivor's responses since #MeToo, this analysis was only of Twitter responses and not of offline behaviors.

Implications. The literature on disclosure patterns, including influences for disclosure and non-disclosure, as well as reactions to disclosure, give insight into what is known about this topic. It is evident that survivors find disclosure difficult, and often cite fear, hopelessness, denial, shame, and a lack of information as to why they do not disclose (Garrett & Hassan, 2019; Moors & Webber, 2013). Moreover, ramifications of negative reactions are immense (Borja et al., 2006; Campbell, 2009; Mason et al., 2009; Orchowski & Gidycz, 2012; Ullman, 2010; Ullman & Peter-Hagene, 2014). However, with the availability of social media platforms for disclosing and the online anonymity that comes with it, these disclosure patterns may be changing. Notably, both Wolitzky-Taylor (2011) and colleagues and Kilpatrick and colleagues (2007) found that the largest predictor for formal disclosure was to stop crimes against others. Lastly, it is evident that informal supports may act as the first responders, as they are often told first of the sexual assault. However, survivors may only follow through with post-assault care and the prosecution process if they make the decision themselves and are not forced (Campbell et al., 2015).

Health risks of sexual assault. The literature is replete with the numerous health risks, both physical and mental, from sexual assault victimization. They also include both short and long-term risks. For example, female survivors of sexual assault are at risk for numerous gynecologic problems; these include higher rates of urinary tract infections and bladder infections, STIs, pelvic pain and dyspareunia (Campbell, Lichty, Sturza & Raja, 2006; Mark et al. 2008). Survivors of sexual assault may find pelvic examinations distressing, embarrassing and frightening (Weitlauf et al., 2010). This could raise the risk of cervical cancer if survivors are less likely to attend routine gynecologic visits where cervical cancer screenings via pelvic examination are performed (Coker, Hopenhayn, Desimone, Bush & Crofford, 2009).

Hawks and colleagues (2019) studied forced first sexual encounters – in their sample, one in 16 women’s first sexual encounters were forced. They discovered that these female sexual assault survivors were more likely to contract pelvic inflammatory disease (PID), and have ovulatory or menstrual problems at a higher rate than those who have not been sexually assaulted. They were also more likely to report poorer health overall and illicit drug use, and have a more difficult time finishing tasks due to physical or mental complaints (Hawks et al., 2019). Forced sexual encounters also led to higher rates of unwanted pregnancy or abortion (Hawks et al., 2019).

Sexual assault survivors are at a higher risk of developing depression, anxiety, eating disorders, weight change, sleep disorders and PTSD than those who do not experience sexual assault (Black et al., 2011; Campbell et al., 2009; Chen et al., 2010; Dworkin et al., 2017; Zinzow et al., 2012). Researchers have suggested that up to 94% of sexual assault survivors will exhibit acute PTSD symptoms in the first 2 weeks following an assault (Riggs, Murdoch & Walsh, 1992). Additionally, among both adult and adolescent survivors, there is a higher risk of suicide and suicide attempts (Chen et al., 2010; Tomasula, Anderson, Littleton, & Riley-Tillman, 2012).

Survivors' health seeking behaviors post sexual assault. Despite the known negative impact sexual violence has on health, the majority of survivors do not seek formal health care post sexual assault (FPAC) (Garcia-Morena et al., 2006; Lindquist et al., 2013; Wolitzky-Taylor et al., 2011; Zinzow et al., 2012). Although some researchers have documented that up to one in four (26%) survivors may receive care post sexual assault (Resnick et al., 2000), others have estimated this number to be less than one in five sexual assault survivors (Ahrens et al., 2009; Lindquist et al., 2013; Kilpatrick et al., 2007; McCauley, Kilpatrick, Walsh & Resnick, 2012; Orchowski & Gidycz, 2012; Wolitzky-Taylor et al., 2011; Zinzow et al., 2012). This sought care is also often delayed past the window of evidence collection of 120 hours (Du Mont & White, 2007; Resnick et al., 2000; Zinzow et al., 2012). However, data are limited as none of these researchers have collected data since the #MeToo movement began.

Disclosure to health care professionals and seeking health services post assault, especially to SANEs (which is trauma-informed care within five days), is paramount to avoiding health risks and facilitating healing (Campbell et al., 2014; Crandall, & Helitzer, 2013; Fehler-Cabral et al., 2011). In the following paragraphs, delayed and informal health seeking behaviors, as well as formal health seeking behaviors is examined. Strengths and weaknesses will be assessed, and implications of the review will be offered.

Delaying care and general health seeking behaviors post sexual assault. Multiple research teams have found that if the survivor knows the assailant they are more likely to delay post assault care (Adefolalu, 2014; Kilpatrick et al., 2007; McCall-Hosenfeld, Freund & Liebschutz, 2009; Millar, Stermac & Addison, 2002; Nesvold, Friis, & Ormstad, 2008). Adefolalu (2014) reported that both fear of the assailant and reprisal, as well as fear that informal supports (e.g. family members) would not believe them, is one reason to delay medical care. Nesvold and colleagues (2008) reported that survivors having experienced verbal threats or coercion were also more likely to delay care. Additionally, Millar and colleagues (2002) described briefly being held captive as a reason to seek out timely formal care, although Adefolalu (2014) found that was a reason to delay care. These last conflicting results are surprising, as one might assume that verbal threats and being held captive for a short period of time would influence earlier presentation. However, Adefolalu's (2014) study took place in South Africa, and this discrepancy could imply larger differences in FPAC access and quality in other countries. Additionally, it's also possible these situations would have caused more emotional trauma, which in turn would have instilled more fear and overall perceived lack of control in the victim. Additionally, this lack of power is evident across all the reasons to delay care described in this section.

Survivors are more likely to delay care past the evidence collection window if they were intoxicated during the assault, and/or if they were assaulted in their own home (Kilpatrick et al., 2007; McCall-Hosenfeld et al., 2009). Survivors are also less likely to seek out formal forensic care if they are less than 18 years old (Nesvold et al., 2008). Additionally, concern about cost was cited by 32.7% of survivors as a reason not to seek out formal help (McCauley et al., 2013). Tjaden and Thoennes (2000) found that while almost a third (31.5%) of sexual assault survivors had a resulting injury, only about one third of those with injuries sought out some type of health care (35.6%). This care included hospital care, physical care, dental care, paramedic care and/or physical therapy (Tjanne & Thoennes, 2000). Lastly, Wadsworth and colleagues (2019) found that survivors chose to seek general post sexual assault care if they knew their providers were empathetic, knowledgeable and female. However, survivors were reluctant to seek general health care post assault because their provider was male, they feared being judged and dismissed, and they would be reminded of the assault (Wadsworth, Krahe, & Searing, 2019).

Formal post assault care seeking. There are multiple documented reasons for formal health care seeking, including verbal and physical threats to the survivor and/or having experienced severe physical violence during the assault (McCall-Hosenfeld et al., 2009; Millar et al., 2002). Zinzow and colleagues (2012) found that FPAC is most often sought when the assault was a ‘classic rape’ scenario and/or the survivor already reported to the police and was encouraged to undergo a forensic examination. The survivors who sought care also likely had specific health concerns such as STI and HIV acquisition and pregnancy (Zinzow et al., 2012). Johnson and Hiller (2016) reported that geographical access to a health care center matters; if the assault was in the same community as the health care facility providing the exam, the survivor was more likely to present for formal care. Experiencing PTSD symptoms also increased lifetime mental health professional utilization services (Amstadter, McCauley, Ruggiero, Resnick, & Kilpatrick, 2008). Amstadter and colleagues (2008) also found that race was correlated with help-seeking – those identified as White were more likely to seek FPAC than individuals of color. Women of color who have low socioeconomic status (SES) may face increased barriers to accessing help, such as transportation issues (Kennedy et al., 2012). However, contrary to this finding, Zinzow and colleagues (2012) found that Black participants were more than three times as likely than White participants to seek formal health care following an assault. Resnick and colleagues (2000) found that those who disclosed to formal supports, such as legal authorities, were nine times as likely to receive post assault care than those who did not. Zinzow and colleagues (2012) echoed that finding, despite being after 2005, when the Violence Against Women Act (VAWA) mandated that states receiving VAWA funds could no longer require sexual assault victims to report the incident to the police in order to receive and/or be reimbursed for a forensic examination (Violence Against Women and Department of Justice Reauthorization Act, 2005).

Once FPAC is sought, the chance that other forms of formal help will be sought increases (Kennedy et al., 2012). However, this may be based on the type of response received. For example, Campbell (2008) found that upwards of 30% of survivors who sought formal support found it not helpful and even harmful. Thus, survivors may become more hopeless and stop seeking help from formal supports if such a reaction is garnered (Kennedy et al., 2012). Moreover, it is estimated that only 14% of emergency departments (EDs) nationwide provide specialized post assault forensic care (IAFN, 2017). Thus, even if survivors do seek help from formal supports, they may be turned away from EDs that do not offer FPAC services (U.S. Government Accountability Office, 2016).

Strengths and weaknesses of existing data. Similar to the disclosure literature, most researchers designed their own questions for health seeking behaviors, detracting from comparisons across studies and muddling understanding of these concepts. For example, service utilization and medical care seeking were terms used in the research but that did not encompass the formal post assault care behavior this study examined. However, it is clear that there is no study that only examines survivors accessing or seeking specific forensic nursing services after #MeToo began. 'Delayed treatment' in seeking formal health care was also not congruent across studies – the term ranged from over 12 hours to over a year – with many other definitions in between (Lanthier, Du Mont, & Mason, 2018). Some researchers presented contrary findings in health care seeking, such as race/ethnicity and being held captive. Lastly, it is evident that in both the disclosure literature and the health seeking behavior literature, the majority of study participants were middle class White females, with lower sample sizes, making it difficult to determine generalizability.

Implications. These findings are compelling for multiple reasons. First, there is little known about forensic evidence or FPAC seeking, and the literature often combines the concepts of medical care (GPAC) and forensic care (FPAC), while in reality, these are very different concepts that should be evaluated separately. Secondly, some of the rationales for informal or delayed disclosure and care, outside the 5-day evidence collection window, are synergistic to rationales for receipt of early care. Third, it is noteworthy that cost has been documented as a deterrent for survivors to seek formal help, especially because forensic evidence exams have been free for survivors per the Violence Against Women Act since it was signed into law in 1994. It is problematic that this is not clear to the public. Lastly, about one third of survivors reported experiences of negative encounters when seeking formal support. This demonstrates a need for further examination of this phenomena, and further intervention among health providers and law enforcement. Clearly, further exploration and understanding of factors associated with seeking FPAC vs GPAC are needed, particularly in light of potential changes in cultural attitudes after #MeToo.

Overall implications. In the past decade, social media has become a new way to communicate, share information, and network (Mendes et al., 2018). This is a new era, as scholars are just beginning to explore the influence social media movements may have on offline health behaviors. However, to date there is a gap in research examining the influence #MeToo may have on sexual assault disclosure and health behavior patterns. Knowledge gained by this study informs (1) interventions for formal and general post assault care, and (2) public health campaigns to capitalize on this and future social media movements to improve sexual assault outcomes by disseminating concrete post assault steps to take/plans of care and rationales for needed care.

Conclusion

In this chapter, the literature focused on social media movements, the current understanding and influences related to survivors' disclosure patterns to formal and informal supports, health risks of sexual assault and health seeking behaviors to formal and informal supports post sexual assault, as well as the theoretical and philosophical frameworks for the current research study was reviewed. In the following chapter the methods for the present study are discussed.

Chapter 3: Design & Methods

The literature review from Chapter 2 was formative in determining the extent of the knowledge gap regarding the influence of social media campaigns on survivors' disclosure and health seeking behaviors post sexual assault. This qualitative study addresses that stated gap in knowledge. The study methods, sampling, and data analysis plan are described in detail in this chapter.

Methodology

To date, there is a lack of understanding about disclosure and health seeking behavior in the context of the #MeToo movement. Therefore, this investigation utilized a qualitative descriptive design (Morse & Field, 1995). Qualitative inquiry is a foundational method suitable for health care research (Sandelowski, 2000), and its goal is a pragmatic, naturalistic approach to understanding the phenomenon (Sandelowski, 2000). The chosen method answered who, what, and where of events and experiences, and provided a comprehensive summary of the phenomena under study (Sandelowski, 2000). The aim of qualitative description methods is to produce a clear, straightforward, final product, with a rich description of the phenomena, where the results can be easily understood (Sullivan-Bolyai, Bova, & Harper, 2005).

This qualitative descriptive study utilized an online focus group design. This design is an effective and efficient methodology to achieve the study aims. Focus group designs generate a robust data set from multiple participants in a relatively short time frame and have been known to produce powerful interpretive insights (Denzin & Lincoln, 2005). Additionally, focus groups may produce data that are complex and rich due to the conversations and interactions that occur among the group members – this may illuminate deeper understandings of individual perspectives (Denzin & Lincoln, 2005). Focus groups are semi-structured which allow for both direct and open-ended, expressive questioning.

Focus groups traditionally have been conducted in person. However, in recent years, an online platform for focus groups has been employed as a successful data collection method. Synchronous online focus groups are conducted in real time via online text-based discussions (no audio or video is used). Participants actively engage with the moderator and other participants from the privacy of their own computers (or borrowed computers) and from their own home (or a place of their choosing). Participants who have logged into the secure online focus group portal engage by typing answers to questions, making additional comments, sharing thoughts and perspectives, and responding to other participants' comments in real time. The online focus group portal also allows for participant-moderator private messaging to answer questions or to encourage engagement. The tone of text and expression of thoughts (agreements and disagreements) are noted by the research team during the online discussions.

Documented benefits of online focus groups, in particular, are numerous. They include: (1) convenience for participation, as online discussions eliminate known barriers to participation such as transportation, time, and scheduling, (2) efficient, as typed text data is saved automatically which eliminates the transcription needs and allows for rapid transition to data analysis, and (3) sensitivity to vulnerable populations, as the method allows for participant anonymity which has been known to increase participant comfort to openly express thoughts, perspectives, and feelings in a safe manner (van Eeden-Moorefield, Proulx, & Pasley, 2008; Fontenot et al., 2019; Fontenot et al., 2020). Additionally, an online focus group method was safe and effective during the Covid-19 pandemic. Lastly, this methodology was consistent with this study's feminist underpinning, as each participant had an equal voice in the conversation (e.g. potential authoritative tone of voice and physical mannerisms are diminished). However, it was still possible for one participant to contribute more than others – steps to reduce this are discussed in detail in the Strengths and Limitations section.

The committee chair, Dr. Fontenot, is a highly experienced and federally-funded researcher, and known to be an expert in this methodology. Her body of work, plus evidence from other researchers using this design, demonstrate effectiveness of online focus groups in providing rich data with a depth and quality of communication similar to in-person focus groups (Fontenot, Domush & Zimet, 2015; Fontenot et al., 2019; Fontenot et al., 2020; van Eeden-Moorefield et al., 2008; Ybarra, DuBois, Parsons, Prescott, & Mustanski, 2014).

Site & Sampling

Sample. A purposive sampling method was utilized. This type of nonprobability sampling is a conscious selection of participants, with specific criteria in mind (Crookes & Davies, 2004). Purposive sampling in qualitative research ensures the participants are the experts of the phenomena being studied. In order to be included in this study, participants must have been cis-female (born female and identify as female), at least 18 years of age, residents of Massachusetts (MA) at the time of their assault (even if the assault took place outside of the state), and be survivors of a sexual assault that occurred between October 2017 (the beginning of the #MeToo movement) and July 2020. Participants were excluded if the PI had conducted their SANE examination post assault. The sample was limited to MA because it is one of the few states in the US that has a state-run SANE program; thus, the access and quality of FPAC was standardized. The participants must have been able to read, speak and understand English, as this is the only language the PI is fluent in to facilitate focus group discussion and ensure accurate transcriptions. Lastly, participants must have had access to a computer with internet during the designated date and time of the online discussion.

Recruitment. Recruitment took place online via MA Craigslist, Facebook (FB), and via partner organizations [Boston College Women's Center and the Boston Area Rape Crisis Center (BARCC)] and began on June 8th, 2020. All recruitment was passive (i.e. posted advertisements online via Craigslist or partner organizations' social media pages and newsletters). The Craigslist posts and the #MeToo Study FB post with the link for the eligibility screener was published and shared. The FB post was shared with MA SANEs and violence research colleagues. On Wednesday, June 10th, BARCC posted the study advertisement and eligibility screeners on their four social media accounts (FB, Instagram, LinkedIn, and Twitter). On the same date, the Boston College Women's Center sent out a newsletter to their listserv of over 4,000 members (consisting of current students, staff, and alumni of the college), advertising the study.

All online posts contained the same information though formatted differently depending on the platform (see appendix A). For example, the title of the five online Craigslist posts (for each MA region) were "Online #MeToo Study - $50 for Participation!" but the BARCC social media posts had no title and began with "Hi BARCC community!" before introducing the study. All study recruitment advertisements included the same image in an effort to create cohesive branding, and recruit a sample that was racially/ethnically diverse and inclusive of all ages over 18 years.

Originally there were to be in-person posted flyers at the three BARCC rape crisis center sites in MA and at local university women's centers, however, due to the COVID-19 pandemic and the fact that BARCC sites and universities had closed their physical locations, all recruitment moved online. The PI had full support of BARCC and the Boston College Women's

Center to recruit for and conduct this study. The described recruitment method (online recruitment via Facebook, Craigslist, and through partnered community centers) had shown to have been effective in previous studies (Fontenot et al., 2019; Marchetti, 2012; Post, 2019; Worthen, 2014).

Each of the online ads provided a link that directed potential participants to a Qualtrics eligibility screener that explained the study purpose and procedures, assessed eligibility, and provided the electronic informed consent (see appendix B). If eligible and consenting, participants were given six options for dates and times to participate in one of the four online discussions; they were to indicate the time/date(s) that would be convenient for their participation. At the end of the survey, the participants provided the PI their first name and contact information (email and/or phone number for text reminders). The PI sent introductory emails within 24 hours of the eligible participants' finishing the screener (see appendix C). Recruitment ended earlier than the expected date due to a robust response – on June 18th, 2020 instead of June 22nd, 2020 (10 vs 14 days). The PI assigned each participant to one discussion group based on eligibility and provided participants instructions via an informational email (see appendix C) on how to 'attend' their assigned study's online focus groups (date, time, and login information) before the study date. A copy of the informed consent was also attached to that email.

Recruitment information was kept organized on the PI's password-protected computer. All eligibility screener surveys were exported to the PI's password protected Google Spreadsheets. Data was initially organized by IP address, so if the IP address was used more than once (i.e. if the participant had taken the survey more than once), it was easily noted by the PI. If an eligible survey respondent's IP address was used only twice, the PI then assessed what answer the participant changed in the survey that led them to qualify; that participant was sent an email for clarification before they were invited to continue to participate. If the participant used the same IP address more than twice (i.e. took the survey more than twice) they were deemed ineligible. Out of the 519 completed survey respondents, 30 IP addresses were used more than once, seven of those more than twice. Four were marked by Qualtrics as ‘spam.’ Out of the 425 survey respondents who were not eligible, eight were male, one identified as less than 18 years old, 370 were not sexually assaulted between October 2017 and June 2020, and 39 were not residents of MA at the time of the assault. As the advertisements did not have the assault date or MA resident eligibility criteria on them, these numbers were expected.

Eleven of study eligible participants’ IP addresses were used twice. Thus, 11 clarifying emails were sent, and seven participants responded, clarifying why they had changed their answers. For example, one participant did not know if being a college student in MA was considered being a resident of MA at the time of the assault. Another participant responded that she had clicked that the PI was her SANE nurse without meaning to. This is ultimately why, because of human error, there was no limit placed on the number of times the participants could take the eligibility screener. Those seven participants who clarified were henceforth invited to be in the study. The four that did not respond to the clarifying email were deemed ineligible for the study. Lastly, all survey respondents consented to the study after having qualified.

Recruitment was very successful: by the end of week one (June 16th), 76 participants had consented via the Qualtrics eligibility screener. Recruitment ended on June 18th, one week after the second set of advertisements went live – the survey had been taken 612 times, 78 eligible participants had consented, and 64 of these 78 had confirmed via email their interest by the following day.

Introduction/confirmatory emails were sent out as soon as participants began enrolling. The overwhelming response from participants was enthusiasm for partaking in the study, with such language as “Sounds great!” and “Thank you for offering this opportunity!” via email. Two participants asked for more clarification via email about the focus group method itself (in which informative emails from the PI were promptly sent), one about the focus group date(s) and time(s), and one participant emailed that she wanted to reflect on participating for another day before deciding to continue with the study although she had already consented (she ended up agreeing to participate). Out of those who were eligible and who consented to the study (78), 65 ended up confirming via email that they were interested in participating (a rate of 83.3%). Within the next few days, a copy of the informed consent, their designated time and date of their focus group, and instructions for how to participate in the online platform were emailed. In the end, 56 survivors participated in the focus groups, with an average of 14 per group.

Based on similar research in this area, the PI anticipated that approximately 40 participants were needed to achieve saturation (Corbin & Strauss, 2015). Thus, four focus groups were conducted, inviting up to 20 participants each to allow for attrition (Grove, Burns & Gray, 2013).

Measures

The stated aims and the guiding social ecological theory and feminist philosophy informed the focus group’s semi-structured script. The semi-structured script included open-ended questions about (1) #MeToo’s influence on sexual assault survivors’ decisions to disclose to a formal support (health provider) and (2) #MeToo’s influence on sexual assault survivors’ health seeking behaviors post assault, including: seeking forensic nursing care, care from another health provider, and the timeframe for care post assault. See appendix G for the focus group script guide.

The study demographic questionnaire included age range, race/ethnicity, date range of the sexual assault, level of education, employment status, and reported social media use. This data provided background and context for the qualitative data (see appendix F for the demographic questionnaire).

Procedures

The study partner for this research was InsideHeads, which provided the online focus group platform. InsideHeads is an online research company with over 15 years of experience facilitating online focus groups with a state-of-the-art secure online platform. They also worked with the PI on any technical support needed prior to and during the study.

A list of unique URLs and pseudonyms was generated by InsideHeads and sent to the PI once recruitment concluded. The PI randomly assigned the URLs and pseudonyms to participants. Once participants were assigned to one of the four online scheduled discussions, study reminders including the date, time, URL, pseudonym and login instructions were sent directly to participants via email four days prior, two days prior, and the day of the scheduled online discussion (Dillman, Smythe & Christian, 2009; Fontenot et al., 2019). If participants opted to receive text message reminders, they received these in addition to the email reminders (see appendix C).

Four focus groups were held in 2020 on Thursday, June 25th at 6p and 8p EST, and Monday June 29th at 6p and 8p EST. These dates and times were chosen based on participants' availability. They had been given six date/time options to choose from – June 30th was excluded as it was not a popular choice. The first and second focus group had 14 participants each. The third focus group had 13 participants and the fourth focus group had 15 participants. The total number of participants was 56, which was a rate of 86.1% of those confirmed and a rate of 71.8% of those eligible. Each participant was assigned a group based on their availability (with no more than 20 participants invited to a group), and they received an individual URL link to the online platform from the PI via email beforehand. Their randomized pseudonym was also included in the email. These URLs and pseudonyms were created by InsideHeads and sent to the PI, who then assigned them to the participants. Only the PI and the committee chair had access to this information.

On the day of their assigned focus group discussion, the participants clicked on the URL in their study reminder email(s) and each participant entered the secure online focus group study area/secure browser window as their pseudonym. A countdown timer showed when the group discussion was scheduled to start. Once the secure room/portal opened to invited attendees, participants were welcomed by the PI and directed to complete the study's brief Focus Group Demographic Questionnaire as described above. The link to the questionnaire directed the participants from the online focus group portal to the PI's secure Boston College Qualtrics Account.

Once everyone has completed their demographic questionnaire (approximately 3-5 minutes) and returned to the portal, the PI made introductory comments and reviewed the focus group guidelines: participants were encouraged to talk and express their thoughts and beliefs freely, but also engage in respective discourse with each other. After making these introductory comments, the semi-structured, online focus group began. During the designated time, the online discussion (60-90 minutes) was administered by the PI. The committee chair assisted by taking observational field notes, noting important aspects of the discussion, and providing further probing questions.

The PI and the committee chair were in comfortable, quiet, and private conference space(s) over the four focus group sessions (Morse & Field, 1995). The first two online focus groups were conducted from the committee chair's office – both the PI and the committee chair were present and communicated in-person during the online discussions. The second two focus groups were conducted at the respective committee chair and PI offices – they maintained constant communication during the online focus groups via an encrypted Zoom video call using the PI's Boston College private account. Two other committee members (out of three) were observing the online discussion at their respective home offices.

Open-ended questions were used during the focus groups, and probes were tailored to the participant's responses (Hsieh & Shannon, 2005). At the conclusion of each online focus group the transcript data was sent to the PI via email by InsideHeads and downloaded (to Microsoft Word) to the PI's password-protected encrypted laptop. Field notes about the environment, context and tone of the focus group discussion (e.g. agreements and disagreements) were noted during and recorded at the end of the transcript in Microsoft Word by the PI as soon as the group concluded and the participants exited the online forum (Lincoln & Guba, 1985; Morse & Field, 1995). At the end of the focus group all participants were asked to click a link to a post-discussion questionnaire. At this point the participant either chose to provide their pseudonym and a preferred email in order to obtain their Amazon Gift Card or not. If a participant left the discussion early they were still able to enter the post-discussion questionnaire. The questionnaire with emails for payment processing were kept confidential and separate from all study data. The

PI confirmed these remuneration results with the participants' participation – there were no discrepancies found.

Protection of Human Participants

Boston College Internal Review Board (IRB) approval was secured prior to commencing the study, on May 18th, 2020. This IRB was expedited, confirming minimal risk to participants. The PI also collected letters of support for this study from participating parties, and had permission to recruit through BARCC and local university women's centers.

Online informed consent was obtained from all participants, and they were advised that their participation was voluntary and non-binding. They were also advised that they had a right to refuse to continue even after giving consent, should they have decided they no longer wanted to participate (Corbin & Strauss, 2015; Oakley, 1981). Participant confidentiality was retained throughout the study. Participants, however, were informed that the PI was a mandated reporter – thus any reports of elderly abuse, child abuse, or abuse towards those with disabilities would have been needed to be disclosed to the proper legal authorities. Threats of harm to themselves or others would also have needed to be disclosed to the appropriate health care personnel.

Participant confidentiality was maintained in several ways. The PI randomly assigned pseudonyms to the participants (generated by InsideHeads) and sent this information to them via email before they logged into the system. This ensured that the qualitative data was completely non-identifiable and only known to the PI and to the dissertation committee chair. Additionally, the demographic questionnaire was non-identifiable (participants only identified their assigned pseudonym on the questionnaire). The master list with participants' names and contact information, collected during the recruitment and consent phase, was stored separately from the transcript and questionnaire data on the PI's password protected research computer. Only the PI and the committee chair could link participant data to the study data (transcripts, demographic questionnaire and remuneration questionnaire). All study information and data were saved on the PI's study laptop with an encrypted passcode only known to the PI. At the end of the study, once data analysis was complete, all identifiable study materials (participant data) was saved, and will be saved, for three years per Boston College IRB. At the end of the three years the data will be deleted.

Given that the nature of this topic was sensitive and potentially emotionally triggering, the PI partnered with BARCC; as some recruitment took place through BARCC, those participants would have already had made contact with, and have had access to, resources such as counseling. All participants prior to the study were also emailed a Resource List (see appendix E). This list included (1) MA rape crisis centers and their 24-hour hotline numbers to access counselors (2) the Rape, Abuse and Incest National Network (RAINN) hotline number, and (3) the name and contact number for Dr. Julie Dunne, a member of BC's faculty and a board-certified psych mental health nurse practitioner who practices in the metro Boston area. Lastly, if any participant became upset during the focus groups due to the subject matter, they could have chosen to stop at any time. They could have or the PI could have privately messaged each other during the focus group as well, if needed.

While these safeguards were in place, the PI was unaware of any participant concerns or distress. Other researchers have found online focus groups to be empowering and therapeutic for the participants from vulnerable populations (Fontenot et al., 2019; Fontenot et al., 2020). All participants who participated 30 minutes or greater (100% of the participants) were emailed a $50 Amazon gift card at the conclusion of the study as compensation for their time and willingness to share their expertise. Those who did not participate at least 30 minutes of the discussion (i.e. exited the discussion early or arrived too late) would have received half that amount (as noted in the informed consent). Lastly, while unlikely, it was possible that a potential participant would have been a former patient of the PI. If this happened, during the initial recruitment phase, that potential participant would have been thanked for their willingness to participate, though would have been excluded due to the previous patient-provider relationship that could unintentionally have influenced the interview and data collection process.

Considerations. Despite an existing power imbalance between researcher and participant (Oakley, 1981), every effort was made to keep the participants feeling in-control and empowered. In order to help build rapport and trust between the PI and the participants, the PI was transparent in her roles as registered nurse (RN), board certified women's health nurse practitioner (WHNP-BC), certified SANE, and doctoral candidate at Boston College's School of Nursing, in the advertisements, on the eligibility screener, and prior to the start of the online focus groups. Encouraging and supportive feedback was given throughout the focus group discussions. Additionally, the open-ended questions and probes were designed to maximize the participants' voices and perspectives, as they were the experts. The PI reflected on and attempted to 'bracket' the potential biases while immersed in the study due to her positionality and predetermined notions of the phenomenon through her clinical and academic experiences (Lincoln & Guba, 1985; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016) while remaining cognizant that the researcher was an integral part of the research (Darawasheh, 2014; Munhall, 2012). Bracketing is defined as setting aside preconceived notions and beliefs of the phenomena during the qualitative study to fully see it as the participants describe it (Grove et al., 2013). Lastly, honoring the voices of the participants during the analysis was of utmost priority, as will be disseminating the findings in future publications (other than this dissertation) (Davies & Dodd, 2002; Munhall, 2012).

Data Analysis Plan

Coding. Analysis began with coding, which is taking raw, textual data, organizing it and bringing it to a conceptual level (Corbin & Strauss, 2015; Hsieh & Shannon, 2005). Coding was performed by the PI in an iterative process, and the analysis influenced the next focus group session(s) (Lincoln & Guba, 1985). The PI fully immersed herself in the data by reading the transcript(s) in full multiple times. Once an overview of the transcript was completed, a deeper comprehension of the data took place during the coding process (Hsieh & Shannon, 2005; Morse & Field, 1995). Coding helped the PI "uncover underlying meanings" (Morse & Field, 1995, p. 127). In vivo coding was used as first level coding – this type of elemental coding is appropriate for nearly all qualitative research designs (Saldana, 2016). Per Saldana (2016), it is an "action-oriented" method that "prioritizes and honors the participant's voice" (p. 106) by using the interviewee's words verbatim. The transcript data was parsed into codes based on these "impact nouns, evocative vocabulary, and action-oriented verbs" (Saldana, 2016, p. 107). The codes were then arranged into categories of similar codes, which were categorized into even further subcategories and/or themes, depending on the quantity of data (Morse & Field, 1995). Analytic memoing was an imperative exercise throughout the coding process to help organize thoughts, immerse deeper into the data, and reflect on first impressions and biases during the coding process (Creswell, 2013; Hsieh & Shannon, 2005; Saldana, 2016).

Thus, in sum, the steps of coding were (1) preparing and organizing data, (2) re-reading each focus group script for overall orientation and data immersion, (3) reducing data into initial codes, (4) combining codes into broader thematic categories, and (5) developing category definitions, examining relationships, and highlighting exemplar quotes.

Analysis. The de-identified quantitative data were entered into Google Spreadsheets and were used to describe the sample and serve to frame the qualitative data collected. Descriptive analyses were completed (see Chapter 4).

The qualitative data were analyzed using conventional content analysis. This is the preferred methodology for qualitative descriptive designs (Sandelowski, 2000), when there is a dearth of information about the phenomena under investigation (Hsieh & Shannon, 2005). Per Hsieh and Shannon (2005), one benefit of using conventional content analysis is getting unbiased information from the participants, especially when there is limited knowledge about the phenomenon. Content analysis aims to analyze the data by topic and then these topics are organized into categories (Corbin & Strauss, 2015) while exploring similarities and differences (Willis et al., 2016).

For this qualitative analysis, the four focus group transcripts were downloaded from the online portal onto a secure file on the PI's password protected computer. Microsoft Word and NVivo software (version 11) software were used for data management. After immersion in the data – multiple readings and reflection of the transcripts and the corresponding field notes and reflective journaling the PI had completed after every focus group session – the PI began the process of coding the data. Sentences, phrases and words that were consistently repeated in the transcripts were highlighted. The same was repeated for all four transcripts. These initial in vivo codes were words/phrases taken verbatim from the transcripts. Notes and comments were made in the margins of the transcripts to help keep focus of the important aspects of the participants' voices. Four journal entries were written, one after each focus group session, highlighting initial thoughts and summarizing main take-aways.

After completing initial coding for each of the four transcripts, comparison of the in vivo units across transcripts was performed. Broad themes were then made, and descriptive patterns of responses were used to further detail them. See Table 1. Four themes were finalized, their titles deriving from the in vivo units. Within these themes, categories emerged, often originating from the descriptive patterns in the first table. Some were condensed even further into subcategories to reflect topics within the categories. These were displayed with the associated quotes in a final table. See Table 2.

The PI and the dissertation chair met regularly at each step of the analysis for ongoing re-examination and discussion of the data, which allowed them to (1) make connections between the research questions, coding categories, and raw data, and (2) discuss discrepancies to ensure inter-coder reliability.

Table 1: Sample of Initial Coding Process

Invivo units of major content	Themes	Descriptive patterns of responses
I felt **heard** Wasn't my fault I was **no longer alone** **Strength** in solidarity	#MeToo and Survivors	Validation and empowerment – *Positive*
I haven't yet '**joined**' me too Didn't highlight **everyday women**		Disconnect – *Negative*

Table 2: Sample of Final Coding Process

Theme	Category	Subcategory	Quote
I Have a Voice	Healing	Normalization	"When we normalize talking about our traumas, it becomes easier to heal. #MeToo I think helped do some of that." "MeToo helped normalize therapy because my family is very traditional where you keep your feelings to yourself."

Trustworthiness. Rigor (Morse, 2015) and trustworthiness (Lincoln & Guba, 1985) in qualitative designs are achieved through specific techniques. Per Lincoln and Guba (1985) credibility, transferability, dependability, and confirmability were used to uphold rigor and trustworthiness of the research; these are described below.

In order to establish credibility and dependability, the PI first triangulated or validated the data against other sources, such as observation from field notes and journals (Lincoln & Guba, 1985). Secondly, the PI spent prolonged time with the data to fully immerse in and fully comprehend it (Lincoln & Guba, 1985). Thirdly, peer debriefing took place throughout the interview and analytic process with committee members, to keep the PI on track, to explore next steps, and to actively reflect (Lincoln & Guba, 1985). Records took place of these meetings. In order to uphold confirmability, (1) an accurate audit trail, including adequate records of each action was kept, as well as (2) a reflective journal which the PI wrote in after the focus group sessions and during the analytic process (Lincoln & Guba, 1985). Lastly, to establish transferability, a thick, rich description of the data was employed (Lincoln & Guba, 1985).

Strengths, Limitations & Feasibility. The strengths of using a qualitative design include being able to uncover the voice of the female perspective regarding post sexual assault behavior patterns in the era of #MeToo. Using focus groups was a strength because the group dynamic led to a deeper, more involved, and rich discussion of the topic. The goal was that survivors' voices be heard, and their stories and perspectives informed this study and future studies. The design was feasible, as online focus groups have been used successfully in prior research with vulnerable populations (Fontenot et al., 2019; Fontenot et al., 2020; Ybarra et al., 2014), and the recruitment method had been successful with similar populations (Marchetti, 2012).

Furthermore, this method also decreased participant burden, eliminated travel, was less disruptive to work schedules, and was safe during the Covid-19 pandemic.

Despite these strengths, limitations of this research were anticipated and planned for. Due to the sensitive nature of the topic, participants may have found it difficult to comment on their disclosure(s) or health seeking experience(s). There was a chance that some participants would contribute too much, while others may contribute little or not at all. However, the committee chair (moderator for the discussions) could have probed any participant in private messaging to control for this (though ended up not having to take place during the focus groups). Furthermore, because participants were interacting with mediators as well as other participants, there was a risk of giving socially desirable answers (Dillman et al., 2009) and risk acquiescence, or the "culturally-based tendency to agree with others" (Dillman et al., 2009, p. 314). To further mediate these potential limitations, adequate and sufficient time was devoted in the beginning of each focus group to build rapport, introduce the topic, and discuss why it was important to hear from everyone in the group and respect opposing views (Grove et al., 2013). It was made clear that the participants were there to share their experience about their decisions post sexual assault about disclosure and health seeking behaviors. Lastly, the PI is an expert in the trauma-informed care of sexual assault victims, and thus moderated the discussion accordingly.

Study Funding

Funding for this study was secured through the International Association of Forensic Nurses (IAFN), the Sigma Theta Tau International Honors Society of Nursing Gamma Epsilon Chapter and the Sigma Theta Tau Nurses Honor Society Alpha Chi Chapter. IAFN awarded the PI $4950, the Gamma Epsilon Chapter awarded $1550, and the Alpha Chi Chapter awarded

$1500 for the study. These awards were spent directly on participant incentives and the use of the online focus group platform, InsideHeads.

Chapter Four: Results

The following chapter is a review of the descriptive quantitative data (from recruitment and the demographic questionnaire) and qualitative data (from the focus groups) collected during the study. Both sets of data were important in telling the participants' stories. Through immersion and multiple levels of analysis of the qualitative data, four themes emerged: It Exposed a Problem, I Have a Voice, Never Felt like Mine, and Only the First Step. The latter three themes were further parsed into categories and subcategories.

Quantitative Results

All demographic data from the Qualtrics survey were exported to Google Spreadsheets, on the PI's password-protected private server. All participants completed the demographic survey. See Table 3 for a summary of these demographic results.

Out of the 56 participants, 38 (67.9%) were aged 18-25 years, eight (14.3%) were aged 26-30 years, five (8.9%) were between 31 and 35, two (3.6%) between 36 and 40, two (3.6%) between 41 and 54, and only one participant (1.8%) was 46 or older.

The majority of participants identified as White (38, 67.9%), followed by Hispanic/Latina (8, 4.3%), more than one race (7, 12.5%), Asian (5, 8.9%), Black (5, 8.9%), and Other (1, 1.8%). All of the participants reported having health insurance: private (38, 67.9%), public (8, 14.3%), college (8, 14.3%), and other (2, 3.6%).

More than half of the participants (34, 60.7%) stated they had a bachelor's degree or higher, while 21 (37.5%) identified as 'being in college now or having some college.' No participants indicated they had 'some high school or less', and only one participant (1.8%) identified as a high school graduate.

Twenty-three participants (41.1%) were employed full-time, with 14 (25%) stating they were full-time students. One participant (1.8%) identified as a full-time child/family caregiver, one identified as employed part-time, one identified as a part-time student, one identified as a part-time student with part-time employment, and one identified as a full-time student with full-time employment. Eleven (19.6%) marked they were full-time students with part-time employment, and very few (3, 5.4%) stated they were unemployed or 'none of the above.'

In terms of social media, 52 participants (92.9%) indicated they used social media every day. See Table 4 for this data. Only one participant (1.8%) used social media two to three times per month and three participants (5.4%) used social media two to three times per week. Every participant (100%) had heard of the #MeToo movement.

Twenty-three participants (41.1%) were assaulted between October 2017 and September 2018, 20 (35.7%) between October 2018 and September 2019, and 13 (23.2%) between October 2019 and June 2020. Most (48, 85.7%) stated they disclosed to an informal support (friend or family) member after the assault. When asked when they disclosed to an informal support, the majority reported 'within five days' (14, 29.2%) or 'within 24 hours' (13, 27.1%). Fewer disclosed to a formal support (HCP) (26, 46.4%), and out of these participants, the majority disclosed 'within a few months' (7, 26.9%). Lastly, the majority of the participants (46, 82.1%) did not have a forensic sexual assault examination.

Of the participants who reported the social media platform from where they were recruited, twenty-eight (50%) were recruited from a college-based platform, 14 (25%) from BARCC's social media platforms, and nine (16.1%) from Craigslist.

Table 3. Demographic Data

	n	**%**
Age Range		
18-25	38	67.9

26-30	8	14.3
31-35	5	8.9
36-40	2	3.6
41-45	2	3.6
46+	1	1.8
Hispanic/Latina/Latinx		
No	48	85.7
Yes	8	14.3
Race		
Asian	5	8.9
Black or African American	5	8.9
More than one race	7	12.5
Other	1	1.8
White	38	67.9
Native Hawaiian or other Pacific Islander	0	0
Health Insurance		
No	0	0
Yes	56	100
Type of Health Insurance		
Public	8	14.3
Private	38	67.9
Through a college	8	14.3
Other	2	3.6
Education		
Some high school or less	0	0
High school graduate	1	1.8
Some college or in college now	21	37.5
College graduate or more	34	60.7
Work		
Full-time employment	23	41.1
Full-time student	14	25.0
Full-time child/family caregiver	1	1.8
Part-time employment	1	1.8
Part-time student	1	1.8
Full-time employment & Full-time student	1	1.8
Part-time employment & Full-time student	11	19.6
Part-time employment & Part-time student	1	1.8
Unemployed or none of the above	3	5.4

Table 4. #MeToo Data

	n	%
Social Media Use		
Every day	52	92.9
2-3 times per week	3	5.4
2-3 times per month	1	1.8
Sexual Assault Date Range		
Between Oct 2017 and Sept 2018	23	41.1
Between Oct 2018 and Sept 2019	20	35.7
Between Oct 2019 and June 2020	13	23.2
Disclosed to friends or family?		
No	8	14.3
Yes	48	85.7

***If yes, when?**		
Right away (within 24 hours)	13	27.1
Within 5 days	14	29.2
Within a few weeks	5	10.4
Within a few months	9	18.8
Within a year or more	7	14.6
Disclosed to HCP?		
No	30	53.6
Yes	26	46.4
***If yes, when?**		
Right away (within 24 hours)	5	19.2
Within 5 days	4	15.4
Within a few weeks	5	19.2
Within a few months	7	26.9
Within a year or more	5	19.2
Had a forensic evidence kit (rape kit)?		
No	46	82.1
Yes	9	16.1
Did not respond	1	1.8
How did you hear of this study?		
Craigslist	9	16.1
MeToo Study’s Facebook page	2	3.6
Boston College Women’s Center Newsletter	28	50
BARCC overall	14	25
(BARCC’s Facebook post)	5	8.9
(BARCC’s Twitter post)	2	3.6
(BARCC’s Instagram post	6	10.7
(BARCC’s LinkedIn)	1	1.8
Someone shared the study link with you	8	14.3

Qualitative Results

Through immersion and multiple levels of analysis of the qualitative data, four themes emerged: It Exposed a Problem, I Have a Voice, Never Felt like Mine, and Only the First Step. The later three themes were further parsed into subcategories, so as to form coherent chapters of shared participants’ stories.

It Exposed a Problem. When asked about the impact of #MeToo on society, all participants were quick to comment how they felt there were a myriad of positive outcomes, the most significant being an increased awareness of sexual violence. “#MeToo raised awareness around sexual harassment and assault” they wrote, and “[#MeToo] was a way to bring to light how frequently [sexual violence] happens.” One participant commented how “[#MeToo] exposed a problem that hides in the dark far too often,” the problem referring to both sexual violence as well as the trauma that can result for the survivor post assault. Another reported "#MeToo is for solidarity, and shows how extensive the problems are." "Finally, the word is out [on sexual assault]" one survivor penned.

Furthermore, even more so than raising awareness, the majority of participants noted that #MeToo influenced the country's perception and response to sexual violence. For example, one participant explained that "it not only showed how large of a society problem [sexual violence] is, I think influenced society at large to take sexual harassment and assault more seriously." Another participant wrote "#MeToo has impacted how people talk about sexual violence in our culture for the better" and "it has impacted many, many communities – even religious ones." Still another participant noted "I think it showed a new generation that things can be done differently, and that talking about sexual violence is important in order to fight it." One thought that #MeToo influenced people's response to disclosure:

> Now with this movement I feel like people around me know to say certain things when someone discloses it to you (me included lol) I'll say 'I'm sorry this happened to you' 'what do you need' etc.

One survivor mentioned how she felt that "policemen, court people and my professors have become more aware of this kind of assault" which she believed has had positive legal impacts on her sexual assault case. Another echoed this sentiment, as she mentioned her own legal situation - "I'm waiting to testify against the person who assaulted me, and my biggest hope is that the jury are aware of #MeToo and so are more educated." One survivor reported, "[#MeToo] has provided a platform to do prevention work and spread conversations" which showed the possible actionable power that can be attributed to the movement. Lastly, another participant commented, "I think the #MeToo movement created spaces for women to talk about their experiences."

However, as explored further later on in this chapter, this was not always the case. There were also still many survivors who felt that in order for individual and larger societal change to take place, more needed to have emerged from the movement.

I Have a Voice. In addition to positive outcomes from the movement for society in general, participants noted many benefits for themselves and like survivors. A community was created, silence was broken, and healing took place.

Community & connection. While some participants highlighted how the movement empowered them and validated their experiences with sexual violence, many participants also relayed how it helped them feel part of a community. Examples of these responses included "strength in solidarity," "[#MeToo] made me feel like I'm not alone," and "I felt empowered, like I could talk about it in a safe space if I wanted to." One commented, "I saw myself as a part of this larger community, as more than just an ally, but as someone standing in solidarity of experience." Another reported, "for me it has been a way of connecting with a community that understands me." One mentioned how "being in college during #MeToo has made me feel like I have a voice, and it makes me feel more connected to other survivors," and another explained this further saying that they felt a "connection to people who are kind and supportive." When the movement started gaining momentum, one participant commented how she thought "*finally* somebody is looking out for the unspoken," for those survivors who feel silenced after an assault. Lastly, a participant penned how "when I first heard about #MeToo I didn't think much about it. Then I was raped a year later and I had a lot more appreciation for the movement."

Disclosure. As mentioned previously, close to 90% of participants disclosed to a friend or family member after the assault, with over 50% reporting that these disclosures occurred within 5 days of the assault. These are much higher rates than found in the literature (see Chapter

5). Many of these participants felt that they found personal strength from the movement itself to disclose their assault to informal supports. “[#Metoo] helped me confide in a close friend,” and “[#Metoo] made me feel more inclined to tell people,” noted participants. “[#MeToo] gave me more security to report,” penned one survivor, and yet another remarked, “it has made me a lot more comfortable coming to terms with the sexual assault I experienced, and a lot more comfortable sharing about it.”

There were many iterations concerning how the #MeToo movement helped participants disclose. One noted “it did influence me [to disclose] – I grew up in a culture where we don’t talk about those things,” referring to the culture shift from the movement granting her courage to speak about her own experience. Another participant mentioned how “the #MeToo movement mixed with the scandal surrounding Judge Kavanaugh gave me enough courage to speak out about my assault” – the confluence of the movement plus a very prominent Supreme Court hearing put the participant in a position where she felt strength to disclose. Another remarked about this newfound courage: “when I saw the numbers of people equal to me, and I felt I was not the only one, that I could say it and that someone would listen to me – I felt courage to speak!” “[Since #MeToo] I am now confident in reaching out and not being judged” stated one survivor.

For other survivors, the movement allowed them to disclose in a manner that felt more comfortable – “I could be like ‘I’ve been assaulted’ without disclosing everything about the experience.” Similarly, another participant wrote “after #MeToo I felt like I could tell people that I was assaulted and that all I had to say was something short, I didn’t have to disclose details or anything.” This was the idea behind the movement’s original purpose, which certainly resonated with these survivors. Another remarked how the community at large spurred her disclosure, almost as a way of giving back – "so I actually knew someone who was assaulted by the same person and I guess by hearing her experience it definitely motivated me to voice my story ASAP." Likewise, yet another participant reported:

> [#MeToo] influenced me sharing with like the greater community at my school because I saw how effective people telling their stories had been for changing the narrative and ending sexual violence.

One participant mentioned how they thought the movement did impact them to disclose, though "probably more subconsciously though than on a conscious level." Comparably, another reported:

> I personally told a couple people at first, and then slowly told a person or two over longer periods of time. I never really considered how the movement impacted me telling these people who learned a lot after it happened, but maybe it was a lil (sic) easier.

Furthermore, a few survivors noted how they knew "who *not* to tell because of their reaction to #MeToo, which was good" and another similarly stated, "the way my parents talk about #MeToo made me decide not to tell them, so I guess that was good? But very disappointing." Knowing who to trust was clearly a determining factor for who disclose to. For example, "I was assaulted before and after [#MeToo] and afterwards I felt more comfortable talking about it with specific people who I trusted and who reacted well to the #MeToo movement" and, "I still did not feel comfortable telling lots of people but the few people I chose [to tell] I knew they would believe me."

If they hadn't yet disclosed, some posited that #MeToo could possibly help them disclose in the future, noting "it's more of, 'I'm not ready yet, but whenever I am, I'll be more comfortable sharing,'" and "I am much more likely to talk about it in the future on social media.

Before #MeToo it was never on the table." A few echoed this, how they felt #MeToo made it possible to even consider talking about their assault – "like before I was like there is no way in hell I can talk about it, but now there is a public community that is supportive." One reported that this ability to talk about her experience, due to the movement, was very impactful in her trauma journey - "if the #MeToo movement wasn't there I think I'd be in a much worse state right now."

Healing. While #MeToo may not have helped all participants disclose to close friends or family, it was nevertheless helpful to many for other reasons. "#MeToo helped me process later" said one survivor, "[#MeToo helped me in] a lot of ways - it just made me feel like I could be more myself" remarked another. One participant stated "the self-guilt was lifted off my shoulders, and I was determined to get justice" because of the movement. Another reported that #MeToo helped her say that "this wasn't right" which is monumental, as it is often the first step in disclosing or seeking care. Another participant even commented how "#MeToo gave me the courage to denounce my aggressor and recognize that I was not alone." A few noted how they were surprised by the breadth of sexual violence: "[#MeToo] helped me understand what sexual assault is and that it can affect anyone" and "it's made me more aware (and sad) that sexual assault and harassment is more prevalent and frequent that I had thought." One participant reported how she realized that the "culprit" behind sexual assault is "really our culture and how we've socialized boys and girls around sex and sexuality." This was agreed by another survivor who remarked:

> #MeToo showed me that sexual assault is happening on such a large scale because of how society has handled and talked about sexual interactions. So when I was assaulted, it made me think, 'yup, this dude has been socialized to think this is ok.'

One participant reported, “it’s helped me realize the moments that I have been sexually assaulted. I always hear that women don’t know until they do and the movement helped me realize that.” These are very profound conclusions, initiated by the movement.

Although very few participants stated that they attributed reporting to police and/or seeking help from a health care provider to #MeToo, one did mention that they had, “#MeToo helped me tell someone [HCP] and seek help [FPAC]” and another participant noted that “[the movement] made me want an STD check.” However, this was not the collective consensus of the group.

Normalization. Participants found that normalization of both the trauma and the process of recovery post sexual assault was especially helpful. One reported, “when we normalize talking about our traumas, it becomes easier to heal. #MeToo I think helped do some of that.” Another commented how #MeToo helped her “normalize therapy” because her family is “very traditional where you keep your feelings to yourself.” “It’s been helpful from a mental health perspective” one mentioned, and another mentioned how #MeToo allowed her to “just feel like I could be more myself.” This in turn could reduce the stigma surrounding mental health care and increase health seeking behaviors. There were some that said “I read some other survivors’ stories and made me learn about the warning red flags of my experience.” Another reported, “I just read what others wrote [online] and it helped.” One participant felt as though #MeToo helped her come to some powerful conclusions: “Once talking about sexual violence was more main stream and normalized, I realized that a lot of @!#% was done to me that I was told was normal.” One echoed that sentiment, remarking:

> I had been assaulted one other time before #MeToo even started, made me realize the

> @!#%ing PTSD from that is very real and I need to call it for what it is (an assault) and not try to convince myself my actions are to blame.

Another participant agreed, commenting:

> I think #MeToo helped people to realize that gray scenarios were actually not gray scenarios and were assault and this helped victims (or at least me) know that they had a right to stand up for themselves.

Lastly, one participant noted how the movement helped her "to see the behavior of others (the women who slut shamed me) more clearly." Post #MeToo, these normalized behaviors in society were clearly visible to these survivors, which in turn helped them heal.

Never Felt Like Mine. There are two sides to every story, and personal connection to the movement post assault is no exception. Although there were many positive outcomes of the movement, both for society as a whole and for survivors, there were both limitations to the movement and unintended negative consequences that followed. For example, some participants expressed how they personally never connected to the #MeToo movement, and even shied away from it. "It's a movement that never felt like mine," and "it was hard for me to truly connect to the movement" reported some participants. Similar iterations of the same idea include "I've never felt comfortable using it," and "I wasn't sure whether I belonged to the movement and other women who associated with the movement." One survivor said this feeling of not having yet "joined #MeToo" was because she "felt dehumanized, as if I were just a statistic of a hashtag" and another echoed that sentiment by saying, "It really takes away from the individuality of my own experience." One participant stated, "I hate to say it but I think after being assaulted the movement lost meaning to me. I thought at first the movement would help make things better, but after experiencing my assault I felt more alone."

When prompted to elaborate further on these feelings of disconnection and isolation, these participants brought up guilt, pressure, even comparison to other survivors. Overarching all were long-held beliefs about sexual assault and stigma about what is means to be a survivor. Thus, these feelings, elaborated further below, had very clear consequences on disclosure and help-seeking.

Guilt & pressure. Common feelings expressed by these participants were guilt and unintentional pressure coming from the movement after their assault. Several remarked how they felt guilty about not participating in #MeToo, by saying it or posting it online, as if they "let people down." One participant elaborated, remarking "I felt pressured to say '#MeToo' but I wasn't really interested in sharing." One commented how she was "so thankful for other people who did [post] and I know it took so much out of them, but I feel guilty that I am not there yet." Another commented "[#MeToo] made me feel like I needed to share my story which I wasn't ready for" and another said, "the more inundated I was with #MeToo stuff, the weirder I felt because I didn't really talk about it with anyone." One survivor eloquently stated, "I felt pressured to share my story, and open up to be a voice for other women, yet I have not reached that place yet. This has caused anxiety." This was not an isolated feeling – many felt the movement was actually triggering for them, using adjectives such as overwhelming and emotional. One participant stated, "not helpful was the pressure to participate. It put me in a situation where I felt I needed to share but I also was extremely triggered and not ready…I avoided the movement." One even mentioned how she felt pressure to report to the police, due to #MeToo. She explained:

> In some ways [#MeToo] makes me feel more shame that I didn't report my perpetrator. I realize this impacts a lot more people and there is a cohort of really brave people who

> made a different choice than I did. I feel shame that my perpetrator may repeat.

Comparison & stigma. Besides feelings of guilt and pressure, some participants mentioned that the #MeToo movement made them feel judged, and made them compare their experience to other survivors as if they weren't worthy of saying '#MeToo' or being a part of this newfound group. One participant explained this further, reporting that "it made me feel like my experience *wasn't valid*, like it was almost like 'oh this happens to everyone it's not that bad that it happened to me." Another participant mentioned how "it has made me feel like I'm overreacting to my own experiences because of reading so many women's experiences that would be considered 'worse'" and another, "if other people can [disclose] and I can't, does that make me weak?" Lastly one remarked "I was definitely comparing and deciding if my experiences 'counted' or if it was even worth saying anything when so many people were and nothing came of it."

Stigma was another reason there was hesitation to disclose. One survivor commented, "I felt like if I disclosed in the form of me too I would get a response like 'why did you drink so much or why did you go over to his house', etc, etc." Another reiterated this notion, "I couldn't confide in anyone because I feared people would blame me" and still another said "I could never tell my parents – too much shame." One noted, "my mom is a doctor and I didn't feel comfortable telling her due to stigma." Another participant mentioned how "I felt like my sexual assault was not 'clear cut' enough for me to want to have people evaluate me in the court of public opinion." There was concern from some that they would be seen as attention-seeking if they disclosed – "I didn't want people to think I was trying to be trendy…so I kept it to myself for a very long time," with another remarking:

> To be honest when I graduated college this year I really wanted to mention it in a

> Facebook post talking about how meaningful this graduation was and all that I'd overcome. Ultimately, I felt it would be perceived as attention seeking, so I didn't.

Some participants mentioned in addition there was fear in false allegations. Victim blaming and consequently fear and shame, which have been highlighted in the literature for decades remain still quite pervasive despite the movement. Furthermore, there was a focus by some on what they thought they *ought* to be feeling or even how they would be viewed. For example, "I felt alone in *not* reporting, which is weird, because I know a lot of people don't."

Formal disclosure. It was evident from participants' responses that despite the movement, there were continued long-held societal beliefs about both sexual assault and survivors of assault, which impacted their disclosure to close friends versus health care professionals. Of those who have not told anyone about their assault, participants mentioned "I'm still very secretive about my assault" and how there remains fear in disclosure "I never told anyone in my family, I'm afraid to." One touched upon the limits of the movement:

> While #MeToo did help in some ways, it didn't help me disclose to anyone - it [sexual assault] is still a heavily personal experience and a hashtag online doesn't really provide enough courage to disclose something like that.

Lastly one participant reported that "[#MeToo] did not have a huge impact for me [to disclose], but I know some people that it helped so I was happy to hear that."

Almost all participants remarked that #MeToo "did not have any influence" or had "no effect" on their decision to formally disclose to a health care provider. Feeling connected to a group of women who were assaulted was one thing, but impacting offline health behavior was something else altogether. For example, one stated, "I basically just wanted an STD check, didn't feel like bringing up the trauma well after the fact" and another echoed that sentiment saying, "I disclosed to a health provider more to be treated for STDS, I didn't really think of #MeToo." One said "I disclosed to health providers but not because I was influenced by #MeToo" and another said "#MeToo did not influence my decision to talk to a health provider, out of control depression and panic attacks did." Lastly, one remarked "I didn't realize I should disclose to a health care provider until right now."

If participants had disclosed to a healthcare provider, there were many (mostly negative) opinions about that interaction with the health care system. One reported "I tried telling my doctor, but she just brushed it off and she turned it into me having a drinking problem." Another commented how "when I ultimately told my PCP a year later [after the assault] she essentially blamed me for not reporting." One even noted:

> I'm not sure #MeToo impacted my willingness [to disclose] on a subconscious level, but when I did indicate on a form that I had an experience of an assault, and the provider (doing a GYN exam) completely IGNORED that…that impacted my decision to tell a future doc.

Another stated, "my healthcare provider knew I had had more partners, wish more had gone into her maybe checking if it was consensual" and yet another mentioned how "my healthcare provider knew I had one partner at the time and implied I wanted an STD test because the partner had maybe cheated, so I decided to *not* bring [the assault] up with them."

Anonymous & online disclosure. While most participants did not disclose to formal supports, some saw the benefit of online, anonymous disclosure. These participants found comfort in weak-tie support networks, like Reddit ("Reddit for the win" and "Reddit, so anonymously") or Facebook ("my podcast Facebook group heard everything – it's called who weekly and they have a private group for assault survivors"). A twitter user reported "I was featured on the page @whyididntreport" last month." However, for those that did not disclose online, most reported it was due to fear of being recognized. "I was afraid of screenshots" and "I am still scared to identify #MeToo online but I have no problem telling my closest friends." One participant commented:

> I remember posting #MeToo on Facebook and deleting it 10 minutes later in a panic. It was too soon and I was not ready to be public about my trauma. To this day I still worry about who may have seen that post.

One mentioned that "I actually looked for [an online] group recently because I just feel so incredibly alone and isolated as a result of the combined nature of my sexual trauma and Covid19 and I couldn't find one."

Exclusivity. While there were many noted benefits of the movement, some felt it was 'co-opted' for the rich, famous white woman and not for the everyday survivor. "I wish it highlighted everyday women" commented one, and another stated "I know that it has given a platform for many relatively famous women to tell about their experiences with sexual assault, but I don't know much about 'regular' people using it as a way to express their experience." Furthermore, "LGBT [lesbian, gay, bisexual, transgender] and WOC [women of color] make up a significant portion of women wo are assaulted in the U.S.…but the main figures I recall were always white women" and "it ended up focusing on celebrities rather than marginalized women."

A good summary of the myriad of feelings, often conflicting, came from one participant who opined, "[#MeToo] has empowered me, angered me, upset me, frustrated me." Another had similar conflicting feelings: "I feel empowered and less alone, but also shocked like how the hell is this the world we live in and it's terrifying that we are only talking about it now and there is still so much push back," this push back being from those who argue there are many false accusers.

Only the First Step. It was clear from participants that although the movement brought significant awareness to the plight of sexual assault and spurred momentum for actionable change, there was a great deal that still lacked for survivors that the movement did not influence. At the forefront of this conversation was the need for more education and resources for the public. One participant remarked, "I think social media campaigns are important, but really the first step, not the end goal." "There are still a lot of hurdles," reported one participant, and another, "I think it's helped people start the public conversation, but that's just the first step, and it doesn't even touch tackling the trauma." One commented, "I think it created an awareness but hasn't had tangible results" and another remarked, "the combination with cancel culture I think has created 'fear' where there needs to be conversation and education." Lastly, one participant stated "I think people hear about it [#MeToo] but don't engage – like the 'movement' can be ignored because there's a lot of education that people still need."

Formal post assault care (FPAC). As previously mentioned, the vast majority of participants (82%) did not seek FPAC and for those that did, only one noted that #MeToo helped her initiate this care. "I wasn't even thinking about #MeToo" remarked a participant, "#MeToo did not influence me in any way to get my kit done…my mom did" said another.

There was a myriad of reasons why participants did not seek out PAC, some which have all been noted previously in the literature (see Chapter 5) – "it was such a he said/she said situation, even if I did get a kit done, nothing would've help up in court and I wasn't ready to admit that it happened yet" mentioned one participant. Another noted, "I didn't even realize it was a rape until a year later. My brain blocked out the trauma." Lastly, others mentioned how they had heard that post assault care was scary and retraumatizing, which led them to avoid it. One actually mentioned how "[#MeToo] made me less likely [to seek treatment post assault] because a lot of stories revealed how negative the experience from healthcare providers was."

Larger Picture. Still others felt there were even more barriers to them seeking out this type of care. "It's so messed up but I feel like I assume the kit won't get processed and nothing will happen, or I assume my insurance won't give me coverage for treatment." One referred to not knowing about the five days post assault she had in order to have a SAECK performed: "if I had known the time, I would have maybe gone." Furthermore, there was a sentiment that the focus post assault was not on post assault care ("I never realized I should go to a hospital after my assault until right now"; "I didn't really know I should have [gotten post assault care]"). Even one participant mentioned how "I feel like so much of #MeToo is about empowering victims to be able to share your story with those close to you, but I don't remember anyone saying to see a doctor."

Participants also noted that there were larger picture barriers as to why they didn't seek out care, such as the SAECK backlog and other legal issues. Few saw any posts on social media sites from a healthcare provider or organizations providing instructions on how to obtain care or what to do after an assault ("for me simply the online system failed [post assault]"). Some mentioned how "rape kits never get processed," and how "there needs to be more anonymity and quick processing of rape kits – otherwise, what's the point [of having a kit done]?" Another reported how, "I want to feel like if I go for post assault care, something would happen to my kit and potentially legal ramifications for the perpetrator – this would require a larger social change." "[#MeToo] didn't result in consequences for perpetrators," concluded one participant, so even if a survivor reports, "it doesn't always mean [the assailant] will be held accountable." These were all large enough roadblocks to prevent survivors from receiving GPAC or FPAC.

Resources. It was clear that the majority of participants agreed that the movement didn't create lasting legal change and furthermore, didn't provide the needed education and resources for survivors. One participant succinctly reported, "I think it's greater awareness but it didn't necessarily come with a follow up – like what to do if someone says '#MeToo', or shares their experience." "It's one thing to say #MeToo, or to stand with survivors, but if you don't give them resources, what's the use?" said one participant. "More posts that refer to the #MeToo movement should include resources," reported another. One eloquently posed, "I think #MeToo laid important ground work for raising awareness about sexual violence but I don't think it offered viable solutions for survivors for what to do after, what healing looks like, how life can continue on."

When prompted to consider resources that they felt sexual assault survivors needed, many echoed this participant's thoughts: "I think a lot of it is not knowing what is the best course of action to take [post assault], so if there is more awareness in general people would know what to do." For example, survivors were frustrated that they had to find resources on their own – one reported "as a student in Boston, I'm appalled that I had to find BARCC on my own" and "knowing about SANE would have been helpful" commented another, and "I've never seen anything advertised about a rape kit" added yet one more. Another mentioned that she wished "it was easier to find stories or resources" online. One participant echoed this from a health care perspective:

> I think nowadays we are seeing more HCPS [health care providers] on different social media platforms that have gained a lot of popularity. As someone who is pursuing a

> career in healthcare, I'd like to see some of these individuals just *talk* about [post assault care] more."

Lastly one survivor mentioned how she felt the campaign "should have focused more on breaking down barriers and changing healthcare to support survivors." This was agreed on by others - it was clear post assault care was important to these participants.

Recommendations. Participants were aware that post assault care was crucial for STD prophylaxis and therapy/counseling referrals. However, there were still a lot of unknowns, albeit curiosity, about the post assault exam and the SAECK in general. Thus, there were many thoughtful and comprehensive recommendations for the future about post assault care, some that could stem from social media campaigns. For example, "I wish I could go online, see all the elements of the rape kit, and then like a picture of the nurse who would be completing if or something" because "if [you] can't touch it feel it or see it leaves doubt." Another participant stated "I feel like nurses or health organizations could post info about where, when, and what kits entail" or even, "if there was like a flow chart for what to do in the even that 'x' thing happens (surrounding sexual assault for example)." In order to accomplish this, a participant mentioned how "today social media has a lot of resources for COVID and they could have had links or direct links." Echoing this, "more links and less stigma," commented one participant. Another further mentioned how for her, post assault care "would need to offer paths for taking back my life and body that were not just reliving my trauma for the world" in a way that was less clinical.

When queried, only one participant out of 56 knew a forensic exam with a SAECK was free, and many of those 55 found that fact surprising. One even mentioned "if I knew [the kit] was free I would have sought care." A participant reported how she thought already there were "plenty of resources online already about rape kits" but "just directing people to resources that already exist would be helpful." Another participant remarked:

> In my particular situation I felt very supported by my mom who is an NP…so she helped me navigate the assault medically and emotionally, but I think in my university health clinic and at my OB's office it would be great to have someone like this.

Because "people think you can only get a kit if you are raped in an alleyway by a stranger," it would have been helpful for this survivor to have more information about:

> consent and more about how common it is. More about WHO does it to you (because I always thought rape was by a stranger like in the movies, not someone who is supposed to be my friend.

Another mentioned simply having "more information on post-assault care, easy to understand legality information, etc." on hand for people, especially "BEFORE THEY HAVE TO BE 'SURVIVORS.'" Lastly, one mentioned how she wished "there was more affirming my basic rights so maybe I would have felt more empowered to act, not just understand what happened." There was also a need for the information to be more readily accessible - "it feels like you really have to go looking for it which is exhausting" and another echoed this by saying "I hate searching for things – it's so scary."

In terms of what participants thought should be provided for general education among youth, one noted how there needs to be a "sex positive culture and completely holistic sex ed" with a focus on "mental healthcare, PTSD symptoms, unhealthy coping mechanisms versus healthy ones" and "rape kits, STD/STIs, and pregnancy." One furthered this saying how "the misogynistic sex culture is part of rape culture…like god forbid women enjoy sex," so she believed the core of what sex means in our culture should be challenged. Still more thought that having more resources about how to navigate sexual relationships after being raped, and how to get out of potentially dangerous situations.

There were recommendations for the healthcare system as well. They included having HCPs starting conversations about sexual assault earlier, at pediatric visits, and asking at every reproductive health visit whether there had been a non-consensual encounter. One participant stated how more information about trauma and mental health post assault was vital and needed to be more a focus in healthcare and beyond. Another mentioned how there should be "more information about how to reduce stress, how to get back your confidence, free support groups in your area." Lastly, one reported how "in this location we believe survivors' would be SO validating – even if it wasn't relevant to the visit." Another reiterated this sentiment saying that "a validating hashtag e.g. #webelieveyou could be helpful as well."

Participation

Worth noting was the overwhelming positive response from participants at the end of the four focus groups. Researchers have provided some evidence that qualitative studies can be beneficial for the participant from a mental health standpoint, but this study is further supportive of that fact. For example, one participant remarked:

> I found this discussion very useful and enlightening. It was reflective of the problems and challenges that the #MeToo movement has and how it demonstrated the positives of this movement and possible improvements. I enjoyed it 'til the very end and I appreciated both the moderator and the opportunity :)

Others were appreciative of the space we created for them to talk about their views on the subject ("without you guys, our voices would not be heard! Thank you for all that you do") and of the subject matter we were investigating ("thank you for conducting studies on things like this!").

Participants were also eager to share what they gained from the study, such as the strength they felt afterwards, and how much it has helped emotionally ("thank you for the chance to talk about these things, it means a lot," "I didn't realize that discussions like these could be so helpful!" and "thank you – talking about this has made me feel strong.")

Chapter Five: Discussion

The 2017 #MeToo movement was a global paradigm shift for sexual violence, as awareness about its extensive nature was illuminated. Historically, sexual violence in the U.S. and elsewhere had been largely ignored by clinical and legal fields. Consequently, the health needs of survivors had also been neglected. Now, nearly five years after the movement began, the outcomes from this study have led to many insights into the connection between #MeToo and sexual assault survivors' healthcare decision making processes post assault. These insights will impact future clinical practice, education, policy, theory and research.

In this study, the majority of participants were well-educated, White, high users of social media, and between the ages of 18 and 25. While homogeneous at first glance, this sample was in fact more diverse that MA demographic patterns, including education (U.S. Census Bureau, 2019) (additionally see 'strengths' below). Their accounts of what #MeToo meant to them and how it influenced them post sexual assault answered the research question "what are the patterns of sexual assault survivors' disclosure and health seeking behaviors in the era of #MeToo?"

Through immersion and multiple levels of analysis of the qualitative data, four themes emerged: It Exposed a Problem, I Have a Voice, Never Felt like Mine and Only the First Step. These themes and their subcategories provided evidence that while #MeToo influenced (1) patterns of disclosure, it (2) did not influence patterns of health seeking behavior.

Patterns of Disclosure

In this study, many survivors found that #MeToo helped them disclose to informal supports, while it did not influence their decision to disclose to formal supports (Aim 1). This was the first study to provide this data. Additionally, some participants found online, anonymous disclosure beneficial, which is similar to other literature findings (Lokot, 2018; Mendes et al., 2018; O'Neill, 2018).

Informal disclosure. The majority of participants (86%) disclosed to an informal support, with about 60% disclosing to this support within five days. These rates are much higher than those found in the literature, where overall less than 50% of survivors eventually disclose (Krebs et al., 2007; Lindquist et al., 2013; Littleton, 2010; Orchowski & Gidycz, 2012). However, the five-day window timeline was not examined by previous researchers so a direct comparison is difficult to make. Additionally, many participants noted in their responses that #MeToo was influential in helping them disclose to this informal support, as evidenced by the theme 'I Have a Voice.' This is a valuable outcome from the data – this not only reinforces what we know from the literature, that informal supports are often disclosed to at a higher rate than formal supports (Ahrens et al., 2007; Campbell et al., 2001; Campbell, 2008; Filipas & Ullman, 2001; Fisher et al., 2003; Liang et al., 2005; Orchowski & Gidycz, 2012; Starzynski et al., 2005), but that #MeToo is influencing these rates. It also appears as though #MeToo has lasting influence, even multiple years after the beginning of the movement, which is an important take-way. These findings also can pertain to health behavior: disclosure can help the survivor begin the recovery and healing process in the aftermath of the assault (Ullman, 2010), and informal supports are important bearers of 'next step' information and intervention for these survivors (Campbell et al., 2015; Kilpatrick et al., 2007). Thus, this may also suggest that *indirectly* this social media campaign influenced health behavior (see 'patterns of health seeking behaviors').

Another avenue of informally disclosing was online disclosure. Some noted positive feelings from disclosing online such as connection to other survivors, feelings of empowerment, and normalization of trauma post assault. This had previously been seen by other researchers

(Lokot, 2018; Mendes et al., 2018; O'Neill, 2018). Participants reported that additionally, #MeToo was crucial in raising awareness about sexual violence and creating a community of healing through shared informal disclosure, where before, that really didn't exist. Increase in awareness and connection to other survivors certainly have the potential to reduce the stigma surrounding mental health care and increase health seeking behaviors, which continue to be explored.

However, it is important to note that some participants also relayed that #MeToo created unintended negative consequences, such as pressure to "participate in the movement" or report, guilt if they did not, and comparison to other survivors' disclosed assaults. This was illustrated with the theme 'It Never Felt Like Mine.' These are new patterns that have not yet been reported in the literature and certainly need more exploration.

Formal disclosure. Slightly less than 50% of participants in the study disclosed to a formal support, and of those that did disclose, only roughly one third (34.6%) did so within five days. Even still, this is much higher than numbers previously reported, where only about 10-15% of survivors disclosed to formal supports (Fisher et al., 2003; Jones et al., 2008; Wolitzky-Tayler et al., 2001). All nine participants who disclosed to a formal support within five days had FPAC with a SAECK completed (16% of participants), which is similar to other reported rates (Ahrens et al. 2009; Kilpatrick et al., 2007; Lindquist et al., 2013; McCauley et al., 2013; Orchowski & Gidycz, 2012; Wolitzky-Taylor et al., 2011; Zinzow et al., 2012). This is a very meaningful result, seeing as it is evidence that the definition of FPAC is sound and captures the correct criteria. It also provides evidence that the other two thirds of participants who disclosed to a formal support outside of the five day FPAC window could have benefitted from information about earlier disclosure and post assault care.

Patterns of Health Seeking Behaviors

This study provided evidence that the #MeToo social media movement ultimately did not directly influence these survivors' offline health seeking behaviors. The majority of participants relayed that #MeToo did not impact their decision to receive either general post assault care (GPAC) or formal post assault care (FPAC) following an assault (Aim 2). In this study, rates for FPAC remained relatively low (16%) among the participants and were consistent with the reporting literature (less than 20%)(Ahrens et al., 2009; Lindquist et al., 2013; Kilpatrick et al., 2007; McCauley et al., 2013; Orchowski & Gidycz, 2012; Wolitzky-Taylor et al., 2011; Zinzow et al., 2012). Gaps remain in relation to disseminating educational health information online about GPAC and FPAC to survivors.

Formal post assault care (FPAC). Every 68 seconds someone is sexually assaulted in the U.S. (U.S. DOJ, 2020) – and yet according to these participants, FPAC is often unknown, limited, or (seemingly) out of reach. One participant even questioned the focus on FPAC in the study – as if she didn't believe this type of health care warranted this much attention – "it's interesting that this conversation is about health and aftercare…I think a lot of sexual violence doesn't even involve healthcare." As previously mentioned, the majority of the participants did not have FPAC (82%) and for those that did, only one reported (1.7%) that #MeToo was the impetus for her seeking out this type of care.

Of the survivors that knew about FPAC, the majority had negative preconceived ideas about this type of care. They had heard of or experienced the extensive length of time it took to complete this exam, and they lamented the fact the exam was "too clinical" and "invasive," "with a focus on the protocol and not the victim." There was also fear of re-traumatization, and they believed it was expensive and/or not covered by insurance. There was distrust in the

SAECK processing itself, uncertainty about what institutions provided FPAC, as well as apprehension about the anonymity of the exam. While most of this is new, nuanced data, previous literature has suggested that barriers such as cost and fear of re-traumatization were reasons why survivors do not seek care (McCauley et al., 2013; Wadsworth et al., 2019).

General post assault care (GPAC). As mentioned, almost half of participants disclosed to a formal support, with two thirds doing so after five days. These participants still need evidence-based, empathetic care and resources, even when FPAC was no longer an option. Although there is some evidence in the literature that conversations about and screening for sexual violence should be happening in primary care/women's health visits, especially in a trauma informed manner (O'Doherty et al., 2015; Palmieri & Valentine, 2020; Williams, Gonzalez-Guarda, Halstead, Martinez, & Joseph, 2017), there is a dearth of evidence showing that they in fact are. This study is also evidence that when these conversations do happen, they are often awkward, belittling, and further traumatizing. Negative experiences related to both formal disclosure and health seeking have been previously cited in the literature (Campbell, 2008; Kennedy et al., 2012). Thus, future research to determine if GPAC in both MA and nationally is of quality and how to improve this care, is of great importance.

Additionally, the vast majority of participants did not know what a SANE was, they did not know about FPAC or SAECKs, how to obtain either, or the time frame in which to do so. Survivors voiced frustration that the #MeToo movement did not make this information accessible. One participant summed up the movement eloquently, saying "I think #MeToo laid important ground work for raising awareness about sexual violence but I don't think it offered viable solutions for survivors for what to do after, what healing looks like, how life can continue on." Other reports also note that lack of information is a barrier to disclosing and seeking care

(Centola, 2013; Gagnon, Tejaswinhi, & DePrince, 2018; Spencer et al., 2017). Recommendations for how in fact how this could happen were offered by participants.

Lastly, participants reported how larger social change was important for them in order to access FPAC. They perceived barriers at the systemic level (“there needs to be more anonymity and quick processing of rape kits – otherwise, what’s the point”; “investigations aren’t always pursued”; “just because you report doesn’t mean the assailant will get in trouble”). These are novel insights due to the changing landscape of sexual violence awareness, influenced by #MeToo.

So, while the movement was a paradigm shift for sexual assault awareness, it was not for these survivors from a health care standpoint. This study illustrates the complexity of sexual assault care – survivors are not accessing and/or are not even aware of care for them that can mitigate the numerous negative effects from sexual assault trauma. And yet there remains hope for future practice – this study also provides optimistic discourse that survivors ultimately do *want* this type of care, though are currently hesitant, unaware, and/or uninformed.

A discussion of the findings in greater detail as they specifically relate to the implications for practice, education, policy, research and theory are discussed in the following pages. Both limitations of the study and next steps will also be explored.

Implications for Practice

Indeed, the need for research to inform practice is of the utmost importance, as the wellbeing and health of survivors is the ultimate goal. The following is a summary of what health care providers can take away from this study.

FPAC & GPAC. #MeToo began the conversation about the pervasiveness of sexual assault, but there was no follow through from HCPs, academic institutions, nor healthcare institutions that weren't already spreading messages of anti-sexual violence about how or why survivors should access FPAC. Yet HCPs can still be the link that provides this information in either a clinical setting or via an online, social media setting.

Close to 50% of participants did disclose to a formal support, but about two thirds of these disclosures were after the five day FPAC window. It is well understood that HCPs face a multitude of barriers to even discussing sexual health and sexual wellness, let alone sexual violence. These include limited time during clinical visits and lack of adequate training, thus concern about what to say or do if a patient wants to discuss sexual violence, and fear about offending them or causing discomfort (Gott, Galena, Hinchliff & Elford, 2004; Humphery & Nazareth, 2001; Sobecki, Curlin, Rasinski, & Lindau, 2012). Because some participants had negative experiences with their HCP pre or post disclosure (victim blaming, belittling or minimizing, etc.) or had heard of others having negative experiences, it made them less likely to disclose or seek out FPAC or GPAC. However, whatever barriers HCPs are up against ultimately mean lost opportunities for survivors.

This is vital knowledge from a practice standpoint; HCPs must be aware of barriers and facilitators of disclosure so their timely recommendations and resources are of utmost importance. There is also a need for evidence-based, standardized, mandated training for providers especially in the light of this movement, since, as evidenced above, HCPs must not just be a trauma-informed support in the case of disclosures they must also be aware of and able to educate patients about FPAC and GPAC. Additionally, they should be able to provide this education to *all* patients even before an assault takes place, such as by posting or providing informational flyers in exam or waiting rooms. Institutions should have easily accessible information online. This was heartily endorsed by participants.

It would also behoove the health care community to explore current HCPs' attitudes and beliefs about discussing sexual assault in primary care. If rates of formal disclosure are in fact increasing due to #MeToo, HCPs must be prepared to have these conversations with patients as well as provide appropriate next steps for them. At this time there is a dearth of content pertaining to this phenomenon in the literature.

Social media, nurses & health. For the past 20 years, nurses have been voted the most trusted profession in the nation (Saad, 2022), due to their ethical and professional standards (AACN, 2006). Nurses also make up the largest segment of the U.S. healthcare profession with over four million registered nurses (Smiley et al., 2018). As a strong collective, nurses, advanced nurse practitioners, and nurse scientists have an opportunity to support, build upon, and provide further health promotion interventions that capitalize on social media movements. This study provided the foundation for this effort by uncovering the impact of #MeToo on sexual assault survivors' health behaviors.

As evidenced by the theme 'Only the First Step,' the majority of participants believed that social media campaigns are important to start conversations, but are "only the first step, not the end goal." Unfortunately, in the case of #MeToo, there really was no next step, or follow through, by HCPs in a clinical setting if someone did disclose. Thus, more emphasis on conversation, education, and promotion of GPAC and FPAC must be the focus, especially, as per the participants, some HCPs are becoming more influential on social media ("I'd like to see HCPs just TALK about it more").

However, at the same time, "[#MeToo] has provided a platform to do prevention work and spread conversations." Online platforms have been shown to do just this (McFarlane et al., 2015; Zhang et al., 2016, 2019). Thus, knowledge gained from this study provides valuable insights for nurses related to capitalizing on social media movements to advance public health. Social media campaigns have staying power and resonate across all users of social media. Based on the findings, it is necessary to develop and implement interventions and programs in post-assault care for not only those that have been assaulted, but for the public as a whole. Participants want clear steps, options, and explanations for "demystifying the kit" *before* they need them. Also, while these participants very much valued the survivorship community post #MeToo, they acknowledged that anonymity for obtaining FPAC was of concern. This can be used as an important tool for tailoring interventions and programs in post assault care. Also, some expressed that they'd rather "just know [about resources] from exposure to social media" instead of having to go somewhere to find it after being assaulted. Thus, this information should be part of public healthcare's message, such as pandemic awareness ("today social media has a lot of resources for COVID – they could have had direct links").

This study also provides insight into how #MeToo has impacted behaviors of survivors, and for how long a movement's effect is sustained overtime. Sexual violence was thrust into the limelight, and this information will help nurses shape interventions that capitalize on, and are synergistic with, social media movements to have positive impacts on health.

Implications for Education

This research contributes to the development of sexual violence prevention science. Based on the findings from this study, it is necessary to develop and implement interventions and education programs in post-assault care.

Awareness about both GPAC and FPAC is vital, as noted above in 'Implications for Practice.' Post assault care includes providing options for individuals such as: whether or not to have an in-person clinical exam for general care, evidence collection, prophylactic antibiotics and antiviral medications that are not available over the counter, and continued counseling or safety assessments. Furthermore, post assault care provides resources such as support groups, individual counseling, and safe housing, and can connect survivors directly to those programs in real time. Ultimately this information helps survivors regain control and be able to make choices in their care, which is a foremost trauma-informed principle (Butler et al., 2011). Even though the majority of the participants in this study were well-educated, between the ages of 18-25, had health insurance, were frequent users of social media, and knew about the #MeToo movement, almost all were unfamiliar with how an HCP could help them in the aftermath of their assault. There was little to no knowledge about available crisis counseling centers which specialize in sexual assault and other community resources for survivors. Lastly, participants reported little knowledge about SAECKs and that FPAC was free of charge, and what hospitals provided these services.

When informed of available services and resources during the focus groups, participants were obviously frustrated. They voiced a desire for increased awareness of available services before they needed it ("I've never seen anything advertised about a rape kit"; "I had to find BARCC on my own"). Survivors also wanted easily-accessible guidance at their fingertips that they didn't have to go looking for, that directed them to FPAC information and mental health support ("I wish it was easier to find stories or resources"), or that provided a flowchart or infographics that provided survivors with a visual depiction of FPAC and/or the SAECK, so that it wasn't so intangible. Thus, participants are open to more information about both general and formal PAC and other resources, and in particular having this information provided via social media with a focus on anonymity.

Study participants also advocated for more remote, anonymous exchanges with providers prior to having FPAC (“I wish I could go online, see all the elements of the rape kit, and then like a picture of the nurse who would be completing it or something”; “Previewing everything, and having that online, and ensuring that the survivor has complete control”; “I think I would like to be able to talk via chat or phone to the person that would be performing the exam”). More visuals and information online are a feasible request. Seeing as it would help survivors present for the exam is certainly a strategy worth pursuing.

Information concerning sexual assault should impress upon all that everyone’s experience is unique. Certainly, comparing one’s personal trauma to someone else’s can be damaging to one’s mental health. Additionally, feelings of guilt and pressure surrounding disclosure will only certainly make things worse. These are new phenomena due to #MeToo that has not yet been documented in the literature – thus, the appropriate healthcare fields should be alerted.

Lastly, because some participants wanted to detach from social media afterwards (e.g. concerns about connecting with their assailant) it’s important to make educational information available pre assault, so that individuals already know of resources and services available if they need (“I’d rather just know [about resources] from exposure to social media”; “I didn’t want people telling me what to do, I just wanted someone to tell me I could take a deep breath).

Implications for Policy

The field of nursing has historically been dynamic, able to adapt to the changing nature of society’s needs (Neuman, 2012) – from pandemics and epidemics, to germ theory, to the human genome project and genetic testing, to telemedicine, and now, to social media and online health campaigns that influence offline health behavior – nurses are skilled at evolving with the times. And yet, even as the #MeToo movement is closing in on its fifth-year anniversary, neither state nor federal policies have yet to ensure services are available, accessible, and provided without stigma related to victims of violence.

There were a plethora of policy issues highlighted by participants in this study. Participants reported how larger social change was important for them in order to access FPAC. Distrust in the legal system had been cited in the literature previously as a deterrent to disclosure (Wolitzky-Taylor et al., 2011), but not as of yet for accessing post assault care. These participants perceived barriers at the systemic level ("there needs to be more anonymity and quick processing of rape kits – otherwise, what's the point"; "investigations aren't always pursued"; "just because you report doesn't mean the assailant will get in trouble"). These insights are due to the changing landscape of sexual violence awareness, influenced by #MeToo. Nurse leaders are well-positioned to facilitate post-sexual assault care policy change and can provide the voice for or tell the stories of survivors as needed for legislators. As one participant penned, #MeToo can act as the gateway, or the "platform, necessary for actual #policychange to be implemented."

Because nursing goals, outlined by both the American Nurses Association (ANA) and the International Council of Nurses (ICN) are "the protection, promotion and restoration of health and well-being; the prevention of illness and injury; and the alleviation of suffering" (ANA, 2015, p. vii) as well as "advocacy, promotion of a safe environment, research, education, participation in shaping health policy and in patient and health systems management" (ICN, n.d. para. 1), this places nurses in a position to respond to the needs of survivors. While these goals "serve as the main anchors for understanding our ethical responsibilities" (Grace, 2018, para. 6) to the public, nurses do not currently have a strong presence in health policy despite evidence that it's necessary to implement change (Boswell, Cannon, & Miller, 2005). Additionally, findings from this study provide evidence that larger policy issues are barriers to FPAC, and nurses have the opportunity to become leaders in policy change. As there has been national discourse around the issue of combatting the health inequities in post-assault care, this momentum should be capitalized on by those working on the frontlines.

Access. There are certainly changes from a policy standpoint that could be made to increase access to FPAC. Firstly, there are stark inadequacies of existing post assault services. There is a severe SANE shortage, thus post-assault healthcare access is not guaranteed or equitable across the country or even across states (Frellick, 2018). Only 14% of EDs nationally provide forensic services (IAFN, 2017) and out of the approximately 100 hospitals in Massachusetts, less than a third of them are SANE affiliated (Commonwealth of Massachusetts, 2019). Based on 2018 data, only 143 out of 151,076 licensed nurses in Massachusetts, were practicing certified SANEs (Commonwealth of Massachusetts, 2019). That amounts to less than 0.1% of nurses in the state that are certified to perform forensic examinations.

In addition to the SANE shortage, there is no national mandate for FPAC resources or standards (Frellick, 2018). This impacts the quality of the exam, whether or not the patient is cared for under the model of trauma-informed-care (TIC), and whether or not the forensic evidence collection is done correctly or completely (U.S. Department of Justice, 2017). Furthermore, patients are continually turned away from hospitals that do not offer SANE services (IAFN, 2017). Thereby, many do not follow up at the hospital they were referred to, thus never receiving care (U.S. Government Accountability Office, 2016). Even still, there is little accountability if survivors are turned away or even how long they wait for care (Frellick, 2018). These barriers to access could be attributed to time and cost of training, as well as a lack of awareness of the need. For example, many healthcare workers believe the SANE program is simply a part of the criminal justice system, and not an integral part of the healthcare system (Potiker, 2016).

Lastly, the no-fee FPAC exam and SAECK must be addressed. As previously mentioned, in order to access the victim's compensation fund and thus have a free examination, the survivor needs to present for forensic exam care within the designated five-day window post assault (U.S. DOJ, n.d.; Violence Against Women Reauthorization Act of 2021, 2021). Without access to this fund, medical service or counseling service costs incurred post assault are up to the survivor to pay, even if they disclose to a healthcare provider or legal authorities. Furthermore, if patients do present for FPAC within those first five days, they may opt out of the SAECK but still need STI prophylaxis which will incur cost. Participants in this study noted being unaware that the forensic examination is covered by this fund, and therefore did not seek care for fear of having to pay or have it billed to insurance. The overall result of lack of access for forensic examinations means missed opportunities to provide recovery services (physical and mental health services) for individuals.

Quality*:* FPAC. There is no federal or state law mandating ED providers should be trained to conduct forensic exams when specifically-trained SANEs are not available. Facilities that do not have trained specialists available may transfer or encourage victims to go to another facility, which is problematic as described previously. Survivors may also, however, be treated by a medical professional who had not received specialty training and is not competent in handling evidence or providing trauma-informed care. This is problematic because inadequate care or incorrect handling of forensic evidence may jeopardize a legal case and/or may re-traumatize the patient. From a provider and hospital standpoint, barriers include cost/time of training, healthcare system and ED organization, and lack of perceived need.

Quality: GPAC. As mentioned above, there is a dearth of information concerning the quality of GPAC, including formal disclosures in health care outside of FPAC. However, this study shows almost half of participants disclosed to a formal support, with two thirds doing so after five days. These participants still need evidence-based, empathetic care and resources, even when FPAC was no longer an option. Although there is mention in the literature that conversations about and screening for sexual violence should be happening in primary care/women's health visits, especially in a trauma informed manner (O'Doherty et al., 2015; Palmieri & Valentine, 2020; Williams et al., 2017), there is a dearth of evidence showing that they are. This study is also evidence that often when these conversations do happen, they are often awkward, belittling, and further traumatizing. Thus, future research to determine if GPAC in both MA and nationally is of quality and how to improve this care, is of great importance.

National SAECK backlog. As survivors reported, knowledge that there is in fact a backlog deterred some from seeking out FPAC. Due to lack of funding, resources and adequate organizational structures in crime labs and police departments, hundreds of thousands of SAECKs have not been examined, and sometimes stored where the evidence could be contaminated (End the Backlog, 2019; Hargitay, Adlesic, & Gandbhir, 2017). This study is evidence that survivors are aware of the backlog, which in turn causes distrust in the legal system, and furthermore discourages survivors to come forward. If this backlog is not addressed, efforts to increase awareness of, access to and quality of forensic exams are meaningless.

Implications for Research

Recent evidence suggests that social media use has a potential negative impact on adolescents' mental and physical health. In 2021, the ex-Facebook employee and whistle-blower Frances Haugen, gave testimony that harmful social media content and algorithmic, targeted advertisements are linked to increased depression, anxiety, eating disorder behavior and body dysmorphia, especially in young girls (Allyn, 2021). But can campaigns themselves, developed for online use, influence offline behavior and provide positive offline impacts? This study was the first to investigate these questions in regards to #MeToo and sexual assault survivors' health behaviors post assault.

This study was a first step in assessing the impact of social media on knowledge, awareness, and offline behavior change. Future research should focus on ways institutions and organizations can address sexual violence, strengthen the nation's health system structures to reduce and eventual eliminate sexual violence, and improve access to FPAC. These goals have been endorsed by many institutions nationally and internationally (United Nations, 1993; U.S. Office of Department of Disease Prevention and Health Promotion, 2014; Transforming Our World, n.d.; WHO, 2016; IAFN, 2016). Findings from this study and the literature review are compelling for multiple reasons, and are summarized below.

Positive behavior change. #MeToo influenced the behaviors of participants in this study. Participants noted that #MeToo helped them disclose to informal supports, such as friends and family. Future research should explore bystander responses to disclosure and how those individuals may influence survivors to seek FPAC. #MeToo also served as an online community for study participants. This newfound community created, for many, feelings of healing, normalization, and empowerment, though what this empowerment meant to them should be more explored in further studies (e.g. did it lead to pursuit of legal action?). Lastly, there was usage of online platforms to disclose anonymously, lending evidence that weak-tie support networks can be beneficial to healing post assault. Clearly, further exploration and understanding of factors associated with seeking health care are needed, particularly in light of potential changes in cultural attitudes after #MeToo.

Negative behavior change. Participants in this study also noted that #MeToo had negative impacts on their well-being, such as self-doubt, comparison to others, and pressure/guilt feelings related to reporting. This last finding is reminiscent of previous reports noting the main reason for reporting was to prevent crimes against others (Kilpatrick et al., 2007). Certainly, comparing one's personal trauma to someone else's can be damaging for mental health and feelings of guilt and pressure surrounding disclosure can only worsen the problems at hand. And yet, reporting so as to eliminate or reduce future crime is a phenomenon that should be investigated further.

Rape myths. As evidenced in the literature (DePrince & Gagnon, 2018), outdated rape myths and stigma are still influencing research participants' decisions post assault, even in this era of #MeToo. On top of these myths are new feelings of guilt, pressure, and even comparison of assaults. As mentioned, this should be clearly outlined to multidisciplinary healthcare providers, and further explored qualitatively and quantitatively as this may be contributing to further trauma post assault.

Dichotomy. There was ambiguity from participants in this study related to feeling connection with the #MeToo movement, as evidenced by the themes 'Never felt like mine' and 'I have a voice.' Participants may have 1) not wanted to be part of a movement that made them feel like a victim or a statistic, 2) felt like the movement was exclusive or didn't speak to them, and/or 3) were not ready to say '#MeToo'/acknowledge their circumstances. Clearly, the movement elicited both positive and negative feelings and further research is needed.

Methodology. This online anonymous method of qualitative data collection was incredibly effective. The method yielded results that gave a platform for a large group of diverse sexual assault survivors to voice opinions in a private, safe manner, even as the COVID-19 pandemic was in its early stages. From recruitment to conducting the study, to follow-up with remuneration, everything was online/remote. This method was key to the study's success in both recruitment and participation, as seen in other research (Cahill et al., 2021; Fontenot et al., 2019; Fontenot et al., 2020). Participants were able to clearly express and articulate their feelings and opinions related to this difficult and emotional topic. This methodology should be utilized in future research among vulnerable populations, including sexual assault survivors, especially in studies looking at social media influences on their health behaviors. Previous reports had similar successful outcomes among other vulnerable groups including adolescents and those who identify as gay or transgendered (Cahill et al., 2021; Fontenot et al., 2019; Fontenot et al., 2020).

GPAC vs FPAC. As noted in the dissertation literature review, past studies have combined the concepts of general post assault care (GPAC) provided by a primary care provider and formal post assault care (FPAC) provided by an HCP specifically trained in forensic care, while in reality, these are very different concepts that should be evaluated separately. These concepts must be defined in the same manner across studies to accurately capture the phenomenon at hand. To-date, this study is the only known study to define GPAC and FPAC clearly and accurately determine whether social media campaigns influence survivors' attitudes and behavior about post assault care (either GPAC or FPAC). Future research should clearly articulate types of care so that accurate assessments of provision of care and types of services can be captured/evaluated. It will be important in future research to determine why at baseline FPAC was not perceived to be more important for these participants. Additionally, it will be vital to determine how best HCPs can provide patients with FPAC information.

Second, cost has been documented as a barrier for individuals accessing FPAC (McCauley et al., 2013). Similar was true in this analysis. Clearly, the general public remains largely unaware of availability of free services (particularly FPAC) provided per the Violence Against Women Reauthorization Act (2021). Health educational campaigns are clearly needed.

Nationally, researchers have documented that over 30% of survivors have negative experiences with HCPs when disclosing a sexual assault (Campbell, 2008). Similar experiences were noted in this study, highlighting a need for further investigation about care post assault, as well as health providers attitudes/beliefs about FPAC and GPAC.

Implications for Theory

Both Liang and colleagues' (2005) help-seeking theory and feminist philosophy were used was used to guide the study script. Based on study findings, the help-seeking theory can possibly be adapted. Influences of 'problem recognition and definition,' 'decision to seek help,' and 'support selection' were all discussed in this manuscript. #MeToo could certainly be a subset of sociocultural influences, overarching all three of these behaviors, given its influence on culture and n participants' decisions to disclose to informal supports. If the same phenomena are seen using a national sample and quantitative methods for future research, findings can be used to further clarify this theory.

This study also provides further evidence that we have entered into a fourth wave of feminism. In this age of social media campaigns and heavy social media usage, participants were even more aware of larger societal issues that influence sexual violence outcomes (e.g. the SEACK backlog, legal cases, perpetrator consequences, etc.). This knowledge played a part in health seeking behaviors. There was a sense of altruism among participants as well, and even feelings of guilt if they did not report knowing they could have done more to prevent others from victimization. This should be further explored with the lens of feminist philosophy. The impact of social media movements on offline behavior appears to be another part of this digital feminist wave.

Limitations

This study is not without limitations. As noted in Chapter 3, the qualitative method does not allow for large generalizations of results nationally. This study provided a snapshot among individuals in the Northeast region and therefore results can't be transferred beyond these participants.

Another limitation was that during the recruitment phase, 'sexual assault' was not defined in the eligibility criteria. One participant remarked that she had to google the term to confirm that she was eligible. Thus, while this oversight was caught by the end, there was not enough time to amend it before recruitment was complete. There were thus potentially participants that did not in fact meet criteria of the study.

Lastly, based on the demographic data, 50% of participants were recruited from a private, Jesuit college with the use of its a women's health center's newsletter (which included alumni, staff, and current students). Overall, the sample was homogenous and women with less education and those from underrepresented groups not included in large numbers. Additionally, only cisgender women were included and the results can't be transferred to LGBTQAI individuals.

Strengths. The study was strengthened by elucidating the voice of 56 individuals and achieving saturation. The method also allowed for participants to contribute despite geographical distances - while all were assaulted in MA, they now live in 13 different states. This wouldn't have been possible using other methods. Additionally, this choice of method allowed examination of participants to elucidate their thoughts in a safe, anonymous manner.

Even if there was a question about said definition above, there was ample opportunity to 1) not partake in the study after post completion of the eligibility screener and 2) communicate directly with the PI for clarification. Additionally, based on participants' answers in both the qualitative and quantitative portions of the study, the chances this in fact happened are slim.

Lastly, in comparing the study sample's demographic data to state data, this sample was actually more diverse than state rates across all races. This sample had lower rates for those identifying as White (67.9% vs 71.1%), higher for those identifying as Hispanic (14.3% vs 12.4%) and Asian (8.9% vs 7.2%), much higher for more than one race (12.5% vs 2.6%), and almost identical rates for those identifying as Black (8.9% vs 9%) (U.S. Census Bureau, 2019).

Unfortunately, direct comparison of education attainment across states and this study sample was difficult as the question was worded differently (U.S. Census Bureau, 2019). However, while 100% of this study's participants had high school education and above, that is only a 9% difference from state data. This is not a large discrepancy, providing evidence that MA residents are on average well-educated, this sample being testament to that fact. Additionally, the university women's center newsletter was the most successful out of all the recruitment platforms, offering academic colleagues insight into future online recruitment choices.

Conclusion

According to the American Nurses Association, the mission of nursing is to protect, promote, and optimize health and abilities, prevent illness and injury, alleviate suffering, and advocate for individuals, families, communities, and populations (ANA, 2015). The National

Institute of Nursing Research (NINR) stresses scientific inquiry focused on wellness and its relationship with technology (Grady, 2016). This study sought to optimize health for sexual assault survivors and explore how new technologies and social media movements impact health. This study was the first to examine the influence of a national social media campaign on sexual assault survivor's decisions to disclose and seek care.

With the breadth of the online #MeToo social media campaign, it was thought that with it would perhaps come a larger paradigm shift for survivors' health behaviors, that they would be more inclined to seek out health care services post assault. However, this wasn't the case; while most discovered a newfound empowered community, that led to healing and disclosure to informal supports, there was no direct increase in utilization of GPAC or FPAC services. Participants reported no increased messaging about what kind of resources were available or how to go about getting this type of care. However, they very much wanted this care and this information. Ways to improve education about, access to, and quality of these resources were outlined. Lastly, there were many resulting opportunities for future research, such as further exploration of how online communities influenced survivors' overall healing post assault.

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Appendix A: Recruitment Advertisement(s)

i. FB study page information

*The principal investigator is Kate McNair, RN, NP, SANE and PhD candidate at Boston College

June 1st posted:
Upcoming study in July! Recruitment ads and criteria will be posted soon! Chance for sexual assault survivors' voices to be heard. You can help shape future online and social media health interventions.
Women from Massachusetts will be asked to participate in an online focus group for approximately 60 minutes and will be paid $50!
Please follow for updates and share with your social networks!

June 8th posted:
SEEKING RESEARCH PARTICIPANTS!
Want to shape online and social media educational interventions to help victims of violence and sexual assault?
A nurse researcher at Boston College is seeking women, ages 18+, for a one time, 60-90 minute, online discussion. The discussion will include questions about your thoughts and beliefs about social media, disclosure, and health seeking behaviors of women who have been sexually assaulted.
If interested, you will need access to a computer with internet access during the online discussion. All participants will be offered a $50 Amazon Gift Card for their time.
Click on https://bostoncollege.co1.qualtrics.com/jfe/form/SV_0D2cNpHso46vwLr
for more information!
Please feel free to share this study information with others!

June 10th – shared Barcc's FB post
Boston Area Rape Crisis Center: BARCC
June 10 at 2:29 PM ·
Hi BARCC community! A nurse researcher at Boston College is currently seeking cisgender women survivors of sexual violence, ages 18 or older, for a one-time, 60 to 90 minute, online discussion. The discussion will include questions about thoughts and beliefs about social media (specifically, **#MeToo**), disclosure, and how they affect a survivor's health decisions in the aftermath of violence.
This is a meaningful opportunity for survivors to safely voice their opinions in order to shape online education and health interventions for other survivors. Eligible participants will need access to a computer with Internet access and will also be compensated.
If you or someone you know are interested, make sure to take this screening survey: https://bit.ly/2XHsIL2
#MeToo **#SupportSurvivors** **#PreventionEducation**
[Color graphic: several different women survivors holding hands.]

June 18th posted:
Thank you to everyone who shared the MeToo Study's information and who took the eligibility survey! Recruitment has concluded - we are lucky to have recruited over and above the expected number of participants! Best to all, Kate

June 30th posted:

The MeToo Study has completed all of its data collection! Thank you to all who participated! Your voice matters!
Be well, Kate

ii. Craigslist post

Online #MeToo Study - $50 for participation!

© craigslist - Map data © OpenStreetMap

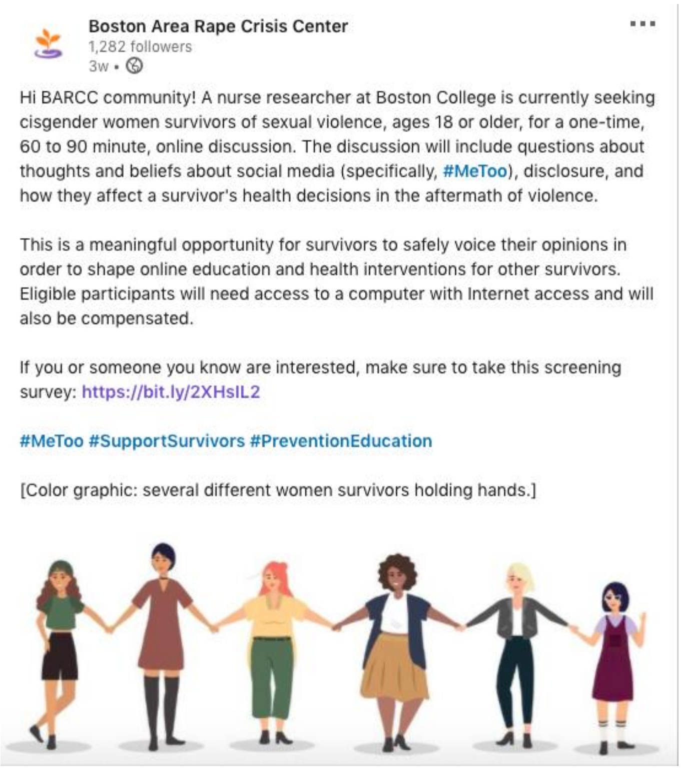
Want to help shape online and social media educational/health interventions to help victims of violence and sexual assault?

A nurse researcher at Boston College is seeking women, ages 18+, for a one-time, 60-90 minute online discussion. The discussion will include questions about your thoughts and beliefs about social media, disclosure, and health seeking behaviors of women who have been sexually assaulted.

You will need access to a computer with internet during the online discussion. All participants will be given a $50 Amazon Gift Card for their time!

If interested go to XXX for more details! Please feel free to share this study information with others!

iii. BARCC post example



Boston Area Rape Crisis Center
1,282 followers
3w •

Hi BARCC community! A nurse researcher at Boston College is currently seeking cisgender women survivors of sexual violence, ages 18 or older, for a one-time, 60 to 90 minute, online discussion. The discussion will include questions about thoughts and beliefs about social media (specifically, #MeToo), disclosure, and how they affect a survivor's health decisions in the aftermath of violence.

This is a meaningful opportunity for survivors to safely voice their opinions in order to shape online education and health interventions for other survivors. Eligible participants will need access to a computer with Internet access and will also be compensated.

If you or someone you know are interested, make sure to take this screening survey: https://bit.ly/2XHsIL2

#MeToo #SupportSurvivors #PreventionEducation

[Color graphic: several different women survivors holding hands.]

iv. Boston College Women's Center E-Newsletter

Image description: Six cartoon women figures with outstretched arms holding hands. The first woman has long brown curly hair and is wearing a green hat that matches her green shirt. She is also wearing black shorts and her legs are crossed at the ankles. The second woman has short black hair and is wearing a brown dress with tall black boots. The third woman has orange hair and is wearing a yellow shirt and green pants. The fourth has short curly brown hair and is wearing a white shirt with an open blue cardigan and a tan skirt. The fifth has yellow hair and is wearing a white tank top with an open short cardigan and jeans and the final woman has chin length black hair and glasses. She is wearing a purple short sleeve shirt with a plum jumper over it.

Online #MeToo Study
$50 for Participation!

Want to shape online and social media educational/health interventions to help victims of violence and sexual assault?

A nurse researcher at Boston College is seeking women, ages 18+, for a one time, 60-90 minute, online discussion. The discussion will include questions about your thoughts and beliefs about social media, disclosure, and health seeking behaviors of women who have been sexually assaulted.

If interested, you will need access to a computer with internet access during the online discussion. All participants will be offered a $50 Amazon Gift Card for their time.

Click here for more information!

Please feel free to share this study information with others & see FB page MeToo Study!

Appendix B: Eligibility Screener and Informed Consent

Welcome!

The purpose of this study is to understand women's perspectives of the influence of social media, in particular #MeToo, on health behaviors. If you are eligible, available, and willing to participate in an online focus group (60-90 minute online discussions) you will be asked to provide your thoughts and beliefs about the influence of social media on sexual assault survivors' decisions to disclose and seek health care. You will be compensated $50 for your time.

Please complete the following eligibility screener. If you are not eligible, the screener will let you know. If you are eligible, you will be directed to the study's Informed Consent page at the end. If you consent to the study, the study's Principal Investigator (PI), Kate McNair, will be in touch with you soon.

Thank you so very much!

-Kate McNair, PhD(c) MSN WHNP-BC RN

Question 1

Please indicate the sex you were assigned at birth: (Male/Female/non-binary and/or I do not identify as male or female)

*Skip logic. If MALE, then send to thank you - you are not eligible to participate

Question 2

Please indicate the sex you identify with: (Male/Female)

*Skip logic. If MALE, then send to thank you - you are not eligible to participate

Question 3

Are you 18 years or older?

*Skip logic. If NO, send to thank you - you are not eligible to participate

Question 4

Have you been sexually assaulted since the social media movement #MeToo began? (Between October 2017 and July 2020) (Yes/No)

*Skip logic. If NO, then send to thank you - you are not eligible to participate

Question 5

Were you a resident in Massachusetts at the time of the assault? (Even if the assault took place outside of the state) (Yes/No)

*Skip logic. If NO, then send to thank you - you are not eligible to participate

Question 6

If you have a sexual assault nurse examiner (SANE) exam after your assault, was Kate McNair your nurse? (Yes/No/Unsure)

*If NO or UNSURE, continue on to question 7

* Skip logic. If YES, then send to thank you – you are not eligible to participate

Question 7

Please indicate your availability - you must have access to a computer with internet on any of the following times (choose all that may apply):

[Thursday, June 25 6pm EST]

[Thursday, June 25 8pm EST]

[Monday, June 29th 6pm EST]

[Monday June 29th, 8pm EST]

[Tuesday, June 30th 6pm EST]

[Tuesday June 30th, 8pm EST]

[None of these dates would work for me, but I would be willing to be contacted for future dates]

*Skip logic, if none of the above, then send to thank you- you are not eligible to participate

*If one or more is indicated then progress to study informed consent

Question 8

Please read the following in its entirety and indicate at the end whether you consent or not to the study. Thank you!

<u>Informed Consent</u>

Title: THE INFLUENCE OF #METOO ON SEXUAL ASSAULT SURVIVORS' DECISION MAKING AND HEALTH BEHAVIORS: A QUALITATIVE INQUIRY
Principal Investigator (PI): Kate McNair, PhD(c), MSN, WHNP-BC, RN, SANE
Study Supervisor: Holly Fontenot, PhD, WHNP-BC, FAAN
Contact Information: tulpk@bc.edu

1. Study Purpose: You were selected to participate in a research study conducted by a researcher at Boston College because you are a woman, 18 years and older, a resident of Massachusetts, and who was sexually assaulted at any time in October 2017 or after. The purpose of this study is to understand women's perspectives related to the influence of social media, in particular #MeToo, on disclosure and post sexual assault care.

*Your opinions and ideas will help to inform development of social media strategies and approaches to support women's access to and knowledge of post sexual assault care.
* Your participant in this study is voluntary
* You can contact the Principal Investigator (contact information above) at any time prior to the study with questions.

2. Procedure and Duration: We hope that about 40 women will join this study, with about 8-10 in each discussion group. You are eligible to participate if you are 1) age 18 and older, 2) able to read and understand English, 3) were sexually assaulted October 2017 or later while a resident in Massachusetts, and 4) have online computer access for a scheduled discussion. If you agree to participate, you will be asked to complete a brief demographic questionnaire (3-5 minutes) and participate in a 60-90 minute online focus group discussion. We will ask questions about your thoughts about social media, disclosure, and post assault care. You are free to withdraw or skip questions for any reason, without penalties.

3. Potential Risks and Discomfort: We do not anticipate that anything bad will happen to you during this study. However, there may be unknown risks, such as remembering details of the assault and feeling emotional because of this. If any questions are upsetting, you do not need to answer them, and you may leave the group discussion at any time for any reason.

4. Potential Benefits: There are no direct benefits for participating in this study, but your thoughts and opinions will help shape future online and social media educational interventions to help victims of violence and sexual assault. We will also provide each participant with a resource list for violence recovery services in MA.

5. Compensation: There is NO cost to participate in this study. All participants will be compensated with a $50 Amazon gift card for their time. The PI will email the gift card directly to your email at the end of the discussion. If you choose to leave the study prior to the halfway point or enter later than the halfway point, you will receive half the amount ($25).

6. Assurance of Privacy and Confidentiality: The demographic questionnaire and focus group discussion is **confidential** and your participation is **voluntary.** Your confidentiality is one of the researcher's top priorities. The PI will know the identities (names and email addresses) of the participants, but will not store a given focus group response together with the actual identity of that participant. Your privacy will be protected in many ways. (1) We will store all of the discussions and any research information on the secure online focus group platform and on secure computer files. (2) While you will provide some individual data, the data collected in the online discussions will not have actual identifiers (it will not directly connect you with the answers that you provide), this data will be protected by the use of pseudonyms (usernames). Any information linking your assigned pseudonym with your name, email address or phone number will be stored separately from your focus group and questionnaire responses. (3) Any contact information or identifiers (your email and/or phone number) that you provide to the PI for research coordination and distribution of payments for study participation will be kept confidential; neither InsideHeads nor third parties shall access data in the PI's secure account. (4) When you join the online focus group discussion you will use the username that was computer generated and randomly assigned to you for this focus group - this will help protect your privacy. (5) All members of the research team that interact with you have been trained in ethical conduct of research. The researcher will save and store the text of the discussions for no more than 3 years after the completion of the study.

*The Institutional Review Board at Boston College and internal Boston College auditors may review the research records. State or federal laws or court orders may also require that information from research study records be released. Otherwise, the researchers will not release to others any information that could indicate your identity unless you give your permission, or unless we are legally required to do so.

*All of the discussions will be summarized together and may be used in future reports, publications, or presentations. If you have any questions or concerns regarding this research, you may contact Kate McNair, the Principal Investigator, at tulpk@bc.edu. If you have any questions about your rights as a research participant, you may contact the Office for Research Protections, Boston College, at irb@bc.edu.

*This study was reviewed by the Boston College Institutional Review Board and its approval was granted on May 18th, 2020.

If you are ready to participate and agree to the statements above, please press the "yes - I consent" answer below. You will then continue to work with the study PI, Kate McNair, who will provide additional details about participation including the dates, times, and other procedures for how to participate. Kate McNair will coordinate all invitations to participate in our online focus groups and distribution of all study compensation (communication with you will be via email, phone or text as you indicated your preference).

Thank you!

____ Yes, I consent (proceed to question 8)

____ No, I do not consent (end of survey)

Question 9

Please provide your contact information. This information will be used by Kate McNair (PI) to help coordinate the focus group attendance and distribution of study compensation ($50 Amazon Gift Card).

An email will be sent to you confirming your completion of the eligibility screener, with next steps of the study outlined. A copy of the Informed Consent for your records will be attached to the email.

Thank you!

First Name _________________

Email Address _________________

Phone Number (optional if you would like text reminders sent to you) _________________

Appendix C: Confirmation and Introductory Emails

Confirmation Email
Subject: #MeToo Study – Confirmation Needed
Dear [Name],
Thank you for agreeing to be part of the #MeToo Study! I will be in touch soon with your focus group date and time, a copy of your informed consent, and instructions for the discussion.
Please respond back at your earliest convenience to confirm that you received this email!
Best, Kate

Introduction Email
Subject: Welcome to the #MeToo Study!
Dear [Name],

A spot in the #MeToo Study has been reserved specifically for you!

Your focus group time slot is **[day of the week, date]** at **[time].** Please let me know ASAP if that time no longer works for you. After you participate in the 60-90 minute online chat discussion (NO video *OR* audio) you will receive a $50 Amazon Gift Card for your time and opinions.

To access the Discussion Room online:
Go to: **[unique url]**
Please access the Discussion Room BEFORE the group discussion so you can be sure everything is visible to you.
NOTE: Your assigned anonymous username (aka your pseudonym) is **[unique alas]**. This will be the name that shows up next to your typed messages during the focus group.

I will be sending out a few more reminder emails and texts before your time slot. I look forward to “speaking” with you online soon, and thank you again for your interest in participating in this important research study. If you have any questions do not hesitate to email me.

Sincerely,
Kate McNair

PS. Attached you will find a copy of your informed consent

Appendix D: Study Email Reminders

Email Reminder 1
Subject: #MeToo Study Reminder
[Name],
Just a reminder – your focus group time slot for the #MeToo Study is this coming **[day of the week, date, time]!** Refer to the email I sent on [date] for your specific URL and pseudonym. If you can't find it or need additional clarification, let me know!
Best, Kate

Email Reminder 2
Subject: #MeToo Study Tomorrow!
[Name],
Just a reminder – your focus group time slot for the #MeToo Study is *tomorrow*, **[day of the week, date, time]!** Refer to the email I sent on [date] for your specific URL and pseudonym. If you can't find it or need additional clarification, let me know!
Best, Kate

Email Reminder 3
Subject: #MeToo Study Today!
[Name],

Your focus group time slot is **TODAY** at **[time]!**
To access the Discussion Room online go to: **[unique url]**
Your assigned anonymous username (aka your pseudonym) is **[unique alias].**

Looking forward to "speaking" with you this evening!!
Best, Kate

Appendix E: Final Email and Resource List

Thank you so much for participating this evening! I really appreciate all of your insights and hope to make future interventions to support survivors guided by your comments.

Below is a list of resources for you. While I did not expect this conversation to be triggering, I wanted to give you some options for additional support if needed.

Hotlines available 24/7:

1. RAINN (Rape, Abuse, and Incest National Network) – **800.656.4673**
2. BARCC (Boston Area Rape Crisis Center) – **800.841.8371**
    *Web chat found at https://barcc.org/help/services/hotline

If you would like to set up a meeting with a **mental health practitioner**, we have partnered with **Dr. Julie Dunne PhD, PMHNP-BC, RN**
Her office is located at Cambridge Health Alliance, 1493 Cambridge St, Cambridge MA 02139
She can be reached at **617.665.3900**

I will be in touch in the next few days via email with your gift card! Thanks again!

Sincerely,
Kate

Appendix F: Demographic Survey

Welcome to the #MeToo Study's demographic questionnaire! Please complete in its entirety. It will take you less than 5 minutes. When you are done, go back into the online focus group.
THANK YOU!
-Kate

1.What is your assigned name (pseudonym) for the focus group? __________

2. What is your age bracket? (drop down list)
   18-25
   26-30
   31-35
   36-40
   41-45
   46+
3. Are you Hispanic or Latina/x? (yes/no)
4. What is your race?
   a. American Indian/Alaska Native
   b. Asian
   c. Native Hawaiian or other Pacific Islander
   d. Black or African American
   e. White or European American
   f. More than one race
   g. Other
5. Do you have health insurance? (yes/no/I don't know)
   *If yes, what type of insurance do you have?
      a. Private
      b. Public
      c. Health insurance through a college
      d. Other
6. What is your highest level of education?
   a. Some high school or less
   b. High school graduate
   c. Some college or in college now
   4. College graduate or more
7. Please indicate your employment, caregiver, or student status (choose all that apply)
   a. Full time employment
   b. Full time child/family caregiver
   c. Full time student
   d. Part time employment
   e. Part time child/family caregiver
   f. Part time student
   g. Unemployed or none of the above
8. How often do you use social media? (Twitter, Facebook, Instagram, Snapchat, etc.)
   a. Every day
   b. 2-3 times per week
   c. Once a week
   d. 2-3 times a month

    e. Once a month or less
    f. I do not use social media

9. Have you heard of #MeToo? (yes/no)

10. Approximately when were you sexually assaulted? (indicate the choice to the best of your ability/memory)
    a. Between October 2017 and September 2018
    b. Between October 2018 and September 2019
    c. Between October 2019 and now

11. Have you ever told a friend or family member that you were assaulted? (yes/no)
    *If yes, did you tell them:
        a. Right away (within 24 hours)
        b. Within 5 days
        c. Within a few weeks
        d. Within a few months
        e. Within a year or more

12. Have you ever told a health care provider that you were assaulted? (yes/no)
    *If yes, did you tell them:
        a. Right away (within 24 hours)
        b. Within 5 days
        c. Within a few weeks
        d. Within a few months
        e. Within a year or more

13. Did you have forensic evidence collected, also known as a ‘rape kit’? (This would have been within 5 days of the assault, provided at a hospital, usually by a specialized nurse called a SANE) (yes/no)

14. Lastly, how did you hear about the #MeToo Study? Click all that apply.
    Craigslist
    BARCCS Facebook post
    BARCC’s Instagram post
    BARCC’s LinkedIn post
    BARCC’s Twitter post
    #MeToo Study’s Facebook page
    Boston College Women’s Center Newsletter
    Someone shared the #MeToo Study link with you

Appendix G: Focus Group Script Guide*

Welcome!

The purpose of our discussion today to understand your thoughts and perspectives about social media and how social media, in particular #MeToo, may or may not have had an influence on women who have been sexually assaulted. We want to get as many different thoughts and opinions as possible and want everyone to have a chance to share. There are no right or wrong answers and it's ok if you disagree with someone else. Our goal is to learn from you, so we can help shape online and social media educational interventions to help victims of violence and sexual assault in the future.

The focus of our discussions today will be about social media. We do not anticipate any discomfort during the discussions, however if any questions are upsetting you do not need to answer them. Also, if you feel upset, you may leave the group discussion at any time for any reason. Additionally, we have provided all participants a list of resources, including BARCC in Massachusetts and RAINN – those hotline numbers are provided. For those who would like to make an appointment with a mental health nurse practitioner, we have partnered with Dr. Julie Dunn. Her office number is listed on the resource information resource list emailed to you at the before this online discussion.

We thank you for your time in advance…let's get started!

QUESTIONS

Let's get started by talking about social media

1.What do you think of when someone uses the term social media?

Probes:

a. What types of social media do you have? Facebook, Instagram, Twitter, etc…
b. Tell me about your social media use? How much and to what extent do you engage with your social media? What is the reason for your social media use?

2. In what ways does social media impact your life?

3. In what ways does social media impact the lives of your friends and family?

4. Before today, have you ever heard about #MeToo?

Probe:

a. Please share what you know about it. How did you hear about it?

5. Please share how #MeToo has impacted you or others?

Probes:

a. What do you think was good about #MeToo? What do you think was bad about #MeToo?
b. Do you think #MeToo helped women who have been sexually assaulted, harassed, or were victims of violence in any way? How did it help? How did it not help?

6. After your assault, did #MeToo take on a different meaning for you? How so?

6a. Did it in any way influence your decision to or not to:

i. disclose to a friend or family member
ii. disclose to a health provider
iii. receive post assault care
…How so? Please describe

7. After your assault, did you ever talk to anyone online (in any online platform) about your experience? How so? What online platform?

7a. Did that in any way influence your decision to or not to:

i. disclose to a friend or family member
ii. disclose to a health provider
iii. receive post assault care?
…How so? Please describe

8. In what way was social media helpful for you after your assault?

9. In what ways could social media have been **more helpful** after your assault?

Probes:

a. What was missing?
b. What would you have wanted?
c. What resources do you think social media could have informed you of?

10. Did you ever see any posts on any social media sites from a healthcare provider or organization providing instructions for people on how to obtain care or what to do after an assault? Tell us about these posts.

11. How do you think nurses and/or any type of health provider or health organization could be helpful or more helpful for women?

Probes:

a. What could be some barriers for obtaining care? What could be some ways that nurses/health providers/health organizations can help women overcome barriers to care?
b. What could be some facilitators for obtaining care? How could nurses/health providers/health organizations promote these facilitators?

*Extra clarifying question if needed:
12. Please describe in any way if and how any type of social media or #MeToo:
1) Provided or did not provide you needed information about what to do after your assault
2) Influenced or did not influence your decision to disclose to a health care provider, or
3) Influenced or did not influence your decision to obtain healthcare (what type of health care did you obtain? Did you obtain forensic sexual assault care?)

13. Do you have any other thoughts or opinions about the topic of social media and #MeToo and its influence that you would like to share?

*This guide was used initially for the first focus group – questions were tailored to it. The subsequent scripts were amended based on past participants’ responses.