Providing a supportive environment for disclosure of sexual violence and abuse in a sexual and reproductive healthcare setting: a realist review

**Abstract**

Background: Sexual and reproductive healthcare services [SRHS] are an environment where medical care relevant to sexual violence and abuse [SV] is available. However, barriers to disclosure need to be overcome to allow timely access to this care. There is limited research identifying and explaining how interventions remove barriers and create a safe and supportive environment for disclosure. The purpose of this review was to develop and refine theories that explain how, for whom and in what context SRHS facilitate disclosure.

Methods: Following published realist standards we undertook a realist review. After focusing the review question and identifying key contextual barriers, articles pertaining to these were identified using a traditional systematic database search. This strategy was supplemented with iterative searches.

Results: Searches yielded 3172 citations and 28 articles with sufficient information were included to develop the emerging theories. Four evidence-informed theories were developed proposing ways in which a safe and supportive environment for the disclosure of SV is enabled in SRHS. The theories consider how interventions may overcome barriers surrounding SV disclosure, at levels of individual, service-delivery and society.

Conclusions: Benefits of SRHS engagement with health promotion and health activism activities to address societal level barriers like lack of service awareness and stereotypic views on SV are presented. Although trauma informed practice and person-centered care were central in creating a safe and supportive environment for disclosure the review found them to be poorly understood and implemented.

**Keywords** sexual violence, realist review, sexual health, disclosure

Introduction

Sexual violence and abuse [abbreviated to SV] leaves people at increased risk of harmful sexual and reproductive health outcomes with links between SV and unwanted pregnancy, sexually transmitted diseases [STDs], HIV/AIDS, hepatitis B, recurrent urinary tract infection, pelvic pain and pelvic inflammatory disease as well as genital injury and trauma ([Caceres, Vanoss Marin, & Sid Hudes, 2000](#_ENREF_16); [Campbell et al., 2002](#_ENREF_17); [Grose, Chen, Roof, Rachel, & Yount, 2020](#_ENREF_27); [Jewkes, Dunkle, Nduna, & Shai, 2010](#_ENREF_35); [Johnson & Hellerstedt, 2002](#_ENREF_36); [Mota et al., 2019](#_ENREF_44); [Weiss et al., 2008](#_ENREF_63)). The psychological impact of SV is also well documented ([Dworkin, Jaffe, Bedard-Gilligan, & Fitzpatrick, 2021](#_ENREF_24)). Individuals affected by SV therefore need to be able to access appropriate healthcare to address and mitigate these poor health outcomes ([Linden, 2011](#_ENREF_38)).

Global standards exist for provision of healthcare after SV ([World Health Organization (WHO), 2013](#_ENREF_66)) and there is a clear need for a holistic and integrated response to sexual health care ([Satcher, Hook, & Coleman, 2015](#_ENREF_55)). Sexual and reproductive health services are a setting where appropriate healthcare following SV is commonly available and is the focus of this review.

In the United Kingdom, a national network of sexual and reproductive health services [SRHS], similar to the Planned Parenthood services in America [<https://www.plannedparenthood.org>], offer a range of STD and blood borne virus testing, treatment and management, and a full range of contraceptive provision, along with health promotion and prevention activity. These services also play an important referral point for other services related to SV, for example, for forensic medical examination, social welfare support, community mental health support and legal aid.

Despite services being available many people experiencing SV do not seek any type of health care or other support, and some wait years before disclosing SV ([Truman, 2013](#_ENREF_59)). Reasons for non-disclosure are complex but include fear of negative reactions, victim-blaming [where the victim is fully or partially held responsible for the harm that occurred, including questioning what they might have done to avoid it], fear of retaliation and shame ([Lanthier, Du Mont, & Mason, 2018](#_ENREF_37)). Interventions within SRHS can promote and facilitate disclosure by creating a safe environment where people feel able to speak out, where they recognize they will be believed and not judged and where they feel in control of their future health decisions. The aim of this review is to identify why, how, for whom, and in what circumstances can SRHS provide this environment. Despite the review focusing on SRHS, and in keeping with realist methodology, the findings are also likely to be transferable to other healthcare settings.

**Method**

*Realist review*

To address the aims of the review, we followed a realist approach as opposed to the traditional systematic review process; as such, the review is theory led, purposive, iterative and with stakeholder involvement in the form of an advisory group and key informant interviews ([Wong, 2013](#_ENREF_65)). We chose a realist approach rather than a traditional systematic review because we wanted to examine the influence contextual barriers have on disclosure and how interventions work to overcome them. The link, or in realist terms, the mechanism [M], between the context [C] and outcome [O] was sought, to provide a generative understanding of causality ([Pawson, 1997](#_ENREF_50)). During this review, intervention [I] is added to the heuristic CMO [Context-Mechanism-Outcome] making CIMO, to allow for a clearer demarcation between an intervention and the mechanism that unpacks why an intervention may or may not work ([Wong, 2013](#_ENREF_65)). Although interventions in SRHS may work for some to provide a safe and supportive healthcare environment, because of the complexity of SV and disclosure, these interventions may not work in all cases and the realist approach is therefore useful in understanding the contexts where the mechanisms are enabled [or not enabled] to bring about change. The CIMO configurations identified during the review were used to develop and refine program theories. Program theories in realist terms are theories of how an intervention works given the contextual influences and underlying mechanisms of action.

*Initial review stages*

The review protocol is registered with the international review database, PROSPERO [unique ID number CRD42019129986]1. In keeping with realist review standards, the published protocol describes how the review was focused after exploratory scoping of the literature and initial CMOs described ([Caswell, Ross, Maidment, & Bradbury-Jones, 2020](#_ENREF_18" \o "Caswell, 2020 #10878)). The advisory group met to plan and discuss findings at each stage of the review. Its members included patient advocates, researchers and other stakeholders recruited who had a range of experience and expertise in the care of people after disclosure of SV, and with experience in the use of different research methods.

*Search criteria and appraisal of evidence*

Subsequently a systematic literature search was performed using broad search terms relating to ‘sexual violence’ AND ‘disclosure’ AND ‘sexual healthcare’. Nine databases were searched [PRISMA diagram, Appendix 1] ([Page et al., 2021](#_ENREF_48)): AMED [Allied and Complementary Medicine], BNI [British Nursing Index], CINAHL [Cumulative Index of Nursing and Allied Health Literature], Cochrane database, Embase, HMIC [Health Management Information Consortium], MEDLINE, PsycINFO and PubMed. Citation tracking was used in SSCI [Social Sciences Citation Index] via the Web of Science, Scopus and Google Scholar, and reference list screening of included studies.

Articles were included for full text review if they related to the context, intervention, mechanism or outcome [CIMO] in line with the published protocol and could assist in theory-building. Full text articles were not rejected based on the type of evidence, but consideration was given to how each article might contribute to theory-building in response to the review question [relevance]. For example, Meier’s work scored ‘high’ in relevance as their research question, considering how previous sexual abuse impacted on reproductive health care experience and access, was closely matched to our review question ([Meier et al., 2020](#_ENREF_43" \o "Meier, 2020 #10890)). Studies were also assessed in terms of rigor as to whether the study design was robust enough, for example, in supporting the studies outcomes. The review authors’ weighting was then applied in interpreting data whilst developing program theories. Finally, each article was considered for its richness, defined as the ‘degree of theoretical and conceptual development that explains how an intervention is expected to work’ ([Booth et al., 2013](#_ENREF_14" \o "Booth, 2013 #5966)). The relevance, rigor and richness for each article was assessed as high, moderate or low, along with any significant limitations [Table 1].

Due to the iterative nature the realist review, additional informal literature searches continued throughout the review process adding greater depth and understanding to the developing program theories. Referred to as cluster searching, these increased the richness and depth of understanding of both context and mechanisms ([Booth et al., 2013](#_ENREF_14)). These additional searches used different terms from the systematic searches and developed a richness around prominent emerging factors that have key roles in creating a safe and supported environment for disclosure. For example, as the review progressed it became clear that ‘routine inquiry’ [asking people routinely about SV whether or not there are indicators of such abuse, also referred to as ‘screening’ or ‘routine enquiry’] was a key intervention with the potential to address some of the contextual barriers. Key informant interviews and advisory group meetings further assisted with program theory development. Appendix 1 outlines the overall search process for this realist review.

*Data Extraction*

For each article identified by the initial or cluster searches, the following descriptors were collected where applicable: year of publication, country, data type, group under study, health setting and a brief summary of findings. NVivo® software for Mac [V.12] was used to organize the data into themes and then to collate it into CIMOs. Key findings from each article identified in relation to CIMO are presented in Table 1.

*Synthesis process*

The initial synthesis stage involved considering how the articles addressed the review question in terms of CIMO and we considered a variety of interventions that supported the creation of a safe and supportive environment. As many of the articles focused on context, another aspect at this stage was to consider *how and why* the contexts created significant barriers. We abstracted mechanisms for CIMO configurations using retroduction, a key principle in realism, described by Jagosh as:

the activity of theorizing and testing for hidden causal mechanisms responsible for manifesting the empirical, observable world [p.121] ([Jagosh, 2020](#_ENREF_33" \o "Jagosh, 2020 #11330)).

As part-formed theories emerged from the literature, the expert opinions of service users, advocates and researchers from the advisory group combined with key informant interviews [n=4], helped steer theory development by prioritizing findings. Each key informant provided us with a different perspective on SRHS [they included a chief executive officer of a voluntary sexual violence specialist service, a patient who attended SRHS after sexual violence and two doctors experienced in working in SRHS]. With consent, each interview was recorded, transcribed and analyzed using a realist lens. This data provided further clarity on findings from the literature review, highlighting important aspects of care and helped steer early theory development. Evidence-informed theories about how and why attributes of SRHS optimised safe and supported disclosure of SV for particular groups of adults in certain contexts were generated.

**Results**

Twenty-eight articles were included [Table 1]. In addition to primary data studies, the review contains six review articles, one published national standard, one website and one article reviewing a service. The majority were based in the USA [n=19] and the other articles were from UK [n=4], Canada [n=2], Sweden [n=1], Australia [n=1], Netherlands [n=1]. Four studies were set in Sexual and Reproductive health settings while others were set in community and mental health, Sexual Assault Referral Centers [SARC], college-based healthcare, tertiary or mixed healthcare settings. Studies focused predominately on females [n=17] with the others including data from males or both male/female [n=4] or from healthcare professionals [n=5]. The included website and national standard addressed all genders. The majority reported on SV [n=26], however 2 articles focused on domestic abuse with interventions applicable to SRHS. The findings are presented in Appendix 3 with the differing contexts at individual, service and societal levels, diagrammatically represented by the enlarging and overlapping circles that can only be overcome by interventions that generate significant change. The cluster searches identified four articles, included in the overall total of 28 articles, two set in the field of domestic abuse using routine inquiry, another reporting survey results regarding the use of routine inquiry and SV, and an article outlining trauma-informed care in a clinic for ‘female survivors of sexual violence’ ([Ades et al., 2019](#_ENREF_1); [Bacchus et al., 2010](#_ENREF_5); [Bacchus, Buller, Ferrari, Brzank, & Feder, 2018](#_ENREF_6); [Littleton, Berenson, & Breitkopf, 2007](#_ENREF_39)).

We developed and refined four initial program theories using the review articles, key informant interviews and input from the advisory group. CIMO notations are added.

*Theory 1*

*Healthcare services should consider health promotion and health activism activities [I] to challenge rape myths, stereotypes and gender inequalities [C] so people realise they will be validated and believed [M] if they choose to disclose SV at SRHS [O] irrespective of non-stereotypic presentations of SV or their background.*

Multiple barriers to disclosure of SV persist at a societal level. Ten review articles highlight these contextual barriers ([C. Ahrens, Stansell, & Jennings, 2010](#_ENREF_2); [Amin, Buranosky, & Chang, 2017](#_ENREF_4); [Backes, 2016](#_ENREF_7); [Baker, 2012](#_ENREF_9); [Donne et al., 2018](#_ENREF_22); [Jancey, Meuleners, & Phillips, 2011](#_ENREF_34); [Logan, 2005](#_ENREF_40); [Munro, 2015](#_ENREF_45); [National Sexual Violence Resource Center, 2018](#_ENREF_46); [Ullman & Townsend, 2007](#_ENREF_61)). Stereotypical views of SV create barriers to disclosure, for example by people not recognizing SV or by fearing they will not be believed when they fall outside the “classic rape scenario”:

Survivors who experience assaults that conform to “classic rape” scenarios [e.g., involving strangers, weapons, and severe injuries] are more likely to disclose. [The study] results suggested that *non-disclosers* experienced more non-stereotypical assaults and were more likely to not initially consider the assault to have been rape than the other groups. [p.632 & p.642] ([C. Ahrens et al., 2010](#_ENREF_2" \o "Ahrens, 2010 #9378))

One excerpt describes a ‘disbelieving system’ faced by those not falling into the “classic rape scenario” resulting in environments that are neither safe nor supportive:

Therefore, a woman reporting a rape by a family member, friend, or acquaintance does not fall into the stereotypical rape scenario [e.g., stranger offender, severe injury, weapon use, physical helplessness] and is faced with a disbelieving system that questions her motive for reporting [p.113] ([Backes, 2016](#_ENREF_7" \o "Backes, 2016 #10762))

Some groups may be impacted more than others by stereotypical views on SV.

The societal stigma around being “weak” and “not masculine enough” prevent men from talking about their experiences. According to one participant, this causes men to be ashamed. “They’re ashamed of what happened and what people might think of them, you know?” [p.195] ([Donne et al., 2018](#_ENREF_22" \o "Donne, 2018 #10021))

Key informant interviewee 03 agrees societal norms create additional barriers to men disclosing SV:

What makes it difficult is that stereotypical patriarchal message that women are nurturing and men are strong. So those two things automatically become a barrier to that male saying, ‘I have been sexually abused and it was my mother’

Where overlapping discrimination and disadvantage stemming from race, class and gender exists then further challenges to disclosure and access of healthcare results ([Crenshaw, 1994](#_ENREF_20" \o "Crenshaw, 1994 #11378)). Intersectionality includes many additional characteristics such as sexuality, gender, religion, disability and age ([Dill & Kohlman, 2012](#_ENREF_21" \o "Dill, 2012 #11391)), which are seen frequently in those attending SRHS and influence their ability to access help:

One theme cut across both the interviews and the focus group discussions and thus merits special focus: how existing at the intersection of multiple stigmatized identities influences recognizing and support-seeking around sexual violence. Experiences at the intersections among sexual orientation, gender identity, and race/ethnicity were raised by participants from both the interviews and the groups [p.197] ([Donne et al., 2018](#_ENREF_22" \o "Donne, 2018 #10021))

The effects of intersectionality may also negate attempts by professionals to create a safe and supportive environment.

It is much more difficult for advocates to combat not only rape stereotypes affecting all rape survivors but also additional stereotypes about “less deserving” rape victims who because of age, race, sexual orientation, occupation, mental illness, or immigration status are viewed as unworthy of the system’s attention or response.[p.420] ([Ullman & Townsend, 2007](#_ENREF_61))

Theory 1 recognizes the need to challenge societal norms that have resulted in barriers to care, and as one article reflects;

These barriers suggest that there is much work to be done in rural areas around educating the community, coordinating service system, and changing norms and attitudes to be supportive of survivors of rape seeking services. The difficulty is that there are no clear pathways on how best to address these strongly ingrained attitudes and reactions at this time [p.22]([Logan, 2005](#_ENREF_40))

Three of the review articles contained standards or policy that acknowledge the need to recognize and address barriers that exist beyond the immediate medical needs of individuals ([Baker, 2012](#_ENREF_9); [Healthcare Improvement NHS Scotland, 2017](#_ENREF_30); [National Sexual Violence Resource Center, 2018](#_ENREF_46)). Whilst no article detailed specific interventions for SRHS to employ to challenge the harmful social norms within their communities we have identified contemporary health promotion, health activism and health marketing to be worth considering ([RCOG, 2022](#_ENREF_52" \o "RCOG, 2022 #11389); [Subramanian & Weare, 2020](#_ENREF_57" \o "Subramanian, 2020 #11390)).

*Theory 2*

*People who experience sexual violence and those who informally support them, may be unaware of services, what they offer and how to access them [C]. By promoting SRHS with due consideration to the message and media used [I], people’s knowledge and confidence [M] in being able to access care in a safe and supported environment will improve disclosure [O].*

A total of 11 articles supported this theory with 3 referring to the lack of awareness of services ([Halstead, Williams, & Gonzalez-Guarda, 2017](#_ENREF_29); [Logan, 2005](#_ENREF_40); [Munro, 2015](#_ENREF_45)), 7 to the importance of messages used ([Amin et al., 2017](#_ENREF_4); [Bicanic, Hehenkamp, van de Putte, van Wijk, & de Jongh, 2015](#_ENREF_12); [Donne et al., 2018](#_ENREF_22); [Du Mont, Woldeyohannes, Macdonald, Kosa, & Turner, 2017](#_ENREF_23); [Halstead et al., 2017](#_ENREF_29); [Olsen, Majeed-Ariss, Teniola, & White, 2017](#_ENREF_47); [Patterson, Greeson, & Campbell, 2009](#_ENREF_49)) and 3 that considered the choice of media ([Bacchus et al., 2018](#_ENREF_6); [Patterson et al., 2009](#_ENREF_49); [Sabina & Ho, 2014](#_ENREF_54)).

Services offering support after SV should be promoted so people are knowledgeable and feel confident in accessing care.

[]([Munro, 2015](#_ENREF_45" \o "Munro, 2015 #10821))

...there is a need to expand the availability of services for sexual assault victims and to better market currently available services [p.19] ([Logan, 2005](#_ENREF_40" \o "Logan, 2005 #10831)).

SRHS offer a range of medical care after SV including those required to be given in a timely manner such as PEPSE [Post-Exposure Prophylaxis to HIV after Sexual Exposure], emergency contraception and hepatitis B vaccination for post-exposure use. Messages need to address these potential physical health consequences of SV;

Education may include medical information on rape-related pregnancy and STDs, as well as the need for timely emergency contraception and prophylaxis, given that these concerns appear to be facilitators of seeking medical help ([Zinzow, Resnick, Barr, Danielson, & Kilpatrick, 2012](#_ENREF_69)) as referenced [p.7] ([Bicanic et al., 2015](#_ENREF_12))

Theory 2 means tailoring the message to reach the communities served by SRHS with recognition of less easily reached groups.

If you're a disabled survivor I think you're even more invisible because you're not supposed to be having sex in the first place. Sorry, that's kind of the message that we get around disability, physical and learning disability. So, we have just got to make sure I think whatever response we try as far as possible to make sure the broad every group of survivors is acknowledged and their particular barriers and needs and understood [Key informant interviewee 03]

A study from a SARC in the United Kingdom considered those with learning disabilities as a group often not identified as candidates for their service. They recommend outreach work to

..raise awareness of the increased vulnerability to sexual assault for people with learning disabilities as well as services that can support them [p.243]([Olsen et al., 2017](#_ENREF_47" \o "Olsen, 2017 #10785))

Other communities, like some ethnic minority groups, are also less likely to be reached through the usual channels of communication ([Holmes, 2021](#_ENREF_32" \o "Holmes, 2021 #11388)) and ‘effective signposting to services’ is needed ([H. Rodger, 2020](#_ENREF_28" \o "H. Rodger, 2020 #11387)). This will involve an appreciation of cultural differences, careful choice of imagery, of languages used, and consideration of the degree of illiteracy within different communities and the strengths of oral messaging. Social media platforms such as TikTok, Instagram and Facebook and dating apps Tinder, Grindr, Bumble were not covered in the included articles but will be important to consider in reaching wider groups of people.

The messages in promotional material should also address *how* care is provided in order to safely navigate internal barriers such as fear and embarrassment. People need to feel trust in the HCP before they choose to disclose.

The findings of the current study would suggest that a social marketing plan should address survivors’ concerns about help seeking, such as loss of privacy and fear of services intensifying their emotions to an unmanageable level [p.134] ([Patterson et al., 2009](#_ENREF_49" \o "Patterson, 2009 #10842))

[In addition], emphasizing the availability of confidential help or developing anonymous services may address fears around being identified as a victim or being outed as someone who has sex with men or as a male who experienced sexual violence from a female [p.198] ([Donne et al., 2018](#_ENREF_22" \o "Donne, 2018 #10021))

*Theory 3*

*Trauma informed practice and person-*centered *care [I] induce a change of culture and practice in SRHS creating a safe and supportive environment for disclosure [O]. Healthcare professionals trained and supported using these approaches will feel confident and equipped [M] to support people attending the service. People attending the service will be aware it is a safe place where they will be believed, validated and in control of their healthcare options [M] if they choose to disclose.*

Trauma informed practice [TIP] involves adhering to principles rather than a list of actions or procedures, and is well-documented in the literature ([Covington, 2008](#_ENREF_19); [Hegarty, Tarzia, Hooker, & Taft, 2016](#_ENREF_31); [Substance Abuse and Mental Health Services Administration (SAMHSA), 2014](#_ENREF_58); [Wycoff & Matone, 2019](#_ENREF_67); [Zelin, Cadman, Amara, Marnoch, & Vosper, 2017](#_ENREF_68)).

The trauma-informed approach is guided four assumptions, known as the “Four R’s”: Realization about trauma and how it can affect people and groups, recognizing the signs of trauma, having a system which can respond to trauma, and resisting re-traumatization. The trauma-informed approach also operates under six key principles: Safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues ([Substance Abuse and Mental Health Services Administration (SAMHSA), 2014](#_ENREF_58)) p9

Person-centered care [PCC] promotes shared decision making ([Barry & Edgman-Levitan, 2012](#_ENREF_10" \o "Barry, 2012 #11360)). PCC is also considered to be culturally competent and in practice involves an awareness of;

identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism, among other factors [p34] ([Epner & Baile, 2012](#_ENREF_26))

The standards set by NHS Scotland for ‘[Heatlthcare] Services for People who have experienced Rape, Sexual Assault or Child Sexual Abuse’ emphasize that people should receive ‘person-centered and trauma-informed care’ ([Healthcare Improvement NHS Scotland, 2017](#_ENREF_30)) but it remains challenging to incorporate it successfully into healthcare settings.

17 articles are used in the development of theory 3 ([Ades et al., 2019](#_ENREF_1" \o "Ades, 2019 #11314); [Bacchus et al., 2010](#_ENREF_5" \o "Bacchus, 2010 #11324); [Bacchus et al., 2018](#_ENREF_6" \o "Bacchus, 2018 #11326); [Baker, 2012](#_ENREF_9" \o "Baker, 2012 #10834); [Healthcare Improvement NHS Scotland, 2017](#_ENREF_30" \o "Healthcare Improvement NHS Scotland, 2017 #10127); [Littleton et al., 2007](#_ENREF_39" \o "Littleton, 2007 #5413); [Logan, 2005](#_ENREF_40" \o "Logan, 2005 #10831); [Meier et al., 2020](#_ENREF_43" \o "Meier, 2020 #10890); [National Sexual Violence Resource Center, 2018](#_ENREF_46" \o "National Sexual Violence Resource Center, 2018 #10833)) *[need to add the other articles here]* For change to occur TIP and PCC will need to employ a range of strategies to overcome barriers to safe disclosure. TIP and PCC will also need service-wide implementation and not isolated piecemeal changes:

..studies focused on the reactions of formal support providers often do not address the overall process of service seeking and utilization, including the possible need to disclose the nature of their problems to clerical personnel or having to repeatedly tell their stories to “get in the door” to services, and how that process can affect women [p.20]([Logan, 2005](#_ENREF_40))

This was echoed by key informant interviewee 04 having accessed SRHS on multiple occasions, she describes her interaction with reception staff in order to make an appointment:

You have to phone the receptionist…they often go, ‘is it serious?’ and then at that point they will expect you to explain it, but … you don’t want to explain it.

Adaptations within the healthcare environment are also needed. For example, a study from St Mary’s SARC identified some simple adjustments that they believe help people with learning disabilities in attending:

Suggestions ranged from having clearer signposting, easy read literature and pictures available in waiting areas… ([Olsen et al., 2017](#_ENREF_47" \o "Olsen, 2017 #10785))

This safe environment was further developed during a review:

Create an environment to support disclosure. The importance of being able to speak with the survivor in a private, safe, and supportive environment and ‘‘not rushing’’ [p.11]([Lanthier et al., 2018](#_ENREF_37))

A key mechanism will be people realizing they are believed, safe, and disclosures expected and welcomed, as key informant interviewee 03 explains:

I think it's also giving the message that ‘I believe you’, because people will have disclosed before and won’t have been believed

The environment must be conducive to ensuring choice is available. Many of the suggestions provided by Wadsworth focus on empowering patients:

Allow patients to choose their nurse practitioner or other health care provider; Allow patients to remain fully clothed p.4

For some participants in this sample, having a male health care provider exacerbated feelings of powerlessness ([Wadsworth, 2019](#_ENREF_62" \o "Wadsworth, 2019 #7175))

Healthcare professional training is a vital component of Theory 4. Benefits of specialist training were recognized in a study focused on asking about and responding to disclosure of domestic abuse:

training programme results were promising, with demonstrable improvements in health professionals' knowledge and clinical practice ([Bacchus et al., 2010](#_ENREF_5" \o "Bacchus, 2010 #11324))

However, for the training to ensure people feel they are believed, supported and in control, it needs to encompass more than medical competencies. The training will need to involve a change to the consultation style and approach, educate on how to provide safe responses to disclosure and give HCP an awareness of how to avoid or minimize re-traumatization [also referred to as secondary victimization]. Furthermore, specialist training should challenge those HCP who, perhaps inadvertently, hold to rape myths. Key informant interviewee 03, Chief Executive Officer of a specialist rape and sexual abuses support center supports specialist training being given to HCP in SRHS:

I think the other thing […] in terms of training and making sure there's some specialist training where staff have [medical] knowledge, but also have an opportunity to have some of their own victim blaming and their own understanding of sexual violence and abuse challenged and changed.

Current healthcare training and resultant consultation style uses a medical model not always lending itself to acknowledge and respond to the impact of psychological trauma. The traditional western practice of medicine has focused on a hierarchical doctor patient relationship with the physician as expert, diagnosing, prescribing and managing conditions.Sharma argues this patriarchal approach to medical education is extant and continues to be the dominant approach to teaching and practice of medicine ([Sharma, 2019](#_ENREF_56)). It does not lend itself to creating a safe response to SV:

Healthcare providers are trained to diagnose and treat those who are ill and are also accustomed to people adhering to management and treatment. However, this method of healthcare can be counterproductive when working with victims of sexual assault as it may be like the controlling behaviour of a perpetrator and may heighten the risk of secondary trauma [p.9] ([Jancey et al., 2011](#_ENREF_34" \o "Jancey, 2011 #7260)).

In contrast to the more traditional approach, person-centered care promotes shared decision making ([Barry & Edgman-Levitan, 2012](#_ENREF_10" \o "Barry, 2012 #11360)). Theory 3 proposes HCP training within SRHS should not only cover the specifics of the medical care of a patient after SV but should require HCP to undergo training in *the approach* to care ([Elisseou, Puranam, & Nandi, 2019](#_ENREF_25" \o "Elisseou, 2019 #11355)).

Within SRHS much of the ‘routine’ aspects of care such as history taking, taking of STD tests and genital examination require a trauma-informed approach if a safe environment is be maintained. HCPs should be aware of how previous trauma can impact a person attending for care and should tailor their consultation and examination accordingly [[Ades et al., 2019](#_ENREF_1" \o "Ades, 2019 #11314)]. This is reiterated by key informant interviewee 03:

[the] professional might also have some trauma informed knowledge and understand that some of the things which people will be coming for, to sexual health, like tests for STI [STD], may potentially be triggering, really traumatizing and difficult.

For example, if HCPs are practicing person-centered care, the balance of control and health choices should rest with the ‘patient expert’, and declining testing, treatment or onward referral may be part of that.

If, after the discussion of trauma, the patient seems too upset or apprehensive to tolerate an examination, she is offered the opportunity to defer the examination to a later visit. Emphasizing the control that the patient has over her medical care is one of the foundations of a trauma-informed care approach ([Raja, Hasnain, Hoersch, Gove-Yin, & Rajagopalan, 2015](#_ENREF_51))[p.805]([Ades et al., 2019](#_ENREF_1))

The training for HCP should emphasize the importance of their attitude and demeanour during the consultation as key informant interviewee 04 explains, ‘you definitely don’t want to tell it [experience of sexual violence] to anyone unsympathetic or untrained’. This is in keeping with findings from included review articles:

…the manner in which help is provided is at least equally as important as the type of assistance rendered [p.9] ([C. E. Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007](#_ENREF_3" \o "Ahrens, 2007 #10120)).

The training should also prompt awareness among HCPs of how differences between them and the person disclosing can have an impact:

A culturally competent health-care provider is sensitive to potential power differences between themselves and the survivor and shows a general level of sensitivity to diverse communities ([Long, Ullman, Long, Mason, & Starzynski, 2007](#_ENREF_41); [Roberts, Watlington, Nett, & Batten, 2010](#_ENREF_53)) as referenced [p.4] ([Lanthier et al., 2018](#_ENREF_37))

People believe that seeking assistance from formal systems means exposing themselves to additional psychological harm.

[One participant reported] “I heard before like at the hospital, they make you feel like it’s your fault” [p.132] ([Patterson et al., 2009](#_ENREF_49" \o "Patterson, 2009 #10842))

Choosing not to seek help can be a self-protective mechanism as people fear re-traumatization by HCP in response to their disclosure. The response to a disclosure therefore should be carefully considered;

..nurses need to be self-aware of the way in which they react to students who disclose, ensuring that they do not react insensitively, place blame and/or express doubt. …recommendations have been made for providers to be trained in trauma-sensitive/ informed care [e.g. White House 2014a, U.S. Department of Education Office of Safe and Healthy Students [OSHS] 2015] [p.14] ([Halstead et al., 2017](#_ENREF_29))

Disclosures should be validated and the HCP should avoid negative responses such as victim-blaming;

In a study conducted by Ullman ([Ullman, 1996](#_ENREF_60" \o "Ullman, 1996 #10117)), 10% of women cited not being blamed as the most helpful response they received from a formal support provider, including health-care providers [p.10] ([Lanthier et al., 2018](#_ENREF_37" \o "Lanthier, 2018 #49))

Another aspect of PCC is the need to positively embrace the differences in people’s backgrounds and create environments that promote inclusivity. The importance of paying attention to the diversity of people who experience SV is highlighted by key informant interviewee 03

Anything that's out of the ‘norm’ [white male physically able mentally able]. I think we don't hear those voices. We don't acknowledge those minority groups, those people, they haven't got as much power. And I think that gets reflected in not hearing what they've been subjected to

One strategy considered here in more detail is routine inquiry, where all who attend when safe to do so are asked if they have experienced SV and would like support. Routine inquiry can support TIP by normalizing disclosure no matter what a person’s background and helps avoid stereotypic rape assumptions. Routine inquiry, as a clinic procedure is addressed in the following articles [([C. Ahrens et al., 2010](#_ENREF_2); [C. E. Ahrens et al., 2007](#_ENREF_3); [Bacchus et al., 2018](#_ENREF_6); [Berry & Rutledge, 2016](#_ENREF_11); [Lanthier et al., 2018](#_ENREF_37); [Littleton et al., 2007](#_ENREF_39); [Meier et al., 2020](#_ENREF_43); [Wadsworth, 2019](#_ENREF_62); [Wendt, Marklund, Lidell, Hildingh, & Westerstahl, 2011](#_ENREF_64)) three of which were identified during the CLUSTER searches to provide more explanatory power to the this developing theory ([Bacchus et al., 2010](#_ENREF_5); [Bacchus et al., 2018](#_ENREF_6); [Littleton et al., 2007](#_ENREF_39)). The following excerpts provide reasons to support this practice:

In our study we found that women desired to be screened for sexual violence, but there was a lack of screening performed by healthcare professionals [p.561]([Berry & Rutledge, 2016](#_ENREF_11)) .

The women believed that it would be easier if health professionals initiated a dialogue about sexuality and sexual abuse, as they found it difficult to raise such issues themselves [p.4] ([Wendt et al., 2011](#_ENREF_64)).

Additional reasons for not disclosing sexual assault included that their physician did not ask [27%] [p.9]([Lanthier et al., 2018](#_ENREF_37); [Mazza, Dennerstein, & Ryan, 1996](#_ENREF_42)) .

Some articles capture the patient voice in support of routine inquiry. In a study by Wadsworth looking at healthcare seeking after sexual assault, routine inquiry is addressed by one of the interviewees:

I didn’t plan on telling anyone. But I did want to get STDs [Sexually transmitted disease] checked.... I made an appointment with the doctor.... She was asking me questions and, I said, “you don’t need to know, I just need to get STD testing.” ... I guess she sensed something isn’t right ... she said, “Was it consensual?” My reply was “barely.” ... It was a good thing, because she referred me to [SA services organization] [p.3] ([Wadsworth, 2019](#_ENREF_62))

However not all are happy to be asked about previous experiences of SV:

[]([Wendt et al., 2011](#_ENREF_64" \o "Wendt, 2011 #2340))

There were fewer studies looking at men and routine inquiry. Using cluster searches we looked to similar fields to develop this aspect of the theory. A study considering domestic abuse inquiry by sexual health practitioners with gay and bisexual men found that selective inquiry [inquiry where there is a suspicion or concern the person is experiencing abuse] was preferred over routine inquiry.

A third of men in the survey supported routine inquiry for DVA [domestic violence and abuse], while two thirds preferred selective inquiry [i.e., asking in the context of symptoms or conditions that are consistent with experiences of DVA] ([Bacchus et al., 2018](#_ENREF_6" \o "Bacchus, 2018 #11326))

One reason, provided in subsequent interviews by these men, was they felt concerned HCP would focus on the abuse disclosure and not the sexual health reason that led to their attendance ([Bacchus et al., 2018](#_ENREF_6)).

These objections highlight that routine inquiry will not create a safe and supported environment for disclosure in and of itself, but only support it when set in a culture of TIP and PCC. Establishing the person’s priorities for the consultation and being sensitive to their wishes will help alleviate some concerns regarding routine inquiry. Highlighting the importance of training for routine inquiry as part of TIP and PCC, key informant interviewee 01 [HCP working in SRHS] says:

So, we don't let people [HCP] ask it [routine inquiry about SV] unless they've had the training, they just don't ask. It's better not to.

*Theory 4*

*Lack of joined up care [C] creates barriers to safe and supported disclosure of SV. Effective partnership working and robust referral pathways to medical, psychological, social, forensic and legal services [I], result in people feel valued, understood and supported [M] after disclosure [O] as their needs are considered and provided for holistically.*

Six review articles support this theory ([Ades et al., 2019](#_ENREF_1); [Amin et al., 2017](#_ENREF_4); [Bacchus et al., 2018](#_ENREF_6); [Du Mont et al., 2017](#_ENREF_23); [Lanthier et al., 2018](#_ENREF_37); [Wendt et al., 2011](#_ENREF_64)). Processes are needed within SRHS to ensure people are offered appropriate services after disclosure. As Lanthier points out:

Healthcare providers are uniquely positioned to assist adolescent and adult women survivors of past sexual assault by providing relevant health care and acting as an important gateway to other support services ([Lanthier et al., 2018](#_ENREF_37" \o "Lanthier, 2018 #49)).

It is important those offered additional support do not feel overwhelmed or confused with the myriad of possible referral options ([Birdi et al., 2022](#_ENREF_13" \o "Birdi, 2022 #11385)). The referral process needs to be straightforward and without additional hurdles in accessing additional support. This coordination of care is also recognized as an element of TIP;

Developing interprofessional relationships with other providers who have specific training in trauma and coordinating patient care with those individuals is another important application of trauma-informed care [p.5] ([Ades et al., 2019](#_ENREF_1" \o "Ades, 2019 #11314)).

Having different therapeutic options available can support the use of routine inquiry and people should be made aware there are onward referral options if they decided to disclose. HCPs will also feel more confident in inviting disclosures if they know the referral processes:

Provider fear of opening “Pandora’s box” could be overcome by increasing knowledge of care roles, such as providing referrals. Residents in one study who were aware of referrals for intimate partner violence [IPV] were 3.54 times more likely to ask about IPV ([Baig, Shadigian, & Heisler, 2006](#_ENREF_8" \o "Baig, 2006 #11363)). This correlation between IPV referral knowledge and screening practices may hold true for sexual assault ([Amin et al., 2017](#_ENREF_4" \o "Amin, 2017 #10761)) p47

Robust partnerships and referral pathways are also recognized by patient groups as a prerequisite to routine inquiry:

Men felt that inquiry for DVA should not take place without available resources, which could potentially be provided by the clinic. For example, having a link to a local DVA organization with an identified advocate for the clinic [p.239] ([Bacchus et al., 2018](#_ENREF_6)).

This does mean that the additional services should be accessible to those that need them. Some may find further barriers to services, for example due to waiting lists, financial cost or other unrecognized barriers faced by some groups:

Counselling is available to all patients who have attended St Mary’s SARC following a sexual assault…These figures suggest that people with learning disabilities who have experienced sexual assault or rape were 50% less likely to access counselling than people without learning disabilities [p.242] ([Olsen et al., 2017](#_ENREF_47)).

SRHS must have robust pathways to provide safe and supportive environment for some disclosures in particular:

As survivors of sexual assault by a current or former intimate partner can suffer serious consequences, with more severe violence perpetrated against them than those sexually assaulted by other assailants, health services responding to these women need to be sure to provide a comprehensive range of care options, particularly those that address the potentially ongoing nature of this type of sexual assault [p.2] ([Du Mont et al., 2017](#_ENREF_23" \o "Du Mont, 2017 #10770)).

**Discussion**

We developed four evidence-informed program theories that consider how a safe and supportive environment for disclosure of SV can be provided within SRHS. Interventions need to be able to bring about sufficient change through activation of generative mechanisms and have sufficient leverage to overcome the contextual barriers which exist at individual, service delivery and societal levels [Appendix 3]. The theories generated unearthed causal mechanisms that can lead to feelings of trust, empowerment, being in control, being valued and being believed. Although the mechanisms identified focused primarily on the person subjected to SV, mechanisms are also at work in the HCP. Theory 3 involves training of HCP so they become cognizant in a TIP and PCC increasing the confidence of HCP to be able to respond well to disclosure. Examples of how TIP and PCC might look in SRHS in addition to HCP specialist training include; promotion of services which is inclusive of all backgrounds irrespective of age, gender, ethnicity etc.; providing choice within health consultations; use of routine inquiry; and effective coordination of care between agencies. Each of these are not proposed as standalone activities adequate to overcome the barriers but need to be set in a culture of TIP and PCC and introduced with care. For example, the benefits of routine inquiry are acknowledged to normalize disclosure, address rape myths and stereotypic assumptions about SV, however, we also recognize associated risks with this practice if performed insensitively, or without clear and effective pathways for the next steps in care. Findings from this review also strongly suggest the use of routine inquiry as a tool to support disclosure of SV should only take place after specialist HCP training and where the people being asked are clear they have the choice as to whether to answer or not. Further research is needed to examine further ways of how TIP can be implemented into SRHS to meet the complex needs of people with a history of trauma ([Brewer, Colbert, Sekula, & Bekemeier, 2020](#_ENREF_15" \o "Brewer, 2020 #11310)).

Although much of the review focuses on interventions at the level of service-delivery, theory 1 in particular suggests SRHS have a wider role to play in tackling societal barriers. The promotion of services should address cultural and social barriers particularly relevant to the population served. The review suggests that by addressing the diversity of those subjected to SV people will be made aware disclosure is expected and supported irrespective of their background. For example, the use of promotional material depicting the elderly, male, mix of ethnicities, people with disabilities rather than the more often seen white non-disabled women-only illustrations may generate feelings that it is a safe place to seek help irrespective of background.

**Strengths and limitations**

As with any realist review, the interpretive nature of the review process means it is possible that another reviewer might derive a different set of theories from the evidence. However, to mitigate this risk we followed RAMESES guidance and involved content expertise and experienced realist researchers ([Wong, 2013](#_ENREF_65" \o "Wong, 2013 #10578)). The interpretive nature of the review process also involves the reflexivity of the authors. In the context of this review, the authorship group discussed the different weights as regards the contextual barriers, with particular consideration of the role of heteropatriarchy in different contexts. These insights were used to reflexively develop the program theories.

In performing a secondary data analysis, we were limited by the availability of published data. In particular, there was a paucity of evidence in the review literature detailing mechanisms, particularly when groups of people were identified to face additional barriers in disclosure, articles frequently failed to address the underlying reasons why [or why not] interventions might work to reach the intended outcome. Despite this, one strength of the realist approach is in the development of theory whilst using supporting evidence.

We note that the majority of the articles identified through the searches include only women, and a limitation faced by the review was the paucity of published data on men and transgender people. This review does consider diversity and its impact on disclosure. It seeks to address how and why services provide a safe environment for some groups of individuals and not others. Despite the paucity of diversity in the literature a strength of the realist review is the evidenced-based theories developed use data beyond that typically included in a systematic review. In this review one of the advisory group members is an advocate for LGBT [Lesbian, Gay, bisexual and Trans] people and has guided the findings and theory development. Another example is the wider scope and iterative nature of the review searches for example permitting the inclusion of a paper on routine inquiry for domestic abuse in gay and bisexual men attending SRHS ([Bacchus et al., 2018](#_ENREF_6" \o "Bacchus, 2018 #11326)).

The findings from this realist review should be regarded as a starting point to understand how a safe and supportive environment for SV disclosure is provided. The findings are transferable and can be tested in different contexts with different groups. The value of providing a safe and supportive environment is likely to benefit beyond the SRHS setting:

We need to make sure that all our health service, sexual health and other health services, have appropriate responses for those who have been subjected to sexual violence and abuse. And if we get it right for people subjected to abuse, then it's going to be right for everybody else as well because it is going to be a safe space for people to talk about really difficult things [Key informant interviewee 03]

**Conclusion**

People subjected to SV face a variety of barriers to disclosure within healthcare settings and this results in an inability to access timely healthcare. Contextualizing these barriers at individual, service-delivery and societal levels, and understanding what it is about interventions that create sufficient change to overcome them, will be useful in healthcare service design and delivery. This review puts forward 4 theories to answer how a safe and supportive environment for disclosure of SV is provided in a SRHS. The theories emphasize the importance of challenging the silence that often surrounds SV. They refer to the need to challenge current healthcare practice and existing social norms. Ongoing challenge to norms that perpetuate rape myths and victim-blaming responses are needed at many levels both within and outside the clinic setting.

The review has identified TIP and PCC as approaches that can create sufficient leverage to overcome many of the contextual barriers to safe disclosure of SV but are often missing from clinical practice. These approaches can induce a culture change and ultimately give people choice and control over their healthcare. Future work is needed to identify how best to implement a safe and supportive environment for different groups of people. Research considering the mechanisms which underlie how interventions work to overcome barriers to disclosure will allow these approaches to be transferred to wider settings.

**Implications of the review for practice, policy, and research**

1. By SRHS challenging rape myths, stereotypic views on SV and gender inequalities though media, marketing and policies, people from diverse backgrounds and those presenting with a non-stereotypic rape, will see themselves as candidates for the support.
2. Approaches used by SRHS to advertise their services need to consider both the message and media used. People of all backgrounds need to be included in the design and use of promotional material to ensure it is acceptable, helpful and reaches a wide range of diverse groups.
3. Trauma informed and person-centered care is recommended in SRHS in a service-wide approach.
4. Specific aspects of trauma informed practice require further research to test acceptability and level of importance for different groups of people attending health services.
5. Joining up care with other services to provide a co-ordinated management pathway is needed in order to respond safely to disclosure.

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Footnotes 1. The protocol for this review was registered on PROSPERO [Unique ID number: CRD42019129986] and is available in full on the BMJ Open [URL http://dx.doi. org/10.1136/bmjopen-2020- 037599]