Making sexual and reproductive healthcare environments safe and supportive for disclosure of sexual violence

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Making sexual and reproductive healthcare environments safe and supportive for disclosure of sexual violence: Interview findings from patients and healthcare professionals

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WHAT IS ALREADY KNOWN ON THIS TOPIC

Sexual and Reproductive Health Services (SRHS) have previously been identified as places where disclosure of sexual violence (SV) occurs.

WHAT THIS STUDY ADDS

This is the first time that data has been collected from both service users and healthcare professionals to identify mechanisms needed to create an environment for safe and supportive disclosure of SV.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

For those practicing in SRHS the findings will help to create a safe and supportive environment for disclosure of SV with an emphasises on ensuring appropriate mechanisms (for example, service users feeling in control during the consultation) are promoted. Our findings provide valuable insights into the essential components required to improve service delivery for those who have experienced SV. The major implications are for healthcare planners, providers and educators in service commissioning and delivery.

Title

Making sexual and reproductive healthcare environments safe and supportive for disclosure of sexual violence: Interview findings from patients and healthcare professionals

Introduction

Sexual violence (SV) remains highly stigmatized and considerable barriers persist for individuals to seek help and redress which are exacerbated by widespread myths about what defines 'real rape' and the concept of a 'legitimate victim' [1, 2].

Healthcare input after SV addresses the associated risks to health, including pregnancy; sexually acquired infections (STIs) such as *Chlamydia trachomatis*, hepatitis B and HIV; genital and other physical injury; acute and chronic pelvic pain; as well as psychological morbidity. Healthcare settings can also act as a conduit to access further care and support such as counseling, safeguarding, social and legal advice, collection of forensic evidence and police reporting. STI and blood borne virus testing, treatment and management, contraceptive provision, and health promotion/disease prevention are provided through healthcare services such as the national network of Sexual and Reproductive Health Services (SRHS) in the United Kingdom.

Barriers to accessing this support vary but can include a fear not being believed, of being blamed, and of not having control of what happens next [3]. Furthermore, the accessing of healthcare can in itself be challenging. People can fear specific aspects of the medical check-up, like the taking of genital swabs, as they may trigger traumatic memories of the SV [4]. Although disclosure seems to be desirable for many individuals who have experienced SV and has a role to play in recovery [5, 6], the relationship between disclosure and benefit (or harm) to the individual is not straightforward [7, 8]. Disclosure outcomes vary, for example according to

the responses to disclosure, the characteristics of the SV and to whom the disclosure is made (see summary by [9]). Disclosure may also be a process rather than a single event and attempts to correlate outcomes to a single and partial disclosure may not be possible [10]. Despite these complexities, most people choose to disclose SV at some point [11, 12].

This study is part of a larger project, which includes a realist review, on resolving the gap between the challenges faced when seeking support and having a safe healthcare environment to disclose SV [reference held for peer review]. The review provided the basis for this study where we used a qualitative realist approach to further investigate what key changes are needed within health services to ensure they are safe and acceptable for survivors of SV.

Methods

Choice of realist approach

Achieving the outcome of a safe and supportive environment for disclosure of SV is challenging, as potential barriers exist at personal, interpersonal, institutional and societal levels [13]. A realist approach acknowledges the complexity of the 'messy' healthcare intervention required to stimulate change in such contexts [14]. Not only does it consider interventions, but a realist approach also looks at why they work and in what context. The 'why they work' or mechanism element is central to realism. Mechanisms are often hidden but real, and can be viewed as the reasoning and reactions to interventions.

Recruitment and participants

A purposive sampling strategy was used to identify study participants including service users, healthcare professionals and a third sector organization worker. The service users were interviewed 1-1 and had all previously disclosed SV within a SRHS setting. Healthcare

professionals and a third sector organization worker participated in focus groups. They were recruited through two SRHS UK National Health Service sites and through one UK based third sector organization specialising in advocacy and support after SV.

Data collection

The interviews were semi-structured and conducted face-to-face, via Zoom videoconference, by telephone or by email communication as requested by the service user. Interviews lasted approximately one hour. RJC carried out all interviews. A qualitative realist approach was used for the interviews. This involved the 'teacher-learner cycle' realist technique in which 'theories are placed before the respondents for them to comment on, with a view to confirming, denying and refining the theory' [15]. The focus group interviews with healthcare staff and other professionals promoted the generation of ideas and theory development using discussion between group members.

Data analysis and synthesis

Interviews were audio recorded, transcribed verbatim and uploaded to the NVivo qualitative data analysis software. Recurrent themes relating to the creation of a safe setting for SV disclosure were identified in the transcripts. Each transcript was also analysed retroductively which is consistent with a scientific realism approach [16]. Retroduction is 'the identification of hidden causal forces [mechanisms] that lie behind identified patterns or changes in those patterns' [17]. A second member of the research team (CB-J) reviewed the analysis of a random selection of interview transcripts. Any inter-reviewer disagreement was resolved by discussion between the three authors.

Results

There were three focus groups (made up of 6, 4 and 5 people) incorporating a range of healthcare professionals, including two doctors, five nurses, seven health advisors and a counsellor. There was also representation from a third sector organisation specialising in advocacy after SV. Eighteen service users were interviewed, 12 by Zoom videoconference, four face-to-face, one by telephone and one by email (table 1).

Table 1 Background characteristics of service users (n=18)

Characteristics	N (%)
Age (years)	
18-24	7 (39%)
25-34	5 (28%)
35-44	4 (22%)
>45	2 (11%)
Sex assigned at birth	
Male	3 (17%)
Female	15 (83%)
Ethnicity	
White British	7 (39%)
White other	1 (5%)
Asian British	4 (22%)
Black	4 (22%)
Mixed race	1 (5%)
Other	1 (5%)
Gender identity	
Man	2 (11%)
Woman	15 (83%)
Transwoman	1 (5%)
Sexuality	
Heterosexual	13 (72%)
Homosexual	2 (11%)
Pansexual	2 (11%)
No label	1 (5%)
Religion	
Christian	5 (28%)
Muslim	3 (17%)
Other	2 (11%)

None	7 (39%)
Disability (self-identified)	
Yes	11 (61%)
No	7 (39%)

Findings were organised around the mechanisms that users and healthcare professionals reported to be important in creating a safe and supportive healthcare environment for disclosure of SV.

Service users feeling empowered to seek help and believing they will be viewed as candidates for care on disclosure of SV.

Those interviewed expressed a wish to have been given information about sexual health services, such as location and opening hours.

> I definitely don't think it's advertised enough because like I had to go out of my way to try and find a clinic. Participant 18

The interviews not only highlighted the need to promote detailed and accurate information about the service on offer but also the need to challenge widely held harmful stereotypes regarding SV, also known as rape myths. Examples of rape myths include 'men don't get raped', 'disabled people don't get raped' and 'she wanted it as she didn't fight back' were alluded to in the interviews. The importance of promotional material where these myths are challenged, where individuals recognise themselves as candidates for healthcare and assume their disclosure will be validated irrespective of presentation was noted.

> I'm a partial wheelchair user but I don't see anyone in a wheelchair on a rape poster. So, it's trying to like, you know, you need to feel you're represented. Participant 08

> I mean it sounds really obvious but kind of, no kind of judgment. Participant 05

The silence surrounding SV also creates a barrier to a safe and supportive environment for disclosure. Using promotional material to inform people that they will be listened to, and their

disclosure validated by healthcare professionals, irrespective of ethnicity, disability status, gender, age or clinical presentation was found to be important.

> I think I mentioned earlier, just about the concept of being silenced, so…I think healthcare, particularly sexual health clinics, should be the place where you're heard and believed. Participant 03

Healthcare professionals being confident and competent in their role and supporting a healing relationship alongside service users having choice, feeling listened to and in control.

The interviews described support for a trauma informed approach and helped to explain why aspects of this approach resulted in the desired outcome of a safe and supportive environment. For example, the importance of providing choice and giving control back to service users was emphasised.

> You have to always come back to the fact that once you've been abused, raped, violated, choice was gone, choice was taken, urr… options were taken, you were forced into it, you weren't free, someone controlled you, […] and you've always got to kind of [think], how can I give that back to somebody? Participant 02

The interviews provided examples of specific service interventions felt to be important to implement during the care process.

> And we do of course offer choice of gender of health care professional. Focus group #3 (Doctor)

However, even with the use of routine enquiry (asking all who attend about potential exposure to SV in order to provide support) the mechanism for ensuring the service user still has choice and control was seen as central.

> Give people a choice, again that's, that I think is being quite trauma informed, it's giving them choices and options but not insisting that they respond in anyway, they may just shrug their shoulders and say, "I don't want to answer," or they may think, "okay, the door is open." Focus group (SV Advocate)

The relationship between healthcare professional and service user was viewed as essential for creating a safe and supportive environment for disclosure. Service users

appear dissatisfied with the medical model of disease approach to care and they spoke of the importance of demonstrating compassion and of building a nurturing relationship.

> You can't have that 'doctor front' all the time. Participant 10

> I mean, you can, you can talk to me all day long about what AIDS means, what syphilis means, chlamydia means, medically, but my life's falling to pieces. […] You know you *need* to go, "hang on a minute, this is a human being that I am [speaking to]" Participant 02

> Also, it's the trust…trust is such a hard thing. Participant 02

Part of responding well to disclosure and building a therapeutic relationship between healthcare professional and service user was to have well-trained professionals, who are confident and competent during this consultation.

> I think it's the clinician being comfortable to flex [the guidelines] and that's where training would come in really. Because if somebody feels that they've got to do everything in the guideline, that patient isn't going to get their trauma managed and their patient centred care addressed. It's just going to be a tick box exercise which sometimes it can be unfortunately if clinicians aren't comfortable. Focus group #1 (Specialist nurse)

To be competent in responding safely to SV requires a significant level of understanding of the value of a therapeutic relationship:

> I think it can be hard because sometimes we're so solution based and we want to feel like we can do everything for that person and we want to feel like they've left here and we've felt like we've done something for them and sometimes you know they just don't want anything and we just have to accept that, which can be hard. Focus group #1 (Nurse)

The interviews did elicit some potential unintended outcomes. For example, even with choice, some service users felt that rather than empowering people to speak out by using routine enquiry it had the potential to be a negative experience:

> But for me, like even like the word [rape], I've not been able to like even s*ay* the word or read the word since what happened to me, like I avoid any article, any news anything, in relation to that because it's really triggering to me. […] Even though I know that's not a constant reminder but like if I'm not ready to speak about it I don't want to be reminded about it [with use of routine enquiry]. Participant 18

Discussion

To create a safe and supportive healthcare setting where people can disclose SV and access medical care this study has identified specific mechanisms which are needed to overcome the considerable barriers survivors face. Our findings recognise the diversity of people affected by SV and calls for services to incorporate this knowledge into the promotion of services to help individuals who have experienced SV to see themselves as potential service users, feel able to seek help, know that their disclosure will be listened to and feel validated irrespective of their clinical presentation or background. Another way to empower potential service users is to confront the silence that surrounds SV. The conspiracy of silence, described as 'an agreement to say nothing about an issue that should be generally known' has been recognised within this research field since Butler's early work on the conspiracy of silence surrounding incest [18, 19]. Evidence from the 1-1 interview sources described a fear of reprisal, fear of disbelief, fear of victim blaming, and cultural related fears e.g., family shame if/when sexual violence and abuse was out in the open. However, despite these fears the majority of the same interviewees still wished to have it more openly spoken about. It was felt that if SV was more widely discussed then this may 'normalise' disclosure and make accessing support easier. If sexual health services are not using promotional material which tackles these barriers to care then there is an associated risk of perpetuating the silence and limiting access to healthcare.

SRHS health care delivery using a trauma informed approach, with a focus on the relationship between service user and healthcare provider, can create a context for the mechanisms of having choice, feeling in control and being listened to. The principles of a trauma informed approach have been widely published and include those of safety, trustworthiness, collaboration, empowerment and choice [20]. A trauma informed approach aims to make services more accessible for those who have experienced trauma and is not about delivering

treatment for specific trauma or traumas. A specific practice which can promote disclosure, and is considered acceptable in this setting, is routine enquiry about SV [21]. Within some healthcare settings we theorise that routine enquiry for SV promotes a safe and supportive environment and is in keeping with a trauma informed approach as it normalises discourse about SV, removes stereotypic barriers because the enquiry is non-selective, and minimises the risk of re-traumatisation by offering a choice as to whether to answer or not.

During the interviews we found the context of a biomedical approach to healthcare created barriers and could block mechanisms important within trauma informed practice such as feeling empowered and of having choice during the healthcare consultation. This is especially relevant because the biomedical approach, with its focus on biological factors of disease, can result in the patient becoming a passive participant. Some interviewees explained how the focus on diseases such as 'AIDS or *Chlamydia'* became a barrier to experiencing a supportive consultation. This highlights the importance of identifying service user priorities, ensuring they have choice over their health plan and the important role of the relationship between the individual and the healthcare provider, which support a move away from historical models of healthcare. Rocca and Anjum argue that a more holistic approach with an 'ecological shift in medicine' is 'not only necessary but also unavoidable, if we acknowledge that human biology is genuinely complex and we truly reflect on the meaning and implications of this' [22]. Delivering trauma-informed care embraces this holistic approach and results in a model where services, provided for and used by all, become more accessible for those who have experienced trauma.

The implementation of a trauma informed approach will involve healthcare professional training. This training ensures healthcare professionals are aware of the impact of trauma, have

a focus on the importance of building rapport and trust, and address the power imbalance in the consultation. We concur with Rocca and others that this change in practice should start from a change in ontology, in how we view the world and what medical models we adhere to, rather than focus only on specific interventions [22, 23]. In practice, if this fundamental change in the approach to care is to be considered [4, 24, 25], changes to the teaching at an undergraduate level will also be needed [26].

Potentially negative outcomes associated with potential SV disclosure were identified in the interviews, e.g., retraumatising by the seeing of posters about SV or through a reminder of the SV through use of routine enquiry, are important to note. Through increased awareness of the potential impact on service users whilst promoting SV disclosure, retraumatisation can be minimised though not fully eliminated by those working in this setting [9]. For example, when a service employs routine enquiry, service users must feel they have choice and control over whether they answer or not. During focus group interviews adhering strictly to guidelines was not always seen as a creating an optimal environment for service users: 'if somebody [healthcare professional] feels that they've got to do everything in the guideline, that patient isn't going to get their trauma managed and their patient centred care addressed'. Copeland, in her chapter *The Guidelines Challenge*, acknowledges there is a 'tension between clinical guidelines, based on general medical knowledge and aimed toward standardisation, and their use in the clinical encounter, based on local knowledge about the patient and aimed toward tailored interventions' [22]. In the implementation of changes in service delivery, training and service promotion to improve the care of those who have experienced SV, our findings emphasise that sensitive and nuanced approaches are needed so that negative outcomes are minimised.

Limitations

We were unable to include non-English speaking participants due to study resource constraints, and these individuals are likely to face additional barriers to safe and supportive disclosure in SRHS. Another challenge was in ensuring the emphasis was on creating a safe and supportive environment for disclosure rather than on always promoting disclosure. Although evidence points to the benefits of disclosure, a positive outcome is not guaranteed. One of the most important factors as to whether disclosing is beneficial or not, is the response of the disclosure recipient [27-30]. To this end our study focuses on creating and ensuring a safe and supportive environment within healthcare, ready to receive and respond to SV disclosures. Finally, the interpretative nature of the baseline review and of this study's findings makes it possible that others might arrive at different conclusions. However, we believe that the transparency of our methodology will allow our approach to be followed by others and permit transferability. The conclusions drawn are also consistent with our extensive knowledge of the field as clinicians and researchers. We know that safe and supported disclosure following SV are important, but until now, the mechanisms that need to be enacted to facilitate this have been poorly understood. Our findings therefore make an important contribution to better meeting the healthcare needs of survivors of SV.

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Competing Interests
JDR reports personal fees from GSK Pharma, Hologic Diagnostics, Mycovia and Janssen Pharma as well as ownership of shares in GSK Pharma and AstraZeneca Pharma; and is author of the UK and European Guidelines on Pelvic Inflammatory Disease; is a Member of the European Sexually Transmitted Infections Guidelines Editorial Board; is a Member of the National Institute for Health Research Funding Committee (Health Technology Assessment

programme). He is an NIHR Journals Editor and associate editor of Sexually Transmitted Infections journal. He is an officer of International Union against Sexually Transmitted Infections (treasurer), and a charity trustee of the Sexually Transmitted Infections Research Foundation.

Ethics

Ethical approval for the study was granted by Health Research Authority (REC reference 19/WM/0297 IRAS project ID 266583). Informed consent was obtained for all interviews either written, or verbal when interviews were not face to face.