Høgskulen på Vestlandet

Bacheloroppgave

BSS9

Predefinert informasjon

Startdato:	12-05-2020 09:00	**Termin:**	2020 VÅR
Sluttdato:	22-05-2020 14:00	**Vurderingsform:**	Norsk 6-trinns skala (A-F)
Eksamensform:	Bacheloroppgave		
SIS-kode:	203 BSS9 1 H 2020 VÅR		
Intern sensor:	(Anonymisert)		

Deltaker

Kandidatnr.:	384

Informasjon fra deltaker

Antall ord *:	9972
Egenerklæring *:	Ja
Jeg bekrefter at jeg har registrert oppgavetittelen på norsk og engelsk i StudentWeb og vet at denne vil stå på vitnemålet mitt *:	Ja

Gruppe

Gruppenavn:	(Anonymisert)
Gruppenummer:	88
Andre medlemmer i gruppen:	Deltakeren har innlevert i en enkeltmannsgruppe

Jeg godkjenner avtalen om publisering av oppgaven min *

Ja

Er bacheloroppgaven skrevet som del av et større forskningsprosjekt ved HVL? *

Nei

Er bacheloroppgaven skrevet ved bedrift/virksomhet i næringsliv eller offentlig sektor? *

Nei

Western Norway University of Applied Sciences

BACHELOR'S THESIS

Empowerment after sexual assault

Empowerment etter seksuelle overgrep

Candidate number: 384

Bachelor of Nursing

Western Norway University of Applied Sciences

Campus Bergen

Submission Date: May 22nd 2020

I confirm that the work is self-prepared and that references/source references to all sources used in the work are provided, cf. Regulation relating to academic studies and examinations at the Western Norway University of Applied Sciences (HVL), § 10.

Summary

Title: Empowerment after sexual assault

Background: Approximately one third of all women has experienced physical and/or sexual violence at some point in their lives. The women often struggle with both psychological and physical sequelae which may impact them as individuals, but also the society. There is a need to facilitate empowerment amongst these women to mitigate the negative effects of sexual assault.

Research question: What empowerment methods do nurses utilize to women in the acute phase after they have experienced sexual assault?

Aim: Explore which methods nurses can utilize to facilitate empowerment among sexual assault survivors, and both patients and nurses view of these methods.

Method: The method used is a literature review to answer the problem statement with a comprehensive and systematic data collection, analysis and synthesis. Both qualitative and quantitative studies are included.

Results: Care is always the nurses' first priority. They facilitate empowerment through providing choices, acknowledging, thorough explanations, and professional empathy. Negative experiences occur when nurses do not explain adequately, do not provide choices and are cold and distant.

Conclusion: No specific nursing methods were identified. Though nurses follow official guidelines when caring for the survivors, there is a need for guidelines specific to nursing theory and practice.

Key words: Sex offences, rape, emergency treatment, trauma, method, intervention, nurse

Sammendrag

Tittel: Empowerment etter seksuelle overgrep

Bakgrunn: Omtrent en tredjedel av alle kvinner har opplevd fysisk og/eller seksuelle overgrep i løpet av deres liv. Kvinnene sliter med både fysiske og psykiske følger som kan påvirke dem som individer, men også hele samfunnet. Det er et behov for å fasilitere empowerment blant disse kvinnene for å motvirke de negative effektene av seksuelle overgrep.

Problemstilling: Hvilke empowerment metoder bruker sykepleiere for kvinner i akuttfasen etter de har opplevd seksuelle overgrep?

Hensikt: Utforske hvilke metoder sykepleiere kan bruke for å fasilitere empowerment blant overlevende av seksuelle overgrep, og både pasientenes og sykepleiernes synspunkter på disse metodene.

Metode: Metoden brukt er et litteraturstudium for å svare på problemstillingen med en omfattende og systematisk datasamling, analyse og syntese. Både kvalitativ- og kvantitativforskning er inkludert.

Resultater: Omsorg og pleie er alltid sykepleierens første prioritet. De fasiliterer empowerment gjennom å tilby valg, annerkjennelse, grundige forklaringer, og profesjonell empati. Negative møter oppstår når sykepleierne ikke gir gode nok forklaringer, unngår å tilby valgmuligheter og er kalde og distanserte.

Konklusjon: Ingen spesifikke sykepleiermetoder ble identifisert. Selv om sykepleiere følger offisielle retningslinjer i pleien av overlevende, er det et behov for retningslinjer som er spesifikke for sykepleierteori og praksis.

Nøkkelord: Seksuelle overgrep, seksuell vold, voldtekt, metode, intervensjon, sykepleie

A thank you to Dr Denis Mukwege Foundation for pointing me to relevant research material, and to Bodø Emergency Care Centre for a warm welcome and conversations which helped this bachelor thesis come alive.

Together we might find ways to strengthen vulnerable sexually assaulted women.

Table of Contents

Word count excluded references, titles, tables, table of contents, front-page, thank-you note and summary: 9972

1. Introduction

1.1. Background

"Sexual violence is a global problem that affects all humanity, not just women."

Dr Denis Mukwege

We live in a world where one woman in every third (35 percent) has experienced physical and/or sexual violence at some point in their lives (WHO, 2017, p. 6). After being sexually assaulted the women recognize feelings of shame, blame and anger (Aakvaag, et al., 2016, pp. 16-17) (Miller, Handley, Markman, & Miller, 2010), and many struggle with long term effects such as post-traumatic stress disorder, anxiety, depression and some with physical damages and diseases (WHO, 2003, pp. 12-16) (Sosial- og helsedirektoratet, 2007, p. 24). Women are even in some places of the world targeted as victims to tear down whole communities (2.2.2. Rape as a weapon of war).

Above are presented the atrocities of sexual assault. There is no doubt that women can struggle with the aftermaths of sexual assault, but we should also recognize factors promoting the recovery of women. Facilitating patient empowerment often entails helping them achieve better health through learning how to take control of the factors that are health-promoting (Lønne, 2019). When it comes to the topic of sexual assault, some research has found correlations between early nursing interventions and the patient's recovery, especially regarding post-traumatic stress reactions (PTSR) (Rothbaum, et al., 2012).

1.1.1. Personal background

It shuddered my bones to hear about babies, down to 9 months, who had been penetrated both of manly genitalia and machetes in Congo from Dr Denis Mukwege (2.2.2 Rape as a weapon of war). I was made aware of this aspect of sexual violence through my work in the youth organization Changemaker. In Changemaker, we try to find the root cause of development issues, and how Norway plays a part in the global perspective. How do the choices we as a nation make affect others? How can we learn from each other? Furthermore, how does the international community affect our lives in Norway?

During my bachelor thesis, I will relate the topic of sexual assault to the Sustainable Development Goals (SDGs) and war crimes, but the main focus is on how the nurse can help a female patient in the acute phase after a sexual assault.

1.2. Problem statement

What empowerment methods do nurses utilize to women in the acute phase after they have experienced sexual assault?

1.3. Context

Concerning gender-based violence, and explicitly sexual assault, the health sector plays a vital role in the prevention, identification, treatment and care of the survivors (WHO, 2005). I will, therefore, put the focus on how the health sector, and specifically how nurses, play an essential part in the care and recovery of sexual assault survivors. National and international strategies describe how the health sector should meet and take care of the women, both in the acute phase and long-term. The focus in the acute phase is on the woman's physical health and proper documentation, as evidence in case there will be a criminal case, and on her psychological health in both short- and long-term care (Justisdepartementet, 2019, p. 17) (Hansen & Finsrud, 2014, p. 244) (WHO, 2014, p. 1).

Different countries organize care for sexual assault survivors differently. In Norway, survivors of sexual violence often meet up at or are referred to an emergency care centre (Sosial- og helsedirektoratet, 2007). In the USA, the survivors usually meet up in an emergency department, but some places there are separate assault centres where the survivors are referred to after visiting emergency wards (Lewis-O'Connor & Chadwick, 2015). The care for the survivor will in most parts be transferable, whether it takes place in an emergency ward or an emergency care centre. What is common is that there is a woman in need of acute care after experiencing a sexual assault, and the meeting between the nurse and the patient is what is central. That is where the focus for this bachelor thesis will be.

1.4. Limitations

Since women more often than men are the victims of sexual assault (Sosial- og helsedirektoratet, 2007, p. 8) the focus of this thesis will be on women who have experienced sexual assault. The problem statement is based on women who have already been sexually assaulted. The bachelor thesis will, therefore, have a more health-promoting approach rather than preventative. The survivors will have diverse physical and psychosocial needs, so in order to limit the thesis, the focus will be on the psychosocial care the nurses can provide. The focus for this thesis will be on the acute care a nurse can provide, but will discuss how this might affect long-term needs and health problems.

The interaction between nurse and patient is essential. There will not be a focus on the patient's family, friends or other social relations. Because sexual assault and abuse towards children often requires specialized knowledge, the chosen focus is on adults, more precisely on survivors of 18 years and up. This does not exclude women who have experienced sexual assault as children. There is a likelihood that the women included in the different studies will have experienced sexual assaults before since some evidence link experiences of sexual assault at a young age with further victimization during adulthood (WHO, 2002). There is no higher limit as women are sexually assaulted in all ages.

1.5. Relevance

There are a lot of both somatic and psychological sequelae related to sexual assaults like sexual health problems, intestinal dysfunction, suicide attempts and suicide, depression, and anxiety, post-traumatic stress, eating, sleeping and unspecific pain disorders (Steine, et al., 2012) (Hutschemaekers, Zijlstra, de Bree, Wong, & Lagro-Janssen, 2019, p. 949). Many survivors will therefore have regular contact with both primary and specialist healthcare services. When including other types of abuse women experience, both psychological and physical, they utilized health service two to three times more than non-abused women (Bonomi, Anderson, Rivara, & Thompson, 2009, p. 1061). When patients come in after an acute sexual assault, they meet up either at an emergency ward or an emergency care center. They are in both places often greeted by a nurse who assesses their physical and mental state.

Even though there have been a fair amount of prevalence studies in recent years, and survivors of sexual assault are being recognized to a greater extent, there are still a lot of dark numbers in the statistics. Because even though there might have been a focus on sexual assault through campaigns like #MeToo, there are still many misconceptions about sexual assault, and there is still occurrences of victim-blaming (Fehler-Cabral, Campbell, & Patterson, 2011, p. 3619) (Hutschemaekers, et al., 2019, p. 955) (Du Mont, White, & McGregor, 2009, p. 778). Acknowledging, believing and showing respect towards the survivors are crucial to their healing, and that this happens from the first time the nurse meets the patient (Fersnes, 2014, p. 189). This is relevant as it helps them feel like they are in control and that the healing process can start. Nursing values are grounded in a view with "[…] respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect" (ICN, 2012, p. 1) (NSF, 2011, p. 17). Nurses also have a mandate to advocate for equity and social justice, access to health care and other social and economic services (ICN, 2012, p. 2). This means that nurses have a responsibility beyond the one-to-one care they provide their patients. When they are treating survivors of sexual assault they should also be aware of the social-economic effects on the individual person and on the society as a whole. To make it easier to know where the nursing profession and the world should be heading, the Sustainable Development Goals were put into effect in the year of 2015. The goals, meant to be reached within 2030, is the world's shared responsibility, which includes the nursing profession.

1.6. Concept clarifications

1.6.1. Acute phase

Acute means "sudden" or "abrupt" and usually refers to the way some diseases or situations occur abruptly and fast (Kåss & Hem, 2019). The acute phase is therefore an expression for the period of the acute situation or disease and usually does not last long (Hem, 2020). The acute phase of a sexual assault is usually not defined. When reading the Norwegian guide for health professionals working in an emergency care centre, the acute phase can be interpreted to be within the first 24 hours (Sosial- og helsedirektoratet, 2007, pp. 47-48). However, this seems to refer to the physical injuries the survivor might have suffered. The University in Bergen, states that the acute phase is often defined as the first week after a traumatic experience (UiB, 2018). According to the guidelines of the emergency care centre, evidence collection and toxicological

samples have to happen within seven days (Sosial- og helsedirektoratet, 2007, p. 26). Because some of the nursing care of survivors involves the execution of or participation in the medical/forensic examination, most of the research articles will define the acute phase to be seven days or shorter. Based on the views as mentioned above on the acute phase, I have chosen to put the time frame for the acute phase to less or equal to seven days when choosing articles.

1.6.2. Sexual Assault Nurse Examiners (SANE)

The first Sexual Assault Nurse Examiners (SANE) program was started in Memphis in 1976 with the wish to broaden nurses' knowledge about sexual assault survivors and their needs. A SANE nurse is a registered nurse who has completed specialized education and clinical preparation to provide holistic care for patients who have experienced sexual assault (Office of Justice Programs, 2020). This includes forensic evidence collection specialized techniques and equipment, and the treatment/prevention of STDs and pregnancy. It also includes providing survivors with crisis intervention, emotional support and referrals for counseling and medical follow-up (Fehler-Cabral, et al, 2011, p. 3620). SANE nurses have to be aware of both the acute- and long-term sequelae of sexual assaults and treat both. There are SANE nurses in the USA, Canada and England (Office of Justice Programs, 2020) (Cowley, Walsh, & Horrocks, 2014).

In Norway, the work of the nurse is organized differently. Nurses can work in an emergency care center with a bachelor degree in nursing, but it is required that one has knowledge of sexual assaults which can be provided through systematic capacity building and experience (Sosial- og helsedirektoratet, 2007, pp. 21-22). In the national guidelines for emergency care centers there are lists of what the healthcare personnel needs specific knowledge about, while it is the municipalities responsibility to make sure all health care personnel have qualified knowledge and skills (2007, p. 21). However, the medical examination of the patient in Norway, unlike in USA and Canada with SANE's, is always conducted by the doctor in the emergency care center. The nurse who is taking care of the patient is present during this examination and functions as a support for the patient and an assistant of the emergency care doctor (2007, pp. 25-26).

1.7. Disposition

The bachelor thesis is written according to the IMRaD format: Introduction, Method, Results and Discussion (Search and write, 2017). The IMRaD does not include a separate theory part, but will here be its own part because of its size.

2. Theory

2.1. Sexual assault

2.1.1. Definition

There is not one universal definition of what sexual assault is; however, The World Health Organization defines sexual assault as:

> *"Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the survivor, in any setting, including but not limited to home and work"*
>
> (WHO, 2002, p. 149).

Sexual assault is viewed as a spectrum of a perpetrator's actions directed towards another person's sexuality without this person's consent. These actions include involuntary physical contact such as touching, licking, masturbation, intercourse-like acts, intercourse and rape, and acts or attempts of actions without physical contact such as sexual talk, blotting, photography, filming, and viewing and displaying pornography (NKVTS).

The Norwegian Penal Code (NPC) punishes these actions, considered as sexual assault, with regards to three main categories: sexually abusive behavior, sexual actions and sexual intercourse (NKVTS). These categories set the premises in a sexual assault case, where actions falling into the last category are gravest. Under this category, rape can be separated as the gravest form of sexual assault. Rape is under the Norwegian Penal Code defined as:

- having sexual intercourse with the use of coercion, threats, force or assault

- intercourse with someone unconscious, sleeping or drunk enough to be unable to protest
- threatening or using assault to make someone have sexual intercourse with someone else or themselves.

(Lovdata, 2009).

I will focus my work on what falls under "sexual intercourse". The law does not define what this is, but the case law points out what is meant by "sexual intercourse". First of all, the term encompasses intercourse as defined in NPC §292 (Lovdata, 2009). Moreover, the term includes all forms of masturbation, insertion of fingers into the vagina or anus, and licking of genitals.

2.1.2. Reactions during and directly after a sexual assault

During the assault women's stress, fear and anger will be heightened and our defense system will be activated (Fersnes, 2014, pp. 189-209). Our defense system can be divided into two parts: the mobilizing (flight or fight) or the immobilizing (surrender and collapse). This system is instinctive, not voluntary and not something we have control over. The first two reactions are more natural to accept, the latter more difficult as it suggest that nothing was being done to stop the danger. However, if the danger is interpreted to be too high the mind will protect itself from the physical and psychological pain by "playing dead". The body becomes paralyzed and incapable of speaking or feeling. The stress from the traumatic event can force the memory of it to be saved as fragments in the mind. Specific details can stand out, such as the walls being red, but maybe the face of the perpetrator becomes unclear and one can no longer remember properly how one got into the situation. Instead the situation is remembered with anger, mental "flashbacks", pain, numbness and paralysis.

Right after, the survivor might experience shock, overwhelming, anger and numbness. As the tension and stress from the event leaves the body it might react with shivers and tears. The memory and ability to take in new information might still be affected (Sosial- og helsedirektoratet, 2007, p. 24) (Du Mont, et al., 2009, p. 779). In Norway a questionnaire revealed that 80,2 percent felt ashamed after being raped, and 65 percent struggled with self-blame (Justisdepartementet, 2019, p. 14). Sexual assault is not about sex, but about the power differential between the abuser and the victim (Grohol, 2018). Often an imbalance of power between a man and a woman.

2.1.3. Prevalence

Prevalence studies can show a variation between seven and 53% (Vea, 2001). From a study of prevalence in Norway, it was shown that a total of 55,3% of women and 22,7% of men had experienced a form of sexual assault (Steine, et al., 2012). In the same study 11,4% of women and 0,9% of men say that they have experienced unwanted sexual intercourse. Another Norwegian prevalence study shows that 33,6% of women and 11,3% of men in Norway have experienced some form of sexual assault during their lifetime (Thoresen & Hjemdal, 2014, p. 15). In the same study 9,4% of women and 1,1% of men have experienced being raped. A slightly lower percentage of women and a doubled percentage of men, 8,9 and 2,8% respectfully, report they have experienced "Unwanted sexual contact while being drugged/unable to consent or stop it" (2014, p. 86).

When looking at numbers combining Intimate Partner Violence (IPV), both physical, non-physical and sexual, and non-partner sexual violence the prevalence in Africa is highest with a 45.6%, South-East Asia as number two with 40.2% and Eastern Mediterranean countries with 36.4% as third, closely followed by American countries (North and South-America) with 36.1%. Lowest is Western Pacific countries and Europe with 27.9 and 27.2% respectfully (WHO, 2013, p. 20).

2.2. Global perspective

The health system is often the first point of contact with survivors of sexual assault, and looking at sexual violence in a broader global health perspective offers a way of capturing the many dimensions of the phenomenon (WHO, 2005). What we do as nations and individual professionals become increasingly relevant for the rest of the world. It also means that we share a greater responsibility towards each other. The sustainable development goals recognizes the impact nations and people have on each other, and puts forth 17 goals the world is meant to reach within 2030 (UN, 2019). Included in these are major global health issues like access to safe water, infectious diseases, and reproductive, maternal, new-born and child health, as well as sexual assault. In a global health perspective, sexual assault is often seen under a broader term: gender-based violence.

2.2.1. Gender-based violence

Gender-based violence (GBV) is a significant public health problem and a violation of basic human rights (WHO, 2014). The UN General Assembly defines the term as any act that:

> *"[…] results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."*
>
> (UN, 1993, p. 2)

Gender-based violence is a neutral term, but it is often women who suffer the most (Kirkens Nødhjelp, 2019). It is therefore often used as an interchangeable term to "violence against women" (UN, 1993, p. 2). Though violence is a word often associated with physical acts of damage, gender-based violence encompasses every aspect of human life. UN through the United Nation's Population Fund (UNFPA) divides the forms of gender-based violence into five groups:

- Sexual violence (sexual assault, sexual harassment)
- Physical violence (hitting, kicking)
- Psychological violence (psychological abuse, manipulation)
- Economic violence (denial of resources, lower salaries than men)
- Harmful traditional practices (forced marriages, genital mutilation, bride price)

(UNFPA, 2016, p. 26)

Unlike many other global health problems, gender-based violence is something which affects every corner of the world and every social class. Globally, women have only 75 percent of the legal rights of men. The discriminatory laws continue to threaten women's economic security, career growth, and work-life balance (World Bank Group, 2020, p. 1). Working on abolishing gender-based violence, therefore, has huge positive repercussions for all parts of every society.

As we see, cases of rape and sexual violence against women are not isolated, and putting a focus on eliminating it can have positive effects for entire communities. In order to tackle this the international community, through UN, has put eliminating all forms of violence against women as its own focus area in the Sustainable Development Goals (SDGs) (UN, 2015). This includes the end of all sexual exploitations as well, and the goal is to *achieve* gender equality (UN, 2019,

pp. 6-7). To be able to achieve this, the Millennium Development Goals (MDGs) have shown us that communities and community mobilization are essential to achieve development results (UN, 2019, p. 22). It might seem like an intimidating task to end all forms of violence against women, but the SDGs are formed to be applicable and possible to work towards on every level of society. As nurses we will therefore, as long as we have the SDGs and have accepted them, always have a responsibility to do our part to achieve them.

2.2.2. Rape as a weapon of war

"Destroying women is to destroy [the] nation, [it] is to destroy the community"

Dr Denis Mukwege (2015)

Sexual violence is also being used as a military tactic of war to drive families and whole communities away from their homes (Browes, 2016). In patriarchal societies, when a woman is supposed to be loyal, pure and humble, being raped may lead people to look at her as "spoiled" or "impure". Her "impurity" brings deep feelings of shame both to the victim and to those around her and puts her in danger of being ostracized by her family and forced out of her community. When sexual violence is being used systematically without assailants being prosecuted, it normalizes risky sexual behavior (Browes, 2016). Even though sexual violence has been officially recognized both as a war crime and a crime against humanity in The Rome Statute of the International Criminal Court (UN General Assembly, 1998, pp. 3, 5) (ICC, 2018) (UN, 2012), no one has yet been convicted.

Both Nadia Murad and Dr Denis Mukwege were announced as the winners of the Nobel Peace Prize for their "[…] efforts to end the use of sexual violence as a weapon of war and armed conflict" (Nobel Committee, 2018). Mukwege has worked with acute and long-term care of survivors in the Democratic Republic of Congo, since he opened the Panzi Hospital in 1999. Mura survived captivity and torture, including systematic rape, by ISIS and goes against social codes by speaking up on behalf of other victims (Murad, 2018) (ICC, 2018).

2.3. Patient empowerment

"People should have to ask your permission before they march into the centre of your soul."

(Koehn, 2007, p. 49)

In WHO's clinical handbook on healthcare for women subjected to sexual violence, they highlight the importance of first-line support, as this might be the only opportunity to help the women (2014, p. 15). First-line support is described as practical care, response to a woman's emotional, physical, safety and support, and one of the goals is to *empower* her. The clinical handbook does not explicitly describe how one as a nurse can empower the women.

There is still a challenge to provide a comprehensive definition of *patient empowerment.* For this current thesis, an operational definition put forth by Johnson, Worrell and Chandler is applied. They define empowerment as "enabling women to access skills and resources to cope more effectively with current ass well as future stress and trauma" (2005, p. 109). Empowerment is further conceptualized as encompassing a set of attitudes and behaviors including positive self-evaluation and self-esteem, a favorable comfort/distress ration, a sense of self-efficacy, self-nurturance and self-care, competent use of assertiveness skills, effective access to multiple economic, social, and community resources, gender and cultural flexibility, and socially constructive activism (Perez, Johnson, & Wright, 2012, p. 104). However, empowerment cannot be created in a person by another person. In other words, a nurse cannot directly *empower* a patient, but can facilitate the process of empowerment (WHO, 2009, p. 191).

In a healthcare setting, an empowerment process concerns the individual's ability to gain control over health-related decisions (Palumbo, 2017, p. 2). Patient empowerment therefore involves an achievement of a balance of power between the healthcare professionals and the patients. This happens through a cognitive process which is based on the patients' awareness, self-confidence, engagement and control. Some research suggests that women in particular experience empowerment when they are in control of their thoughts, feelings, and behaviors (Ullman & Townsend, 2008, p. 300). In order for the patients to be empowered, the patients need to be adequately informed, willing to participate in the delivery of care and actively involved in health decision making (Palumbo, 2017, p. 2).

2.3.1. Components of the empowerment process

A facilitating environment for empowerment will develop when patients are given knowledge and resources in an *environment of mutual respect and support* (WHO, 2009, p. 191). In order to be empowered the patient need to have gathered enough information, understand how to use it and be convinced that this knowledge gives them shared responsibility in their healing. This is also known as *health literacy* and is a skill that needs to be improved in order to be empowered.

Another skill to improve is *self-efficacy*. Self-efficacy is defined as an individual's belief that he/she has the capabilities to produce an effect or reach a certain goal. Four ways to improve self-efficacy is through mastery experiences, vicarious experiences, verbal persuasion and psychological responses. (WHO, 2009, p. 191). Another term related to self-efficacy is perceived control. Perceived control is the perception one has over their response: "Do you feel like you have control over your reactions?" Self-efficacy is the confidence one has in his or her ability to behave like desired. "Do you feel like you can gain control over your reactions?" (Medicine Encyclopedia).

3. Method

A research method is the strategies, processes or techniques utilized in the collection of data for analysis in order to uncover new information or create a better understanding of a topic (University of Newcastle, 2019). Methods for collecting raw data is for example by qualitative, quantitative or mixed design. Quantitative methods can be used to determine how many people undertake particular behaviors, whereas qualitative methods can help researchers to understand how and why such behaviors take place (Sutton & Austin, 2015, p. 226). A mixed-method combines the two methods within the same study to allow researchers to explore diverse perspectives of multifaceted research questions (Shorten & Smith, 2017, p. 74).

For this bachelor thesis it suited to look at different types of articles. As the goal was to identify specific tools, quantitative studies such as randomized controlled trials which tested the tools,

would fit the best. However, since sexual assault is a sensitive subject with a lot of psychological and physical factors playing a part, it was important to review both survivors' and nurses' experiences with acute care. Qualitative studies suited this part the best and was therefore also included. A combination of both allows some generalization, but if conducting purely qualitative research one should not attempt to generalize the findings to a wider population (Sutton & Austin, 2015, p. 226).

3.1. Literature study

The method used for this bachelor is a literature review. Undertaking a literature study is a key feature in nursing studies, an essential step in the research process, and is fundamental in the development of clinical practice and policy (Cronin, Ryan, & Coughlan, 2008, p. 43). The process includes identification of a question, which is answered by a comprehensive and systematic identification, analysis and synthesis of a relevant body of published and sometimes unpublished research and other evidence (Aveyard, Payne, & Preston, 2016, p. 1).

3.2. Search strategy

After identifying a research question a PICO-framework was used in order to prepare the question for a literature search and the following critical review (Helsebiblioteket, 2016). The meaning of the abbreviation and how it is connected to my problem statement is presented below:

P (patient, problem) - Women who have experienced sexual assault

I (intervention) – Methods/tools

C (comparison) -

O (outcome) – Empowered women

For the further literature search it was important to connect the PICO to clearly defined theoretical terms and related MeSH-terms. Quick searches in different databases helped to identify these terms:

TABLE 3.1. Overview over terms used in the literature search

P - population	I - intervention
Sexual assault Sexual violence Rape (MS – Medline + PsycInfo) Sexual abuse (MS – CINAHL + PsycInfo) Sex offence* (MS – Medline + PsycInfo) Sexual trauma Seksuell vold Seksuelle overgrep Voldtekt Seksuell traume	Nursing methods Nursing procedures Nursing tools Nursing intervention Nursing assessment Nursing knowledge (ProQuest) -------→ Nurs* Communication in nursing Emergency treatment/nursing Emergency treatment/methods Emergency care Early intervention Verktøy for sykepleiere Metoder Prosedyrer Kommunikasjon Sykepleier verktøy Akutt behandling

Searches for articles were made in Medline/Pubmed, CINAHL, SveMed+ and PsycInfo. Additional searches were made in UpToDate and "Nasjonalt kunnskapssenter om vold og traumatisk stress". The results are presented in a PRISMA flow diagram in **Attachment 1**. Both Medline and PsycInfo are databases which use the Ovid search engine. They are useful in identifying single studies, but also journals and books (UiO). Whereas Medline contains articles primarily in life sciences, with a focus on biomedicine (NLM, 2019), PsycInfo provides literature on psychology (Helsebiblioteket, 2012). Both are relevant as survivors will struggle with both physical and psychological changes after a sexual assault. SveMed+ is a lot smaller database for articles in medicine and physical and psychological health in the Nordic languages (Karolinska Institutet). Searches here were made to try and find research close to home. CINAHL, which uses the EBSCO search engine, also contains a wide range of literature, but the database is suited explicitly for finding qualitative research (Helsebiblioteket, 2013).

3.3. Inclusion and exclusion criteria

Inclusion and exclusion criteria is used to find the articles which can give an answer to the research question (Polit & T., 2018). The inclusion and exclusion criteria chosen for this thesis are derived from 1.4. Limitations and are presented in TABLE 3.1.

During the research it was discovered that the terms "sexual assault", "sexual abuse", "sexual violence", "sex offenses" and "rape" was interchangeable in different articles. To include all relevant articles there was made no distinction between the terms in the search.

TABLE 3.2: Inclusion and exclusion criteria.

Inclusion	**Exclusion**
Women over 18 years of age	Men OR under the age of 18
Studies viewing emergency care, or care within the first week of a sexual assault	Long-term consequences, unless they compare it to emergency care given after the initial assault
Sexual assault either by a stranger or someone familiar	Intimate partner violence if it does not have a focus on sexual assault
English or Scandinavian language	Other languages than English or Scandinavian language
Articles from 2009-2020	Studies older than 2009
Peer-reviewed articles	Not peer-reviewed articles
Empirical studies	Reviews
Emergency ward (hospital, primary emergency care center)	
Intervention within 7 days	

Different searches were made in different databases as mentioned above. A more detailed search history is presented in **Attachment 2**. As specific terms can limit or broaden the search too much (Aveyard, et al., 2016, p. 74), different combinations were used to identify as many relevant articles as possible. A different combination of limiting factors were also tested. Only articles from 2009-2020 were looked at. After searches and collection of sources, duplicates were identified and removed using EndNote. 130 articles' abstracts were screened based on relevant titles, from which 29 were identified to a further reviewing. The 29 articles includes 9 articles which were identified using other search methods like reference list searching and citation tracking. When one article which seemed relevant was identified, the reference list and other sources citing the article were identified. Other bachelor and master degree thesis in

nursing were also used to identify relevant research articles. At first, the initial goal was to find specific nursing tools which could help facilitate empowerment in survivors of sexual assault. This was, however, impossible to find, and through a little change in problem statement and new searches three more articles were identified, which ended up being included.

The inclusion criteria of participants having to be 18 years or older was chosen to ensure the research articles were not focused on childhood sexual abuse. Three studies had populations which were under the age of 18 years of age, but there was no focus on childhood sexual abuse, and most of the participants were over 18 years old. The Du Mont et al. study was included despite some of the participants in the study being 17 years old. There is only one year difference, and the focus was not on child abuse. In the Lewis-O'Connor & Chadwick study some of the participants were under the age of 18 years, but most were between the ages of 19 and 26. Six of the participants were men, but this of a total of 310 participants which constitutes to under two percent. The Gilmore et al. study was included despite some of the participants being 15 years old because it was the only relevant study which presented a specific intervention tool. It was therefore interesting to include to look at as a possibility for nurses to start using in acute care of sexual assault survivors.

3.4. Ethical considerations

While developing high-quality evidence for practice, researchers have to adhere to rules for protecting human rights (Polit & Beck, 2018, p. 79). First step in assuring that their research is ethical is the selection of an important topic that has the potential to improve patient care (p.83). As healthcare professionals, we have a responsibility "[…] to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects" (WMA, 2013). In order to do so, the Declaration of Helsinki sets out four fundamental principles healthcare professionals have to follow: the principle of autonomy, of doing good, of not harm, and of fairness (Olsson & Sörensen, 2006, p. 58). As nurses we have a mandate to show respect for every persons' life and inherent dignity and to base our practice on compassion, care, and respect for human rights (ICN, 2012, p. 1). Furthermore, we are to base the nursing field on research, evidence-based knowledge and user knowledge.

Ethical issues must be addressed, especially in nursing research because the line between the collection of research data and expected practice of nursing sometimes gets blurred (Polit & Beck, 2018, p. 77). It is especially important to be aware during qualitative studies because they often involve in-depth exploration into highly personal areas (p. 80). If it at any point, for any reason, becomes too difficult for the participants to partake in a study they have the right to drop-out (p. 80). Avoiding any drop-outs are nearly impossible especially in quantitative research, and research on sexual assault, but the researchers can at least ensure that the study is not more intrusive than it needs to be, by for example doing a risk/benefit assessment (p. 82).

Another essential point to have in mind is that it can be challenging to convert a single study into clinical practice and the full range of patients one finds here. There is often a need for further research and for several different studies to come to a similar conclusion before results can be applied to clinical practice.

4. Results

4.1. Needs and expectations

Sexual assault survivors have both needs and expectations when they seek healthcare services, and is strongly linked to the experiences they had during the assault. Survivors reported that they felt completely unsafe and frightened during the assault, and that they lost all control. (Hutschemaekers, et al., 2019, p. 953). Two even feared they would get killed and described their feelings as a “haze”. Right after the assault all the survivors wondered if it was their fault (2019, p. 954) and many felt the urge to deny the event (2019, p. 953). As a result of this all the survivors had a need to be heard and acknowledged (2019, p. 954). They need to be told that it had in fact been a sexual assault and they were not to blame (Hutschemaekers, et al., 2019, p. 954) (Fehler-Cabral, et al., 2011, p. 3627) (Du Mont, et al., 2009, p. 777). There was also a need to have their experiences like shame, confusion, crying, numbness and dismay validated and normalized (Fehler-Cabral, et al., 2011, p. 3627) (Hutschemaekers, et al., 2019, p. 954). The need for thorough explanations and information extends to the whole care the patients receives from their own reactions to the procedures, like the medical forensic examination (MFE) (Fehler-Cabral, et al., 2011, p. 3625).

Some survivors went through with the MFE with the expectations it would make them feel safe, protect their loved ones from the assailant and make sure the assailant would be held accountable (Du Mont, et al., 2009, p. 776). Others expected it to lead to the extraction of "proofs" which could help in prosecution (Fehler-Cabral, et al., 2011, p. 3625), but also work as social recognition of the harm done. Some survivors spoke of the harmful effect of friends and family who doubt their experiences, (Hutschemaekers, et al., 2019, p. 952) (Lewis-O'Connor & Chadwick, 2015, p. 3631), and how they felt like having proofs could help counteract that doubt in others (Du Mont, et al., 2009, p. 777). If the survivors showed any (non)-verbal signs of panic and despair, they wanted nurses to be able to respond by interrupting the MFE, for example (Hutschemaekers, et al. 2019, p. 954).

4.2. Helpful encounters with nurses

4.2.1. Feeling safe, comfortable and validated

The nurses respond to the patients' needs with care and compassion by taking them seriously and showing kindness (Fehler-Cabral, et al., 2011, p. 3627) (Lewis-O'Connor & Chadwick, 2015, p. 244) (Du Mont, et al., 2009, p. 777). SANEs in England view one of their primary purposes to be firmly grounded in patient care, which includes support and non-judgemental attitudes (Cowley, et al., 2014, p. 80). They put the needs of the patient first, and evidence collection second.

Including reassurances and showing patience to make the survivors feel comfortable, the nurses were also personable, by for example asking questions about their personal life (Fehler-Cabral, et al., 2011, p. 3627). This played a critical role in making the survivors feel safe and validated. Another comforting factor was the knowledge that experts on violence were available (Lewis-O'Connor & Chadwick, 2015, p. 244). One survivor expressed how essential it was for her that the nurse was "on her side", and believed her (Fehler-Cabral, et al., 2011, p. 3627). While it was critical that the nurses were on their team and expressed empathy, this needed to be done professionally (Hutschemaekers, et al., 2019, p. 953). What helped one survivor was to have nurses who did not respond emotionally but took their time to examine what was happening (2019, p. 953).

4.2.2. Feeling in control

While some were afraid of not being believed, others were afraid of losing control. “Once you tell them everything, you set the ball rolling, and then you’ve lost your grip and you’re out of control” (Hutschemaekers, et al., 2019, p. 953). What helped survivors regain control was to be provided with choices and to be able to take their time (2019, p. 952) (Lewis-O'Connor & Chadwick, 2015, p. 244). SANEs emphasize that helping patients feel safe and in control is one of their highest priorities (Campbell, Greeson, & Patterson, 2010, pp. 20-21). To assist the survivors’ decisions, the nurses provide all relevant information, while they still remain neutral (2010, p. 21) and unpresumptuous (2010, p. 23). They also make sure they provide patients with strength and a belief in being able to make their own choices (2010, p. 22). The nurses hope this leaves patients with a sense of mastery, that even though it was scary to come, they still feel safe and comfortable enough to believe they can keep healing (2010, p. 22).

One of the most common positive experiences cited by survivors was how nurses thoroughly explained what they were going through both emotionally and practically (Hutschemaekers, et al., 2019, p. 954) (Fehler-Cabral, et a., 2011, p. 3625). When it comes to explaining the MFE survivors needed information about what would occur before the exam, why each procedure was being done, and description of any visible injuries (2011, p. 3625). Nurses who were being honest and open helped alleviate the secondary victimization survivors might have felt during a MFE or in a line of questioning from law-enforcement (2011, p. 3626).

The MFE in itself, was for some women empowering. Even though many felt distressed during the MFE, most stated that they would recommend it “in a heartbeat” (Du Mont, et al., 2009, p. 778). One woman stated that it was all for herself and not necessarily about filing a report, but another woman stated that she wanted evidence for the purpose of convicting her assailant.

On a more long-term basis, a video has been tested as an intervention to prevent PTSD and increased perceived present control in the acute phase (Gilmore, et al., 2019, p. 1). No present research connects less PTSD symptoms to increased empowerment, but increased perceived present control has been connected to increased empowerment (Honegger & Appelbaum, 1998, pp. 426, 434). In the Gilmore et al. study, participants who had previously experienced sexual assault and who were assigned the video intervention had higher perceived present control than those in the control group. Women who had no history of sexual assault and were assigned the video intervention had lower perceived present control than those in the control group. There

was found no correlation between method and perceived present control. The depending factor was previous sexual assault history (Gilmore, et al., 2019, pp. 10-14).

4.2.3. *Humanizing*

When nurses showed care and compassion, provided survivors with choices and acknowledgement, and explained things thoroughly, survivors perceived the care as "humanizing". Since rape is dehumanizing, nurses in first-line care are in a unique position to restore the survivors' humanity. The humanizing experience seemed to be instrumental in facilitating survivors' recovery (Fehler-Cabral, et al., 2011, p. 3628). When all formalities were put aside, nurses seemed to be the first support providers who treated the survivors like "real" people. All the actions provided by the nurse is what makes the survivors' healing process begin.

4.3. Negative encounters with nurses

4.3.1. Lack of explanations

Negative experiences often occur when the needs and expectations of the survivors are not met. When nurses provided survivors with thorough explanations they felt informed and in control of their bodies, both of which has been established as important for healing. However, when this did not occur, survivors were left less informed and in control, and more confused (Fehler-Cabral, et al., 2011, p. 3631). The confusion for some was linked to self-doubt (2011, p. 3631), while it for others was linked to not understanding the purpose and scope of the MFE. Some believed they would not receive the proper treatment if they did not go through with the MFE (Du Mont, et al., 2009, p. 777) (Lewis-O'Connor & Chadwick, 2015, pp. 245-246). They went through with an MFE with the primary reason of not getting pregnant, and making sure they did not have any diseases (Du Mont, et al., 2009, p. 777). Others believed it would help out in a prosecution to a greater extent than it did. One patient in believed the MFE was a form of lie detection test intended to prove the woman was lying (2009, p. 777). Survivors who decided to report seemed to have more regrets than women who did not report (Lewis-O'Connor & Chadwick, 2015, p. 246). Also, a fifteen percent of the women who went through with the MFE, regretted having evidence collected at all (2015, p. 240).

4.3.2. No choices

The MFE can be difficult to undergo for the survivors as it might evoke feelings of fear, stress, nervousness, anger, embarrassment, vulnerability, and feelings of disruption, and being exposed (Du Mont, et al., 2009, p. 777). Then, to feel like you did not have a choice in going through with it could be traumatizing (2009, p. 777) and leave you with a feeling of being revictimized (2009, p. 778). A number of the participants in the Lewis-O'Connor & Chadwick study shared the same views. They felt like they had been "pressured" or "talked into" having evidence collected (2015, p. 245), which is not conducive to an already uncomfortable and invasive exam (Fehler-Cabral, et al., 2011, p. 3631). One nurse reported that it can be difficult to remain completely neutral (Campbell, et al., 2010, p. 21). There are situations where a nurse might encourage a patient to report if the nurse is concerned about the patients' safety.

4.3.3. Cold and chaotic

Being too business and routine-like made nurses seem cold and distant towards their patients (Fehler-Cabral, et al., 2011, p. 3629). One patient spoke of how the nurse just wanted to do the job and then leave: "That's all she talked about, how she had to get out of bed" (2011, p. 3630). It made the survivors feel uncared for. Other feelings survivors expressed was disappointment, fear, sadness and anger when nurses did not acknowledge them, had taken enough time, trivialised the event or blamed the victim (Hutschemaekers, et al., 2019, p. 954). Survivors also reported about chaos when there were too many providers, which forced them to have to retell their story numerous of times, and which made the care feel disjointed (Lewis-O'Connor & Chadwick, 2015, p. 240).

5. Discussion

5.1. The empowerment approach

This part is build up after the components of empowerment presented by WHO (2009, pp. 191-192), and supported by theory based on Palumbo (2017) and Ullman & Townsend (2008). The working definition is of Johnson, et al., and Perez, et al. present a further conceptualization.

5.1.1. The environment of mutual respect and support

The creation of a facilitating environment of empowerment is a process in which patients are encouraged to develop and practice open communication in an environment free of barriers. There are three requirements of healthcare professionals to be able to create this facilitating environment. The first one is of a structural nature and will not be discussed here. The other two is:

a) a psychological belief in one's ability to be empowered
b) acknowledgement that the relationship and communication of healthcare professionals with patients can be powerful.

To be able to facilitate empowerment and recovery, one needs to believe it is possible, and one needs to be motivated to provide the appropriate care (José dos Reis, et al., 2010, p. 3). In the study done by Fehler-Cabral et al, survivors expressed how they perceived nurses' actions to be humanizing (2011, p. 3628). One of the factors of the humanization of care is inner motivation which gives rise to the actions taken (José dos Reis, et al., 2010, p. 3). Further, nurses perceive receptiveness as being key for humanized and individual care, and when trying to make a bond and empathizing with the patient. Treating patients with empathy professionally, is part of what Ullman & Townsend describe as a client-centered approach where care is central (2008, p. 306). Studies from Hutschemaekers et al. (2019, p. 956), Campbell et al. (2010, p. 22), and Fehler-Cabral et al. all point out the importance of an empathic approach and how it seems to encourage healing. This can be part of what one patient described as a nurse being "on her side" (Fehler-Cabral, et al., 2011, p. 3627).

It is important when supporting the survivors that the nurse uses the expression "it was not your fault" in some form (Johnson E.) (Hutschemaekers, et al., 2019, p. 952). Clear acknowledgement can counteract strong feelings of self-blame (2019, p. 955). However, this might not be enough if one still treats survivors with a judgmental attitude. Questions like "Do you think your drinking set him off?" can leave patients disappointed, sad and angry (Lewis-O'Connor & Chadwick, 2015, p. 245) (Hutschemaekers, et al., 2019, p. 954). Giving choices and believing the survivor will make the right decisions for herself is essential and it demonstrates the nurses patience and respect (Fehler-Cabral, et al., 2011, p. 3626). Recognizing how powerful the relationship and communication of healthcare professionals with patients can

be might also mean that nurses must disengage as a coping mechanism. One SANE emphasized that being too attached will start to affect you (Cowley, et al., 2014, p. 79).

5.1.2. Health literacy

The relationship between nurse and patient should be balanced to ensure patient empowerment. Patient empowerment can only be reached when the patient has attained a certain level of health literacy (WHO, 2009, p. 191). Lower health literacy is associated with lower health outcomes, increased rates of hospitalization and higher costs of care.

Nurses have to ensure that "[…] the individual receives accurate, sufficient and timely information in a culturally appropriate manner on which to base consent for care and related treatment" (ICN, 2012, p. 2). It is, therefore, not enough to just give the patient information, the nurse also has to make sure it is understood (NSF, 2011, p. 19). A challenge with sexual assault survivors is that after the traumatizing events, they may be unable to absorb the information fully (Du Mont, et al., 2009, p. 779) (Sosial- og helsedirektoratet, 2007, p. 24). Lewis-O'Connor & Chadwick suggest a teach-back method (2015, p. 247) which has been proven effective for different patient groups before (Liu, Li, Liu, & Chen, 2018, pp. 199-200) (White, Garbez, Carroll, Brinker, & Howie-Esquivel, 2013, pp. 141-142) (Nickles, Dolansky, Marek, & Burke, 2020, pp. 73-74), but it has never been tested on sexual assault survivors. In the Norwegian guidelines it is a requirement to provide both oral and written information (Sosial- og helsedirektoratet, 2007, p. 24) according to survivors' preferences (Lewis-O'Connor & Chadwick, 2015, p. 247). Some of the information can be provided in form of statistics, for example the likelihood of a conviction based on the MFE (Du Mont, et al., 2009, p. 778).

5.1.3. Self-efficacy

Patients with high self-efficacy have greater motivation and undertake more challenging tasks than individuals with low self-efficacy (WHO, 2009, p. 191). The four primary ways to increase self-efficacy is through mastery experiences, vicarious experiences, verbal persuasion and psychological responses. Mastery experiences relate to the fact that previous success will raise self-efficacy. Even though a MFE has been described as challenging, uncomfortable and

stressing it has also been regarded as important in regaining a sense of self-efficacy by the survivors (Du Mont, et al., 2009, p. 779). It was also suggested that the MFE was empowering in regards of holding the assailant legally responsible. However, there is a low conviction rate for sexual assault and these women might end up with a different view of the MFE if the case is lost.

Verbalizing the victims' strengths can be another way to help survivors regain a sense of self-efficacy. Verbal persuasion relates to how encouragement affects an individual's perceived self-efficacy (WHO, 2009, p. 191). Nurses make it clear by telling patients that it was out of strength that they sought help, and that they do have the ability and opportunity to feel safe also after acute care (Campbell, et al., 2010, p. 22). The goal is to stop the high levels of self-blame and instead try to focus on self-confidence, positive self-evaluation, self-nurturance and self-care (Perez, et al., 2012, p. 104).

A third way to increase self-efficacy is through vicarious experiences. Nurses can show the patient that their healing process has to start with them, but that as a nurse they can be there to support them. A way nurses can do this is through mirroring and empathy. Ullman & Townsend describe mirroring as a type of non-directive, client-centered counseling used to help their patients make decisions for themselves, even in a vulnerable state (2008, pp. 305-306). After nurses show the patients' their options, the patient is then asked to look at themselves and chose what they want to do with available alternatives. The goal is to reinstate the feeling of control in the patient, which is crucial in order to facilitate empowerment.

Psychological responses such as moods, emotional states, physical reactions, and stress levels also influence one's perception of self-efficacy (WHO, 2009, p. 191). Right after a sexual assault survivors might feel a range of emotions and many will struggle with finding a balance between acknowledgement and denial (Hutschemaekers, et al., 2019, p. 955). Finding a balance is a dynamic process with big emotional changes which threatens survivors' identity. Moving from the affected self to the recovering self is a long process (2019, p. 956) which nurses can help to start as they are often the first health-care professionals to great and take care of the survivors. Even though SANEs usually come on call after other healthcare professionals have provided the survivors with safety, survivors report that SANE's are skilled in providing them with stability and leading them to a non-victim state (Fehler-Cabral, et al., 2011, p. 3627) (Hutschemaekers, et al., 2019, p. 954) (Du Mont, et al., 2009, p. 777) (Campbell, et al., 2010,

p. 21). There is a search for a balance between comfort and distress (Perez, et al., 2012, p. 104) where a focus on present control can be beneficial.

5.1.4. Perceived present control

Focusing on what is controllable in the present, including the recovery process, is associated with lower distress. In earlier studies higher perceived present control in sexual assault survivors has been associated with less problem drinking, more positive reactions to mental health professionals, and fewer suicide attempts. Also, interventions aiming to increase present control reduce symptoms of anxiety, depression, and stress (Gilmore, et al., 2019, p. 3). In the acute care it is therefore vital to put a focus on what can be controlled right then and there. These facts might be why one sees such positive effects of presenting the survivors with options they get to control. Having control over events in the treatment, might help them start to feel in control of their behaviors, thoughts and feelings. Being in control of these factors makes women especially feel empowered. (Ullman & Townsend, 2008, p. 300).

A tool which has been shown to improve perceived present control among sexual assault survivors is the PPRS video tested in the Gilmore et al. study (4.2.2. Feeling in control). The results of this study show that it had the most significant effect on women with a prior sexual assault history, both on PTSD symptoms and on higher perceived present control, which is consistent with previous research (2019, p. 15). Women without prior sexual assault history who were assigned to the TAU group had higher perceived present control than the PPRS group. It is possible that whereas women with a prior sexual assault might find the material more apparent, that women without prior sexual assault initially believe they are able to cope and therefore disregard the video. Later they discover that they are in need of more help than they first anticipated and therefore scores themselves lower on perceived present control.

What is important to point out is that the video shown was supposed to be 18 minutes long and included information about the MFE. Because it disrupted the clinical flow the MFE component was removed. Only one out of five got to see the whole video, while the rest only watched the nine minutes version. This might have affected the results. It also brings forth the question of how ethical it is to put someone who has recently experienced sexual assault in front a video which will give further instructions. Even after the patient is reality oriented and is more stable,

they can still have troubles with memory and taking in new information. Then they are supposed to sit in-front of a screen for 18 minutes to receive all the information they need. How can one be sure they have understood the information? All the patients did receive treatment as usual (TAU) which included the MFE and information about local resources, but it does not say if information about the MFE was included in the TAU. It is difficult to imagine that they could have sent in women to receive a MFE without information prior to the exam, especially when studies report how crucial it is to the survivors' healing. The 18 minutes version disrupted the clinical flow. Maybe this was because the video repeated the information already given to the women? However, repetition could be seen as positive as it is difficult for the survivors to take in new information. Having it repeated makes it easier to remember, and understand. A video seems like a cold way to guide them on coping skills, but it is used *in addition* to standard treatment and will not replace the normal human contact provided by nurses.

5.2. Further practice

5.2.1. Guidelines and standard programs

To ensure a holistic care of high quality, the Norwegian government has made a guide book for emergency care centers in Norway (Sosial- og helsedirektoratet, 2007). It is made for health care professionals who come in contact with patients who have been assaulted (2007, p. 5). It is thorough and informative on a general basis. However, there has not been made guide books for the specific professions working with the survivors. It is mentioned how care should be given so that it motivates and supports the survivors to process the trauma, and that safety, respect and acknowledgement must be provided (2007, pp. 24-25). There is, however, no descriptions of how this should be executed so that the nurse can be sure to take care of the survivors psychological health. There are for example certain things which could be harmful to say to a survivor of sexual assault, even though they are said with the best intentions. A simple phrase like " I can't believe that person would do such a thing", can imply that one does not believe the survivors' story (Johnson E.). Even though the meaning might be to express worry and show that one does not agree with the pain caused upon the survivor.

Specific knowledge and capacity building is the municipalities responsibility. There is no official training program except from courses the municipalities find suiting (2007, p. 20). This

makes the information received and learned by healthcare professionals more random. There is a list of what healthcare professionals need to know to be able to work in an emergency care center, but it is not adapted to the specific healthcare professions (2007, p. 21). Despite national guidelines and routines, treatments can differ significantly (Cowley, et al., 2014, p. 81). It was suggested that this may be due to the different training backgrounds of the SANEs. As there was a lack of standardized training in England (2014, p. 79), there is still a lack of standardized training in Norway. This aspect should be researched further.

5.2.2. SANEs vs nurse

In Norway there is no program which equals to the SANE-program. SANEs report that there can be challenges in cooperating with law enforcement as they often push nurses to give their opinion on whether it was a "real rape case" (Campbell, et al., 2010, p. 24). Law enforcement share the same misconception as the survivors when they believe injuries are the proof of the sexual assault, when there are no injuries normally (2010, p. 22). It can be trying for the SANEs to have to explain this to every new officer even though they view it as within their role to educate them (2010, p. 23). SANEs also reported that the transition between nurse and SANE could be challenging as it felt like the two roles conflicted (Cowley, et al., 2014, p. 79). Nurses are trained to be caring, compassionate, empathic, but forensic examiners have to be neutral and unbiased. For some it is challenging to find the balance because they have to provide emotional support along with technical competence in a seamless process (Fehler-Cabral, et al., 2011, p. 3635). Despite challenges, SANEs felt they provided better patient service as they believe they have a more holistic approach to care and take their time (Cowley, et al., 2014, p. 82). Care being of the first priority is not inherently understood.

In a study by Patterson, Pennefather & Donoghue they discovered that most nurses, before going through the whole SANE training program, had a prosecutorial view of their role (2017, p. 8). This means they viewed their role as evidence collectors for the justice system, with a focus on doing the kit and not on how the patient was doing emotionally. Patient-centered care was emphasized during their training which helped the SANEs understand that survivors' well-being comes first while evidence collection is a secondary goal (2017, p. 9). In many ways it is about the nurses attitude and sometimes misconceptions. As a nurse working with survivors of sexual assault you need to be taught about misconceptions to avoid them, and it is essential to

learn your role as a nurse meeting these survivors (Patterson, et al., 2017, p. 10) (Sosial- og helsedirektoratet, 2007, p. 21). This process starts early and *before* you can actually start helping survivors, because mistreatment of the patients can actually lead to more damage (Caswell, Ross, & Lorimer, 2019, p. 432). SANEs learned to take a non-judgmental approach towards the survivors (Patterson, et al, 2017, p. 11). This should always be the case, and survivors should be believed and acknowledged every time they have experienced sexual trauma. It does not matter if a woman has been to the emergency care center five times before. If she comes the sixth or seventh time, she is to be treated with the same respect and curtesy as a woman coming in her first time.

While nurses in Norway do not perform the MFE they are present, and understanding experiences surrounding an examination is essential and relevant to be able to help their patients through it. What is the next course of action? Should there be a standard program for all sexual survivors? Is there a need for specialized nurses in Norway? Lewis-O'Conner & Chadwick support the idea of a more standardized model with a trauma-informed focus (2015, p. 248), while Hutschemaekers et al. does not recommend a standard evidence based intervention program (2019, p. 956). The latter argues that the responses to assault are dynamic and individual, and that survivors consistently attracts and repels professional care. Professional help should, however, be nearby and easily accessible and should focus on individual needs and its changes over time. There are indications for a system focused on personal recovery (Hutschemaekers, et al., 2019, p. 950).

5.3. Strengths, limitations and further discussions

5.3.1. Method

There are different strengths and weaknesses in using a literature study as a method. A literature study tries to make sense of a large body of research by collection and analysis, which makes it easier for the reader to find answers on the topic being researched (Aveyard, et al., 2016). It makes it easier to focus on the details of a specific topic and relate results from studies to existing theory. Within a summation, accomplished results from research are being brought together without repetition, and gaps or omissions are being identified. From looking at the results a different way, new directions for further research become apparent, and sometimes

even new theories are formed. Antonovsky's theory on salutogenesis had its start when he discovered new ways to look at results which researchers previously had overlooked. While the researches had tried to figure out why patients with severe asthma returned to the hospital after a certain amount of time, they overlooked the fact that 65 percent of them did *not* return to the hospital. Antonovsky started to ask why most of the patients did not return (Antonovksy, 2012, p. 30). Building the basis of a new theory and answering a problem statement through a bachelor thesis in a literature review is quite different, but this thesis has been inspired by Antonovsky's vision. A lot of the research on sexual assault is put on the health sequalae following an assault. It is a traumatizing event so it is crucial to understand its harmful effects on the survivors to be able to form proper treatment, but a lot on the focus is on prevention. Where is the focus on building up the survivors' strength and belief in a life after the assault? There are studies on empowerment after assault, but the participants are often survivors of intimate partner violence (IPV) and not just sexual assault (5.3.3. Different definitions on sexual assault). This thesis has viewed results from sexual assault studies in a different light and in doing so also identified a gap in the research.

However, it is to be pointed out that a limited timeframe and word-frame has limited how thorough the research for this thesis has been. It has limited the time both looking for an evaluating articles, and only the most relevant discussion points have been brought up while others have been excluded. Writing this thesis alone has limited how extensive the work could be. When writing alone there is no one else's opinion on which theory to include, which articles are relevant, and what is interesting to discuss. Not discussing with someone else limits the exploration of the articles included as one as an individual will miss out on important/interesting points. Discussing the work as it progresses might help in highlighting different views on the topic. Even whole articles might have been missed because one person has decided that the limit for the search is ten years. What if there was an excellent article written in 2008 or 2007? At the same time, if not limiting the search, the results might have been overwhelming, especially considering the scope of the thesis.

Using one conceptual framework narrows down the focus and makes it possible to explain something more detailed in a simple form, but it also excludes other conceptual frameworks which might be just as good as the ones included. Working out from theory also means narrowing down the reality to make it easy to comprehend and put into a conceptual framework. Choosing to look at the care nurses provide survivors in the acute phase after a sexual assault,

in a way ignores the fact that there are a lot of factors impacting the patients' lives both before and after the acute care. Also, though summarizing articles in a literature review is one of its strengths, there is a risk of losing context of individual studies when they are being summarized (Aveyard, et al., 2016).

5.3.2. Other definitions of empowerment

Something which has not been discussed is how some view the nursing definition of empowerment to be too narrow, as it only focuses on the individual perspective. The original meaning of empowerment stems from the American Civil Rights Movement, self-help organizations, the Women´s Rights Movement, and liberation movements in the third world (Askheim, 2007, p. 21). The empowerment term is used to describe a process where one person or group attains strength and power to *free themselves* from a position of little to no power. Empowerment is, therefore, in itself both a goal and a tool (2007, p. 20). There are three important aspects to empowerment: the individual strengthening and realization, self-efficacy, and the attainment of a position of higher power. The foundation is to make individuals aware of the connection between their living conditions and the community aspect (2007, p. 22). Individual strengthening is the first step, but it would be a form of reductionism to limit empowerment to an individual awareness and strengthening process (2007, p. 28).

5.3.3. Different definitions on sexual assault

Sexual assault is often included in other terms like "gender-based violence" (GBV) and "intimate partner violence" (IPV). A study on IPV has been included in this thesis because there had been made a distinction between survivors of sexual assault and survivors of IPV. Other studies were excluded when the primary focus was on IPV because it encompasses other types of violence in addition to sexual assault. This might have caused a loss of relevant articles.

A problem of the research on sexual assault is that results are often compared without considering the differences in definitions and perceptions of sexual assault (Hurley, 1991). In the national study from Norway by Thoresen & Hjemdal, it was presented that 9,4 percent of women and 1,1 percent of men have experienced being raped (2014, p. 86). To avoid

misunderstandings they asked the participants four specific questions (2014, p. 43). However, misunderstandings and misinterpretations might have occurred when asked if they had ever experienced "Unwanted sexual contact while being drugged/unable to consent or stop it". The results didn't differ greatly when it came to the women (8,5 percent), but the percentage of men answering "yes" to this question doubled compared to when they were asked if they had been raped (2,8 percent). The researchers report that they did not ask if intercourse was involved, and it can therefore not be determined whether it was rape. This illustrates how not only studies differ in definitions which makes it difficult for comparisons, but also how responders' perception of sexual assault, and rape, can complicate matters further. Especially when these perceptions are suspected to cause underreporting because some of the questions includes the word "rape" (2014, p. 35)

6. Conclusion

Nurses view the care of survivors of sexual assault as their first priority. In order to facilitate empowerment they are focused on providing choices, acknowledging survivors' experiences and feelings, thorough explanations and treating with a professional empathy even though they have other responsibilities as well, for example collection of evidence. Negative experiences with nurses occur when expectations are not met, and the nurses do not explain adequately, do not provide choices and are cold and distant towards the patients. Apparent is the lack of focus on nursing interventions to implement in the acute phase. There is a huge potential for more research as nurses usually take part in the whole care of the survivors of sexual assault. Even though a standardized program might be discouraged, based on the healing process being dynamic and individual, there are certainly room for developing guidelines specific to nursing theory and practice.

7. References

Aakvaag, H. F., Thoresen, S., Wentzel-Larsen, T., Dyb, G., Røysamb, E., & Olff, M. (2016). Broken and gouilty since it happened: A population study of trauma-related shame and guilt after violence and sexual abuse. *Journal of Affective Disorders, 204*(1), 16-23 https://doi.org/10.1016/j.jad.2016.06.004.

Antonovksy, A. (2012). *Helsens mysterium.* Oslo: Gyldendal Akademisk.

Askheim, O. P. (2007). Empowerment - Ulike tilnærminger. In O. P. Askheim, & B. Starring, *Empowerment - I teori og praksis* (pp. 21-33). Oslo: Gyldendal Akademisk.

Aveyard, H., Payne, S., & Preston, N. (2016). *A Post-graduate's Guide to Doing a Literatur Review.* New York: Open University Press.

Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2009). Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence. *Health Research and Educational Trust, 44*(3), 1052-1067 https://doi.org/10.1111/j.1475-6773.2009.00955.x.

Browes, N. (2016). *How gender inequalities fuel rape in war.* Retrieved October 2019, from Dr Denis Mukwege Foundation: https://www.mukwegefoundation.org/2017/03/gender-norms-rape-war-sexual-violence/

Campbell, R., Greeson, M., & Patterson, D. (2010). Defning the boundaries: How sexual assault nurse examiners (SANEs) balance patient care and law enforcement collaboration. *Journal of Forensic Nursing, 7*, 17-26 https://doi.org/10.1111/j.1939-3938-2010.01091.x.

Caswell, R. J., Ross, J. D., & Lorimer, K. (2019). Measuring experience and outcomes in patients reporting sexual violence who attend a healthcare setting: a systematic review. *Sexually Transmitted Infections, 95*(6), 419-427 https://doi.org/10.1136/sextrans-2018-053920.

Cowley, R., Walsh, E., & Horrocks. (2014). The Role of the Sexual ASsault Nurse Examiner in England: Nurse Experiences and Perepectives. *Journal of Forensic Nursing, 10*(2), 77-83 https://doi.org/DOI: 10.1097/JFN.0000000000000026.

Du Mont, J., White, D., & McGregor, M. J. (2009). Investigating the medical forensic examination from the perspectives of sexually assaulted women. *Social Science & Medicine, 68*, 774-780 https://doi.org/10.1016/j.socscimed.2008.11.010.

Fehler-Cabral, G., Campbell, R., & Patterson, D. (2011). Adult Sexual Assault Survivors' Experiences With Sexual Assault Nurse Examiners. *Journal of Interpersonal Violence, 26*(18), 3618-3639 https://doi.org/10.1177/0886260511403761.

Fersnes, G. (2014). Kapittel 11. Reaksjoner og stabliseringsarbeid etter voldtekt. In K. Narud, *Vold mot kvinner* (pp. 189-209). Oslo: Cappelen Damm Akademisk.

Gilmore, A. K., Walsh, K., Frazier, P., Meredith, L., Ledray, L., Davis, J., . . . Resnick, H. S. (2019). Post-Sexual Assault Mental Health: A Randomized Clinical Trial of a Video-Based Intervention. *Journal of Interpersonal Violence*, 1-24 https://doi.org/10.1177/0886260519884674.

Grohol, J. M. (2018, September 28). *#MeToo: The Psychology of Sexual Assault.* Retrieved November 2019, from PsychCentral: https://psychcentral.com/blog/metoo-the-psychology-of-sexual-assault/

Hansen, L., & Finsrud, A. M. (2014). Kapittel 14. Overgrepsmottak. In K. Narud, *Vold mot kvinner* (pp. 243-248). Oslo: Cappelen Damm Akademisk.

Helsebiblioteket. (2012, October 3). *Slik søker du i PsycInfo*. Retrieved April 2020, from Helsebiblioteket.no: https://www.helsebiblioteket.no/psykisk-helse/aktuelt/slik-soker-du-i-psycinfo

Helsebiblioteket. (2013, February 14). *CINAHL tilgjengelig i Helsebiblioteket*. Retrieved from Helsebiblioteket.no: https://www.helsebiblioteket.no/om-oss/artikkelarkiv/cinahl-tilgjengelig-i-helsebiblioteket

Helsebiblioteket. (2016, June 3). *PICO.* Retrieved October 2019, from Helsebiblioteket: https://www.helsebiblioteket.no/kunnskapsbasert-praksis/sporsmalsformulering/pico

Hem, E. (2020, April 1). *Akuttfase.* Retrieved April 2020, from Store norske leksikon: https://snl.no/akuttfase

Honegger, K., & Appelbaum, S. (1998). The Impact of perceived control and desire to be empowered: an analysis of perception and reality. *Journal of Service Theory and Practice, 8*(6), 426-438 https://doi.org/10.1108/09604529810235141.

Hurley, D. L. (1991). Women, alcohol and incest: An analytical review. *Journal of Studies on Alcohol, 52*(3), 253-268 https://doi.org/10.15288/jsa.1991.52.253.

Hutschemaekers, G. J., Zijlstra, E., de Bree, C., Wong, S. L., & Lagro-Janssen, A. (2019). Similar yet unique: the victim's journey after acute sexual assault and the importance of continuity of care. *Scandinavian Jounral of Caring Sciences, 33*, 949-958 https://doi.org/10.1111/scs.12693.

ICC. (2018). *Bemba Case - The Proscutor v Jean-Pierre Bemba Gombo.* Retrieved February 2020, from https://www.icc-cpi.int/car/bemba

ICN. (2012). *The ICN Code of Ethics for Nurses.* Retrieved May 2020, from International Council of Nurses: https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_%20eng.pdf

Johnson, D. M., Worell, J., & Chandler, R. K. (2005). Assessing psychological health and empowerment in women: The Personal Progress Scale Revised. *Women and Health, 41*(1), 109-129 https://doi.org/10.1300/J013v41n01_07.

Johnson, E. (n.d.). *How to support someone who has been sexually assaulted.* Retrieved April 2020, from HealthPartners: https://www.healthpartners.com/blog/how-to-support-survivors-of-sexual-assault/

José dos Reis, M., Baena de Moraes Lopes, M. H., Higa, R., Turato, R. E., Chvatal, V. L., & Bedone, A. J. (2010). Experiences of nurses in health care for female victims of sexual violence. *Rev Saúde Pública, 44*(2), 1-6 http://dx.doi.org/10.1590/S0034-89102010000200013.

Justisdepartementet. (2019). *Handlingsplan mot voldtekt.* Retrieved November 2019, from Regjeringen.no:

https://www.regjeringen.no/contentassets/1469f9bedad1476aadb0369ee899ab65/handlingsplan-mot-voldtekt-20192022.pdf

Karolinska Institutet. (n.d.). *Sök artiklar i SveMed+*. Retrieved April 2020, from Svedmedplus: https://svemedplus.kib.ki.se/

Kåss, E., & Hem, E. (2019, October 4). *Akutt.* Retrieved April 2020, from Store norske leksikon: https://sml.snl.no/akutt

Kirkens Nødhjelp. (2019, Ocotber 9). *Kjønnsbasert vold og reproduktiv helse*. Retrieved from Kirkens Nødhjelp: https://www.kirkensnodhjelp.no/slik-jobber-vi/kjonnsbasert-vold-og-reproduktiv-helse/kjonnsbasert-vold-og-reproduktiv-helse2019/

Koehn, C. V. (2007). Women's Preceptions of Power and Control in Sexual Abuse Counseling. *Journal of Child Sexual Abuse, 16*(1), 37-60 https://doi.org/10.1300/J070v16n01_03.

Kristoffersen, N. J. (2016). Kapittel 27: Å styrke pasienters ressurser. In N. J. Kristoffersen, F. Nortvedt, S. E.A., & G. H. G, *Grunnleggende sykepleie B.3 - Pasientfenomener, samfunn og mestring* (pp. 349-398). Oslo: Gyldendal Akademisk.

Lønne, A. (2019, Januar 22). *salutogenese.* Retrieved November 2019, from Store Norske Leksikon: https://sml.snl.no/salutogenese

Lewis-O'Connor, A., & Chadwick, M. (2015, October-December). Engaging the Voice of Patients Affected by Gender-Based Violence: Informing Practice and Policy. *Journal of Forensic Nursing, 11*(4), 240-248 https://doi.org/10.1097/JFN.0000000000000090.

Liu, Y. B., Li, Y. F., Liu, L., & Chen, Y. L. (2018). Effectiveness of the teach-back method for improving the health literacy of senior citizens in nursing homes. *Japan Journal of Nursing Science, 15*, 195-202 https://doi.org/10.1111/jjns.12192.

Lovdata. (2009, June 19). *Lov om straff (straffeloven) Annen del. De straffbare handlingene Kapittel 26. Seksuallovbrudd.* Retrieved October 2019, from Lovdata: https://lovdata.no/dokument/NL/lov/2005-05-20-28/KAPITTEL_2-11#%C2%A7291

Medicine Encyclopedia. (n.d.). *Perceived control.* Retrieved May 2020, from Medicine Encyclopedia: https://medicine.jrank.org/pages/375/Control-Perceived-Control-self-efficacy.html

Miller, A. K., Handley, I. M., Markman, K. D., & Miller, J. H. (2010). Deconstructing Self-Blame Following Sexual Assault: The Critical Roles of Cognitive Content and Process. *Violence Against Women, 16*(10), 1120-1137 https://doi.org/10.1177/1077801210382874.

Mukwege, D. (2015, Ocotber 8). *Kongos kjempe*. Retrieved from Kirkens Nødhjelp: https://www.kirkensnodhjelp.no/nyheter/historier/kongos-kjempe/

Murad, N. (2018). *The Last Girl: My Story of Captuvuty, and My Fight Against the Islamic State.* London: Little Brown Book Group.

Nickles, D., Dolansky, M., Marek, J., & Burke, K. (2020). Nursing students use of teach-back to improve patients' knowledge and satisfaction: A quality improvement project. *Journal of Professional Nursing, 36*, 70-76 https://doi.org/10.1016/j.profnurs.2019.08.005.

NKVTS. (n.d.). *Hva er seksuelle overgrep og seksuell vold?* Retrieved October 2019, from Nasjonalt kunnskapssenter om vold og traumatisk stress: https://dinutvei.no/om-vold/247-hva-er-seksuelle-overgrep-og-seksuell-vold

NLM. (2019, April 10). *MEDLINE: Description of the Database*. Retrieved april 2020, from National Library of Medicine: https://www.nlm.nih.gov/bsd/medline.html

Nobel Committee. (2018, Ocotber 5). *The Nobel Peace Prize 2018.* Retrieved November 2019, from The Norwegian Nobel Committee (NCC): https://www.nobelpeaceprize.org/The-Nobel-Peace-Prize-2018

NSF. (2011). *Yrkesetiske retningslinjer for sykepleiere.* Retrieved mars 2020, from Norsk Sykepleierforbund: https://www.nsf.no/Content/2182990/seefile

Office of Justice Programs. (2020). *SANE program, development and operation guide.* Retrieved April 2020, from https://www.ovcttac.gov/saneguide/introduction/what-is-a-sane/

Palumbo, R. (2017). *The Bright Side and the Dark Side of Patient Empowerment.* Cham: Springer International Piblushing AG.

Patterson, D., Pennefather, M., & Donoghue, K. (2017). Shifting Sexual Assault Forensic Examiners Orientation From Prosecutorial to Patient-Centered: The Role of Training. *Journal of Interpersonal Violence*, 1-22 https://doi.org/10.1177/0886260517717491.

Perez, S., Johnson, D. M., & Wright, C. V. (2012). The Attenuating Effect of Empowerment on IPV-Related PTSD Symptoms in Battered Women Living in Domestic Violence Shelters. *Violence against women, 18*(1), 102-117 https://doi.org/10.1177/1077801212437348.

Polit, D. D., & Beck, C. T. (2018). Ethics in Research. In D. D. Polit, & C. T. Beck, *Essentials of nursing research: appraising evidence for nursing* (pp. 77-87). Philadelphia: Wolters Kluwer.

Polit, D. F., & T., B. C. (2018). *Essentials of nursing research: appraising evidence for nusrings practice* (Vol. 9). Philadelphia: Wolters Kluwer Health.

Rothbaum, B. O., Kearns, M. C., Price, M., Malcoun, E., Davis, M., Ressler, K. J., . . . Houry, D. (2012, July 6). Early Intervention May Prevent the Development of Posttraumatic Stress Disorder: A Randomized Pilot Civilian Study with Modified Prolonged Exposure. *Biological Psychiatry, 72*(11), 957-963 https://doi.org/10.1016/j.biopsych.2012.06.002.

Search and write. (2017, December 19). *The IMRaD format.* Retrieved April 2020, from Search and write: https://sokogskriv.no/en/writing/structure-and-argumentation/the-imrad-format/

Shorten, A., & Smith, J. (2017). Mixed methods research: expanding the evidence base. *Evidince-Based Nursing, 20*(3), 74-75 http://dx.doi.org/10.1136/eb-2017-102699.

Sosial- og helsedirektoratet. (2007). *Overgrepsmottak. Veileder for helsethenesten* (Vols. ISBN-nr. 978-82-8081-089-2). Oslo: Sosial- og helsedirektoratet.

Steine, I. M., Milde, A. M., Bjorvatn, B., Grønli, J., Nordhus, I. H., Mrdalj, J., & Pallesen, S. (2012, October 5). *Forekomsten av seksuelle overgrep i et representativt*

befolkningsutvalg i Norge. Retrieved October 2019, from Psykologitidsskriftet: https://psykologtidsskriftet.no/fagartikkel/2012/10/forekomsten-av-seksuelle-overgrep-i-et-representativt-befolkningsutvalg-i-norge

Sutton, J., & Austin, Z. (2015). Qualitative Research: Data Collection, Analysis, and Management. *CJHP, 68*(3), 226-231 https:doi.org/10.4212/cjhp.v68i3.1456.

Thoresen, S., & Hjemdal, O. K. (2014, January). *Vold og voldtekt i Norge En nasjonal forekomststudie av vold i et livsløpsperspektiv.* Retrieved Ocotber 2019, from NKVTS: https://www.nkvts.no/content/uploads/2015/11/vold_og_voldtekt_i_norge.pdf

UiB. (2018). *Voldtekt og seksuelle overgrep.* Retrieved April 2020, from Kriser.no: https://www.kriser.no/voldtekt-seksuelle-overgrep?rq=akuttfase

UiO. (n.d.). *Fagside fo psykologi*. Retrieved april 2020, from Universitetet i Oslo: https://www.ub.uio.no/fag/psykologi/

Ullman, S. E., & Townsend, S. M. (2008). What is an empowerment approach to working with sexual assault survivors? *Journal of community psychology, 36*(3), 299-312 https://doi.org/10.1002/jcop.20198.

UN. (1993, December 20). *Declaration on the Elimination of Violence against Women.* Retrieved from UN General Assembly: https://www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.21_declaration%20elimination%20vaw.pdf

UN. (2012). *Crimes against humanity.* Retrieved February 2020, from United Nations: https://www.un.org/en/genocideprevention/crimes-against-humanity.shtml

UN. (2015). *5 Gender Equality.* Retrieved from Sustainable Development Goals: https://www.un.org/sustainabledevelopment/gender-equality/

UN. (2019). *Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development.* Retrieved from United Nations: https://unstats.un.org/sdgs/indicators/Global%20Indicator%20Framework%20after%202019%20refinement_Eng.pdf

UN General Assembly. (1998). *Rome Statute of the International Criminal Court (last amended 2010)*. Retrieved March 2020, from United nations: https://www.refworld.org/docid/3ae6b3a84.html

UNFPA. (2016). *Reporting on Gender-based Violence in the Syria Crisis - Facilitator's Guide*. Retrieved April 2020, from United Nation's Population Fund: https://www.unfpa.org/sites/default/files/pub-pdf/-Facilitator1s_Guide_English_InDesign_Version.pdf

University of Newcastle. (2019, September 4). *Research Guide*. Retrieved April 2020, from University of Newcastle: https://libguides.newcastle.edu.au/researchmethods

Vea, H. (2001, April). *Mestring av virkninger etter seksuelle overgrep.* Retrieved October 2019, from Bergen Open Research Archive: https://bora.uib.no/bitstream/handle/1956/1732/Masteroppgave-vea.pdf?sequence=1&isAllowed=y

White, M., Garbez, R., Carroll, M., Brinker, E., & Howie-Esquivel, J. (2013). Is ‘‘Teach-Back’’ Associated With Knowledge Retention and Hospital Readmission in Hospitalized Heart Failure Patients? *Journal of Cardiavascular Nursing, 28*(2), 137-146 https://doi.org/10.1097/JCN.0b013e31824987bd.

WHO. (2002). *Chapter 6. Sexual Assault.* Retrieved October 2019, from World Health Organization: https://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf

WHO. (2003). *Guidelines for medico-legal care for victims of sexual violence.* Retrieved October 2019, from World Health Organization: https://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/

WHO. (2005). *Multi-country Study on Women's Health and Domestic Violence agasint Women: summary report of initial results on prevalence, health outsomes and women's response.* Geneva: World Health Organization.

WHO. (2009). Components of the empowerment process. In WHO, *WHO Guidelines on Hand Hygiene in Helath Care* (pp. 191-192). Geneva: WHO Press.

WHO. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.* Retrieved November 2019, from World Health Organization - Programmes: https://www.who.int/reproductivehealth/publications/violence/9789241564625/en/

WHO. (2014, November). *Health care for women subjected to intimate partner violence or sexual violence.* Retrieved October 2019, from WHO: https://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf?sequence=1

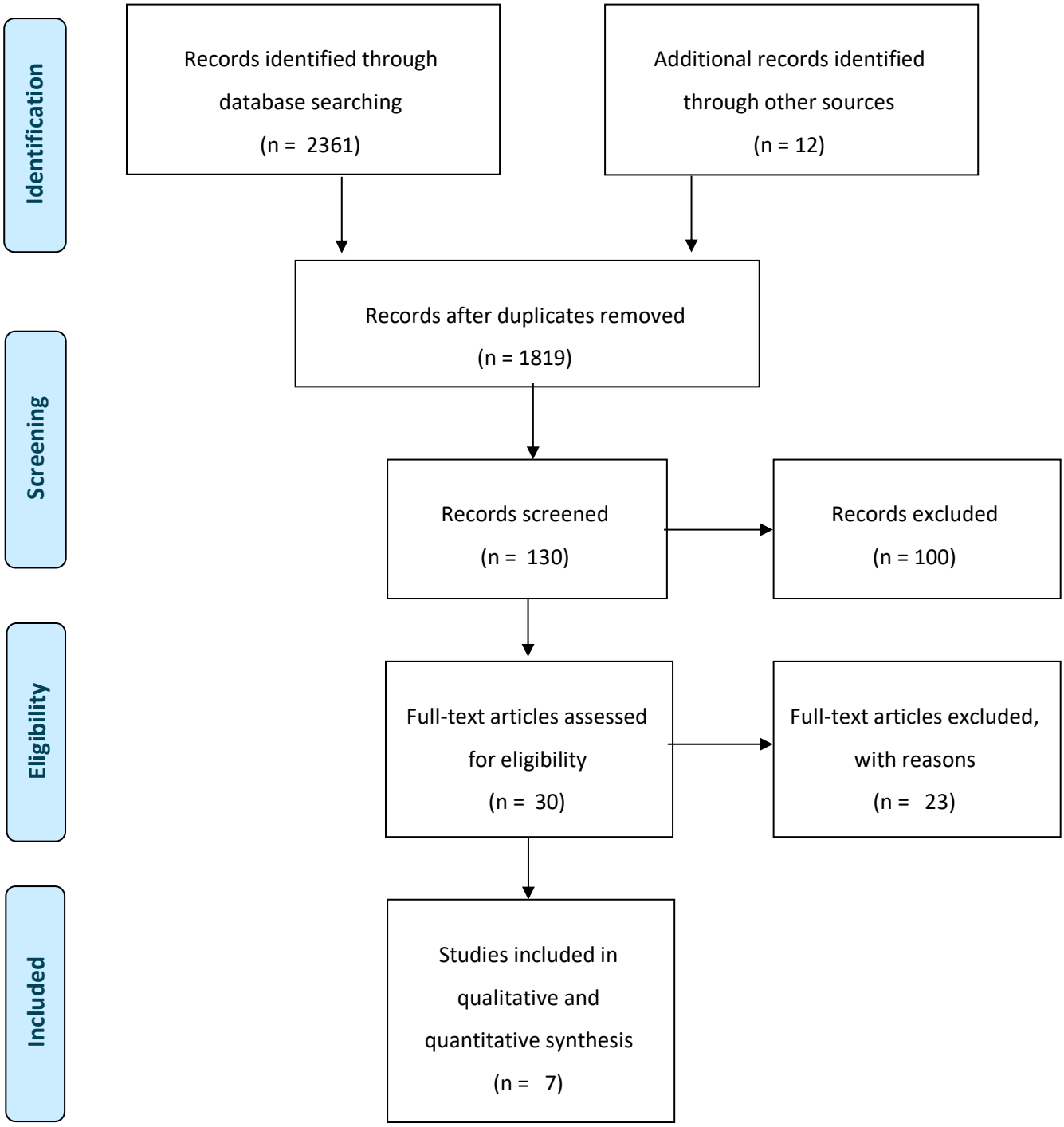
WHO. (2014). *Violence against women - Intimate partner and sexual violence against women.* Retrieved March 2020, from WHO: https://apps.who.int/iris/bitstream/handle/10665/112325/WHO_RHR_14.11_eng.pdf?sequence=1&isAllowed=y

WHO. (2017). *Strengthening health systems to respond to qomen subjected to intimate partner vioelence or sexual violence.* Retrieved October 2019, from World Health Organization: https://apps.who.int/iris/bitstream/handle/10665/259489/9789241513005-eng.pdf?sequence=1

WMA. (2013, October). *the Declaration of Helsinki.* Retrieved from World Medical Association (WMA): https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/

World Bank Group. (2020). *Women, Business and the Law 2020.* Washington: World Bank Publications.

ATTACHMENT 1: PRISMA 2009 Flow Diagram



ATTACHMENT 2: Literature search

Database	Search	Search words/MeSH terms	Nr. of hits	Read abstract	For reviewing
Medline (Ovid)	1	Sex offenses (MS) **OR** rape (MS) **OR** sexual assault **OR** sexual abuse **OR** sexual violence **OR** sexual trauma	31.799	36	4
	2	Nurs*	722.790	-	-
	3	#1 **AND** #2	1.887	-	-
	4	#1 **AND** #2 + limit (2009-now + female)	458	14	3
	5	Emergency treatment (MS) **OR** early intervention **OR** Emergency medical services (education, methods, nursing, standards) **OR** emergency care	151.463	-	-
	6	#1 **AND** #5	240	10	3
	7	Acute	1.246.418	-	-
	8	#1 **AND** #7 + limits (2009-now)	261	16	2
20.03.2020	9	Emergency department **OR** emergency service, hospital (MS)	525	-	-
	10	#1 **AND** #9	235	3	1
Pubmed	1	Sexual abuse **OR** sexual assault **OR** sex offenses (MS) **OR** sexual violence **OR** sexual trauma **OR** rape (MS)	49.783	-	-
	2	Nurs*	946.567	-	-
	3	#1 **AND** #2 + limits (female, languages (English + Scandinavian, 2009-now)	498	0	0
	4	Acute	1.259.147	-	-
	5	#1 **AND** #4 + limits (2009-now, female)	94	2	2
CINAHL	1	Sex abuse **OR** sex offenses **OR** sexual abuse (MS) **OR** sexual violence **OR** sexual assault **OR** sexual trauma **OR** rape (MS)	17.710	-	-
	2	Nurs*	803.042	-	-
	3	#1 **AND** #2	2.356	-	-
	4	#1 **AND** #2 + limits (female, 2009-now)	443	16	0
	5	Sexual assault nurse examiner + limit (09-now)	269	12	0
	6	Acute care	7.394	-	-
	7	#1 **AND** #6	9	3	1
PsychInfo	1	Sex offenses (MS) **OR** sexual abuse (MS) **OR** sexual violence **OR** sexual assault **OR** sexual trauma **OR** rape (MS)	24.320	-	-
	2	Nurs*	77.591	-	-
	3	#1 **AND** #2 + limits (2009-now, adult >18ye)	232	3	0
Nasjonalt kunnskapssenter om vold og traumatisk stress	1	Vold og overgrep, Vitenskapelige artikler og bokkapitler, 2009-2020	136	4	0
UpToDate	1	Evaluation and management of adult and adolescent sexual assault victims		2	2
Other methods			12	12	12

ATTACHMENT 3: Table presentation of articles

Four out of seven articles are from the USA, one from England, one from Netherlands and one from Canada. Most of the research on the acute care of patients revolves around care provided by Sexual Assault Care Nurse Examiners (SANEs). As the USA was first in establishing SANE-programs, a lot of the research on the SANEs role, and experiences from both nurses and patients, come from America. There is a lack of research from Asia and Africa mostly because the studies about sexual assault do not look explicitly at the nurses role in patient care, are on prevalence, are descriptive, or examines the healthcare professionals' knowledge and perceptions. Studies exploring the latter often find that the personnel taking care of sexual assault survivors is untrained which can lead to secondary victimization of the survivors (Morse & Decker, 2019, p. 1259). There is also a problem of low help-seeking which is connected to shame in often highly patriarchal societies, self-blame (Maier, 2012, p. 74) and discriminating laws. For some women there is a chance of being arrested and prosecuted if they report their assailant (Haddad, 2017). There were no relevant studies from South-America identified, possibly because they were in another language than English or Scandinavian.

Articles are presented with author, year, country, title, setting, aim of study, method, design, population, empowerment method and results. There were few possible specific empowerment methods identified. Further discussed in 5. Discussion.

Author, year and country	Title	Setting	Aim of study	Method, design and population	Empowerment method	Results
Campbell, Greeson & Patterson 2009 USA	Defining the boundaries: How sexual assault nurse examiners (SANEs) balance patient care and law enforcement collaboration	A geographically diverse county in the Midwest with a population of 829,453 that included urban, suburban, and rural areas	Examine how SANEs define their work with their patients, how they collaborate with law enforcement, and how they negotiate roles differentiation	In-person qualitative interviews were conducted with 6 forensic nurses.		The nurses strongly emphasized that their overarching programmatic goal is to improve victims' well-being by providing quality acute patient care. As part of that care, the SANEs try to help victims feel safe and in control of their lives again. The SANEs let the patient choose if they want to participate in a report to the police.

CARE = Coordinated Approach to Recovery and Empowerment **CSFW** = Center of Sexual and Family Violence **GBV** = Gender-based violence **MFE** = medical, forensic examination **PDS** = Posttraumatic Diagnostic Scale **PIRI** = Pleasant Imagery and Relaxation Instruction **PPRS** = Prevention of Post-rape stress **PTSD** = Post-traumatic stress disorder **QI** = Quality Improvement **SA** = Sexual assault **SADVTC** = Sexual Assault and Domestic Violence Treatment Center **SAMFE** = Sexual Assault Medical Forensic Examination **SANE** = Sexual Assault Nurse Examiner **TAU** = Treatment as usual **TIC** = Trauma-Informed Care

Cowley, Walsh & Horrocks 2014 England	The Role of the Sexual Assault Nurse Examiner in England: Nurse Experiences and Perspectives	Various locations in England	Explore the role of SANEs currently working in England	One-on-one qualitative semistructured interviews with 5 SANEs completed both face-to-face and over phone		SANEs in this study viewed their primary purpose as being firmly grounded in patient care. Some SANEs find the transition from nurse to SANE to be challenging and contradictory. Collaboration with other professions can be challenging as they do not completely understand what the role of the SANE is. Some also have to take time to accept a SANEs role.
Du Mont, White & McGregor 2009 Canada	Investigating the medical forensic examination from the perspectives of sexually assaulted women	Specialized hospital-based sexual assault centres called SADVTC in Ontario, Canada	Further the understanding of the MFE from a patient perspective.	In-person interviews with 19 women, aged 17-46 years, who had undergone a MFE in the previous six months. Semi-structured interviews were used.	Medical forensic examination	Most women went to a center to have their physical and emotional needs addressed and were overwhelmingly satisfied with their interactions with SANEs. Some women were confused about the purpose of the MFE and believed they had to go through with it to in order to be treated, or they believed the MFE would hold their assailant accountable. Many stated distress during the MFE, while some reported feeling simultaneously empowered.
Fehler-Cabral, Campbell & Patterson 2011 USA	Adult Sexual Assault Survivors' Experiences With Sexual Assault Nurse Examiners	Administrative office of the rape crisis center affiliated with the focal SANE program	Understand adult sexual assault survivors' experiences with SANEs during their forensic examination.	In-person interviews were conducted with 20 women aged 18 or older. Semi-structured interviews were used.		SANEs provided survivors with care and compassion, clear explanations, and choices. Taken together, these positive experiences were perceived as "humanizing". However, some survivors perceived forensic nurses as hurtful when they were not provided with choices, explanation, and/or acted cold and distant.
Gilmore et al 2019 USA	Post-Sexual Assault Mental Health: A Randomized Clinical Trial of a Video-Based Intervention	Medical center were the women received a SAMFE in a Midwestern metropolitan area in USA.	To assess a video-based prevention program delivered immediately after a SAMFE visit on PTSD symptoms and perceived control	n = 233 women aged 15 or older were randomly assorted into three groups: PPRS (n = 77), PIRI (n = 77) and TAU (n = 79) by a computerized random numbers generator. The interventions were compared on PTSD symptoms, using the PDS,	PPRS video intervention compared to TAU and PIRI video	Those in the PPRS condition had lower perceived present control than those in the TAU condition among those with no prior SA 3-months post-SA. However, at 6-months post-SA, among women with a prior SA, women in the PPRS reported higher perceived present control than those in TAU.

CARE = Coordinated Approach to Recovery and Empowerment **CSFW** = Center of Sexual and Family Violence **GBV** = Gender-based violence **MFE** = medical, forensic examination **PDS** = Posttraumatic Diagnostic Scale **PIRI** = Pleasant Imagery and Relaxation Instruction **PPRS** = Prevention of Post-rape stress **PTSD** = Post-traumatic stress disorder **QI** = Quality Improvement **SA** = Sexual assault **SADVTC** = Sexual Assault and Domestic Violence Treatment Center **SAMFE** = Sexual Assault Medical Forensic Examination **SANE** = Sexual Assault Nurse Examiner **TAU** = Treatment as usual **TIC** = Trauma-Informed Care

				and Perceived present control, at 0, 1,5, 3 and 6 months after examination.		
Hutschemaekers 2019 The Netherlands	Similar yet unique: the victim's journey after acute sexual assault and the importance of continuity of care	Assault centre called CSFW, Netherlands.	To examine the short-term and long-term responses of sexual assault victims who attended a sexual assault centre.	Semi-structured interviews were held with 12 victims of sexual assault, 18 years or older, who received help from a sexual assault centre. They were asked how they were treated both in short- and long-term care.		The most important actions of a nurse attending to a survivor of sexual assault were to acknowledge the victim and provide safety with an empathic, skillful attitude.
Lewis-O'Connor & Chadwick 2015 USA	Engaging the Voice of Patients Affected by Gender-Based Violence: Informing Practice and Policy	CARE clinic. Urban Area in northeast of USA.	Survivors of GBV who were referred for follow-up care were asked to participate in a QI initiative in an effort to understand their perspectives of receiving healthcare services	310 survivors of GBV aged 15 and up (6 men) were in one-on-one interviews asked to answer three open-ended questions in regard to their healthcare experience: *What went well?*, *What could we do better?* and *If we could change two things*.	TIC, patient-centered, and relationship-based framework.	Most of the patients stated that they were well cared for and felt safe during their visit. Survivors also appreciated making their own choices. However, many reported "long waits," "disjointed," "chaotic," "too many" providers, "conflicting" and "miss-information," and "confusion" about what to do after their acute care visit.

References

Haddad, M. (2017, May 9). *Victims of Rape and Law: How the Arab World Laws Protect the Rapist not the Victim.* Hentet May 2020 fra Jurist: https://www.jurist.org/commentary/2017/05/mais-haddad-arab-world-laws-protect-the-rapist-not-the-victim/

Maier, S. L. (2012). Sexual Assault Nurse Examiners' Perceptions of the Influence of Race and Ethnicity on Victims' Responses to Rape. *Feminist Criminology, 8*(2), 67-86 https://doi.org/10.1177/155708511254190.

Morse, S. M., & Decker, M. R. (2019, May 14). Response to sexual assault in Bogotá, Colombia: A qualitatie evaluation of health providers' readiness and role in policy implementation. *Health Care for Women International, 40*(11), 1249-1267 https://doi.org/10.1080/07399332.2019.1578776.

CARE = Coordinated Approach to Recovery and Empowerment **CSFW** = Center of Sexual and Family Violence **GBV** = Gender-based violence **MFE** = medical, forensic examination **PDS** = Posttraumatic Diagnostic Scale **PIRI** = Pleasant Imagery and Relaxation Instruction **PPRS** = Prevention of Post-rape stress **PTSD** = Post-traumatic stress disorder **QI** = Quality Improvement **SA** = Sexual assault **SADVTC** = Sexual Assault and Domestic Violence Treatment Center **SAMFE** = Sexual Assault Medical Forensic Examination **SANE** = Sexual Assault Nurse Examiner **TAU** = Treatment as usual **TIC** = Trauma-Informed Care

ATTACHMENT 4: CASP Checklists

The CASP-checklist tool has been used to critically evaluate the quality of the included articles. CASP stands for Critical Appraisals Skills Program and is specifically designed to help health care professionals systematically assess the trustworthiness, relevance and results of published papers (The Oxford Centre for Triple Value Healthcare, 2018). The checklists have been adapted to a word document where the questions and answers have been directly copied from the checklists. The articles are presented one and one with title and author.

Adult Sexual Assault Survivors' Experiences With Sexual Assault Nurse Examiners – Fehler-Cabral et al.

1. **Was there a clear statement of the aims of the research?** - YES
    a. Clearly stated in abstract and later in introduction
2. **Is a qualitative methodology appropriate? -** YES
    a. Exploring survivors experiences with SANEs, but also exploring how this affects them both positively and negatively

Is it worth continuing? - YES

3. **Was the research design appropriate to address the aims of the research?** - YES
    a. They want to bring insight into aspects not fully explored before. Not just a focus on what survivors viewed as positive in the acute care, but how this helped or hindered the healing process
4. **Was the recruitment strategy appropriate to the aims of the research?** - YES
    a. Two recruitment periods to ensure they had an appropriate population size which are described in detail
5. **Was the data collected in a way that addressed the research issue?** - YES
    a. Semi-structured interviews. Described how it was formed in detailed from previous studies, literature and pilot testing.
6. **Has the relationship between researcher and participants been adequately considered?** - NO
    a. Bias not discussed
7. **Have ethical issues been taken into consideration?** - YES
    a. Participants were given a consent form. Received information about further participation, before final participation. Approval from the Institutional Review Board of Michigan State University
8. **Was the data analysis sufficiently rigorous?** - YES
    a. Analysis described with the analytical instruments/methods used. Strauss and Corbin's "open coding". Then pattern coding. Saturation reached

9. **Is there a clear statement of findings?** - YES
    a. Reliability and validity maximised through several verification methods: sampling adequacy, triangulation, working in an iterative process whereby collecting and analyzing data occur simultaneously.
10. **How valuable is the research?**
    a. High, several verification methods. Adequate population. Discussion from several viewpoints. Participants received US$30 each, which might have affected participation

Defining the boundaries: How sexual assault nurse examiners (SANEs) balance patient care and law enforcement collaboration – Campbell et al.

1. **Was there a clear statement of the aims of the research?** – YES
    a. Stated clearly already in summary and repeated in introduction. Aims: How do SANEs define their work w/patients and law enforcement, and how do they negotiate roles differentiations?
2. **Is a qualitative methodology appropriate?** – YES
    a. This is a follow-up study to earlier quantitative research. Now they want to explore SANEs experiences where a qualitative method is suited

Is it worth continuing? – YES

3. **Was the research design appropriate to address the aims of the research?** – YES
    a. They have discussed earlier research which has led to the chosen study design and method
4. **Was the recruitment strategy appropriate to the aims of the research?** – YES
    a. As they wanted to look at SANEs connections with the law enforcement they wanted SANEs who were experienced with this work. However, a program director specifically pointed out 6 SANEs as the most experienced. Would it not be interesting to interview all 11 relevant SANEs as maybe years of experience could be an indicator of type of care they give?
5. **Was the data collected in a way that addressed the research issue?** – YES
    a. Semi-structured interviews. Analysis methods explained. Tape recorded. Data was saturated
6. **Has the relationship between researcher and participants been adequately considered?** – NO
    a. They might have considered this, but it has not been discussed in the article
7. **Have ethical issues been taken into consideration?** – YES
    a. Approval was given from the ethical review board of Michigan State University
8. **Was the data analysis sufficiently rigorous?** – YES
    a. What was not considered was researchers bias. The interviewer had a lot of experience with SANE programs, and though this might help in identifying

topics and questions to ask participants, it might color the discussions. This is not commented on in the article.

9. **Is there a clear statement of findings?** – YES
    a. They had more than one analyst. They present and discuss their findings according to the three aims they had.
10. **How valuable is the research?**
    a. The results are relevant locally. The research is related to earlier research and comments on further research. It is a small population so transfer value is low. The results builds on preexisting knowledge of care being central, but also comments on how nurses balance patient care and cooperation with law enforcement. It comments on how this study gives empirical evidence that a patient-centeres approach leads to more patients participating in the legal system. They discuss who the results are relevant for. Limitations of the study is also discussed where they point out small population size, participants from only one SANE program and only views from a community-based program.

Engaging the Voice of Patients Affected by Gender-Based Violence: Informing Practice and Policy – Lewis-O'Connor & Chadwick

1. **Was there a clear statement of the aims of the research?** - YES
    a. The goal is a quality improvement (QI) based on patients' experiences with SANEs.
2. **Is a qualitative methodology appropriate?** - YES
    a. The goal is a quality improvement (QI) based on patients' experiences with SANEs.

Is it worth continuing? – Yes

3. **Was the research design appropriate to address the aims of the research?** - YES
    a. A qualitative method is appropriate here, but since QI is sought out it is important with a big sample size, which they have
4. **Was the recruitment strategy appropriate to the aims of the research?** - YES
    a. Patients referred to the CARE clinic was asked to participate. Survivors of IPV and/or sexual assault were included. Contact over phone. Contact rate of 94%
5. **Was the data collected in a way that addressed the research issue?** - YES
    a. One-on-one interviews which were hand-recorded or audio-recorded. They asked all participants three questions, and patients relevant for MFE two extra ones. Saturation was met. Several analysts screening for new topics. When no new themes appeared they ended recruitment. Follow-up was done through text messages, as a modified method from phone calls since they were not able to reach a satisfying number of participants.
6. **Has the relationship between researcher and participants been adequately considered? -** NO

   a. This has not been discussed
7. **Have ethical issues been taken into consideration?** – YES
   a. As they had to modify contact method for follow-up this is discussed in detail in the study. They also recieved approval from an ethics committee
8. **Was the data analysis sufficiently rigorous?** – YES, Can't tell
   a. It mentions the method used for saturation, but the description is not in-depth. Also, there is a focus on how they knew they could stop the QI-process and start analysis, but not on topics which appeared during this analysis. Results are devided according to the questions asked, and not themes provided by the participants.
9. **Is there a clear statement of findings?** – YES
   a. The results are presented and discussed according to the questions asked in aims and which were asked patients. There are both positive and negative experiences. And points about the evidence collection is discussed from both sides.
10. **How valuable is the research?**
   a. Moderate to high. They point out that the results cannot be generalised. However, they believe other communities can come to similar results. The results are valuable as they have come with recommendations for care.

Investigating the medical forensic examination from the perspectives of sexually assaulted women – Du Mont et al.

1. **Was there a clear statement of the aims of the research?** – YES
   a. It could have been stated clearer, "The aim of the study is…". It is not clear enough when there is a need to read the introduction to really know what the aim is
2. **Is a qualitative methodology appropriate?** – YES
   a. The goal is to explore sexual assault survivors' experiences with the MFE and SANEs performing it

Is it worth continuing? – YES

3. **Was the research design appropriate to address the aims of the research?** – YES
4. **Was the recruitment strategy appropriate to the aims of the research?** – YES
   a. They sought out the program coordinators to help them get in touch with SA survivors. It was difficult to get in touch with the women. A lot said "yes" and then pulled-out at the last second
5. **Was the data collected in a way that addressed the research issue?** – YES
   a. Semi-structured, face-to-face interviews, with open and closed questions. Measures was taken to make sure the survivors would be okay during the interview. All practice and execution is described under method.

6. **Has the relationship between researcher and participants been adequately considered?** – NO
    a. They have not directly discussed the researchers' role and influences, but they have considered the interviewers responsibility and opportunity to make the survivors comfortable during the interviews.
7. **Have ethical issues been taken into consideration?** – YES
    a. In recruitment they did not contact possible participants if they feared that confidentiality was in danger of being broken. Participants were given information before the interviews about the study and the interview in itself. They had therapists on stand-by incase participants got distressed during the interview. They also made sure to call the women a few days later to make sure they had suffered no ill effects from the interview.
8. **Was the data analysis sufficiently rigorous?** – YES
    a. Analysis process described. They arrived at two main themes, with minor themes belonging to each of the main themes. All three authors analysed. Bias not discussed
9. **Is there a clear statement of findings?** – YES
    a. Results discussed according to themes and different points of view. More analysts were used, but no other considerations of credibility of their results other than the usual of a qualitative study with small research population and generalizability
10. **How valuable is the research?**
    a. Moderate. Qualitative study so small generalizability, but appropriate number of participants. Results are considered to earlier findings and further research.

Post-Sexual Assault Mental Health: A Randomized Clinical Trial of a Video-Based Intervention – Gilmore et al.

1. **Did the trial address a clearly focused issue?** – YES
    a. Clear population criteria, and intervention, clear comparison and outcomes considered in hypothesises
2. **Was the assignment of patients to treatments randomized?** – YES
    a. Participants were randomly assigned, but the method could not be blinded as it was a video shown
3. **Were all of the patients who entered the trial properly accounted for at its conclusion?** – YES
    a. All accounted for, participants analysed in respective groups. High drop-out rate

Is it worth continuing? – YES

4. **Were patients, health workers and study personnel "blind" to treatment?** – NO
    a. They could not be as it was a video, but participants were randomly assigned
5. **Were the groups similar at the start of the trial?** – YES

   a. Factors are accounted for in the analysis. No demographic or other differences.
6. **Aside from the experimental intervention, were the groups treated equally?** – YES
   a. All patients received treatment as usual, though the intervention group also got to watch the video
7. **How large was the treatment effect?** – YES
   a. Primary outcome clearly specified. Significant results are presented. Other results like age and ethnicity was discovered to have an impact and are also presented and discussed. There was no differences between treatment groups, significant differences were between previous SA or not
8. **How precise was the estimate of the treatment effect?** – YES
   a. 0.93-0.95
9. **Can the results be applied to the local population, or in your context?** – YES
   a. The results might be applied to other survivors of sexual assault, and is effective especially for those who have previous experiences with SA, but a universal use of the video intervention may not be warranted. What is a concern is the high drop-out rate, and the fact that the video condition was changed during the middle of trial process. In addition, they did not reach their recruitment goals. Further research on this would be interesting
10. **Were all clinically important outcomes considered?** – YES
   a. Considering PTSD and the purpose of the study all clinical important outcomes have been considered. What would have been interesting to discuss is whether the 9 min long video would be effective also for survivors not going through with a MFE as the video in this study was shown only for survivors receiving a MFE.
11. **Are the benefits worth the harms and costs?** – YES
   a. The question of how ethical it is to just show a video to someone who has undergone SA can be raised, but all participants did receive TAU which includes emotional and social support. It is cost-effective, and does not take a long time compared to other treatment methods like EMDRs
12. **Overall CASP:** LOW

Similar yet unique: the victim's journey after acute sexual assault and the importance of continuity of care – Hutschemaekers et al.

1. **Was there a clear statement of the aims of the research?** – YES
   a. Clearly stated in abstract and then in introduction
2. **Is a qualitative methodology appropriate?** – YES
   a. They want to examine responses of SA survivors.

Is it worth continuing? – YES

3. **Was the research design appropriate to address the aims of the research?** – YES

   a. To enable exploration, and the sensitive nature of the topics discussed, they wanted to do a qualitative study with semi-structured, face-to-face interviews.
4. **Was the recruitment strategy appropriate to the aims of the research?** – YES
   a. They did a purposive sampling as they wanted to obtain variety in ages, prior abuse, types of abuse and perpetrators and reporting to the police
5. **Was the data collected in a way that addressed the research issue?** – YES
   a. Timeframe and setting of interviews stated. Interviews either face-to-face or over phone based on patients' wishes. Interview guide provided so reader can see what the interviewer used as a structure
6. **Has the relationship between researcher and participants been adequately considered?** – NO
   a. Not discussed the researchers' role in choice of focus, analyzis and interviewing
7. **Have ethical issues been taken into consideration?** – YES
   a. Written informed consent was given, or oral consent on tape. Made clear participants do not have to answer all questions. Were informed and reminded of the crisis center's phone number if they needed anymore help after interviews were done.
8. **Was the data analysis sufficiently rigorous?** – YES
   a. Yes, for the most part. Missing out on contradictory data and whether or not the researchers potential bias has affected analysis and selection of for presentation
9. **Is there a clear statement of findings?** – YES
   a. Clearly divided into themes and clearly presented. Divided into short-term and long-term needs and expectations in addition to both positive and negative experiences**.**
10. **How valuable is the research?** – YES
   a. Highly valuable, have included earlier research and how this research will provide new perspectives and new type of data and focus. They identify where research is needed.

The Role of the Sexual Assault Nurse Examiner in England: Nurse Experiences and Perspectives – Cowley et al.

1. **Was there a clear statement of the aims of the research?** – YES
   a. Clearly stated in summary.
2. **Is a qualitative methodology appropriate?** – YES
   a. Exploring the role of the SANE in England. Not a goal to generalize, but to illuminate sides with the SANEs work with SA survivors.

Is it worth continuing? – YES

3. **Was the research design appropriate to address the aims of the research?** – YES
   a. They have justified their choice and explains what their purpose is
4. **Was the recruitment strategy appropriate to the aims of the research?** – YES

   a. They wanted SANEs with experiences since they wanted to explore the role thoroughly. Inclusion criteria of minimum 15 MFE within 180 days also explained. Explained why some did not participate even though they were supposed to at first.
5. **Was the data collected in a way that addressed the research issue?** – YES
   a. Method explained. Semi-structured interviews. Audio-recorded and transcribed verbatim. Saturation was not discussed.
6. **Has the relationship between researcher and participants been adequately considered?** – CAN'T TELL
   a. They have brought the researcher in and given them a notebook in order to get them interested and invested in the study, but it is not discussed whether or how this will affect the participants.
7. **Have ethical issues been taken into consideration?** – YES
   a. Approval was given by University of Leeds School of Healthcare Research Ethics Committee. Consent form was given prior to interviews.
8. **Was the data analysis sufficiently rigorous?** – YES
   a. Interview guide included. Thematic presentation explained, based on aim and research question. Bias not considered.
9. **Is there a clear statement of findings?** – YES
   a. Findings and discussion put together which makes it easy to follow the themes. Makes it easier to follow arguments both for and against.
10. **How valuable is the research?** – YES
   a. Low to moderate. Their considerations are thorough, but the population is still small. Valuable to get a look into the nurses point of view of the MFE and patient care as the patients' side is often explored.