EXAMINING SECONDARY VICTIMIZATION WITHIN NURSE-PATIENT RELATIONSHIPS

by

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ABSTRACT

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Sexual assault (SA) is a public health and human rights problem disproportionately affecting women globally (WHO, 2013). A report conducted by the World Health Organization (2013) indicated that one out of three women globally experience sexual or physical violence. Although sexual assault is widespread, many survivors of SA encounter further traumatic experiences after disclosing experiences of SA and seeking care (Campbell, Wasco, Ahrens, Sefl, & Barns, 2001; Campbell & Raja, 2005; Jackson, Valentine, Woodward, & Pantalone, 2017; Patterson, Pennefather, & Donoghue, 2017). Referred to as secondary victimization (SV), SV has yet to be explored in women's interactions with nurses across specialties including in acute nursing care. Through this qualitative study, I sought to address this gap by examining the help seeking experiences of African American women following an experience of sexual assault from the perspective of women. I also sought to gain an understanding of the interactions between African American women and the nurses responsible for their care in order to analyze nurses perceptions about provision of care to survivors of sexual assault.

In this qualitative study, 30 African American women survivors of sexual assault and 16 nurses were interviewed using in-depth, semi-structured interviews. Most of the participants

resided in urban metropolitan areas across the upper Midwest. Using thematic analysis, two themes were identified. The first theme identified focused on the dehumanizing interactions experienced by African American women when receiving healthcare services in a hospital setting following sexual assault. Experiences of dehumanizing included: discrediting, dismissing, shaming, and blaming. To mitigate and/or prevent future interactions of secondary victimization, we present practice, education and policy recommendations for nursing and healthcare more broadly, based on the voices of African American women survivors of sexual assault.

The second theme identified is called the 4th step. The 4th step entails the process that allows for safe disclosure for African American women who experience sexual assault. The 4th step included (a.) establishing a relationship, (b.) creating a therapeutic space, (c.) providing non-judgmental care, (d.) ensuring a culture of transparency, (e) standing in solidarity, and (f) communicating empathy. Given that healthcare is integral to the healing of women who experience sexual assault, eliminating barriers for African American women's access to healthcare is key. This involves addressing systemic oppression to ensure that women feel valued more broadly in society, and at every interaction with the healthcare system. By incorporating anti-oppressive practices, nursing can lead the cultural shift needed to respond to African American women survivors of sexual assault in a way that facilitates healing at the individual, institutional, and societal level.

Considering the suffering that African American women have experienced dating back to the time in which enslaved women were brought to the shores of the Americas, and the suffering continued after slavery, sharecropping, and the great migration, it is our responsibility as nurses to ensure that women are cared for to first prevent sexual violence. We thereafter need to support

policies that ensure the reinvestment in African American communities that would assure the protection of women and support when sexual violence does occur, to foster healing.

To

listening,

hearing,

& healing

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AOP	Anti-Oppressive Practices
CE	Critical Ethnography
HCP	Healthcare Provider
IPV	Intimate Partner Violence
PCF	Postcolonial feminism
SA	Sexual Assault
SANE	Sexual Assault Nurse Examiner
STI	Sexually Transmitted Infection
SV	Secondary Victimization
VAWA	Violence Against Women Act

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Last but not least, of course, thank you to my partner, Andrew. For your unconditional love and support.

Woman power

is

Black power

is

Human power

is

always feeling

my heart beats

as my eyes open

as my hands move

as my mouth speaks

I am

Are you

Ready.

-Audre Lorde, Now

But, Sister, you have millions of warrioresses who are eternally committed to you. We see you. You are greater, stronger, and much more enduring than the evil that has been done to you. You are infinitely valuable. And you are never alone. As you continue your fight to survive and to heal, know that we are fighting with you. We will challenge those who allowed this to happen to you. We will walk with you, listen to you, support you, and offer you our unconditional acceptance. We are here—unwavering—as your comrades, as your defenders, as your sisters.

-Premala Matthen, Letter 19: I See You from *Dear Sister: Letters from Survivors of Sexual Violence*

Racism is all around us. We eat, sleep, speak and breathe it. We see it everywhere. We feel it inside us. We are discouraged by it more than not—discouraged because fewer and fewer perpetrators of racism are even conscious of their racist behavior—or perhaps they don't care. Their behaviors, which insure that racism remains a part of our lives, are efforts to instill in our minds—deeply and permanently—ideas, attitudes and motivations regarding [racial] purity and pollution.

> -Virginia Harris & Trinity Ordoña, Developing Unity Among Women of Color: Crossing the Barriers of Racism and Cross-Racial Hostility in *Making Face, Making Soul Hacienda Caras: Creative & Critical Perspectives by Feminists of Color*

"Dear Sister,

These are the things I wish I had been told:

I love you. I love you.

Loving yourself is the best way to defeat your attacker. Say *I love you* to yourself every day. On the days you can't say it, use one of the *I love yous* from above. Loving yourself is one of the important things you can do for your peace of mind.

You are loved. You are loved.

Always remember that there are people that love you. They may be in your life, they may no longer be in your life. You may not even know them, but their hands are for you to hold, their shoulders are for you to cry on, and their love will be there any time you need.

Love always,

Your sister

> -Birdy, Letter 2: What I Should Have Been Told from *Dear Sister: Letters from Survivors of Sexual Violence*

Chapter I: Introduction

Often called victim-blaming, secondary victimization [SV] was the re-traumatization of survivors of interpersonal violence (Campbell & Raja, 2005). Common within interactions involving healthcare providers [HCP] (including nurses in many cases) and survivors of sexual assault [SA], these unhealthy interactions recreated minimization, disregard, and devaluation of survivors that mimicked the traumatic experiences encountered within the initial perpetrator-victim dynamics. Frequently described as more traumatic than the initial traumatic experience, SV was known to result in emotional and psychological distress that delayed or impeded survivor's health outcomes (Campbell, Wasco, Ahrens, Sefl, & Barns, 2001; Campbell & Raja, 2005; Jackson, Valentine, Woodward, & Pantalone, 2017; Patterson, Pennefather, & Donoghue, 2017). Practices such as discouraging survivors from discussing traumatic experiences, questioning survivors about their prior sexual histories, and interrogating survivors about their behaviors before the assault were known to inflict SV.

Significance

Referred to as the *second assault* or the *second rape*, inflictions of SV were significant. They violated ethical standards of care requiring nursing services be delivered in a manner that enhanced optimal health and well-being (American Nurses Association, 2015; American Nurses Association, 2018). Instead, survivors of SA who encountered SV within nurse-patient relationships left with additional trauma caused by seeking help within a system designed to protect and support survivor's health needs (Anda, 2018). These dynamics within nurse-patient relationships recreated perpetrator-victim relationships that triggered a re-creation of the experiences of disempowerment and disconnection experienced during the initial victimization or assault (Hopper, 2016; Kennedy & Prock, 2016; Patterson et al., 2017). Survivors that

encountered SV were more likely to develop poorer health outcomes, and were less inclined to access available services in the future even though the services were designed to be potentially beneficial in meeting their needs (Campbell, 2008; Campbell & Raja, 2005).

Physiological Responses to Trauma: Sexual Assault and Secondary Victimization

Although SA was frequently overlooked as a healthcare concern, SA was a traumatic experience holding myriad short- and long-term consequences on individual health outcomes. This included increased risk for STIs including HIV and HPV and poor mental health outcomes such as depression and post-traumatic stress disorder (PTSD) (Center for Disease Control, 2015; Goyal, Mengeling, Booth, Torner, Syrop, & Sadler, 2017; van der Kolk et al., 2007). SA also significantly increased individual risk of engaging in maladaptive coping mechanisms such as substance use, self-harm, and at-risk sexual behaviors (Deliramich & Gray, 2008; Khadr, Clark, Wellings, Villata, Goddard, Weich, Bewley, Kramer & Viner, 2018). These health outcomes resulted from the stress response activated during the trauma of SA.

The traumatic stress response occurred from the activation of the hypothalamus-pituitary-adrenal (HPA) axis that released a flood of hormones including cortisol, opioid, catecholamine, and oxytocin (Adams et al., 2016). This resulted in the body experiencing overstimulation of stress and triggering fear-based behavioral responses such as hyperarousal/hypervigilance symptoms even after the traumatic stressor was gone (van der Kolk, 2007). Hyperarousal/hypervigilance symptoms included: trouble concentrating, inappropriate reactions, sleep disturbances, and mood changes (Center for Substance Abuse Treatment, 2014). Stress was used by the body and protected the body against threat from predators and other threats in the environment (Mayo, 2016). However, hyperarousal symptoms from the HPA axis and trauma were consequences of biological changes occurring over time, altering the structuring,

functioning, and regulating of limbic and neuroendocrine systems (Center for Substance Abuse Treatment, 2014; van der Kolk et al., 2007). Long-term and/or persistent activation of stress responses disrupted bodily processes and placed victims at risk for multiple health problems, including weakened immune system, sleep problems, weight gain, and genetic changes (Mayo, 2016).

These detailed physiological stress responses occurred during traumatic events such as SA, and were reactivated by the trauma that occurred due to negative responses to SV (van der Kolk et al., 2007). Therefore, experiences of SV resulting from HCP's interactions with SA survivors denied and prevented opportunities for healing, and instead caused further physiological dysregulation through the reactivation of traumatic stress responses.

Nursing & Healthcare Implications

Nursing research focused on understanding processes and responses that inflicted or prevented SV in order to be prepared for implementing effective nursing interventions and supporting the best health outcomes for SA survivors. Doing so required that healthcare institutions recognized SA as a health care concern. This recognition was essential because healthcare systems created ideas of what and how nurses treated or managed health and illness (van der Kolk, 2007). These ideas were interwoven into ideas of health within the larger social and political world that healthcare institutions inhabited. As van der Kolk (2007) explained, "Every culture ha[d] its own medical system that embodie[d] ideas of illness and health, as well as hope and the expectation for solutions" (p. 403). As a result, the culture of the medical systems and institutions shaped the ways a community responded to traumatic experiences (van der Kolk, 2007).

Therefore, the dismantling of SA as a taboo topic was essential within healthcare systems. This required fostering a cultural shift to systemic processes rooted in trauma-informed care (TIC) aimed at successfully, collaboratively meeting needs of those affected by trauma (U.S. Department of Health & Human Services, 2018). The essence of such supports effective implementation of policies that focused on processes that influence nurses' responses to women's experiences of SA, as well as healthcare as a larger institution. This included training and screening of patients for experiences of SA, as well as nursing interventions to implement following disclosure. Such processes, when supported by healthcare institutions, normalized interactions that prevented SV, encouraged awareness and discussion that increased opportunities for improving health outcomes for survivors, and dismantled violence as a taboo topic within healthcare settings.

Although current policies began to focus on screening patients for exposure to violence within living and intimate partner situations, these screenings covered less than the full spectrum of interpersonal violence and missed SA (Aghtaie & Gangoli, 2014). With the prevalence of SA as well as its health consequences for women in the United States, such screenings would be more effective if incorporated across nursing practice (CDC, 2018) to allow for nursing interventions that facilitated the availability of options of care that led to healing through addressing the health concerns discussed by women accessing care.

Furthermore, no research was conducted examining inflictions or preventions of SV by nurses beyond emergency room and forensic nursing specialties. We examined nurses' perceptions and experiences of delivering care to SA survivors within acute care settings to aid in understanding processes that contribute to or prevent SV beyond emergency room and forensic nursing specialties. Filling this existing gap in literature presented an opportunity to

improve women's health trajectories after assault, and the quality of care nurses delivered when interacting with women with a history of SA. We thought supporting the removal of SA as a taboo within healthcare as an institution and addressing a prevalent underlying issue impacting women's health outcomes was beneficial.

As the largest profession in healthcare, nurses upheld their responsibility to support patients in achieving and maintaining best health outcomes when they took a stance in support of delivering quality nursing care when responding to SA upheld nurses' responsibility (AACN, 2019). The nursing profession played an important role in establishing a cultural shift for promoting responses that did not inflict violence and avoided further trauma for women with histories of SA. As van der Kolk (2007) stated, "the issue of responsibility, individual and shared, [wa]s at the very core of how society define[d] itself" (p. 29). The nursing profession (a profession built upon relationship practice) defined itself as a profession committed to "values, moral norms, and ideals" that supported changing "aspects of social structures that detract[ed] from health and well-being" (American Nurses Association, 2015, p. 9). The nursing profession assumed accountability for upholding an obligation and commitment in its specific responses to women survivors of SA that prevented further trauma or SV.

These commitments honored ethical codes of conduct that all nurses were and are expected to uphold in their efforts for protecting, promoting, and restoring patient health and well-being (American Nurses Association, 2015). Utilizing nurses' positions of power to allocate appropriate resources towards improving health and well-being, nurses establish themselves as leaders committed to creating social change that would ultimately lead to the provision of inclusive patient-centered care working in collaboration with patients.

The creation of social change wrought through the shifting of healthcare culture with the role of nurses in effectively responding to the healthcare concerns for women sexually assaulted, ultimately is intricately intertwined with influencing policies impacting women's experiences of accessing healthcare after SA. One policy impacting the way in which women interacted and experienced responses from healthcare following SA was the Violence Against Women Act (VAWA).

Passed in 1994, the VAWA was the first legislation passed that sought to address SA and domestic violence crimes against women (Bonner, 2002). Although this bill expanded awareness and established resources in response to SA crimes, there are limitations to be considered. These limitations included the language used within the VAWA. Although the bill has been updated to include more inclusive language targeted towards ending impunity towards Native women and LGBTQ+ communities, the VAWA still uses language such as "prompt" investigation in relation to campus related SA (Leahy, 2012; National Network to End Domestic Violence, 2017). Such language placed an expectation on women who were expected to report SA immediately. However, many women did not report SA immediately, and many did not report because of the risk of SV at the hands of healthcare workers. This approach overlooked a body of knowledge about SV ignored by structural supports i.e. healthcare systems and nurses. Consequences continued today adding to growing evidence of women of color related to structural violence within legal and healthcare systems.

Montgomery (2018) stated:

> …the sustainability, relevance, and effectiveness of any public health intervention designed to prevent violence against women [always failed if it did not have parallel social policy intervention that interrupted structural violence, that was the

> social arrangements that oppressed women and normalized gender-based violence.]will always fail if it does not have a parallel social policy intervention to interrupt structural violence, that is the social arrangements that oppress women and normalize gender-based violence. (p. 1491)

Therefore, future research exploring responses following experiences of SA could help to develop interventions to prevent or mitigate interactions of SV within healthcare responses. The outcomes of future research could help improve the quality of nursing services (and across healthcare) delivered to all women who experienced SA. It is worth noting that this places nurses in a position to appropriately utilize their position of power to inform future policies that address issues of structural violence, particularly for women of color who have experienced SA well aware of the trauma that follows from interacting with healthcare systems and legal institutions. This could improve reporting and investigation of SA, but could also lead to the development of national policies that address SA against women beyond "prompt" reporting and investigating SA.

Given the historical context of US nursing practice, nurses (and healthcare as a whole) failed to recognize their contribution to the negative health outcomes of Black women. They created roles for perpetuating violence against Black women through SV and structural racism. Speaking up and addressing the reality of history could lead nurses who were prepared for their important role in prioritizing patients' health outcomes. The knowledge of the lived experience of Black women could be changed if nurses, specifically those working in relation to SV and the accompanied slew of health risks, understood an approach that changed outcomes across healthcare as an institution.

Prevalence

Sexual Assault: An Expression of Sexism

Despite differences in available data and issues of disclosure, sexual violence was known to disproportionately affect women worldwide (Abrahams, Devries, Watts, Pallitto, Petzold, Shamu, & Garcia-Moreno, 2014). In fact, a global report conducted by the World Health Organization (2013), "1 in 3 women throughout the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner". Sometimes referred to as "the All-American crime", the US is the only modern nation recently ranked as 1 of the most dangerous countries in the world for women due to high prevalence of sexual violence, which included sexual assault [SA] (Scully, 1994, p. 48; Thomson Reuters Foundation, 2018).

Although a prevalent crime impacting women's health in the US, successful conviction rates remain significantly low (U.S. Department of Justice, Bureau of Justice Statistics, 2008; U.S. Department of Justice, Bureau of Justice Statistics, 2011). The contrast in prevalence and conviction rates reflect the normalization of SA in a society prone to various forms of violence against women. Many consider the US a nation prone to SA since rape culture is pervasive and normative. One example of this is the idea that male aggression is a normal and natural part of sexual relations (Hlavka, 2014). Such myths lead men to have a sense of entitlement when it comes to sex. The result is the acceptability of SA as an extension of normative male behavior, in which the use of force is considered justified, as it conforms to the values of a patriarchal society that benefits men (Giroux, 2017). SA is thus a product of oppression understood through the context of patriarchal structures or sexism, in which women are regarded as inferior, incapable, and to be manipulated. The goal of this ideology reduced women to a reproductive or sexual function (Southern Law Poverty Center, 2017). Such patriarchal ideologies implicated not only the trauma of SA itself but also sociocultural and political responses to SA.

Since early the 18th century, US public stigmatization of SA was a gendered phenomenon, in which women were valued based on their proximity to white female purity related to sexuality. The rape of a woman was thus not considered violation against the woman rather a theft of her honor or purity (Bardaglio, 1994). As a result, the rape of a woman was considered a dishonor to the woman and her household, and no violence occurred against the victim. The male head of the household felt the shame. Historically, women held status similar to slaves, considered property possessed by white men (Bardaglio, 1994; National Research Council, 2014). Value was based on a woman's purity. Women who spoke up and brought forward rape charges faced stigmatization, shame, and further reinforced genderdized class stratification where they were viewed as "*contaminated*" or "*impure*".

Such shaming created negative stereotypes that emphasized the idea that once women lost their sexual "*purity*", they lost all moral senses (Bradaglio, 1994). This led to women being viewed as untrustworthy, "*lying temptresses*". In turn, stereotypes based on these beliefs placed emphasis on the notion that "unchaste women [were] more likely to consent to sexual intercourse on any given occasion" and that "they were also more prone to lie about their sexual behavior" (Bardaglio, 1994, p. 766). The resultant idea was that women who engaged in prior sexual relationships were impervious to SA, as if the prior sexual relationships gave consent for any future sexual activity even SA. This was commonly seen in women when they were believed to have engaged in sexual intercourse outside of marriage. This was then demonstrated as evidence of the victim's poor character and to discredit her (Schaub, 2013).

The belief where unchaste women were prone to lying was used by the US legal system to justify distrust in women based on the length of time that elapsed between the SA and the filing of a complaint throughout early US rape law. One example of this can be seen in Chief

Justice William Lewis Sharkey's of the Mississippi Supreme Court statement regarding a case where a young woman who disclosed 7 months after her stepfather sexually assaulted her. In this statement recorded in 1853, The statement described the lapse of time "circumstance powerfully calculated to induce suspicions that she had been a willing victim to a perfidy of a seducer, rather than a resisting subject of a brutal outrage" (Bardaglio, 1994, p. 767).

This distrust of women sexually assaulted within early US American legal systems is also reflected in the language used throughout US rape law. Such statutes reflected "how society thinks its members ought to behave, and they offer[ed] specific insights into the social values and attitudes of the elites that ma[d]e and shape[d] the law" (Bardaglio, 1994, p. 752). For instance in early US rape law, the term sexual assault did not exist. Instead of the words sexual assault, men "*outraged*" women (Block, 2009). This terminology was not changed until the medicalization of rape in the 20th century. At that time, the term was altered from "*outraged*" to "*hysteria*" or false reporting (Schaub, 2013). Schaub (2013) stated, "one textbook published in 1903 declared that obtaining medical evidence was especially crucial 'as probably nine-tenths of the accusations of rape [we]re false'" (p. 26). Such beliefs in false reporting provided basis for medical professions proclaiming the importance of collecting evidence (Scully, 1994).

The beliefs established through medicalizing rape contributed to establishing the basic elements of rape law, or the Model Penal Code [MPC]. Published in 1962, the MPC defined rape as "sexual intercourse with a female not his wife" through force or threat to do severe harm (National Research Council, 2014, p. 24). In order for this to be a felony of the first degree, the code necessitated that rape result in bodily injury, and that the victim and offender were not social companions and never had history of sexual activity together (National Research Council, 2014). These reinforced traditional legal systems and practices in which "real rape" cases were

recognized only if cases presented a stereotypic rape script. This accepted script consisted of false ideas regarded to what normally occurred during rape (Lonsway et al., 2011; Peterson & Muehlenhard, 2004). Examples of stereotypic rape scripts included perpetrator-victim dynamics in which the perpetrator was a stranger to the victim, the use of a hand weapon, and assault that resulted in physical injuries (Hlavka, 2014; Lonsway et al., 2011; Peterson & Muehlenhard, 2004). In reality most cases of rape are experienced by people who are known to one another, most rapes occurred without a weapon, and many rapes resulted in no physical signs of injury to the victim (Lonsway et al., 2011).

The medicalization of rape and SA also led to being considered a symptom of mental illness within the Diagnostic and Statistical Manual (DSM-I) (Tosh, 2011). Categorized often as 'sexual deviance', such utilizations of the psychopathology model within the DSM gave rise to theories that "a few 'sick' men" committed SA (Scully & Marolla, 1985; Tosh, 2011). These theories supported ideas that psychotic "sick" men were not able to control their sexual urges or behavioral impulses. Contrary to these racist, sexist ideologies, historical evidence showed men who committed sexually aggressive crimes (such as SA) rarely struggled with mental illness (Scully, 1994; Scully & Marolla, 1985). Instead, similarly to other types of crimes, crimes of SA were committed as a result of socially learned and rewarded behavior. Scully (1994) explained, "learning include[d] not only behavioral techniques but also a host of values and beliefs, like rape myths, that [we]re compatible with sexual aggression against women" (p. 59).

History demonstrated the healthcare establishment's contribution in upholding stereotypical misconceptions about rape, rape victims, and rapists within legal practice. Legal actions and statutes limited and narrowly defined the definition of rape and SA against the reality of a diverse reality of degrees and types of intimate partner violence and assault against women.

This not only affected prosecution outcomes; it served to disrupt the livelihood of countless women of all colors, especially Black women (Lonsway et al., 2011; Peterson & Muehlenhard, 2004). SA is the most common crime in the US but the majority of predators never went to jail or faced legal disciplinary action (RAINN, 2019; U.S. Department of Justice, Bureau of Justice Statistics, 2008; U.S. Department of Justice, Bureau of Justice Statistics, 2011).

Although SA, included rape, was more recognized as injustice oppressing women, patriarchal sociocultural responses as seen in the early US were echoed in current SA discourse. This included the idea that victim characteristics or actions provoked SA, and empowered the belief that false reports were common because of women lying (Schaub, 2013). These responses ultimately placed the responsibility of SA upon women survivors rather than male perpetrators, a pattern that perpetuated itself through the entire racialized history of the US. For this reason, it was important to understand not only the genderdized components within US history, but also the racialized historical processes that informed SA and how this impacted the knowledge and experiences of women of color and their communities.

Racialization of Sexual Assault

In addition to the gendered components that shaped a racist nation's responses to SA, the historical processes that regulated and harmed women survivors of SA were racialized. The racialization of SA was strongly connected to the regulation of SA throughout US history. In the 18th and 19th centuries, SA was used as a tool for maintaining social control over Black slave communities (Bardaglio, 1994). Rape and SA of Black slave women was intentionally excluded from legal discourse in order that benefitted white masters whose SA power plays frequently led to expanding their supply of labor (Bardaglio, 1994). SA perpetrated against a Black slave woman by a man other than her master could lead to masters receiving compensation for

"*damages"* accrued for the "trespass upon his property" (Bardaglio, 1994, p. 757). As Bardaglio (1994) illustratetd, "the relative silence of the law on the subject of female slaves who [were] raped spoke volumes about the structure of power in…society, dramatizing the double burden of race and gender that these women endured" (p. 758). The lack of legal protection from SA, some was offered to white women but none was offered to Black women slaves and this demonstrated how society saw Black women slaves' position within society as subhuman.

This idea of Black women slaves as subhuman and "uncivilized" in 18th century US, stemmed from accepted ideas that Black women were "naturally promiscuous and sought to copulate with white men" (Bardaglio, 1994, p. 757). This imagery further cast women of color as hypersexual objects, impositions of the Jezebel, and "heathens" in need of taming by European people (Svetich, 2005; Windsor et al., 2011). Jezebel was a harlot biblical figure with an uncontrolled sexual appetite (Davis, 2004, Brown Givens & Monahan, 2005). This image imposed upon Black slave women rationalized and permitted excluding legal protections for Black slave women from 17th through 19th century US rape law. The only time legal protection appeared in 18th century US courtrooms was when the assailant was black (Bardaglio, 1994).

An example of this was seen in George v. State of 1859. This case overturned a death sentence for the rape of a female slave under ten years old committed by another slave. Related to this release, Justice William Littleton Harris said, "the common law is not applicable to the status of the slave" (Bardaglio, 1994, p. 759).

The lawyer of the accused supported:

> The crime of rape does not exist in this State between African slaves. Our laws recognize no marital rights as between slaves; their sexual intercourse is left to be regulated by their owners. The regulations of law, as to the white race, on the

> subject of sexual intercourse, do not and cannot, for obvious reasons, apply to slaves; their intercourse is promiscuous, and the violation of a female slave by a male slave would be a mere assault and battery. (Bardaglio, 1994, p. 759)

The legal processes regulating SA through racialization also were seen with the dismissal of rape cases where women did not explicitly state and provide "adequate evidence of her race" (Bardaglio, 1994, p. 764). Such measures were taken because early US legal systems only protected white women; only the rape of white women was a crime. Once again, the legal regulations placed on SA supported racist notions about stereotyped Black women as hypersexual non-beings (Bardaglio, 1994; Bentley, 2005). This assumption infiltrated society for stereotyped Black women and other women of color who are not of European descent, including Indigenous, Latinx, and Filipina women (Fuller, 2004; Svetich, 2005, Windsor et al., 2011).

Ultimately, these stereotypes created racial codes that cast white women as beholding ideal "*feminine*" characteristics (Svetich, 2005). Racial codes and norms in the US held white women as possessing characteristics such as virtue, morality, and deservingness (DeWaard, 2006). As a result, white women became the expectation, seen as "normal" when considering femininity. People who were not or did not appear like the expected feminine standard were seen as deviant (Fuller, 2004). These social norms and gazes were and became further embedded in US culture with their institutionalization in US legal policies that vilified women of color.

One example in healthcare is the Children Requiring A Caring Kommunity (CRACK)/Project Prevention. This nonprofit private organization that "solicit[ed] and pa[id] women up to $200 who [we]re allegedly drug addicted to become sterilized or have long-term

birth control implanted into their bodies", with the goal of ending drug-exposed pregnancies (Derkas, 2012, p. 179). Created in the '90s, the CRACK acronym was code to target poor women of color within inner city communities that struggled with cocaine abuse, who were seen as unfit for motherhood. Such programs supported notions of women of color as "transferring a deviant lifestyle to their children, dooming them to the cycles of poverty, violence, and despair believed endemic to Black culture" (Derkas, 2012, 181).

Racist notions instilled within social institutions, are often justified through associations that connect color with negative adjectives such as aggressive, hostile, lazy, and rude (Brown Givens & Monahan, 2005). At the same time, positive adjectives such as sincere, friendly, trustworthy, honest, and intelligent are associated with being white. These associations impact the way in which social institutions interact with women of color, which often lead women of color being viewed as unlikely victims of SA. As a result, women of color are less likely to report SA; with African American women being the least likely to report SA than any other ethnic group (Ullman, Starzynski, Long, Mason, & Long, 2008; Williams, 2013). Previous studies also show that when ethnic minority women do disclose, they often receive more negative responses (Ullman et al., 2008). As Ullman and Filipas (2001) explains, "ethnic minority women…may be likely to face disbelief, blame, and stigmatizing responses from those to whom they disclose, given the racist attitudes shown towards these women by the dominant society" (p.379).

Similar to patterns identified within gendered oppression, racist legacies place the responsibility of SA upon women of color based on ideas of race. Because of this, ethnic minority women are considered more at risk for experiencing SV due to the delivery of poor quality care while seeking services post-assault (Campbell & Raja, 2005). Examples of poor

quality care include unaddressed pain management needs, not being provided accurate information to make informed decisions (such as not explaining one's risk for STI/HIV), not being provided options of care (such as HIV/STI prophylaxis and emergency contraception), and lack of cultural competency. One example of poor-quality care come from the findings of one study examining SV, in which ethnic minority women were less likely than white women to receive information on HIV than white women (Campbell et al., 2001). This is of particular concern to women of color, as women of color may be at higher risk for post-assault health outcomes due to higher rates of gynecological issues and disease outcomes compared to white women (Campbell, Sefl, Ahrens, 2003).

This is of further concern as experiences of SV deter individuals from seeking health services in the future. For example, one study conducted among a sample of predominantly African American women veterans found that 80% of the sample that sought care during military service felt the experience made them reluctant to pursue further care after receiving medical services (Campbell & Raja, 2005). In consequence, experiences of SV from healthcare institutions lead to the mirroring of historical trauma because the responsibility of SA is placed on women of color, rather than perpetrators. Such responses contribute to the current health inequalities and deter women of color from accessing healthcare services that could improve health outcomes needed in the future (Bryant-Davis et al., 2010; Martin, 2005).

Individual Attitudes & Belief Systems Prone to SV

Given the complexity that systemic and institutional racism and sexism hold in shaping responses to SA, it's important to reflect on how this impacts what is known of individual attitude and belief systems that contribute to SV. In reviewing the literature, individual negative responses resulting in SV are perpetuated by sociocultural attitudes that instill blame, shame, and

control directed towards survivors (Bryant-Davis et al., 2010; Campbell et al., 2008). Two belief systems specifically known to shape negative responses that cause SV are: rape myth acceptance (RMA) and belief in a just world theory (BJW).

Rape myths are defined as "prejudicial, stereotypes, or false beliefs about rape, rape victims, and rapists…that serve to deny and justify male sexual aggression against women" through the minimization of sexual offenses committed (Grubb, 2012, p. 445). Although rape myths vary culturally among different societies, the main patterns of RMA belief systems remain consistent. As Grubb (2012) explains, RMA belief systems "blame victims for their rape, express a disbelief in claims of rape, exonerate the perpetrator and allude that only certain types of women are raped" (p. 445). This belief system has been found to lead to victim-blaming patterns within seven subcategory domains:

> 1) "she asked for it"; 2) "it wasn't really rape"; 3) "he didn't mean to"; 4) "she wanted it"; 5) "she liked it"; 6) "rape is a trivial event"; and 7) "rape is a deviant event". (Grubb, 2012, p. 445)

Victim-blaming patterns are commonly expressed through three means: "victim masochism (i.e. women enjoy being raped), victim precipitation (women are responsible for their victimization) and victim fabrication (women lie about having been raped)" (Grubb, 2012, p. 445). These patterns of victim-blaming identified within RMA, perpetuate myths such as women lie about SA, despite research showing that actual percentage of false allegations account for approximately 2% of reported cases (Grubb, 2012; Lisak et al., 2010;).

The second belief system found to support the occurrence of SV is BJW theory. Sometimes referred to as a Justice Motive, this system involves the belief in which people attach a "need to believe the world is a fair place" (Pahlavan, 2012). This belief is harmful in its

application to interpersonal relationships, as "getting and deserving lead to psychological distancing from victims, by moving them away from an individual's direct experience" (Pahlavan, 2012, p. 31). In other words, "good" things happen to good people, who are in charge of their lives, and "bad" things happen to "bad" people (van der Kolk et al., 2007). Such beliefs place distance between the survivor and the person responding. These interactions recreate the acceptability of disconnection and disempowerment within initial perpetrator-victim dynamics through responder-survivor relationships (Hopper, 2016; Kennedy & Prock, 2016; Raynal & Kossove, 1981). And so the thought is that if a woman is raped, there is something she must have done to cause this as the world is just and fair.

The expression of these internalized belief systems reflects individual attitudes enforced within larger sociocultural contexts that ultimately support the perpetuation of disadvantaging women today through SA (Pahlavan, 2012; Scully, 1994). Although RMA and BJW have been explored among formal supports, such as police officers, limited studies focus on the impact these belief systems on HCP's delivery of care when interacting with SA survivors (Pistorio, 2015; Rich, 2013; Starzynski & Ullman, 2014). Such recognition is important to consider as HCP represent individuals within healthcare institutions that commonly respond to SA survivors seeking healthcare services.

Healthcare Provider (HCP) Responses to Sexual Assault Disclosure

Although SA is a prevalent public health concern, SA is most commonly not disclosed to formal supports (Ullman et al., 2008). Instead, SA is known as the most underreported crime with approximately 63% of rapes not reported to police (Grubb & Turner, 2012; NSVRC, 2018). Rates of disclosure to HCP are even lower, ranging from 5-27% (Berry & Rutledge, 2016; Lanthier, Du Mont, & Mason, 2000). This is especially low if we consider the prevalence of SA,

and survivors' utilization of healthcare services more frequently compared to those without SA experiences (Lanthier et al., 2000).

One reason for low rates of disclosure to HCP's is the lack of screening conducted by HCP's, despite women's desire to be screened for SA (Berry & Rutledge, 2016; Friedman et al., 1992; Littleton et al., 2007). One recent study conducted among 102 women, found that 71.3% reported having never been screened by HCP's in relation to SA (Berry & Rutledge, 2016). This study also found that only 24.6% of women participants intended to disclose if not asked directly. HCPs need to incorporate direct inquiry into practice, as screening begins the process for allocating appropriate resources and interventions to foster survivors' healing. However, many HCP lack education and training as to appropriate and effective methods to inquire and respond to disclosures of SA that support survivor health outcomes (Berry & Rutledge, 2016).

This lack of education and training in relation to SA contributes to the issue of SA being treated as a taboo subject within healthcare leading to providers experiencing discomfort in discussing the topic of SA with patients, and ultimately being unprepared to provide basic care to SA survivors seeking services (Auten, Ross, French, Li, Robinson, Brown, King, & Tanen, 2015; Jackson, MPhil, & Fraser, 2009; Van den Ameele, Keygnaert, Rachidi, Roelens, & Temmerman, 2013). Other barriers found to contribute to a lack of HCP screening of SA include time limitations, limitations in providing appropriate interventions following identification of survivors, and non-existent or unspecified mandated assessments of violence (Van den Ameele et al., 2013).

In the past, treatment approaches towards SA viewed disclosure as being linked to positive health outcomes for SA survivors; however, the benefits of disclosure are now known to occur in relation to positive social support responses following disclosure (Jacques-Tiura,

Tkatch, Abbey, & Wegner, 2010). Positive responses to disclosure include: apologizing for the survivor's experience, assuring survivors that the SA was not their fault, and validating survivors' feelings (Martin, 2005). However, many survivors do not receive positive supportive responses following disclosure of SA. Survivors who receive negative responses following disclosure of SA are more prone to developing post-traumatic stress (PTS) and depressive symptoms (Campbell & Raja, 2005; Jacques-Tiura et al., 2010).

A common negative response known to cause SV and engaged in by HCPs, is victim-blaming (Starzynski & Ullman, 2014). Victim-blaming is a phenomenon in which victims of SA are "blamed and denigrated for their role in the rape, even to the extent whereby the victim is held responsible for the assault" (Grubber & Turner, 2012, p. 444). Examples of victim-blaming include blaming the victim's behavior, or the way they dress as the cause of SA (Campbell, 2005; Campbell et al., 2001). Other negative responses to disclosure found to be engaged in by HCP's include treating survivors differently following disclosure, doubting survivors, minimizing or creating distractions from discussing experiences following disclosure of SA (Dworkin, 2018; Lanthier et al., 2000).

Another negative response causing SV is the failure to provide quality services for SA survivors accessing healthcare (Campbell et al., 2008). The inability to provide services on the part of HCPs is common (Campbell et al., 1999; Campbell et al., 2001; Munala, Welle, Hohenshell, Okunna, 2018). Furthermore, when healthcare services are provided to SA survivors, many healthcare needs of survivors fail to be adequately addressed. For example, previous studies have found SA survivors accessing healthcare services often are not advised of their risk of pregnancy, risk of STI/HIV risk, and/or the effects of SA (Campbell & Raja, 2005).

Denial of Sexual Assault Within Reluctant Healthcare Partnerships

SV perpetuated by a failure to access and receive adequate healthcare is connected to organizational barriers such as lack of funding (Martin, 2005; Ullman & Townsend, 2007). One study analyzing organizational barriers in collaborating with SA survivors found that 64% of rape victim advocates identified a lack of funding as an issue leading to the delivery of lower quality care for survivors (Ullman & Townsend, 2007). This issue is exacerbated by the issue of stigma and the denial of SA within healthcare organization systems. As Ullman & Townsend (2007) explain, "the high prevalence of rape in combination with widespread denial of this problem contributes to the under resourcing of agencies that serve victims" (p. 421).

This is consistent with a previous study's finding in which health care organizations were described as "reluctant partners" in delivering services for SA survivors (Martin, 2005; Matthews, 2008). The term "reluctant partners" was developed as this study found hospital policies often focus on collecting evidence for legal purposes, rather than supporting health outcomes for SA survivors. In turn, services available to SA survivors were based on the idea among hospital workers (including nurses) of service delivery to SA survivors as a burden, that withheld hospital workers from completing "their "real" or "urgent" work of caring for the sick" (Matthews, 2008, p. 245).

As demonstrated the conditions established within healthcare organizations impact the occurrence of SV, through the denial and minimization of addressing SA survivors' healthcare needs. Such doubtful responses internalized within healthcare organization policies, practice, and culture, echo larger sociocultural attitudes that deny, shame, and blame survivors for experiences of SA (Matthews, 2008).

Considerations to Healthcare Access for Black Women

Mistrust

One reason contributing to a lack of seeking available services is mistrust of healthcare providers and the system (Suite et al., 2007). One example of this can be seen in one study conducted by Ullman and Lorenz (2020) that included African American women, in which many women discussed the "deeply rooted mistrust of mental health professionals" (p. 1951). It is important to remember that historically healthcare institutions have been intertwined with legal institutions in designing interventions for those sexually assaulted. However, both institutions hold a deep history of perpetuating racism that has led to mistrust within African American communities (Suite et al., 2007). Suite et al., (2007) provides one example that reflects on this history in stating "Southern blacks became a prime source for medical school dissection experiments and autopsy specimens. This practice continued in the postbellum South in the form of 'night-doctors' who stole and dissected the bodies of blacks." (p. 880).

As one participant stated in a study that explored the trust and distrust of physicians by African Americans, "I really don't trust the doctors that they really care about me because you know if you don't have insurance, if they don't see where they can get paid, they are really not interested in you" (Jacobs et al., 2006, p. 644).

The Cost of Healthcare

Experiences of sexual assault are known to impose substantial financial burden to those who survive sexual assault especially in relation to healthcare services. A recent study conducted among privately insured survivors' of rape in the U.S. found that "on average, 14% or $948 of the rape cost, whereas insurance providers pay 86% or $5789 of the total cost" (Tennessee et al., 2017). However, Black women experience disparities when it comes to access

to health insurance. According to the National Partnership for Women and Families (2019), Black women between the ages of 18-64 are most typically ensured by either an employer, Medicaid, or an individual plan under the Affordable Care Act. And "nearly one in five low-income Black women is uninsured, compared to eight percent of white women" (National Partnership for Women & Families, 2019, para. 4).

Furthermore, because of social inequalities Black women are positioned in a way that leaves them vulnerable to persistent economic insecurity. For this reason, Blacks in the States are known to experience higher rates of poverty (Gillum, 2019). About 1 in 4 Black women are likely to be in poverty (Inequality.org, 2020; National Women's Law Center, 2015). For this reason, healthcare costs are often a limitation impacting Black women's ability to access healthcare after an experience of sexual assault.

A study recently conducted by Ullman & Lorenz (2020) found, "being of older age and lower income" contributed to seeking less medical services among African American women who had experienced sexual assault. As Ullman & Lorenz (2020) explain "older age and income related to less medical care seeking, perhaps related to poverty that existed at high rates for older African American women who were less likely to be insured and/or have access to and use medical care" (p. 511). This particular study included a sample in which the majority of participants made less than $20,000 a year.

Important factors impacting Black women's access to healthcare. Few studies consider this factor in relation to Black women seeking health services following experiences of sexual assault. Although "similar research on survivors generally has shown that lack of insurance can also affect the quality of care, not just access to care, leading to revictimizing experiences" (Ullman & Lorenz, 2020 p. 511).

Social Stigma

Another limitation affecting Black women's access to healthcare following sexual assault is the "double stigma" associated with disclosing experiences of sexual assault, as well as potentially receiving unfair treatment (Alvidrez et al., 2011; Munroe, 2015). The term "double stigma" refers to the stigma that one may face in relation to disclosing sexual assault itself, and the stigma associated with being of minority status. As a result, many Black women may turn towards informal supports to seek help (Finfgeld-Connett, 2015; West et al., 2014). Disclosure to informal social supports has a great impact on whether or not survivors decided to seek healthcare services (Paul & Sasson, 2013).

The stigma of sexual assault is demonstrated within some studies suggesting that some may not access or disclose sexual assault within health care services due to the stigma of the experience of sexual assault itself (Ullman & Lorenz, 2020). This relates to societal myths which incorporates rape myth beliefs and rape scripts. As Ullman and Lorenz (2020) explain, some may believe in societal myths such as "the assault was not serios enough to warrant services" (p. 1944). For some Black women this may be in addition to stigmas that further racist ideologies or depictions of Black women.

Milwaukee Dynamics

Given that SV is an interaction within nurse-patient relationships, it is important to consider the existing dynamics within Milwaukee, Wisconsin. Home to over half a million people, Milwaukee includes the largest African American community in Wisconsin (United States Census Bureau, 2018; Wisconsin Department of Health Services, 2018). Other racial diversity represented within Milwaukee includes: American Indian (1%), Asian (4.7%), Hispanic

or Latino (15.4%), and mixed race (2.8%) (United States Census Bureau, 2018). One factor impacting the health of Milwaukee's communities of color is racism. Recently declared as a public health crisis in Milwaukee, a contributing factor to racism within the community is segregation (Pierre, 2019).

Milwaukee is commonly known as the most segregated city in the States (Paulson, Wierschke, & Kim, 2016). Redlining has especially contributed greatly to segregation in Milwaukee. Redlining is a term that describes discriminatory practices that deny minority populations access to equal housing and mortgage lending opportunities (Beyer et al., 2016). This leads to racially diverse Milwaukeeans disproportionately residing in impoverished neighborhoods compared to white Milwaukeeans, ultimately contributing to the creation of privileged neighborhoods and "other" neighborhood dynamics dictated by race (Do et al., 2017). These dynamics contribute to upholding social dictations that impact health outcomes through social determinants of health. The issue of high levels of segregation in communities in Milwaukee leads to not only disparate education and employment outcomes, but also leads to poorer health outcomes for communities of color (Do, Frank, & Iceland, 2017).

Furthermore, in 2013 the Wisconsin Center for Nursing found that nearly 95% of the registered nurse (RN) workforce were White with less than 5% of nurses of color in Wisconsin. In response to the lack of diversity within the nursing workforce, statewide initiatives have been implemented to increase the diversity of the nursing workforce in Wisconsin (Campaign for Action, 2016). The idea is that by "supporting the importance of a diverse workforce and helping to prepare the discipline of nursing to care for a substantially increasing diverse population—ultimately to help narrow the health care disparities gap" (Wisconsin Center for Nurses, 2019, para. 3).

Purpose

Although previous studies on SV have included examining experiences of SV perpetuated by HCP's among racial minorities following SA, no studies currently consider the racialized implications that may influence occurrences of SV within the context of a highly segregated community. Furthermore, to date few studies have focused on the perpetuation or prevention of SV specifically by nurses (Auten et al., 2015; Franchitto, & Rouge, 2010; Jackson et al., 2016). Of the studies conducted focused on the perpetuation or prevention of SV by nurses, these studies focus on emergency department and sexual assault nurse examiners (SANE) perspectives.

However, no studies to date have explored nurses practicing in acute care settings perceptions of SV when interacting specifically with Black women who seek services following experiences of sexual assault. For this reason, the purpose of this qualitative study, is to explore interactions between acute care setting nurses and Black women who have experienced sexual assault that better understand interactions that prevent or lead to SV among a sample of adult (18 years and older) Black women in Milwaukee, Wisconsin who have experienced SA and nurses currently practicing in acute care settings.

Research questions

The following research questions are considered:

1. What are Black women's perceptions of the nursing care they receive in acute care settings following an experience of sexual assault.
2. How have social, political, and economic contexts impacted the experiences of SA in the lives of Black women throughout history?

3. How do nurses' interact with Black women accessing healthcare and seeking help following experiences of sexual assault?
4. What are nurses' perceptions and experiences of providing care for Black women survivors of SA?
5. How do nurse's role influence the addressing of SA in health care and society?

Definition of Terms

Sexual Violence: Defined as non-consensual sexual activity, sexual violence is an umbrella term that encompasses all sexual non-consensual sexual activity or attempt, such as sexual assault and rape (CDC, 2020; RAINN, 2020).

Sexual Assault: Within this study, sexual assault is defined as any non-consensual sexual contact, intercourse, or attempt. This includes rape, sexual battery, and forcible penetration. This also encompasses non-consensual sexual contact or intercourse that "causes pregnancy or great bodily harm to that person", that causes the "victim…[to] reasonably…believe" that they are in danger (RAINN, 2020).

Black: This study focuses on African American participants that identify as Black. A term referring to a social political location, Black is often a term used to refer to the way in which one's ancestors were enslaved through processes of racialization.

Survivor: defined as "someone who has gone through the recovery process" following experiences of sexual assault (RAINN, 2019)

Organizational Statement & Aims

The following dissertation is composed of five chapters. The first chapter introduces the significance and prevalence of SV following experiences of SA. The first chapter also outlines

the purpose of the study, research questions, important terms to clarify, and a brief overview of theoretical frameworks used to inform this study. The second chapter presents a historical analysis conducted to understand the impact hegemonic masculinities hold in the lives of ethnic minority women that experience sexual assault. This comprehensive literature review, iterates the way in which racism and sexism have mutually contributed to shaping experiences of sexual assault in the lives of ethnic minority women (through social order hierarchies, "othering" dynamics, economic labor division, and negative media/mass communication depictions).

The third chapter of this dissertation focuses on the methodology of this study. In this chapter, the utilization and application of qualitative inquiry will be discussed, as well as a disclosure of the researchers' social position. This chapter also explicates the research design, sampling, data collection, scientific rigor, and ethical considerations used within this study.

The fourth and fifth chapters of this dissertation focus on the findings of this study.

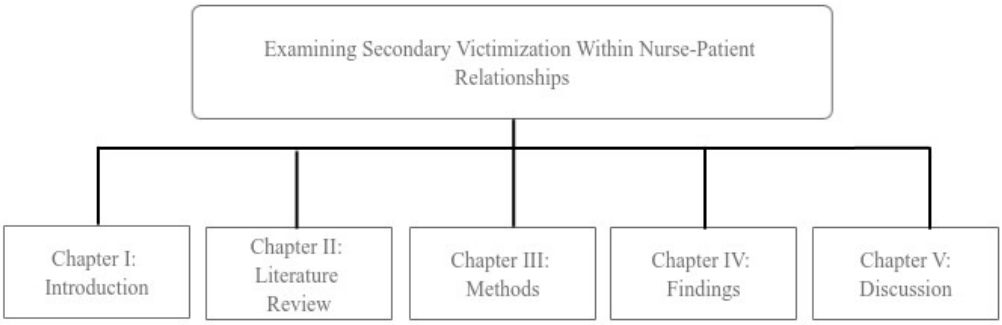

Figure 1. Organizational Statement Illustration

Ultimately, these chapters address the following aims:

Specific Aims

1. To examine the help seeking experiences among Black women following an experience of sexual assault from the perspective of women.
2. To gain an understanding of the interactions between nurses and Black women following an experience of sexual assault from the perspective of nurses.
3. To evaluate nurse perceptions and experiences of providing care to survivors of SA.
4. To analyze the role of nurses in addressing SA in healthcare and in society.

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Chapter II: Literature Review

Manuscript I: A Historical Analysis of the Impact of Hegemonic Masculinities on Sexual Assault in the Lives of Ethnic Minority Women: Informing Nursing Interventions and Health Policy

This manuscript fulfilled the requirements of the manuscript (non-traditional) option for the completion of my dissertation. This article was published in *Advances in Nursing Science*. The manuscript presented here was a historical analysis through comprehensive literature review, and examined the role of hegemonic masculinities, and iterated the importance of acknowledging hegemonic patriarchal histories to inform the future of nursing interventions and health policies.

A Historical Analysis of the Impact of Hegemonic Masculinities on Sexual Assault in the Lives of Ethnic Minority Women: Informing Nursing Interventions and Health Policy

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Abstract. Women's experiences of sexual assault are rooted in and informed by a history that nurses need to understand in order to provide meaningful and effective care. In this article, we present a comprehensive literature review guided by intersectionality theory to deepen our understanding of the historical role that hegemonic masculinity plays in shaping ethnic minority women's experiences of sexual assault. Final sources included were analyzed using thematic analysis. On the basis of our analyses, we identified 4 themes: social order hierarchies, "othering" dynamics, economic labor divisions, and negative media/mass communication depiction. Our findings contribute to our understanding of these important histories that speak to the trauma of sexual violence inflicted upon the bodies of ethnic minority women, which we can incorporate into nursing education curricula. Incorporating this knowledge would equip nurses and allied health professionals with the necessary knowledge and skills that would enable them to help patients navigate multiple systems of oppression as they engage in help seeking following a sexual assault experience. This knowledge also acknowledges rather than dismisses the historically acceptable use of sexual violence against ethnic minority women. In addition, acknowledging these histories enables us to move forward as a society in engaging in an urgently needed cultural shift to address the hegemonic masculinities that perpetuate violence against women in the United States.

Nursing is a profession rooted in relational dynamics, in which nurse-patient interactions are key to improving health outcomes. When it comes to addressing sexual assault (SA) through the development of workable nursing interventions, it is therefore important for nurses to

recognize the ways in which patients' experiences of SA*[1] are shaped by one's social position within existing and intersecting systems of oppression.[2] For ethnic minority women, this positionality is historically situated. In this article, we examine the role of hegemonic masculinities in informing ethnic minority women's experiences, specifically of SA. The ethnic minority populations of women we refer to in this article include, but are not limited to, African American, American Indian, Latinx, and Asian American women. Given the complexity in analyzing contextual differences across geographic regions, the scope of this review is limited to focus on ethnic minority women's experiences of SA in the United States.

A specific form of cultural domination, hegemonic masculinities refer to constructions of masculinity, in which masculinity that is oppressive in nature is cast as normative and a legitimate source of power to be used to subvert women.[3] Hegemonic masculinities enforce patriarchal gender hierarchies, which dictate gender relations and predetermine gender roles. Often rigid in nature, the resultant power dynamics contribute to gender inequalities that at their worst lead to SA, negatively impacting women's health.[3]

SA, as a form of violence against women, is a widespread social, public health, and human rights issue. The right to live free from violence is one of the most fundamental rights as a human being, a right that is a key component in internationally recognized instruments, such as the Universal Declaration of Human Rights.[4] Considered the "foundation of international human rights law," the Universal Declaration of Human Rights is a document proclaimed by the United Nations as the standard "for all peoples and all nations" to achieve in order to universally protect

[1] In this article, the authors define SA as any form of nonconsensual, sexualized activity or contact.[1]

fundamental human rights.[4(para1)] This right is one that many people in the United States take for granted but is not always true for ethnic minority women.

Moreover, violence against women is an urgent public health priority, given its adverse health consequences, which include poor mental health outcomes and poor overall health across one's life span.[5,6] While men also experience SA, women are disproportionately affected by SA.[7] The literature shows the highest prevalence of SA among ethnic minority women. For example, a study conducted in 2012 that included a sample of adolescent girls of various racial backgrounds showed African American girls as having the highest prevalence of forced sexual intercourse at 11.2%.[8] Also, according to the 2016 National Intimate Partner and Sexual Violence Survey report conducted by the National Institute of Justice, up to 56.1% of Native American women have experienced sexual violence (SV) in their lifetime.[9] The report also showed that 84.3% of Native American women have experienced some form of violence in their lifetime.[8] Yet, regardless of the higher prevalence, ethnic minority women are less likely to report SA than White women.[8]

The unique experiences of violence in the lives of ethnic minority women are informed by a history of hegemonic masculinities steeped in slavery and colonialism,[10,11] a history that nurses need to understand in order to appropriately tailor health interventions and nursing care for women who have been sexually assaulted. The social position occupied by ethnic minorities and the history that informs this position determine how one is able to navigate systems of oppression in seeking help following an SA through the various institutions, of which nurses are a part.[2,12] For ethnic minority women who have experienced SA, it is thus important for nurses to recognize patients' unique experiences that result from hegemonic masculinities in order to ensure that interventions are effectively tailored to their unique needs and realities. The goal of

this article is to expand nursing knowledge on the context in which ethnic minority women navigate their experiences of SA in connection to hegemonic masculinities rooted in historical oppression.

Ethnic minority women indeed often experience disparate health outcomes due to limitations in their ability to navigate systems that have historically not served them well. To address these disparities, there is need for a close examination of the historically embedded hegemonic masculinities deemed normative in justifying the image of hypersexualization of ethnic minority women while also rendering normative the control of White men over Indigenous, Black, and Brown women's bodies. These ideologies are the foundation for the high prevalence of SV in US society that renders women silent and limits their ability to seek recourse to find healing through health care and other institutions.[10,13]

The knowledge that we gain in analyzing these histories can lead to the development of well-informed nursing interventions and health policy recommendations.[1,12] Since ethnic minority women occupy multiple intersecting positions of vulnerability, aside from gender parameters, it is essential for nurses to apply contextual healing approaches that acknowledge history, and the ways in which these shape current experiences, in order to deliver effective interventions.[14] Nurses must first, however, learn to engage in resistance of oppression in all its various forms in not only their practice but also through their research.

The Value of Anti-Oppression Research in Analyzing the Experiences of Ethnic Minority Women

An anti-oppressive researcher is one who recognizes the various systems of oppression and how these are inextricably linked. Anti-oppression researchers are reflective and reflexive

and recognize and shed light on power and privilege. Their research ensures action, resistance, and reciprocity. Such researchers avoid replicating oppression by avoiding research activities that might contribute to the further oppression of women already living on the margins of society. Antioppression researchers do not just focus on research, but also focus on making systemic change within institutions so that research can be done in a truly anti-oppressive way and can lead to meaningful findings that inform praxis.[15,16] This approach informed the review, our analyses, and recommendations.

Intersectionality

An emancipatory theory descending from Black feminist thought, intersectionality analyzes the structure and function of social inequalities created on the basis of an individual and/or collective social position.[17]Applying intersectionality to this literature review provided us with the opportunity to critically examine the mutual and interacting impacts that racism and sexism hold in ethnic minority women's experiences of SA.[10] This theoretical application fosters our potential to expand knowledge related to social inequalities (ie, racism and sexism), as well as the ways in which violence (ie, SA) also complicates and perpetuates social inequalities (ie, racism and sexism) over time.[18]

Time, or history, is a component of social context. An essential core concept within intersectionality theory, social context is nonstatic and ever-changing. Since we are generating knowledge across a broad time period, an intersectional framework not only allows but also necessitates the need to incorporate social context that is specific to time in the generation of intersectional knowledge.[18,19]

Moreover, such theoretical application not only aids in generating intersectional knowledge but also acts to challenge practices engaged in by social institutions (such as health care) that contribute or enhance social inequalities (ie, racism and sexism) and, in this case, hinder ethnic minority women's healing from SA.19 Unveiling practices engaged in by institutions that contribute to social inequalities can help address and resolve systemic problems within these institutions. This includes institutions, such as health care, of which nurses are a part. Ultimately, intersectionality as a theoretical framework can lead to knowledge that informs the resolving of untoward practices and improve the quality of care provided to those who are recipients of nursing care.

Methods

Initially, this review was approached as a systematic integrative literature review using nursing and gender studies scholarship. However, such scholarship failed to yield scholarly literature that incorporated the historical processes that we sought. Therefore, a comprehensive historical literature review was conducted using 3 databases focusing on history in the United States.[20] Databases utilized include America: Life & History, Sociological Abstract, and Proquest History Vault. The inclusion criteria used included English text and female subjects. Search terms used in each database include the following: (hegemon* masculinit*) AND (sexual assault) AND (ethnic minority women).

A total of 82 articles were acquired; 2 duplicate sources were removed. The following exclusion criteria were then used to screen article titles, abstracts, and full-text: (1) articles must include ethnic minority women, (2) include a focus on SA, and (3) must be based in or focused on the United States. Scholarly primary and secondary sources were included in this review,

although introductions of books and editorial notes were removed. A final total of 28 sources were included in the Table for thematic analysis using MAXQDA.21

The process of thematic analysis began with familiarization of the literature reviewed.[22] This included organizing the literature in sequence of historical development and identifying potential themes.[23] Initial themes were generated from an analysis of the literature informed by intersectionality theory on the impact of the mutual interactions of racism and sexism on women's experiences of SA.[22] Analyzing the literature based on systems of oppression follows an intersectional approach that helps interpret the ways in which social inequalities function, and have functioned, in shaping women's experiences of violence, specifically SA.

Established themes were then reviewed by returning to the literature to "test for referential adequacy."[24(p4)] Themes were named and defined, and documented and agreed upon, by collaborating coauthors. Finally, a report was produced describing a thorough description of the context of each theme.[20]

Author (Year)	Time Period	Ethnic Minority	Purpose	Gender Findings	Ethnic Minority Findings	Intersection Findings
Freedman (2007)[44]	1700-1940	Native American, African American	Illustrate how sexual violence and its prosecution support patriarchy and white supremacy	Dynamics of sexual power hold different sexual relations forced upon women, against her will, and by men	Cultural construction of sex considered act between aggressive male and desired women gave white men protection from prosecution	White women offered legal protection from sexual assault. African American women excluded from legal protection from sexual assault
Stone (2009)[40]	1788-1865	Slavery	To examine incidents of sexual abuse against slaves in antebellum American history and where it is manifested in literature	Rape only legally recognized if experienced by a white female	"Mixed" slaves seen as labor for whites, not offered protection under the same laws applied to whites lead to the development of the slave code laws	No legal punishment provided to slave women who experienced sexual assault, rather master able to obtain compensation from assault
Vettel-Becker (2009)[35]	1788-1812	Native	Argument that public statues commemorating Sacagawea represents her maternal body as the American frontier and "birth" to a new nation	Women's role considered "natural" for motherhood	Attempts to "whiten" Sacagawea depicted to appropriate for white colonial benefit	Sacagawea depicted as more assimilable or "civilizable" but remains "primitive" as a "natural" representation of motherhood for all women
Whitsitt (2010)[28]	1813-1897	Slavery	Examines hidden messages in the text in "Incidents in the Lives of a Slave Girl" by Jacobs, who was sexually abused	Jacob's refusal to tell the truth of sexual assault represents accounts of girls and women silenced	"True womanhood" specified towards white women excludes women in slavery	Social standards for genders sought to further exclude or include based on race
Bardaglio (1994)[29]	1830-1861	Slavery	Historical reflection on rape laws during the antebellum time in the South	Rape considered theft of honor/purity or devalue of Southern white men's property	Sexual exploitation of slaves rationalized with negative stereotypes that black women were	Belief that only "respectable" women could be raped contributed to racial control for a century

					naturally promiscuous.	
DeWaard (2006)[27]	1852-1855	Slavery Native American	Explore gothic literary themes in Uncle Tom's Cabin in connection to 19th century law	Cecilia considered victim due to associations of white womanhood, in which white women hold virtue. This is presented through imagery of womanhood through angelic blue eyes and flaxen hair.	Black subjects are racialized embodiments, that are seen as "things". Ghosts used to depict the haunting of Native figures that haunt white American imagination representing fragility of national identity.	Cases such as Celia's hold parallel to Cassy as a victim, in which racialized violence is subtly enforced through the law in which Black subjects are criminalized or not human
Newsome (2003)[34]	1861-2002	African American	Investigate relationship between dominant group ideologies, the policing of social and spatial boundaries, cultural representations of African American women, and procedures and criteria US Customs use to target passengers for personal searches	Rape used as an instrument to control women	Representation of black women as Jezebel, tragic mulatto, matriarch, sapphire, and welfare queen all examples of stereotypes in American culture	Stereotype of black women perpetuate exclusion from positions of power in other systems of oppression
Bentley (2005)[45]	1866-1901	Slavery	To explore motives behind the ban on black-white marriage	Opposite-sex spouse of marriages only. 19th century marriage is a contract of bondage in which women were wanted to be unfreed or "enchained".	Antimiscegenation laws punished "shameful matches" of black-white marriages pre-civil war. After civil war, stigma of interracial marriages due to "baseline unworthiness" and	Institution of marriage in 19th century America attempts to cast marriage with stigma of slavery. Black women seen as sexual possessions. Prior to civil war Black women unthinkable to be wives. After civil war stigma of

						attachment of shame due to segregation laws.	being black cast women as undesirable.
	Davis (2004)[39]	1910-2004	African American	To examine the implications that welfare reform, specifically the mandatory work policy, has for Black women who have experienced violence	Historical derogatory imagery of Black women created (Jezebel, Mammy) used as a form of control	Labeling types of work, abilities or statuses to racial/ethnic group profiles	Poverty established in gendered and racialized ways to reinforce labor hierarchies
	National Women's Party (1929)[25]	1929-1960	African American, Asian American	Collection of women's legal rights and laws discriminating against women	Women status distinctions outlined, described as	"Negros" and "Mongolians" banned from interracial marriage with White. Class status distinctions outlined	Distinct separation between women and race, however no inclusion of ethnic minority women
	Cho (2009)[41]	1950-2009	Korean American	Analyzes the way in which the *yanggongju* is a figure that is both central and spectral in a Korean diaspora constituted by the double trauma of war and failure to remember it	Birth of *yanggongju* traced back to early Korean War when U.S. soldiers broke into homes and raped young women and girls	"Forgotten" war central to everyday lives of Koreans in which women workers forced into sex work due to incurred debts	Sexual exchange between American servicemen and Korean women silenced is one example of violence within U.S.-Korea relationship
	Rousseau (2013)[46]	1967-2011	African American	To understand the unique social, political, and economic positions of Black women within the US	Working class women experience unique oppression as producers and reproducers	Black women historically contextualized as an instrument for labor production	Matrix of domination iterates structural roots of oppression in which Black women navigate multiple social locations
	National Women's Party (1971)[47]	1969-1971	African American, "other" minority	Equal Rights Amendment legislation and congressional committee reports	Classification by gender focused on reproductive function, physiological,	Women's liberation movement excludes non-white women	Presents social constructions surrounding categorization of gender, and the "othering" of

				functional, and psychological differences and behaviors related to "sexual urge"		ethnic minorities within women's resistance movements
Ferber (1999)[30]	1969-1993	African American, jews, non-white	Explores the intertwined construction of race, gender, and class in contemporary white supremacist ideology	White women perspectives assumed to represent all women	Protection of white womanhood symbolic to the protection of the white race	Interracial sexuality considered the "ultimate abomination" and a threat to white supremacy
National Women's Party (1970)[48]	1970	African American	To prohibit discrimination against women in federally assisted programs and in employment in education	Standard of womanhood considered white women	Stereotypes created to create social inferiority	Same ideas and characteristics of oppression applied to women as ethnic minorities
Black Panther Party (1971)[49]	1971-1975	African American	Objective is to eliminate all forms of racism and sexism	Women face economic, social, and political oppression due to historical evolution of class	Black women dual role as being mother and wage-earner	Black and working-class women excluded from women's movements
Diamond (2012)[50]	1971-2012	Native American, Asian American, African, Arab	Reflection on identity politics or collective activism	Feminism considered not an identity but a mode of action to challenge social limitations, such as the need to be 'ladylike'	The Cambahee River Collective's 'Black Feminist Statement' in 1977 protest racism in predominantly white women's movement, iterate the importance of coalition within different groups	Systemic violence consistent throughout different systems of oppression requires collective efforts in taking action against sexual violence
Fuller (2004)[26]	1974-2001	African American,	To recognize gender, race, and social class	Women characterized as possessing	People of color experience	Gender, class, and race-ethnicity systems of

		Asian American, Jewish American	differences to increase effectiveness of social change efforts	"sensitive" traits, while Black women characterized as "loud" and "stubborn"	stereotypes that centralize sexuality	domination or oppression in which some people are disadvantaged while others privileged
Jenness (1999)[32]	1985-1998	People of color, Jews	To understand and account for the content of legal categories that define social problems and attendant victims	Violence Against Women Act recognizes hate crime for victims of violent crime motivated by gender	First hate-crime congressional hearings in 1985 mobilized state level laws recognizing bias-motivated violence, specifically related to racialized motivated violence	Victimization a social construction applied to those that have been unjustly targeted such as in racism and sexism
Rajgopal (2010)[43]	1988-2010	Asian American	Analyze discourse of the portrayal of Asian women in cinema and television news	Homogenization of diverse groups of women within Western film	Representation of Asian cultures as premodern and irrevocably opposed to Western	Sexism and racism supported the perpetuation of the hyper sexualization of Asian women in mass media
Mitchell (2013)[31]	1990-2013	African American, Native American, Asian American, Latino/a	Reviews Americanist gender scholarship on race and ethnicity from 1990-2013	Captive-exchange system of women and children within rivalry/war used to reinforce gender hierarchies	Histories of ethnic minority women erased from American women's history	Intersectionality theorizes race, class, and gender in relation to power, privilege, and conflict
Facciani (2015)[51]	1991-2005	African American	Aims to provide a quantitative assessment of themes race, gender, and class in comic books	Women hypersexualized within comic books due to sexism and the acceptance of rape myth culture	Characters of color portrayed in relation to stereotypical roles have less agency equal to white characters	Non-white characters under represented within comic books
Phipps (2019)[36]	1991-2018	African American	Reviews recent mainstream movements and media attention addressing SA	#MeToo considered latest of sexual violence campaigns that privilege white	Political discourse related to sexual violence often	Single issue politics not considered resistance, intersectionality of

				women while failing to recognize work of black women and women of color	exclude people of color	systems need to be connected to struggles
Derkas (2012)[42]	1997-2010	African American	Examines the role Project Prevention plays in problematizing women's struggle for reproductive integrity, especially for poor women and women of color	"eliminating drug exposed pregnancies" translates to determining women deemed unfit for motherhood and governing their sexuality	Racial codes translate women of color as lazy, poor, promiscuous, and hyper-fertile	Power of hegemonic control is domination is imposed through control or manipulation of ideas
Kaba (2017)[33]	2000-2016	African American, South Asian American, Hispanic	Examine American citizenship and how it relates to Black Americans, from the perspective of education attainment and national political leadership positions	Throughout American history citizenship applied to masculine characteristics	American history defines American citizenship based on racial heritage, specifically Whiteness or the extent of non-Black	Dual social citizenship, gender and economic position establishes two tiers of citizenship
Kim (2006)[52]	2001	Korean	To examine women's transnational engagement of hegemonic ideologies of white American masculinity	Economic empowerment in US often considered "Americanization of gender" by Korean women	Korean virginity-until-marriage ethos supported resistance towards "Americanization"	Hegemonic white masculinity ideal often seen as gender progressiveness due to historical implications between US and Korea
Samuels (2003)[38]	2003-2007	Minorities	Explore and analyze the Academy environment and the implemented changes using the framework of privilege	Sexual assault often unchecked and demonize women rape survivors due to male privilege beliefs	Privilege confers dominance and gives permission to control based on one's race or sex	Wide spread cultural change originates from those in a position of power and resisted by those at the bottom of the hierarchy
Behl (2019)[37]	2011-2016	South Asian American,	Autoethnography examining new ways of seeing, being, and	Sexual harassment, SA, and rape prevalent among college women	Indian father shot in post 9/11 environment by perpetrator with anti-	Women of color experiences of violence often silenced and

Asian American Arab American	writing of political science	Arab terrorist motives; EMW voices silenced within dominant paradigms focused on SA/rape	excluded within academia and political science

Results

The literature reviewed focuses on ethnic minority women's experiences of SA from the 1700s to 2016. This time frame is appropriate, as it includes slavery and colonization processes that impact current experiences of SA in the lives of ethnic minority women. Nineteen critical analyses, 5 historical articles, and a case study, book review, autoethnography, and ethnography are reviewed. Twenty-five sources stem from sociology and 3 stem from literature.

Themes identified represent consequences of hegemonic masculinity, and the role this has historically held and continues to hold in the lives of ethnic minority women, informing their experiences of SA today. Four interrelated themes were identified using thematic analysis including social order hierarchies, "othering" dynamics, economic labor division, and media/mass communication depiction.

Social order hierarchies

Social order hierarchies refer to the structuring of gender and race values created through American ideas of hegemonic masculinities. These hierarchies determine the "most" and "least" valued within a society through inclusion and exclusion.[25] For example, in this review, we determined how European American ideas of gender shaped norms and expectations that included men as the standard. This conceptualization of men led to women being seen as the default of men. Consequently, women were acceptably considered inferior to men. An example of this can be seen in a collection of laws gathered by the National Women's Party, which identifies laws discriminating based on gender that explain "it was almost universally believed that a woman's brain was smaller in capacity and therefore inferior in quality to that of a man."[26(p168)]

Hegemonic masculinities excluded ethnic minority women, who were omitted from ideas of femininity based on race. Ethnic minority women often faced racial discrimination that described them as "loud" or "stubborn," the opposite of what White America considered "feminine" traits (ie, "emotional," "passive").[27] An example of this can be seen in a literary critique examining Uncle Tom's Cabin, in which the main character, Cassy, a mixed woman, is described as possessing "debasing influences" as a result of slavery that "create women that were not women."[28(p9)] As this statement expresses, femininity by dominant White American culture was viewed as exclusive to White womanhood.[29] In contrast, the less proximity one had to whiteness, the more one was considered a corrupt or contaminated version of femininity, ultimately leading to the denial of one's womanhood.[28]

The creation of social order hierarchies created through hegemonic masculinities became embedded within individual, systemic, and institutional social actions[30] that regulated SA based on gender and race. For instance, although White women were afforded legal protection from SA, these crimes were not considered a violation against the individual woman's autonomy. Rather, it was a dishonor to the lead male of the household.[31,32] Such patriarchal ways of thinking influenced actions within legal and other institutions that often led to the questioning of a woman's credibility throughout legal processes.[31]

For African American women specifically, this is seen throughout early US history. Slave codes, for example, enacted in the mid-1800s, intentionally excluded the SA of enslaved women in order to benefit White masters who frequently used SA as a means to maintain social control of slave communities, while also expanding their supply of labor through procreation resulting from rape.[30,31] As Bardaglio explains, "The relative silence of the law on the subject of female

slaves who had been raped spoke volumes about the structure of power in. . . society, dramatizing the double burden of race and gender that these women endured."[31(p758)]

"Othering" dynamics

The exclusion of those not valued within society contributed to the creation of beliefs and attitudes that supported "othering" dynamics within interactions. These attitudes and beliefs supported the distancing between the "dominant" and those considered "other" based on the prevailing standard.[30] Those identified as "other" were also considered "deviant" and were viewed as a challenge or threat that had the potential to destabilize societal values.[33,34]

In 18th-century US society, women were considered property to be possessed by White men.[31] Since the value of the "property" was based on a woman's purity, women who brought forward SA charges faced stigmatization and shame through the reinforcement of genderdized class stratification, in which they were viewed as "contaminated" or "impure." Such attitudes and beliefs supported the development of negative stereotypes that upheld the idea that once women lost their sexual "purity," they lost all moral senses.[27] Women who brought forward SA charges were thus viewed as untrustworthy, "lying temptresses." These beliefs and attitudes also perpetuated the idea that women who engaged in prior sexual relationships could not be sexually assaulted and presumed that such women had automatically provided consent for sexual activity. This was commonly seen among women who were known to engage in sexual intercourse outside of marriage, which was used to demonstrate the victim's poor character and to discredit her testimony.[27]

Ultimately, these attitudes and beliefs about women were created and used to discredit women. Through the use of hegemonic masculinities, in which men were seen as the standard

and women as "other," such attitudes and beliefs supported and firmed the upholding of patriarchal values within society. The measures taken stemming from such beliefs and attitudes served to silence women, while also maintaining ideological distance between those who were viewed as dominant and those cast as "other."

Women of color face gendered "othering" dynamics, as well as "othering" dynamics based on race. An example of this is the regulation of SA against women of color in early 18th-century America. At this time, the legal processes of regulating SA were based on race, as legal systems only viewed the rape of a White woman as a crime.[35] Rape cases were therefore often dismissed for women who did not explicitly provide "adequate evidence of her race."[31(p764)] These racial and sexual regulations, built upon racist notions that rendered women of color as hypersexual nonbeings, influenced social pedagogy related to who belonged or deserved to be provided full rights of protection or even who could be granted full citizenship.[27,31,34,36-39]

Historically, citizenship in the United States has been granted on the basis of gender and race.[33] As Kaba explains of this history, " . . . citizenship was analogous with assimilation into the dominant culture . . . ."[37(p106)] The dominant culture being men by gender and White by race, and women of color being "other" on both parameters. The "worthiness" of protection based on full citizenship was then based on how well one embodied proximity to whiteness through assimilation, also known as the "American-White effect."[37] The exclusion of non-White minorities from receiving the same recognition of belonging as American led to their denial of full citizenship or protection. Ideas of citizenship or lack thereof are thus closely related to the acceptable violation of those deemed unworthy of citizenship or protection through SA. This was manifested during the colonial era.

Colonial conquests motivated by the economic interests of European settlers often involved the use of SA against American Indian women.[34,38,39] Even from their very first contact with Indigenous peoples in North America, colonizers felt entitled to possess the land, as well as the bodies of American Indian women who lived on the land. SV against American Indian women became a means of colonial conquest by the colonizers. European men considered Native women sexually promiscuous and exotic, which led them tobelieve that American Indian women, who they deemed as other, not part of their citizenry and therefore unworthy, were available and free for their personal possession and sexual violation. In other words, American Indian women's bodies were free for the taking, just as the land was. Colonial conquest and resultant injustices have continued to the present day, manifesting in the current prevalence of violence in the lives of American Indian women, more than 90% of which occur at the hands of non-Native men.[9]

Economic labor division

Hegemonic masculinities also inform who controls resources based on gender. As Phipps explains, the "capitalist accumulation. . . relies upon women's economic subordination to men in both the family and the workplace, which is a key driver of violent and sexually violent abuses of power."[40(p71)] With recent movements such as Time's Up, the issue of SA in the workplace has become a topic gaining mainstream awareness through online platforms in an effort to promote gender equity. Violence in the workplace, and other places of opportunity such as academia and the military, serves as a form of resistance against women attempting to gain access to opportunities that would enhance their well-being and enable them to contribute in meaningful and rewarding ways to society.[41-44] Ultimately, violence is a form of resistance and an effort to maintain control over what is seen as valuable resources.

An example of this is the mogul film producer Harvey Weinstein, who sexually assaulted a number of women trying to get a role in the film industry. The idea that Harvey Weinstein was able to sexually assault women over a period of decades with no recourse speaks to the power he embodied as a White male over women who were trying to get a break in the industry. In this case, SA was used as a tool to keep women in their designated place, on the lower rung of the hierarchy, and to demonstrate that they could only obtain access to resources and opportunities as those on the highest rung of the hierarchy (read: men) deemed fit. As Samuels and Samuels explain about hegemonic masculinity, men are described as "a man in power, aman with power, aman of power . . .being strong, successful, capable, reliable, in control"[42(p6)] whereas women are seen as the opposite of all these. As a result, SA within labor is deemed normative, acceptable, and "the way we've always done it," creating barriers for recourse in the labor environment or workplace when it occurs.

Furthermore, hegemonic masculinities contribute to shaping the gender and racial politics of labor. Extreme inequalities in educational opportunities, health, and social well-being for many ethnic minority communities in the United States have resulted in generational poverty that see ethnic minority women remaining in low-wage employment.[30,45] For example, it is seen as normative and even expected that ethnic minority women work within service industries that reinforce gendered and racialized labor force hierarchies."[45] These include the food service industry, the hotel industry, and even the health care industry where women of color frequently work as certified nurse assistants or as housekeepers.[45] Ethnic minority women employed in these industries are vulnerable to not only poverty but also violence, as these positions often do not afford women with economic security or protection. Fear of retaliation, losing the jobs, or

losing the limited opportunities available to them render women silent following an act of violence perpetrated against them.[45]

As discussed, SA has been used to maintain control of labor gained from ethnic minority women that can historically be traced back to slavery.[31,35,45,46] These intricate ties between labor and SA contribute to shaping the rationales that support the accepted use of SV, in order to benefit those in power. As Stone explains, enslaved women were intentionally not protected from rape as they were seen as "the ravished body, unlike a broken arm or leg, did not bestow any increment of subjectivity because it did not decrease productivity or diminish value."[35(p67)] Instead, masters of slaves were allowed to "trespass" upon their own "property" (ie, slaves) and/or seek monetary compensation for the rape of a slave committed by someone other than the master.

The intersection of labor and SV also led to the idea of achieving assimilation and resultant economic benefit through heterosexual, interracial marriage arrangements.[47] As Cho explains, "Intermarriages . . . are taken for granted as measures of assimilation . . . it is within this frame that the *yanggongju*[2] as GI bride is an exemplar of assimilation whose progeny become "honorary whites."[48(p325)] The term *yanggongju* emerged in the 1960s, after "the Korean government tried to discipline camp town sex workers into the role of the patriot who was fulfilling her duty to the nation by keeping American GIs happy, and thereby keeping U.S. interests engaged in Korea."[48(p313)] These relations often involved SA, while leading to interracial marriages between White soldiers and yanggongju as a sign of "interracial harmony and international cooperation."[48(p313)]

[2] Yanggongju refers to Korean women who worked in part of the system of militarized prostitution, and translates to "Western princess," but is often referred to as "Yankee whore" or "GI bride."[48(p310)]

Negative media/mass communication depiction

Social expectations of gender created through hegemonic masculinities supported imagery within media and mass communication that depicted ideal femininity as exemplified by White womanhood believed to possess high morals.[49] In contrast, ethnic minority women were often vilified and described as primitive or animalist. Examples of this can be seen throughout literature, such as in Uncle Tom's Cabin, which features femininity in relation to angelic figures with blue eyes and flaxen hair. In contrast, the main character, a mixed slave girl, is described as having "heavy black eyes" that are darker than her light skin, expressing her dangerous power.[28] As Rajgopal states, "Mass culture and cinema in particular plays a crucial role in constructing the categories that reinscribe racial hierarchies, and the process of racialization is often gendered."[50(p146)]

The social construction of race supported through ideas of hegemonic masculinities has been applied to ethnic minority women to determine who is assimilable or "civilizable."[40] One image commonly imposed upon ethnic minority women is the biblical figure of Jezebel. Jezebel is depicted as a seductive deviant woman with an untamed sexual appetite.[45] These "images contradict the defining characteristics of the ideal woman: one who is fit, moral, deserving, selfless, mostly White, middle class, and virtuous."[41(p3),50] Hypersexualized depictions or characterizations, as Jezebel, for example, are then used to justify the exploitation and sexual violation of ethnic minority women based on gender and race.[36,51,52]

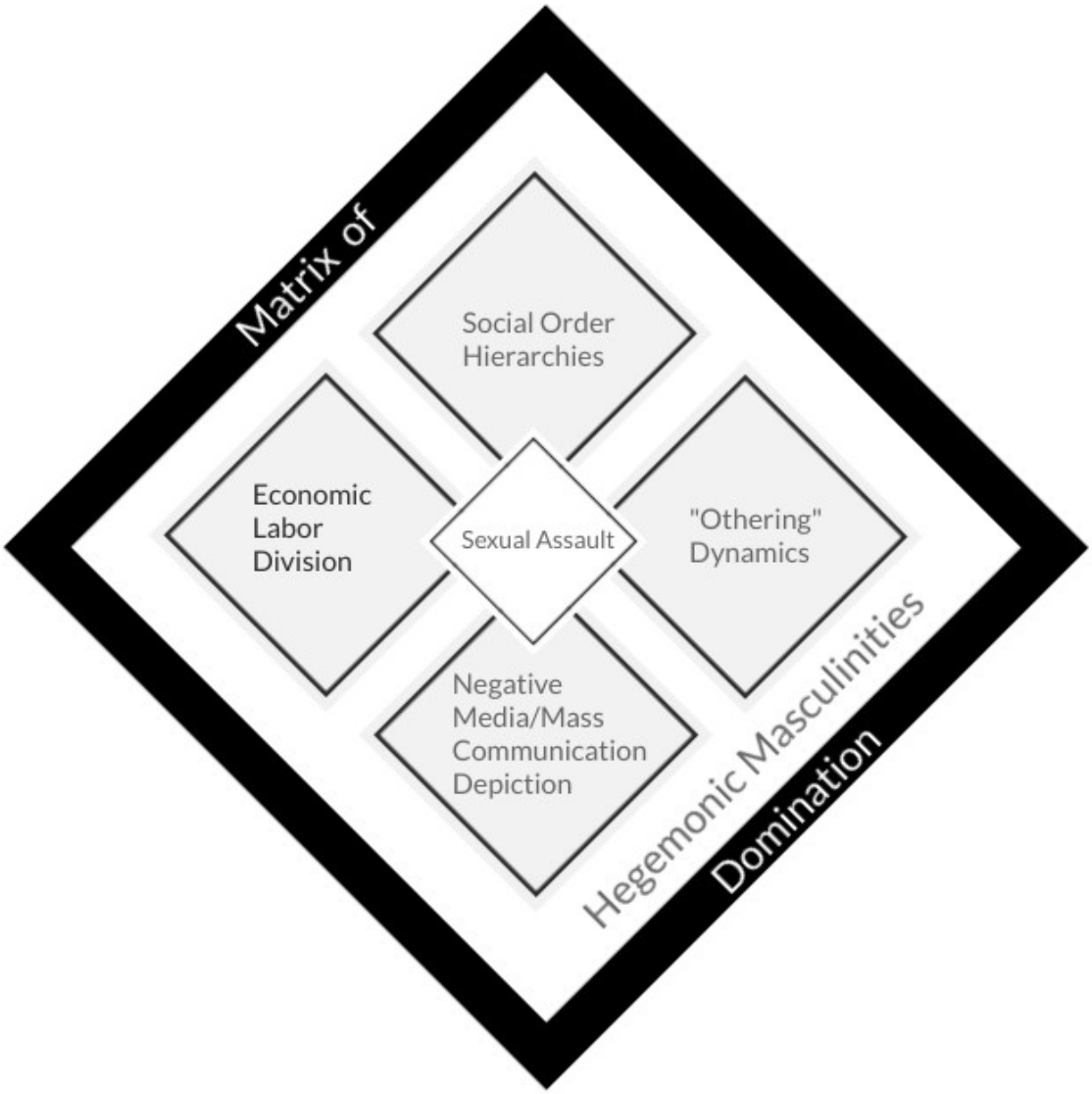

Figure 2. Hegemonic Masculinity Findings Within the Matrix of Domination

Discussion

The themes identified within this literature review (social order hierarchies, "othering" dynamics, economic labor division, and media/mass communication depictions) demonstrate the ways in which hegemonic masculinities have held a central role in perpetuating the social acceptability of SA based on the intersecting gendered and racial systems of oppression. By

normalizing genderdized beliefs, other beliefs and values driven by concepts of classification (ie, race) are easily transferred to silence those already vulnerable to existing systems of oppression based on gender. As a preexisting ideology, the belief systems and values established through hegemonic masculinities become embedded to support other social hierarchies across different systems of oppression (ie, race). The result is an interlocking of oppressive systems that create intersecting vulnerabilities based on gender and race parameters that ethnic minority women must navigate in order to survive the experience of SV.

Ethnic minority women are, however, often classified singularly in terms of race, which also serves to deny women's inclusion into womanhood, a classification that historically as discussed perpetuated laws and policies prohibiting them from seeking recourse following an experience of SA. Women of color were and continue to be excluded from socially constructed identities of femininity and motherhood based on White European American standards. This exclusion has indeed historically served to overlook, silence, and nullify ethnic minority women's experiences of SA, requiring them to navigate gendered and racial systems of oppression even as they seek help following an SA. Our goal in explicating this history is to make visible and to challenge the historical reality that ethnic minority women's bodies were and continue to be considered acceptably available targets for SV.

Furthermore, the public misrepresentation of ethnic minority women attempts to not only homogenize large diverse populations (this includes but is not limited to Asian, Latina, Native, and Black women) but also lead to the denial of recognizing all women as equals and hinder the promotion of gender equality for all. This denial is based on preconceived notions that impose hypersexualized or exoticized views rendering ethnic minority women as primitive or subhuman. As a result, diverse populations of ethnic minority women share similar experiences of

objectification reinforced through sexualized stereotypes, often publicly considered a true representation. It was just earlier this year that Latina entertainers Jennifer Lopez and Shakira were castigated by a predominantly White upper-middle-class audience for their half-time show, which was labeled offensive, inappropriate, and indecent. This is just one example of how the policing of the bodies of women of color occurs today in the form of perceiving entertainment provided by 2 Latina women as socially unacceptable and not in line with what is considered the standard. The hypersexualization of ethnic minority women, the perception of their dance moves as provocative, serves to uphold the historical narrative, rooted in hegemonic masculinities, of them as dangerous, holding the potential to destabilize family and societal values.

The historical processes we have described thus serve to inform the everyday dynamics and interactions in society today. This includes ethnic minority women's interactions with health care professionals, as well as health care as an institution. As a dominant ideology, hegemonic masculinities establish social standards and expectations of how daily interactions ought to occur. These socially accepted standards and expectations inevitably become embedded into institutional policies that individuals create. An example of this can be seen in the creation of Project Prevention, which aimed to eliminate drug-exposed pregnancies.[49] Such programs supported rhetoric that targeted women of color struggling with addiction as problematic in "transferring a deviant lifestyle to their children, dooming them to the cycles of poverty, violence, and despair believed endemic to Black culture."[49(p181)] These programs, designed to address addiction, a public health concern, led to "creating barriers to access, violations of privacy rights and bodily integrity, erosion of autonomy, undermining confidentiality between patients and doctors, and ultimately threatening reproductive choice in general."[49(p186)]

This example shows how ideologies stemming from hegemonic masculinities lead to intersecting sexist and racist rhetoric occurring in daily interactions to ultimately inform health care policy that then fosters the occurrence of ethical violations jeopardizing the safety, health, and well-being of ethnic minority women. The policies of the health care establishment inevitably become expressed in interactions between health care providers, such as nurses, who implement such interventions, and the patients they are meant to serve. It is thus imperative that health care institutions and systems that are designed to address the health of all peoples, particularly when it comes to meeting health needs resulting from the trauma of SA, reestablish a trusting relationship and iterate a commitment to meeting the health of all peoples. Health care institutions also need to critically evaluate their organizational culture and policies from the perspective of patients who are the recipients of their care. The interactions of health care providers and patients also need to be closely examined and reflected upon to ensure that they are not informed by historically oppressive ideologies that further marginalize populations already experiencing disparate health outcomes.

This review also demonstrates the need to analyze the existing resources available to SA survivors when navigating health care institutions. In our analyses, we have shown how the allocation of resources and opportunities, and the ability or power to allocate resources, has historically been used to inflict violence in the lives of ethnic minority women. Nurses have an obligation to ensure that women's potential and opportunity to heal following an experience of SA are not stifled as a result of limited access to health care facilities and resources. This reiterates the need for nurses to understand their position as gatekeepers. As nurses, the resources we allocate, provide, or withhold, whether consciously or not, including health knowledge and interventions, have important implications for the healing of women who have experienced SA.

It is important to note that although we have focused on historical processes and their implications for ethnic minority women who have experienced SA, intersectionality theory calls for an analysis of how all genders experience SA. Related to the concept of relationality, intersectionality leads us to explore the ways in which individuals occupying various social positions relate. As Collins and Bilge explain, "The focus of relationality shifts from analyzing what distinguishes entities, for example, the differences between race and gender, to examining their interconnections."[19(p26)] Therefore, nursing considerations developed from intersectional frameworks focused on ethnic minority women who have experienced SA also apply to individuals experiencing SA who occupy other positionalities. Intersectionality is a valuable framework because it calls for interdisciplinary collaborations, community engagement, and coalitions that center the voices of those most affected by the problem under investigation, in this case, SA.[53] Moradi and Grzanka[53] argue that intersectional problems involving complex factors such as ethnicity, poverty, and gender require a response that involves coalitions across disciplines and difference in order to be effective.

Ultimately, we are analyzing generally power differentials between those who experience SA and those who create oppressive systems that lead to SA, as well as those responsible for meeting the health care needs of survivors.

Finally, it is important to incorporate histories that recognize the trauma of SV inflicted upon the bodies of ethnic minority women within the education and training curricula offered to health care personnel, such as nurses. This education would equip nurses and allied health professionals with the necessary knowledge and skills, knowledge that is contextualized in the histories that inform patients' positionalities today and skills that enable health professionals to help patients navigate these multiple systems of oppression. Knowledge that takes into account

these historical processes serves to inform the development and implementation of more effective health interventions grounded in policies that disrupt the hegemonic masculinities and the ideologies that have contributed to the shaping of ethnic minority women's experiences of SA. This knowledge also acknowledges rather than dismisses the historically acceptable use of SV against ethnic minority women. These are historical acts and realities that need to be revisited and acknowledged because they are too often forgotten, overlooked, and dismissed, rendering ethnic minority women and their realities invisible.

At the writing of this article, the world is experiencing a pandemic, with the United States at its epicenter, alongside racial injustices related to police brutality made more visible in recent times as a result of social media. The problem of violence in the lives of women has become more urgent as agencies meeting the needs of women experiencing SA, as well as intimate partner violence, see exponential increases in the number of calls received, while women also hesitate to seek services when there are orders to stay home due to their fear of contracting COVID-19.[54,55] During nonpandemic times, ethnic minority women used fewer law enforcement or social services when they experience victimization; more commonly, they endure violence until it becomes severe, at which time they may seek help from emergency health services or informal social networks.[56] Globally, there have been reports of increase in the number of domestic violence–related homicides linked to the pandemic.[54]

In this current dispensation, it becomes even more imperative to incorporate histories of racial and gender oppression into nursing education curricula in order to foster nurses' understanding of why ethnic minority women may be hesitant to access health care after experiences of SA. Nursing education has rightly incorporated reflection into nursing education curricula as one way of addressing internalized racism.[57] Reflexivity encourages future nurses to

consider " . . . actions . . . taken for granted as best practice without consideration of the specific needs of the woman being cared for, questioning assumptions based on the race of patients, and identifying acts of implicit and explicit racism in our [nursing] practices."[57(p98)] Although such reflection enables future nurses to self-examine how they might engage with a patient of a different race than they might themselves do, providing historical context to the ways in which institutions have and continue to shape institutional responses to acts of violence, such as SA, specifically for individual and community is also valuable. Such historical context would provide nurses with greater insight into women's help-seeking patterns, enabling them to contribute to minimizing barriers that hinder women's healing, especially as it relates to nursing care.

Limitations

Although this literature review iterates the importance of historical context in understanding and contextualizing ethnic minority women's experiences of SA, the following limitations should be considered. To begin, literature included required the specification of experiences of SA, although SA is often included as a component of other forms of violence, such as intimate partner violence. Literature that did not clarify the occurrence of SA within other forms of violence was not included for review. Second, literature included for the review focused on ethnic minority women's experiences only within the United States. This allowed for the analyses of the experiences of diverse populations of ethnic minority women, including Latinx, Native, Asian, and African American women. It is important, though, to acknowledge that SV is a shared experience among ethnic minority women across geographic borders and even across continents. For instance, indigenous women and enslaved women of African descent across the Americas and not just in the United States faced similar experiences of SA.[9,45] An extensive literature review that covered North, South, and Central America, and even other

colonized countries with a similar colonial history such as Australia and New Zealand, were beyond the scope of this review and would have been challenging to analyze, given the vastness of the literature we may have acquired and the complexities in analyzing the contextual differences across geographic regions. Our hope, though, is that the knowledge we have garnered through this review can be translated to inform nursing education and practice related to meeting the needs of ethnic minority women who have experienced SA in other Western countries.

It is also important to note that ethnic minority women are not a homogeneous group of women and that the experiences of women even from the same people group can also be diverse. It is our hope that our analysis does not homogenize women even as we categorize women in our analysis as ethnic minority.

Conclusion

This literature review presents an overview of the historical legacy that hegemonic masculinities have held, and continue to hold, in contributing to the upholding of social order hierarchies, "othering" dynamics, economic labor divisions, and negative media/mass communication depictions of ethnic minority women and informing women's experiences of SA. Such legacies throughout time contribute to shaping not only the traumatic experiences of SA that ethnic minority women initially encounter but also the ways in which ethnic minority women navigate individual and institutional spaces in an effort to find healing from those experiences. Since hegemonic masculinities lead to social practices that inherently become a part of US society, these ideologies are then embedded into policies created by those in a position of power. As we become more consciously aware of how hegemonic masculinities inform our practice as nurses and our interactions with ethnic minority women, we can contribute to the disruption of such ideologies and pave the way for interventions and policies that allow for

women's healing and, ultimately, a change in societal attitudes that would altogether bring an end to violence in the lives of women.

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Chapter III: Methodology

Utilization & Application of Qualitative Inquiry

As a social phenomenon, our qualitative inquiry provided in-depth accounts for understanding the prevention or infliction of SV. We asked for the perspectives of nurses in acute care settings and Black women survivors of SA who received nursing services in an acute care setting. The new knowledge we gathered had an emphasis on diversity through inclusion, respecting the perspectives of nurses as well as patients who received nursing services. Including both sides of the story of SA, both the giving and the receiving of nursing care following an assault, ensured that our data was detailed, rich, and complex.

Applying qualitative inquiry was appropriate for our study due to the intersection of myriad complicated contexts surrounding SA in US culture. Gathering this sensitive data required consideration of social context, i.e. the history of gendered and racialized regulations governing SA in the US and how this history informed present day responses to SA, in order to understand what occurred between nurses and patients. Understanding these contexts contributed to our qualitative inquiry into barriers perpetuated by nurses and/or perpetuated through the nurse's position within harmful healthcare systems. Qualitative inquiry drew out the embodied knowledge of our participants' lived experiences of Black women who sought and received nursing care following SA.

Qualitative inquiry allowed for examination of Black women's experiences of SV following experiences of SA, acknowledged deeply rooted societal values and beliefs that shaped traumatic responses and experiences lived by Black women, and provided a space for hearing participants' voices. We created a space for listening to and hearing from nurses and survivors,

and this spoke to our recognition that "there are multiple knowledges" where commonly there were some types of knowledge silenced and unheard by one or more systems of oppression (Denzin & Lincoln, 2017, p. 157). Our qualitative inquiry exposed those commonly overlooked or disregarded types of knowledge.

Theoretical Frameworks

This qualitative study answered research questions presented in Chapter I by utilizing black feminist thought and intersectionality theory.

Black Feminist Thought

Black feminist thought posed questions geared towards understanding, analyzing, and reexamining "the relationship between knowledge and power" (Alinia, 2015, p. 2334). An analytical tool and critical praxis, black feminist thought resisted the oppression historically encountered by Black women as a group.

As Patricia Collins (2009) explained:

> The purpose of Black women's collective thought [wa]s distinctly different. Social theories emerg[ed] from and/or on behalf of U.S. Black women and other historically oppressed groups aim[ed] to find ways to escape from, survive in, and/or oppose prevailing social and economic injustice" (p. 11).

As a political process, black feminist thought iterated one's positionality in connection to historical processes and one's relationship to the effects of unquestioned privilege (Lorde, 2007). When applied to research examining SV within nurse-patient relationships with Black women who disclosed sexual assault, black feminist thought presented potential for generating new

knowledge to inform nursing practice, to resist multiple systems of oppression, and to facilitate contextual healing through recognized history.

Qualitative analysis engaged us in dialogue that sought to understand the phenomena of SV, and validated knowledge generated on SV between nurses and Black women who received care after disclosing SA. Such dialogue required a connection or partnership that generated harmonious interactions. A central epistemology of Black feminist thought, Black feminism presented the importance of engaging in dialogue and challenged traditional approaches within academia focused on the use of debate for solidifying and validating knowledge (Collins, 1989; Norris, 2012). As Collins (2019) explained, "For Black women new knowledge claims [we]re rarely worked out in isolation from other individuals and [we]re usually developed through dialogues with other members of a community" (p. 279).

Intersectionality Theory

Intersectionality theory was rooted in Black feminist thought and emphasized the ways in which multiple interlocked systems of oppression shaped women's experiences within individual, social, and health structures (Kaushik & Walsh, 2018). A theory that challenged prioritizing critical examination of a single praxis of oppression, intersectionality raised attention of multiple systems of oppression and the fundamental concepts of power, privilege, and oppression (Collins, 2009; Yuval-Davis, 2006). Intersectionality offered a framework that guided the generation of new nursing knowledge when examining power dynamics within nurse-patient interactions. We used these frameworks and understood the unique positionality of all women, specifically Black women, as they navigated healthcare institutions and the impact these institutions left on health outcome trajectories for Black women who were survivors of SA. Additionally, when we considered the perspectives of nurses in relation to inflictions and

preventions of SV, we gained an understanding of their positionality and role when they interacted with Black women who were survivors of SA.

Theoretical Limitations

There were limitations to the classification of Black women as a group sharing the same racial identity. The first limitation was that a feminist approach contesting hegemonic feminisms created a clear distinction between Western and 'non-Western' populations. As Uma Narayan (1997) stated, "colonialism…connect[ed] and divide[ed] Westerners from subjects in various Third-World nations in a series of complicated and unequal relationships" (p. 44). Attempts to contextualize individual women's social location and to homogenize Black women as a monolith were at risk of failing to encompass the full complexity of the social barriers and norms facing Black women. Black feminist scholars such as Patricia Collins (2000) explained that the oppression experienced by Black women as a group was not the same, "nor that some U.S. Black women do not suppress others" (p. 12). We drew from scholars of Black feminist thought and postcolonial feminist scholars such as Uma Narayan and Chandra Mohanty who emphasized the need to avoid homogenizing women by failing to contextualize the social location of diverse groups of women.

As Mohanty (1988) explained, the categorization of women:

> …defined on a scale which is normed through Eurocentric assumptions, not only [we]re third world women defined in a particular way prior to their entry into social relations, but since no connections [we]re made between first and third world power shifts, it reinforce[d] the assumption that people in the third world just have not evolved to the extent that the West ha[d]. (p. 352).

Research Design

Intersectionality, rooted within black feminist thought, critically examined multiple interlocked systems of oppression within a matrix of domination (Dhamoon & Hankivsky, 2011). The application of black feminist thought/intersectionality in nursing research provided an opportunity to examine critically the power dynamics within the nurse-patient relationship, as well as the patient's relationship to healthcare as an institution. Since SV was the recreation of power dynamics (experienced within initial perpetrations of SA), we utilized intersectionality theory, a theory that emphasized the impact of power dynamics, to understand the social processes involved within these traumatic interactions.

Secondly, since we utilized a theory emphasizing power dynamics, we required a reflection on patient and nurse positionality. Reflections were necessary to generate in-depth knowledge from diverse positions and perspectives. Reflections upheld ethical standards for critical reflexivity. This study focused on diversity among Black women in their recollections of their experiences following SA and their resulting nursing care. We engaged in critical reflexivity to create potential for recognizing and challenging existing pedagogies that contributed to the formation of power dynamics within the patient-nurse relationship. And finally, critical reflexivity encouraged researchers themselves to critically reflect on the practices they engaged in within this study.

Thirdly, we understood the unique positionality of Black women and nurses, through the utilization of Black feminism/intersectionality theory, and this enabled us to understand how history informed the construction of gender and race across multiple axes of oppression. According to Denzin & Lincoln (2017), intersectionality theory described "how social divisions [we]re constructed and intermeshed with one another in specific historical conditions" (p. 157).

This was particularly important to understand how initial perpetrations of SA were recreated through the support of socially constructed ideas of race and gender throughout history.

Black feminist thought and intersectionality theory assumed philosophical beliefs that there was no homogenous social group, as these were social constructions (Corlett & Sharon, 2014). Three types of intersectional frameworks (intracategorical, intercategorical, and anticategorical) each presented a different methodological approach that examined the complexity of social categories or groups.

This study utilized a combination of intracategorical and intercategorical complexities. Intracategorical intersectionality focused on a single social group or setting and the influence of this interconnected social identity (Corus & Saatcioglu, 2015; Kaushik & Walsh, 2018). In this study, our intracategorical approach focused on patients and nurses as single groups. Throughout this study, we utilized an intracategorical approach that focused on a single setting, the experiences of rooms in acute care settings where nurses delivered services to survivors of SA.

Next, instances of intercategorical intersectionality examined the experiences of social categories or groups that shared multiple areas of predetermined social categorization in order to understand structural inequalities (Corlett & Mavin, 2014). In this study we utilized an intercategorical intersectional framework focused on Black women's voices upon their encounters with nursing care following their experiences of SA. Since race and gender were social constructions used to justify SA across history, it was important to acknowledge how systems of oppression (specifically racism and sexism) shaped women's experiences of receiving nursing care following initial trauma from SA.

Lastly, when we used intersectionality theory, we understood the call for not only recognizing participants positions within systems of oppression but also that of the researchers themselves. Having researchers themselves critically reflected on their own practices within the research gathering. The goal: delivering emancipatory praxis in opposition to oppression and racism within research, nursing, and healthcare. For this reason, we used institutional and critical ethnographic methods to understand both nurses and Black women's experiences.

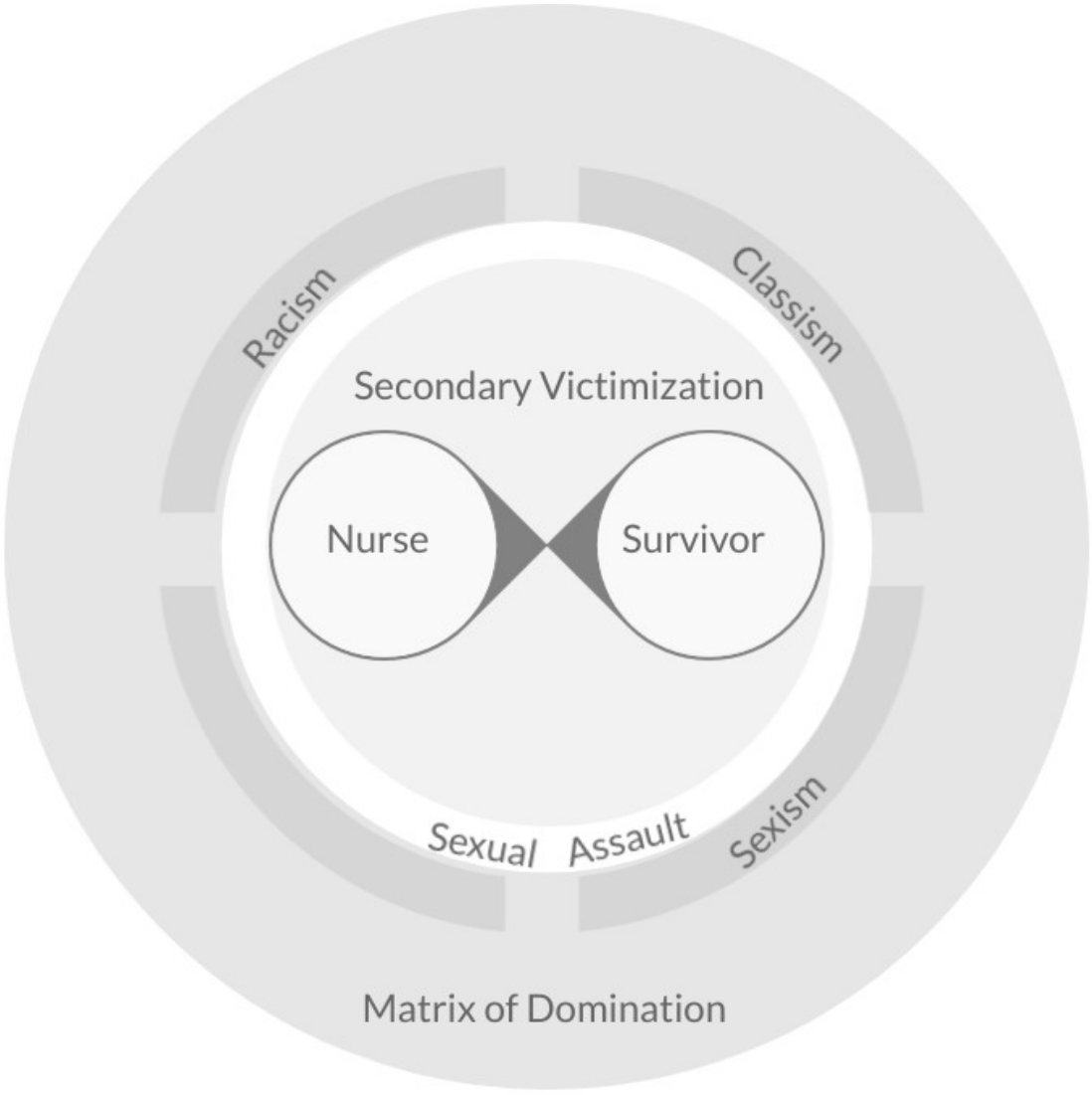

Figure 3. Black Feminist Thought, Intersectionality, and Postcolonial Feminism in Understanding Secondary Victimization Within the Nurse-Patient Relationship

Critical Ethnography

Critical ethnography (CE) was a research methodology "[set] out to critique hegemony, oppression, and asymmetrical power relations in order to foster social change" (Palmer & Caldas, 2016, p. 1). Described as the performance of critical race theory, we chose CE due to its reconciliation with Black feminist thought. Researchers who utilized CE sought to understand how multiple systems of oppression intersected to uphold one another and to inform praxis as "what [was to] be" (Palmer & Caldas, 2016, p. 2).

Like Black feminism, CE is founded on weeding out social inequalities resultant from oppression. In other words, these social inequalities were man-made, avoidable, and socially constructed. This challenged prior assumptions where social inequalities were natural and inevitable. It was not enough merely to observe the creation of social inequalities; CE called for improving interactions between those with power differentials. Note that Black feminism spoke to social inequalities created through meaning attributed to social positions by elite or superior members of society i.e. those in positions of power.

CE examined dynamics of power within individual interactions as well as larger social institutions (Vaught, 2011). Similar to prior use, CE informed this study about systems of oppression and their impact on nurses and healthcare institutions.

Sampling

This study included a critical or typical case sample of 30 patients and 30 nurses. Ritchie, Lewis, Nicholls, and Ormston (2014) explained critical or typical case sampling, "cases are chosen on the basis that they specifically demonstrate[d] a particular position or [we]re

pivotal in the delivery of a process or operation" (p. 114). Since SV within the nurse-patient interaction, we needed to include a sample of nurses and patients.

Purposive sampling stipulated that patients included in the study necessarily met the following criteria: were over the age of 18 years old, self-identified as a Black woman, had an experience of SA prior to recruitment, and had experience receiving care in an acute care setting in Wisconsin. Patient participants were proficient in speaking English. Women with severe intellectual and mental disabilities were excluded from the study.

Nurses included necessarily met the following criteria: practiced in acute care setting within the past year and held a valid RN license within Wisconsin at the time of practice. Nurses included were proficient English and encountered Black women who experienced SA. Nurses practicing outside of Milwaukee, Wisconsin within the past year will be excluded, as well as nurses with severe intellectual and mental disabilities.

This study obtained participants using a flow population sample frame. Flow population sample frames used a particular location or setting to recruit a specific population (Ritchie et al., 2014). In this study, we are focused on survivors who received and nurses who provided care in acute care settings in Milwaukee, Wisconsin in order to understand interactions of SV. Therefore, participants will be recruited using social media, and through local acute care settings in Milwaukee such as Advocacy Aurora, Froedtert, and Ascension. As well as local women's shelters such as Sojourner and the ASHA Project. Through these locations, flyers will be used to recruit participants. The flyers used for recruitment will include a brief overview of the purpose of the study, inclusion criteria, as well as contact information to participate. Survivor participants will be provided a $25 gift card for their participation in this study.

Finally, each participant approached was screened using a screening tool (Appendix A). All potential participants even ones who did not appear in the study were audio-recorded meaning the outcome was documented. [This included potential participants who declined to participate or who were ineligible to participate based on established sample criteria as well as participants who agreed to participate.] This final step helped find potential areas of bias that may have impacted sample recruitment [or our CE/QI].

Data Collection

Our data collection used semi-structured interviews following a questionnaire. Prior to conducting interviews, all participants received informed consent to ensure voluntary participation. Data collected from survivors and nurses through these semi-structured interviews was audio recorded, transcribed, and stored in a secure location. Survivor interviews were conducted individually and nurse interviews were conducted in focus groups. In order to understand the context of each particular participant, demographic data was collected from each survivor and nurse (Appendix C).

For survivor participants, the interview process was divided into four stages. The first stage of survivor participant data collection explained the purpose of the study, which is described as "to better understand how nurses interact with survivors of sexual assault, specifically for Black women". After which, survivors were asked to share their experiences (Appendix B).

The second stage of the interview provided participants an opportunity to discuss their experiences of disclosing SA to a nurse. Questionnaire questions and the safe space encouraged participants to discuss what their experience was, what was helpful and/or harmful to them

(Appendix B). Participants were asked to disclose what type of specialty was the nurse who responded to their case.

Third stage of the interview was in-depth questions. Participants were asked to reflect on the unique experiences and needs that Black women may experience especially following SA (Appendix B). Open-ended questions were presented to survivors related to identifying areas that nurses can improve and/or areas that were helpful in nursing care, when it came to meeting the healthcare needs of Black women survivors. Questions were intended to find nurses' interventions in practice that prevented or caused SV.

The fourth stage of our patient interview reflected on how one has survived such experiences as a Black woman (Appendix B). Such questions aided in ending the interview on a positive note, while encouraging discussion surrounding identifying sources of support in surviving as a Black woman.

Semi-structured interviews for nurses also consisted of four stages. Stage one distributed background information stating, "the purpose of this interview is to better understand how nurses interact with survivors of sexual assault" (Appendix B). We asked for descriptions of their most recent experience as a nurse in acute care settings. We asked them to describe a time in which they encountered patients who experienced SA. We asked to discuss what SA means to them (Appendix B). This proceeded using an enabling technique to elaborate upon the context of SV by stating, "Describe prior training you've received related to responding to survivors of sexual assault". We helped create background and context so these statements and questions deflected blame away from nurses.

Stage two of the nurse participant interviews explored nurses' perceptions of how their nursing experiences may or may not have prepared them to comfortably provide care for survivors. From here, questions in stage three of the interview process will go deeper into specific cases in which nurses may have provided care to sexual assault survivors that identify as Black women. By using mapping questions, nurses will be asked "Tell me about a time you provided care to a patient that identified as a Black woman who had experienced sexual assault". Through this question, nurses will be asked to recall how they provided care to a patient who had experienced SA that had identified as a Black woman. This phase of the interview also considers what was helpful or not helpful in providing care. Nurses will be further probed to illuminate their rationale for how they determined what was helpful and not helpful. Such probing is appropriate to determine if SV was inflicted or prevented.

Stage four ended on a positive note. We asked for their ideas about what they thought they were able to implement in order to best support Black women survivors of SA. "Describe what you think would be most beneficial to survivors that identify as a Black woman while receiving nursing services?".

Interviews were offered in-person or online (via Zoom). All interviews were conducted online. After interviews, audio-recorded interviews were transcribed verbatim. All identifying information was removed from transcripts to ensure confidentiality.

Data Analysis

Transcribed interviews were analyzed using thematic analysis. Thematic analysis is a systematic approach that involves identifying "interpreting and reporting patterns and clusters of meaning within the data" gathered (Ritchie et al., 2014, p. 271). The process of data analysis

began with data management, which first involves familiarization, wherein researchers "immerse themselves in their data" to gain an in-depth understanding of what the content means in order to identify topics of interest (Ritchie et al., 2014, p. 282)

During this stage, the data gathered through interviews is organized through indexing and sorting. This process will be completed using MAXQDA, a computer-assisted qualitative data analysis software (CAQDAS) package, and involves identifying large portions of data that focus on similar topics of interest to the researcher. This process is also referred to as 'topic coding', in which data is organized into 'piles' of similar topics of interest. Once the process of indexing and sorting has been completed using MAXQDA, researchers begin to review the data extracted within the 'piles' of data to ensure that the information within each 'pile' is relevant to a similar topic of interest. Additional labels may be adjusted or applied to refine the information sorted into 'piles'. In concluding the process of data management, the data extracted into 'piles' will be summarized into precise subthemes. These subthemes will be summarized and displayed into a set of matrices to ensure meaning and relevance to the topic of SV.

After the data gathered has been managed, the process of abstraction and interpretation begins. This involves identifying concepts and themes that represent patterns containing meaning (Ritchie et al., 2014). The process of abstraction and interpretation begins with description. This involves determining what identification of SV looks like for patients and nurses, as well as different forms or variations of SV to patients and nurses. Ultimately, the process of description will consider what SV is through actual words used by patients and nurses as well as considering patient and nurse accounts of SV expressed through meaning, in order to create categories and to identify the connection between identified categories.

The second step of abstraction and interpretation involves understanding the different elements and dimensions within themes or subthemes. This step will involve analyzing different experiences, views, perceptions and behaviors previously labeled, in order to understand the various elements that occur in preventing or inflicting SV. While the dimensions identified involve analyzing concepts or themes that capture variations in elements, this process will be added into created matrices to summarize initial subthemes identified during data management.

After different elements and dimensions within themes and subthemes have been identified, the data is analyzed again to combine different elements to form new sets of categories (Ritchie et al., 2014). This stage involves the incorporation of literature and theory in creating new categories, rather than focusing just on the language and meaning of data gathered. During this stage, simple typologies may be constructed through the identification of different dimensions related to SV.

After data collection and analysis, construction occurs to understand patterns of association within the data, referred to as 'linkages' (Ritchie et al., 2014). A stage often referred to as mapping linkage, this stage considers different types of linkages between subgroups and the phenomena of SV. Types of potential linkages that may be identified in this stage include contextual and functional linkages. Contextual linkages may be identified by considering the types of behaviors that inflict or prevent SV that are specific to acute care settings. Functional linkages will include attitudes that contribute to nurse's infliction of SV.

The final stage of data analysis includes explanation of patterns. This final stage examines "what underpins attitudes, decisions, motivations or outcomes" that lead to or prevent SV (Ritchie et al., 2014, p. 331). By identifying conjectures in this stage, or explanations, the data

and patterns of association are cross-examined through reorganizing, summarizing, and rereading transcripts. Explanations of patterns identified can be either explicit or implicit explanations.

Explicit explanations refer to participants direct recollection of their own beliefs or intentions that impacted a specific outcome such as a nurse's recollection of beliefs or intention that lead to or prevented SV. Implicit explanations refer to inferences of logic identified by the researcher (Ritchie et al., 2014). This approach refers to different patterns of linkages and how different factors impact a specific outcome identified in the data.

Ultimately the findings of this study are inferred or transferrable to similar contexts and settings across nursing, and healthcare in general, that respond to the health needs of SA survivors, particularly in urban metropolitan environments. This includes different specialties and levels of nursing and healthcare as a whole. These findings are also transferable to various contexts that can benefit from an understanding of women of colors' experiences of SA, in order to effectively implement health interventions and to improve health outcomes.

Scientific Rigor

Trustworthiness

Trustworthiness refers to the "degree of confidence in data, interpretation, and methods used to ensure the quality of a study" (Connelly, 2016, p. 1). In other words, trustworthiness ensures that the findings generated are truly representative of the phenomena or people studied. Trustworthiness is essential to researchers being certain of the results generated, but also provides confidence for consumers "to implement, or to move forward, building on the results" (Denzin & Lincoln, 2018, p. 814). In qualitative inquiry there are four techniques for demonstrating trustworthiness. This includes: credibility, transferability, dependability, and

confirmability (Denzin & Lincoln, 2018). Three ways that this qualitative study demonstrates to ensure trustworthiness is through credibility, dependability, and transferability.

Credibility

The first technique, credibility asks the question "how congruent are the findings with reality?" (Shenton, 2004), p. 64). Some strategies for ensuring credibility include "prolonged engagement, persistent observation, and triangulation" (Denzin & Lincoln, 2018, p. 801). Other strategies used for ensuring credibility include: examining previous research findings, member checks, "background, qualifications, and experience of the investigator" and engaging in reflexive commentary (Shenton, 2004, p. 68). In this study, two strategies will be used to ensure credibility: reflexive commentary and "background, qualifications, and experience of the investigator".

The first method of credibility to be used is reflexive commentary. Reflexive commentary entails "recording the researcher's initial impressions of each data collection session" (Shenton, 2004, p. 68). Such commentary monitors the patterns that the researcher is constructing throughout the research process. Ultimately, the process of identifying patterns should inform and address the results generated.

The second method of credibility that will be used is "background, qualifications, and experience of the investigator". This involves including any "personal or professional information relevant to the phenomenon under study" (Shenton, 2004, p. 68). For me, my background as a forensic nurse for the past three years enhances credibility towards through specialized knowledge in providing nurse care to those who experience interpersonal violence that enables me to accurately analyze the data collected and to understand its implications on

health outcomes for survivors of SA. Furthermore, my credentials as a Sexual Assault Nurse Examiner among adult populations (which is pending) will also support this studies credibility.

Dependability

Dependability refers to reliability and entails the researcher's documentation of the processes used within the study (Shenton, 2004) to ensures that future researchers can replicate the study and potentially generate the same results. Some ways in which this can be done is by creating an audit trail that considers the research design and the way it was implemented, the "operational details of data gathering", and reflecting on the effectiveness of the processes used (Shenton, 2004, p. 71-72).

Transferability

The third method of trustworthiness that will be used is transferability. Transferability refers to "the extent to which the findings of one study can be applied to other situations" (Shenton, 2004, p. 69). One-way transferability will be accomplished is through peer debriefing (Denzin & Lincoln, 2018).

To ensure scientific rigor this study will initially confirm descriptive data gathered through semi-structured interviews. This involves ensuring appropriate use of interrater reliability, including confirming questions asked to participants were asked in the same manner, and guaranteeing that the interviews conducted are comparable (Denzin & Lincoln, 2017). Interrater reliability will also be ensured by developing a codebook, which encapsulates definitions and responses to items asked through codes (Appendix I).

In addition, scientific rigor will be ensured by utilizing the following verification strategies: triangulation, member checking, and peer-review.

Triangulation

Triangulation is the comparison of data gathered from different qualitative methods (Ritchie et al., 2014). In this study, triangulation is used to enhance credibility by: (1) using of different methods through focus group and individual interviews, (2) analyzing data from two different populations (nurse and patient participants), (3) interviewing nurses across acute care locations, and (4) interviewing women who have accessed services from different acute care locations. Through triangulation diverse perspectives are included in moving towards a more holistic understanding of the interactions that prevent or inflict SV within nurse-patient relationships.

Member Checking

Member checking will also be utilized within this study as a verification strategy. After interviews, three participants from the nurse interviews and three from patient interviews will be provided the opportunity to clarify or confirm the analysis and identified themes. Additionally, the first three interviews conducted will be analyzed by the authors major professor and committee members to confirm themes. Such verification techniques may be useful to clarify areas of data that may be unclear to the researcher, and ensures that the knowledge generated is centered on the participants, embodying their lived experience. Through member checking, researchers are better able to ensure internal validity of data gathered by confirming the conclusions drawn.

Peer Review

Thirdly, the process of peer review presents an opportunity to ensure validity of the themes generated from this study (Denzin & Lincoln, 2017). Peer review involves the process of

presenting findings to experts within the field. Such processes aid in developing and critiquing the process of conceptualizing SV itself, and also the process of abstraction of the data collected.

Ethical Considerations

As Crenshaw (1991) explains:

> Although racism and sexism readily intersect in the lives of real people, they seldom do in feminist and antiracist practices. And so, when the practices expound identity as woman or person of color as an either/or proposition, they relegate the identity of women of color to location that resists telling. (p. 1241)

Reflection & Reflexivity

Engaging in reflection and reflexivity provides a way to ensure that the study design, methodology and findings discussed are emancipatory in nature and uphold the tenets of feminist theory. As a researcher, it is important to recognize your own position of power, and the potential you hold in influencing every process engaged in while generating knowledge. Reflexivity is an essential process to engage in as this involves "actively considering the implications of what has been observed for the observer's own practice" (Easterby-Smith & Malina, 1999, p. 77). Engaging in reflexivity aims to achieve a position that is conscious of biases that may impact the "collection, interpretation, and presentation" of findings (Ritchie et al., 2014, p. 22). Ultimately, it is impossible to reach a position that is completely neutral but engaging in reflexivity provides a way for researchers to be critical about their role and to consider how their beliefs and behaviors impact the research process. As Nilson (2017) explains, "reflexivity in qualitative research is integral to developing a heightened self-awareness of the process and the context of the research" (p. 119). By engaging in such considerations that reflect

on power dynamics that include the researcher themselves, researchers can prevent causing harm or supporting approaches or practices that perpetuate oppression.

Social Position

As a second-generation multiracial Filipina American forensic nurse, nurse educator, and nurse scholar, it is through this social positioning that I have encountered lived experiences that mold the epistemologies that I hold. Described as the interpretive bricoleur, the interpretive bricoleur can be understood as an interactive process between the research and the researcher (Denzin & Lincoln, 2018) in which the researcher's social positionality impacts the way in which the researcher interprets the research.

As Denzin & Lincoln (2018) explains:

> All research is interpretive: guided by a set of beliefs and feelings about the world and how it should be understood and studied…Each interpretive paradigm makes particular demands on the researcher, including the questions that are asked and the interpretations that are brought to them" (p. 19).

In other words, Denzin and Lincoln (2018) call for researchers to engage in self-reflexivity to critically reflect on the questions asked. As a second-generation multiracial Filipina American, I have navigated different worlds shaped by gender and race. Although the system of oppression may be the same (as racism and sexism both mutually shape Black women's positionality), the ways in which these systems of oppression are expressed are historically and distinctly different; however, it is from this positionality that I am able to connect and share parallels with the experiences shaped by positionalities that intersect with being not White and woman.

Through my position as a nurse, in my experience practicing I have provided nursing care that responded to Black women who have disclosed experiences of sexual assault. Not in all of these experiences was I in a position of a forensic nurse, nor did I have specialized training that enabled me to respond to the unique needs of Black women. However, it is through my experience as a nurse (whether forensic specialty or not), that I have seen the ways in which nurses and healthcare in general, regularly respond and/or fail to respond to the needs of Black women who have experienced sexual assault. Therefore, exploring Black women's experiences of interacting with acute care nurses following experiences of sexual assault, will provide insight into and understanding of the ways in which SV is either prevented or inflicted. Such insights hold potential for reexamining, informing, and improving nursing care provided to Black women who seek healthcare services following disclosures of sexual assault.

Protection of Human Subjects

Certain ethical precautions should be considered before working with Black women who have experienced sexual assault. Precautions taken include identifying ways to minimize potential risks towards harming vulnerable populations including Black women who have experienced sexual assault. The first consideration would be emphasizing that this is a voluntary study. This means that participants willingly volunteer to participate. Secondly, given the trauma that is experienced following sexual assault, women recruited for participation will be allowed to participate after a month has lapsed since the most recent experience of sexual assault. In providing at least a month to lapse between the time of the assault and participation in this study, women will have a chance to process the event before sharing their experiences interacting with nurses. Additionally, those with intellectual or mental health disabilities will be excluded from participating in this study. Thirdly, participants will be met and interviewed at a

secure and safe location at a time and place that is comfortable and convenient for the participant.

Before conducting research, IRB approval was obtained from the University of Wisconsin Milwaukee. Participants volunteering to participate were required to provide informed consent. This means that at any time participants could refuse to participate. They could also withdraw from the study at any time and have the right to not respond to any questions that they are not comfortable answering. Throughout this study confidentiality was ensured for the protection of participants.

Potential ethical dilemmas that may be confronted while conducting this research include encountering women who may be in distress throughout the recruitment and interview process. For this reason, strategies to minimize harm include providing patient participants with a list of resources available that provide survivors support throughout recovery. This includes numbers to local rape crisis hot lines, support groups, and counselors. One of these local resources includes a number to Aurora Healing and Advocacy Services (AHAS). This department offers treatment to survivors recovering from SA, and is located on site to where participants will be recruited. Therefore, participants who become distressed will be offered to speak with a crisis counselor through AHAS, who are available 24/7. Since the department is located on site, participants can be provided the option to meet with a counselor in person or to speak with counselors over the phone immediately, as needed.

Another strategy that will be utilized during recruitment and throughout the interview process with participants includes incorporating additional time for interviews. Allotting additional time allows the interview process to be flexible to participant needs. This includes incorporating periods of time that allow for participants to pause or receive additional support as needed.

Another potential ethical issue that may be encountered while conducting this research, is the risk of breaching confidentiality. Therefore, strategies to minimize breaches in confidentiality include using codes to identify participants, and removing identifiers that may expose participants identity including any information that may identify the community of which participants are a part.

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Chapter IV

In this chapter, we discuss the main findings within this study by focusing on the voices of women participating within this study. Informed by intersectionality, by centering the voices of African American women that received healthcare services in an acute/hospital setting after experiences of sexual assault, we aim to examine the help seeking experiences among Black women following an experience of sexual assault from the perspective of women.

Manuscript 2: Experiences of Dehumanizing: Reimagining Healthcare Practice, Education, and Policy for African American Women Sexual Assault Survivors

The following manuscript focuses on the voices of African American women to hear about their experiences receiving healthcare services in an acute/hospital setting after an experience of sexual assault. This manuscript is formatted to the author's guidelines for *Violence Against Women,* the targeted journal for publication. In this manuscript, context as to the history that informs present interactions within the nurse-patient relationship with African American women that experience sexual assault are delineated in order to understand discriminatory responses and interactions that cause secondary victimization. The results of this manuscript found that over half of survivor participants described their experiences interacting with healthcare providers after sexual assault as dehumanizing. In response, we present practice, education, and policy recommendations for nursing, and healthcare more broadly, to prevent or mitigate secondary victimization in the future.

Experiences of Dehumanizing: Reimagining Healthcare Practice, Education, and Policy for African American Women Sexual Assault Survivors

Abstract

Despite efforts that call to recognize the need for culturally sensitive responses, to minimize the occurrence of secondary victimization for African American women following an experience of sexual assault, few studies have focused on hearing from African American women about their experiences receiving healthcare services in a hospital setting following sexual assault. Using intersectionality, we aim to center the voices of African American women about their experiences receiving nursing care in acute care or hospital settings following sexual assault. In this qualitative study, 30 African American women were interviewed using in-depth, semi-structured interviews about their experiences receiving care in a hospital setting following sexual assault. Interviews were analyzed using thematic analysis. Of the 30 women interviewed, 17 reported encountering experiences of dehumanizing when receiving healthcare services following sexual assault. These experiences of dehumanizing include: discrediting, dismissing, shaming, and blaming. To mitigate and prevent secondary victimization in the future, we present practice, education, and policy change recommendations for nursing, and healthcare providers more broadly, based on the voices of African American women survivors of sexual assault.

"Who knows what the Black women thinks of rape? Who has asked her? Who cares?"

-Alice Walker (2004)

Background

Secondary victimization (SV) causes more suffering for those seeking services, specifically for African American[3] (AA) women survivors of sexual assault who are disproportionately affected by sexual violence (Campbell et al., 2003; Campbell, 2005; Campbell & Raja, 2005; Johnson & West, 2013). For instance, over 20% of African American women are raped throughout their lifetime; which is higher than all other women overall (DuMonthier et al., 2020). For this reason, scholars and advocates have called for more culturally sensitive responses for African American women in an effort to minimize secondary victimization (Campbell & Raja, 2005; Johnson & West, 2013). However, no studies focus on African American women's experiences accessing healthcare services in a hospital setting after sexual assault. In this manuscript, we examine the help seeking experiences of African American women following an experience of sexual assault from the perspective of women. Based on the voices of African American women survivors of sexual assault, we present health intervention and policy change recommendations, such as creating interdisciplinary health teams within communities to enhance transparency and access. By hearing from African American women survivors of sexual assault and their experiences of accessing healthcare services after experiences of sexual assault, we can better understand and develop policies to mitigate and prevent secondary victimization.

[3] In this study, a woman identifying as African American is one whose ancestors were enslaved and forcibly brought to the United States during the Trans-Atlantic slave trade. Such women moved with their families to urban metropolitan environments such as Milwaukee and Chicago, during what is known as the great migration, to escape the oppression associated with sharecropping, which was the predominant economic system in the south, following the abolition of slavery.

Although this study focused on African American women survivors' interactions with nurses, many of the women interviewed spoke to healthcare provider interactions in general after disclosing sexual assault. Therefore, the findings of this manuscript are pertinent to not just nurses, but healthcare providers more broadly.

Intersectionality

Our study was informed by intersectionality theory, which is rooted in Black feminist thought. Intersectionality is a concept and lens that speaks to the way in which multiple systems of oppression mutually interconnect to create and perpetuate oppression within the gestalt of American society (Davis, 1981). Intersectional approaches reject traditional single-axes analysis frameworks that fail to recognize the interconnectedness between the ways in which individuals and collectives hold unique and multidimensional social positions. For example, a gender-only framework may recognize the violence perpetuated by patriarchal hierarchies, but fails to consider how violence perpetuated by patriarchy is also perpetuated by other social order hierarchies (i.e. racism, classism, etc). Instead, by recognizing the interconnectedness of multiple systems of oppression within the matrix of domination, constructed binaries traditionally viewed as separate (such as gender and race) can begin to be deconstructed.

As Patricia Collins explains (2017), "Neither race- nor gender-only approaches adequately explain African-American women's experiences with violence, because African-American women's experiences with violence cannot be recast within the guiding assumptions of either approach" (p. 918). As Patricia Collins also alludes to in the previous quote, an intersectional lens is essential to understanding the ways in which various forms of violence, such as sexual assault, have been used to advance multiple systems of oppression (Collins, 1998). For example, African American women have historically been cast as illegitimate victims

of rape by racist, classist, and sexist systems simultaneously. These oppressive realities have contributed to stereotypic sexual scripts used to justify the sexual violence inflicted upon African American women (Boyle & Rogers, 2020; Collins, 1998; Irving, 2007). Such oppressions have also served to hinder African American women's access to healthcare and other services, following a sexual assault.

Interconnectedness of Racism, Classism, & Sexism

The perpetuation and acceptability of sexual assault committed against African American women due to oppression, has direct ties to racism, classism, and sexism, that began at the start of the formation of the United States when African American women were forced into chattel slavery for nearly 400 years (Davidson, 2017; The Black Women's Truth Commissioner Report, 2016).

African American women were intentionally excluded from legal definitions of rape or sexual assault. During the Antebellum period, protection of rape under the law was provided to persons who were White (Stone, 2009). At this time, the protection of White womanhood was represented protection of the White race and required submission of one's genealogy to prove one worthiness of such protection (Ferber, 1999; Stone, 2009). This was justified through the ideology of white supremacy, in which the White race was seen one that was superior, whereas African American people were seen as less human (Bardaglio, 1994). Additionally, the rape of enslaved African American women served to benefit White masters in terms of expanding labor and exerting further social control over enslaved communities (Bardaglio, 1994). These brutalities against enslaved African women and girls occurred at a time in which White citizens were developing independence as a nation, while simultaneously "proliferating an extortionist project which annihilated indigenous lives, colonized and extracted natural resources, and

enslaved, coerced and forcibly bred African human beings" (The Black Women's Truth and Reconciliation Commission Report, 2016, p. 6).

Following the end of slavery, African American women continued to be denied protection of rape, or sexual assault, based on race, class, and gender. For example, the Black codes were a set of laws that governed the conduct of what defined Black freedom following slavery into times of segregation (Feimster, 2009). The Black Codes, or the Black Laws, attempted to limit African American capacity for economic mobility, while also denying African American full citizenship (Feimster, 2009). This meant little protection under the law was available and provided to African American women who experienced sexual assault. Although slavery had ended, there was an increase in violence, often sexualized, committed by White men in support of White supremacy that challenged African Americans' access to full citizenship (such as participating in politics (Feimster, 2009; The Black Women's Truth and Reconciliation Commission Report, 2016).

This history, which deemed African American women as unrapable, continues to inform our present-day context. Expanding police services as an intervention for sexual assault in response to anti-rape movements is particularly problematic as these are the same institutions that have "historically assaulted rather than protected African American women" (Freedman, 2013, p. 286). Resultantly, there has been a "culture of silence" among African American women in relation to sexual assault. As the National Center on Violence Against Women in the Black Community explain, "For every African American woman who reports rape, at least 15 African American women do not report" (Barlow, 2020).

Furthermore, conviction rates for sexual assault in the States are drastically low compared to the rates of incidences of sexual assault. For example, less than 1% of all reported

sexual assault cases result in conviction (source). In Wisconsin, the Wisconsin Sexual Assault Kit Initiative (WiSAKI) found 31,633 victims reported a sexual assault between 2010 and 2015; however, despite this prevalence, only 15 criminal cases were filed; of which, only 7 are currently active cases and 5 cases resulted in a guilty verdict (WiSAKI, 2021).

The Urban Metropolitan Context of the Upper Midwest

In Midwestern African Americans were drawn to urban Midwestern cities such as Milwaukee, Chicago and Detroit, following the Northwest Ordinance of 1787, which prohibited slavery in northern territories (Jones, 2021). African Americans also migrated from the South to the Upper Midwest in order to escape the oppression associated with sharecropping after the ending of slavery. Sharecropping is a term that refers to the use of land, which is not owned by the tenant, "in exchange for a share of the crop" (Milwaukee PBS, 2021, para. 1). This system resulted in further economic disadvantaging of "tenant farm families", particularly during poor growing seasons (such as between 1910 and 1930, which resulted in homeless sharecropper tenants) (Sharecropping, 2015).

Yet, in Northern states to which African Americans migrated, other forms of oppression based on racist ideologies, policies and structures awaited, placing them in a position of economic disadvantage, as they competed for low-income jobs and housing (Jones, 2021). Housing policies, such as redlining and the creation of highways, built in the middle of Milwaukee's African American community, for example, led to disinvestment in African American communities, White flight and a resultant vicious cycle of poverty (Gillum, 2019; Jones, 2021). The lack of opportunities for employment in African American communities accentuated poverty, which has been found to be a key risk factor for violence against women (Gillum, 2019). Women living in poverty lack the ability to exercise their full agency, as they are

limited in their access to resources such as health insurance, transportation, and healthcare (Gillum, 2019).

Discriminatory Responses & Secondary Victimization

The literature identifies the notion of "double stigma" which speaks to the stigma that African American women face in relation to disclosing sexual assault, in addition to the stigma associated with the treatment they receive based on their race (Alvidrez et al., 2011; Munroe, 2015). These discriminatory practices not only perpetuate the normativity of denying opportunities for resources and healing but they also pose a significant risk of secondary victimization for African American women survivors of sexual assault (Ahrens et al., 2001; Littleton & Ullman, 2013).

Secondary victimization leads to African American women experiencing poor quality care when seeking services post-assault (Campbell & Raja, 2005). Examples of poor-quality care include unaddressed pain management needs, not being provided accurate information to make informed decisions (such as a risk assessment for Sexually Transmitted Infections/Human Immunodeficiency Virus (STI/HIV)), and not being provided options of care (such as HIV/STI prophylaxis and emergency contraception). In one study conducted by Campbell et al. (2001) examining secondary victimization, ethnic minority women were found to be less likely than white women to receive information about HIV. This is of particular concern considering that African American women are already at higher risk for poor health outcomes post-assault due to higher rates of contracting HIV compared to White women (Al'Uqdah et al., 2016; Campbell et al., 2003).

Furthermore, experiences of secondary victimization deter individuals from seeking health services in the future. For example, one study conducted with a sample of predominantly

African American women veterans found that 80% of participants who received care during their military service felt the experience made them reluctant to seek further care (Campbell & Raja, 2005). These experiences included encountering behaviors from the medical system that involved not being provided explanation of the risk of contracting sexually transmitted infections after an assault, as well as encountering rushed healthcare services that overlooked survivors' emotional state (Campbell & Raja, 2005). As a result, many African American women may turn towards informal supports (friends and family) to seek help (Finfgeld-Connett, 2015; West et al., 2014).

Methodology

Since secondary victimization is a social phenomenon, utilizing qualitative inquiry allows for an in-depth understanding of secondary victimization from the perspective of African American women survivors of sexual assault who are recipients of nursing services in an acute care setting. Application of qualitative inquiry is appropriate as responses to sexual assault within US culture is complex and requires the consideration of social context in order to fully understand the interactions that occur between nurses and patients. These contexts include the gendered and racialized realities of sexual assault, and how history informs responses to sexual assault today particularly for African American women. Understanding such contexts through qualitative inquiry contributes to our understanding of the existing barriers that nurses may perpetuate through their positionality as healthcare providers.

Although this study involved interviewing both nurses and African American women survivors of sexual assault, this manuscript focuses on centering the voices of women in order to bring awareness to their needs. This is consistent with our use of a feminist framework, which informed the study. Furthermore, although this study focused on nurses, women often referred

to healthcare providers more broadly. Therefore, nurses and healthcare providers will be used interchangeably based on who women refer to in their narratives. Ultimately, the goal of this manuscript is to ensure that nurses, as well as healthcare providers more broadly, understand the context in which African American women seek healthcare services following sexual assault in order to improve the delivery of healthcare services and to advance health outcomes for women,

For this study, we used critical ethnography as the research methodology. Critical ethnography allows for the examination of power dynamics within individual interactions, and larger social institutions such as healthcare (Vaught, 2011). Applying critical ethnography alongside intersectionality to this study enabled us to examine the power dynamics existent within interactions between nurses and African American women survivors of sexual assault.

Participation in this study was voluntary. Women either responded to a flyer that was distributed at various sister circles[4], women's shelters, churches, or through advocate referrals working with sexual assault survivors. The recruitment flyer included an overview of the study, study objectives, as well as contact information for the Principal Investigator. Snowball sampling was also used to recruit women. Nearly half of all survivors who participated in this study were referred by another survivor that had participated.

Using purposive sampling, the following inclusion criteria was used for this study; all women were: 18 years of age and older; self-identified as African American women; had experienced sexual assault at some point in their lives prior to recruitment; were proficient in English; had received care at an acute care/hospital setting in the US; and had discussed their

[4] Sister circles refer to support groups that foster interpersonal connections and community support for African American women (Neal-Barnett et al., 2011).

sexual assault with a nurse at some point in their lives. Exclusion criteria included women with severe intellectual and mental disabilities.

Individual interviews with survivors of sexual assault were conducted between February to August of 2021 using in-depth semi-structured interviews. Since this study began during the COVID-19 pandemic, an amendment was approved to conduct interviews online via Zoom. Interview questions were designed to gain an understanding of survivors' experiences accessing healthcare services after a sexual assault. A total of 30 African American women survivors of sexual assault were interviewed via Zoom, and 1 interview was conducted in-person, as per women's' request. Interviews were audio recorded and on average lasted approximately 1.15 hours. As a token of appreciation, women received a $40 Amazon gift certificate, and an additional $25 Amazon gift certificate if they referred other participants to the study.

Ethical Consideration

IRB approval was obtained from the University of Wisconsin Milwaukee. Women volunteering to participate were required to provide written informed consent. Women were informed that participation was voluntary, that they could withdraw from the study at any time and that they had the right to not respond to any questions that they were not comfortable answering. Throughout this study confidentiality was ensured for the protection of women. This included removing identifying information, storing electronic data on a password protected encrypted computer, and storing paper data in a locked file cabinet in a locked office. Furthermore, interviews conducted via Zoom only recorded audio and no video.

Sample

A total of 30 women were interviewed, as well as 16 nurses, whose findings will be reported elsewhere (See Table 1.). All women self-identified as African American women; Women's age ranged from 23 to 40 years old with a mean age of 29 years old. Women who participated in this study were predominantly single (73.3%). The majority of women interviewed resided in an urban metropolitan city, primarily from Milwaukee, Cook County (Chicago), and a few in Dane County (Madison). Over half of the sample interviewed reported being employed (56.7%) and making less than 30 thousand a year (63%). Women were primarily self-employed, but others were employed in healthcare, accounting, and the food industry. Women's education ranged from 8 years of education (middle school level) to 18 years of education (masters prepared level) with a mean of 14.3 years of education (See Table 1 for participant demographics). Less than half (43%) of women reported having healthcare insurance (See Table 1).

Data Analysis

Interviews were offered to be conducted in-person or online (via Zoom). 29 interviews were conducted online via Zoom, with one interview being held in-person. After conducting interviews, audio-recorded interviews were transcribed verbatim. With all identifying information removed from transcripts we were confidential. Transcribed interviews were then analyzed using thematic analysis. Thematic analysis is a systematic approach that involves identifying "interpreting and reporting patterns and clusters of meaning within the data" (Ritchie et al., 2014, p. 271).

Trustworthiness

Trustworthiness referred to the "degree of confidence in data, interpretation, and methods used to ensure the quality of a study" (Connelly, 2016, p. 1). In other words, trustworthiness

ensured our findings were truthful representations of the phenomena or people studied. Trustworthiness was absolutely essential, but also provided confidence for consumers "to implement, or to move forward, building on the results" (Denzin & Lincoln, 2018, p. 814). We ensured essential trustworthiness for the study following standard practices: credibility, dependability, transferability.

Credibility

In this study, two techniques confirmed credibility: reflexive commentary and the "background, qualifications, and experience of the investigator". We recorded first impressions after each interview (Shenton, 2004, p. 68). We monitored for patterns that emerged particularly in our data analyses. The first author practiced reflexivity for promoting study credibility (Shenton, 2004, p. 68). The Principal investigator had her background in forensic nursing. Her clinical experience increased accuracy and comprehension of rough specialized knowledge of nursing care to those who experienced interpersonal violence. This clinical experience was both magnifier and wide lens; it enabled researchers to precisely analyze and comprehensively grasp implications for applying the data to improved health outcomes.

Dependability

Dependability detailed the researcher's documentation of the processes used within the study (Shenton, 2004) in order for replication by future researchers replicating the study and generating the same data. We created an audit trail that considered the research's design, the way it was implemented, the "operational details of data gathering", and then reflections on the interview process and effectiveness of research protocols (Shenton, 2004, p. 71-72).

Transferability

To "the extent to which the findings of one study can be applied to other situations" is the definition of transferability (Shenton, 2004, p. 69). We accomplished this through peer debriefing with two Sexual Assault Nurse Examiners who have combined 40 years of experience. They confirmed results from our data analysis (Denzin & Lincoln, 2018). Interrater reliability called for our two experts' clarification that questions asked to participants were asked in the same manner and that interviews were comparable to one another (Denzin & Lincoln, 2017). Interrater reliability was also ensured by developing a codebook, which contained definitions and responses coded (Appendix I).

Results

Analyzing the data, a main theme emerged: dehumanization. Our definition of dehumanizing encompassed four subthemes/responses: shaming, blaming, dismissing, and discrediting experiences of sexual assault (See figure 1). All subthemes exemplified dehumanizing. Women spoke of how their realities were poor health, poor treatment, and poor care from healthcare providers following disclosing sexual assault.

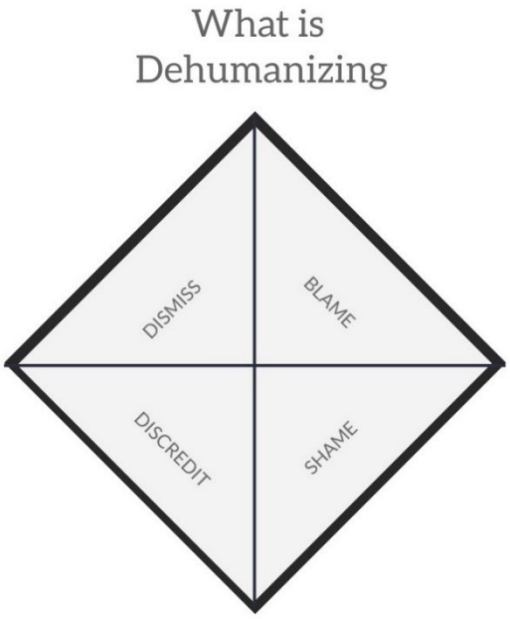

Figure 4. What is Dehumanizing?

Dehumanizing

In our analyses of all the themes of "Dehumanizing", our participants' feedback mirrored that of Goff, (2014) who described dehumanizing as the "denial of full humanness to others" (p. 527). Of the 30 women interviewed, 17 explicitly reported anticipating and experiencing being denied their full humanness while accessing healthcare services.

Women explained how accessing healthcare following sexual assault was just one aspect of the dehumanizing treatment they experienced in relation to accessing healthcare services. In this study, we found many participants experienced dehumanizing treatment from times when they accessed healthcare services prior to their sexual assault. This spoke to their overall experience of healthcare as a dehumanizing experience, let alone following sexual assault.

For example, one woman described how her troubles with healthcare started at a young age, "In general it [was] absolutely horrible from the time, like the times that I remember[ed] …like around 13 … that began this like long history of being dehumanized".

Another woman expressed feeling misunderstood after disclosing SA to nurses. She stated that:

> It [was] dehumanizing in a way in that…You feel like your whole, the whole process, you're explaining…It… it feels your heart at the same time, no one is understanding you at the same time you are breaking down in the middle of everything, so it's pretty much a very sad situation and you fe[lt] like… No one really underst[ood]. No one care[d] as at that point no one [knew] your pain.

This sentiment was echoed by yet another:

> We experience[d] our mishandle. You're being…mishandled in these hospitals. Maybe we fear[d] to go and face them because… They [faced] a lot of rejection, mistreatment and all that kind of stuff. Maybe they need[ed] to improve on how they treated their patients in making them want to come back another day.

Women made it clear how they thought twice before accessing healthcare following sexual assault. Some felt so dehumanized that they were dissuaded from disclosing. For example, one woman admitted, "…when I got raped. I felt like I couldn't disclose it to anybody because… It's a shame these guilt[ed] you wondering what people say, especially the nurses". One survivor noted why she did not talk about her experiences of SA with nurses,

"I [didn't] know how much they actually believe[d] that sexual assault happens to African American women. You know how valid it [was]…"

Dehumanizing entailed past poor treatment of women within the healthcare system that led them to feel they would not be believed if they disclosed an experience of sexual assault, on account of their racial identity as African American women. A 32-year-old woman who experienced SA discussed her hesitation to access healthcare services, "…I feared racism. I feared discrimination because of the case being a sexual assault case." Another woman echoed these concerns:

> First I went to seek…some health services I had that in my mind. I knew now I'm black and I [was] going to experience some sort of racism… discrimination. They may not attend to me. They may judge me…

Similarly, another woman shared, "I can say that it [was] some sort of discrimination by some of the nurses". Yet another woman shared her specific experience with the services she

received, “Another nurse discriminated me because of maybe the age I was and also because I was a black woman, and I didn't find it a cool thing to do.”

Women mentioned their discrimination within healthcare institutions as a separate issue from the discrimination they faced when disclosing sexual assault. For instance, one woman said, “Let me say others experience[d] discrimination. Uh, lack of help because…they [African American women] receive[d] inferior health care”. Another stated, “We tend[ed] to get inferior healthcare on this… discrimination because the color.”

From these excerpts, we saw women experiencing dehumanizing not only at the time they sought care for SA but in many other encounters with healthcare institutions and this on account of their racial identity as African American women. These past experiences informed not only how they navigated the healthcare system but also whether they disclosed sexual assault at all.

Discrediting

Many women identified discrediting as a response that was characterized by not understanding or by invalidating women’s reality. One woman quoted, “They treated me very badly like I had a doctor say… Like I had a doctor…Yeah a resident sa[id] that he [asked] me the same questions because he wanted to see if I would change my answers.”

A woman captured the importance of providing validation to others’ realities. She also illustrated how she was discredited due to her racial identity as a Black woman. She described:

> We need to be validated and believed we need...Nurses who c[a]me in without bias and without like preconceived notions of who we [we]re and what our experiences [we]re, I th[ought] that… Umm, we need[ed] people to consider the inhumane treatment that Black women have received on this continent. You know it's also… [took] into

consideration that sexual violence [was] a part of our ancestral history. You know, like since this… this continent was colonized. You know, so it's not it's… It's also intergenerational… It's also historical… it's ancestral. Uhm, and to know that like we carr[ied] not only the sexual assault that happened to us, but also what happened to our mothers and our grandmothers and our ancestors… Remember that there [wa]s a lineage...

Similar themes rang in another woman's comments:

> It [wa]s very devastating if you get someone who [did]n't understand you, someone judgmental or someone dismissing or denying allegations. It [was] hard, especially if you [we]re dealing with professional nurses which… who at times [were] very rude.

And:

> Being Black sometimes [was]… (laughing) It [was] a bit hard because. Sometimes you [feared] to talk to other people about what you have gone through, so I [said] but first they [the nurses] … The way you were received… [Was] one of the unique things that should, it should help that person who was assaulted so 'cause now if I have to come to I come to a nurse trying to explain to this person what happened to me and then you start[ed] judging me like, 'Ah, no, these things happen. So it's OK. You'll be fine', no, that [did] not help me, but now you tr[ied] to help, but [made] me understand, now it's not the right thing for somebody to do to you. Sorry, trying to make me at least comfortable, better, that [made] everything better. 'cause now you're Black. You may meet somebody, who is not black to talk to so. If that person trie[d] to tell you how. Bad or? To judge you. It [made] you feel bad, yeah?

Dismissing

The women described treatment that made them feel as though they were unworthy of protection or consideration. This form of dehumanizing entailed kept women survivors in the dark about information regarding treatment options available to them, and barred them from inclusion in decision-making in their own healthcare. We talked to one woman who explained, "…not being heard being dismissed…like almost being railroaded through decisions and not giving like all of the options". Another discussed how she experienced several sexual and physical assaults during a five-year marriage to her ex-husband. She shared that her ex-husband forcibly penetrated her without her consent throughout their marriage. On one occasion he came home intoxicated, locked her in the bedroom, and physically beat her. She escaped, ran to a neighbor's house, and the neighbor escorted her to a hospital. She explained that she was not screened for any experiences of violence or sexual assault. She added that she did not disclose the sexual assault directly, "I just didn't go too direct and say that I was beaten. I just said there was so much in pain and my teeth had fallen off. My fingers had bent".

We saw this woman withheld her actual experiences on account of the dismissing of her injuries by healthcare providers. This led to poor and inaccurate assessment of the violence that she endured even though she presented with injuries. Yet another example, one woman experienced sexual assault in relation to an experience of sex trafficking. This particular woman also shared that she lived with substance use disorder. She discussed her experience accessing healthcare services through an emergency department, and how services were not offered even though she requested services. At the time of the interview, this woman was in the process of recovering from her experience with sex trafficking, which she believed led to her struggles with substance misuse and also drug-induced epilepsy, for which she took medication. This woman shared that she experienced multiple sexual assaults, starting from the age of 18, between 2010

and 2018. While accessing healthcare services, she declared that she did not receive the healthcare services requested, which included sexually transmitted infection testing. In discussing her experiences, she said:

> Um...It was the time that I had. I got assaulted by a young man and um...I went to the emergency and I came to get a…the STD check and all of the you know all of the above because this [wa]s a person I didn't know. They… it wasn't a welcoming experience. I asked for a test. Uhm, it's like they perform[ed] a rape kit on you and they supposed to give you meds to protect you from receiving HIV or herpes. If you believe[d] you came in contact with the person and the way they treated me was not… Umm, understanding. They seen the warning signs of me working with the individual and they didn't do the right documentation. They didn't offer me any services… umm. It was just it wasn't a pleasant feeling.

In this case, the woman felt that the dismissal she experienced from healthcare providers was perhaps as a result of what she saw as "prostituting", and that perhaps the healthcare providers were dismissive because they did not actually believe her to be a victim of sexual assault.

Shaming

Shaming was a subtheme that women identified where nurses actively engaged in behaviors or responses that affected how they felt. Women specifically spoke of experiencing embarrassment after disclosing to nurses in acute care settings as a result of nurses' responses. For example, one 23-year-old woman was sexually assaulted during a party when she was 18, and then sought healthcare services at a local emergency department after the assault. Of the experience accessing healthcare she stated:

OK, it was not helpful because…When I shared my story the nurse was not welcoming and so she [said] that I am so young [and] we start[ed] going for house parties and so on. And that [wa]s the cause of the problem…That I was assaulted. And she said that even my parents [we]re not so good in raising their kid because they were not concerned about where I was going at night, which [wa]s not a good thing to do as a kid. So I found that not welcoming because this [wa]s a case that one had been assaulted and one didn't want to have that problem. But unfortunately, it just happened.

Similarly, one woman who experienced sex trafficking and sexual assault shared how she experienced shame following disclosure of SA to healthcare providers in an emergency department:

I just feel like they [judged] me, you know, yeah. They [did]n't look at me as a victim. They looked at me as the basically the perpetrator and then I really was the victim. Just the looks, the whispering in the chart. It's just little things like that ma[d]e you uncomfortable.

Similarly, another woman shared her experience of feeling shame following disclosure to emergency room nurses:

I d[id]n't. I d[id]n't feel like she was sensitive because I fe[lt] like if she was. Uhm, she couldn't try to like push me so hard yeah yeah. And also tr[ied] to be understanding and patient so it's all... It's all about having those efforts. So for me I fe[lt] like... So that's what she kind of laughed, and that made me even much more uncomfortable to even like share. And because she was the first person that I actually encountered. So even the second nurse I was kinda hesitant because I felt like a…yeah, she's kind of like the same.

Women discussed numerous times their encounters with shame perpetuated by nurses. Women spoke of how they felt that nurses overestimated the risk of contracting STI's following sexual assault as a way of pushing them to disclose, and how this caused them shame and also discomfort:

> …And then and they also advised me it's no good to shy away because some of these such experiences could render you sick for a lifetime. You could end up having STD's or HIV.

Blaming

The response of blame by healthcare providers made women question their role in the sexual assault experience, as it placed the responsibility of the assault on the victim. The following quote was from a woman who was made to feel responsible for the sexual assault experienced:

> Uh, in the first time on time, like when I went to seek help… I remember[ed] one of the nurses saying I was the one who was allowing this to happen, like it's part of my fault because of the situation that happened for me to get assaulted. So I felt like she didn't understand me. She didn't understand my pain but later on, I realized that partly I had myself to blame.

Throughout the women's narratives, we noted how women internalized the shame they were made to feel as a result of the nurses' and healthcare providers' responses. In the above excerpt, the woman ended up blaming herself for a sexual assault that was solely the responsibility of the perpetrator. Another woman encountered blame within the nurse-patient relationship and described it as, "Then they were like traumatizing me because she was asking what were you wearing or so it means that my dressing code that led to these, sexual assault…".

Similarly, another woman added, “They looked at me different than a person that just got raped on the street by accident, you know? …It's kind of like this [wa]s what I've brought on myself.”.

The following was yet another example of how blame appeared within a nurse-patient relationship:

> The way she approached me. I didn't like it because she was like like she was judging me. She was asking me for something like what were you wearing during that time? Was it because of maybe alcohol consumption and contact me, which I thought that It's like she's blaming me for the act. Yeah, I felt that she's blaming me for that for the act. Or like I [was] the cause of the sexual assault.

The ultimate form of dehumanizing, one woman described what she experienced as sexualized touch by a physician during a medical exam. While only one woman disclosed such an experience in our study, this is important to note as it demonstrated the dehumanizing treatment that women experienced when accessing healthcare services that deterred them from accessing care following SA. She stated:

> I was getting a pap smear by a doctor and I felt like uh he went overboard with the pap smear like touching me places that he shouldn’t have been that really had nothing to do with the pap smear.

Discussion

It was essential that healthcare providers engaged, upheld, and maintained an anti-oppressive stance that translated into all aspects of nursing practice, education, and policy. By unifying healthcare providers in opposition to violence, rather than perpetuating its acceptability, to apply an anti-oppressive framework across the institution of healthcare, we can provide safe

healthcare services guided by nursing knowledge that minimized the potential for re-traumatization within healthcare provider and patient relationships. The following section delineated recommendations for practice, education, and policy.

Practice

The experiences of secondary victimization within healthcare served to reenact historical trauma by placing the responsibility of sexual assault upon African American women, rather than the perpetrators. Despite national discourse generated by movements such as the #MeToo movement, that iterated the importance of acknowledging that sexual assault is never a survivors' fault, this seemed not to apply to African American women, even when accessing the healthcare system. Instead, African American women anticipated and commonly encountered dehumanizing interactions that compromised opportunities for establishing and building trust, which is necessary to facilitate women's willingness and safety to disclose.

An example of a dehumanizing interaction compromising trust was the assumption by healthcare providers that African American women engaged in risky sexual behaviors that placed them at risk for STIs. Problematic assumptions like this, mimicked from societal discourse in relation to rape culture, perpetuated racialized and sexualized histories of oppression that were used to justify sexual assault. These assumptions created barriers for disclosing, prevented trust building, contributed to health inequities, and deterred African American women from accessing healthcare services that could improve health outcomes following SA (Prather et al., 2018; Sullivan, 2020). Assumption and discourse related to rape culture also removed the blame from the perpetrator and placed it on women.

For all healthcare providers, not just nurses, it was important to recognize that sexual assault, and anything that perpetuated its acceptability, were the result of oppression. For

African American women, this included the intersecting oppressions of sexism and racism. Placing the blame of sexual assault on African American women within present-day contexts, was a continuation of the historical legacy of social institutions that deemed African American women as "unrapable" and non-human, a legacy that needed to end if we were to assure the treatment and support of African American women following an episode of sexual assault (Ruiz et al., 2020).

As the results of this study demonstrated, women's humanity, including their self-worth and dignity, were not upheld. Instead, women shared experiences of feeling like the offender and from their narratives, it was clear at times that women internalized the attitudes and responses of nurses and other healthcare providers. As healthcare providers responsible for optimizing human health, nurses especially were in a position of power to support actions and interactions that advocated for social justice through the delivery of quality care, particularly for women encountering oppression. Providing quality care included ensuring basic protections are provided when people encountered sexual assault. In order to provide basic protections for women, it was essential that healthcare providers believed women. In order to optimize and support the best health outcomes for women seeking healthcare, women needed to receive the necessary treatment available.

Secondly, although the Violence Against Women Act (VAWA) led to mandated practices within healthcare institutions, the details of these policies and their implementation into practice needed to be clarified and better supported in order to be effective. For example, although the VAWA act required healthcare workers to "screen individuals for intimate partner violence" and offer "local domestic violence services"; if a person was identified as having experienced intimate-partner violence, there was no mandate that required screening for sexual assault. The

literature indicated that intimate-partner violence and sexual violence were interrelated and often present together, particularly in the lives of African American women and Indigenous women (Luebke, 2020). Our study showed the same. There was evidence of need for practicing healthcare providers to receive continuing education that fostered opportunities to better understand the interconnectedness and complexity of violence and oppression, to facilitate accurate assessments, and to ensure better health outcomes for women.

In addition, many women reported not being screened for violence when accessing healthcare services after sexual assault. National policies required healthcare institutions to screen all patients accessing care (U.S. Department of Health and Human Services, 2013). This was particularly important for populations that disproportionately experienced violence, such as African American women. As a population that not only disproportionately experienced violence and was hesitant to disclose or even to seek care, failing to screen further negated the opportunity for providing appropriate interventions that met the healthcare needs of survivors and ultimately exacerbated their already poor health outcomes.

Education

Accurate screening of individuals who experienced sexual assault required specialized training and education. Incorporating specialized training into the training of healthcare students and professionals already in practice was not iterated within the VAWA. Every healthcare institution was required to have a person trained in administering a state kit for collecting state evidence. This, however, did not mean that this individual had specialty training in providing care to survivors of sexual assault. There were no minimum requirements for training and it was not clear as to the type of training required for a person to be considered as meeting the standard for evidence collection. Incorporating such training throughout nursing education, for example,

could help address this problem as well as address individual beliefs and values that harmed patients who have experienced sexual assault.

Policy

Originally passed in 1994, the Violence Against Women Act was passed in response to the recognition of "domestic violence and sexual assault as crimes", and provided resources for communities responding to such violence (Violence Against Women Act, 2020). The Office on Violence Against Women (OVW) was created to provide federal support for women who had experienced violence. Every five years the VAWA required reauthorization, providing "special interest groups, and the general public time to reflect about the current need for legislation" (Modi et al., 2014, p. 253). The VAWA however mostly focused on offering support services that involved reporting to law enforcement. Although survivors had the right to an anonymous/unreported rape kit, these services received funding through the state where they are collected. The caveat was thus that experiences of sexual assault must be reported to law enforcement, which served to overlook the historical processes and realities related to the functioning of legal institutions in controlling and regulating experiences of sexual assault specifically in the lives of African American women. Emphasizing the need to report a sexual assault to law enforcement or to involve law enforcement in the treatment of African American survivors created additional barriers related to women's historical experiences with law enforcement.

It was essential that, in implementing policies such as the VAWA, we recognized the need to support African American women across the life course, even generationally, and to identify and develop interventions accordingly. Although Lifecourse theory was not used to inform the study design or analysis of this study, our team felt compelled to recognize this

theoretical framework and lens in our conclusion as a key to prevention of violence and to ensure the care of survivors who identify as African American women.

The next question was how we can reimagine policies that shaped interventions provided to sexual assault survivors who sought services from nurses, specifically for African American women. Furthermore, how can this reimagining interrupt the matrix of domination that perpetuated the acceptability of sexual assault and the violence perpetuated within responses to these experiences in the lives of African American women throughout the healthcare system? These questions were not considered within the many dominant spheres with which survivors interacted when seeking healthcare services following a sexual assault.

First off, it was important to recognize the need for polices that enabled nurses to partner and sustain healthy continuous relationships with individuals and communities that had historical and ongoing encounters of dehumanizing interactions with formal institutions, such as healthcare. Nurses needed to understand this history and bear it in mind when interacting with women from populations that historically and systemically experienced oppression.

Providing nursing services safely require not only the establishment of, but a continued, trusted partnership with the community. This means members of the community should be involved in the development and implementation of community-based programs that allowed for the delivery of nursing services in collaboration with other interdisciplinary specialties (advocacy & mental health). For example, when considering such community-based options, nurses and other interdisciplinary specialties within the community could be involved in the creation of such programs, and be at the forefront of delivering services. By centering members within the community to drive the establishment of community-based programs designed more broadly to provide nursing services (and other interdisciplinary services) after experiences of

sexual assault, we can better ensure the effectiveness of interventions, while also valuing the expertise that community members hold, in order to deliver healthcare services that were intricately tailored to meet the needs of the community (Kuo et al., 2019). Creating such programs required confidentiality particularly within smaller communities. However, it was the connectedness of a community that offered opportunities to foster accountability for delivering high-quality care.

Ultimately, it was healthy relationships with individual women and their communities that prevented secondary victimization following experiences of sexual assault. Fostering healthy connections and commitments to comprehensively caring for the health and well-being of all survivors required a united stance against oppression.

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Tables

Table 1. Participant demographics.

Women participant demographic	
Age	
18-24	3
25-30	16
31-35	10
36-40	1
Ethnic Identity	
Black	30
Marital Status	
Single	22
Married	8
Zip Code of Residency	
Rural Wisconsin	4
Madison, Wisconsin	2
Milwaukee, Wisconsin	4
Chicago, Illinois	5
Cook County, Illinois	11
Winnebago County, Illinois	1
Lee County, Illinois	1
Atlanta, Georgia	2
Type of Employment	
Cashier	2
Waiter	1
Cosmetics	1
Food Industry	2
Accountant	2
Healthcare	2
Sales	1
Social Work	1
Self-Employed	5
Unemployed	13
Annual Income	
Below 20K	7
21-30K	9
31-40K	6
41-50K	3
51+	3
Not Answered	2

Highest Level of Education	
Middle School	1
High School	3
Diploma	2
Associate	5
Bachelors	16
Masters	3
Health Insurance	
Yes	13
No	17

Chapter V

In this manuscript, we focused on what we referred to as the 4th step or the process that African American women navigated that lead to disclosure to a nurse following sexual assault. Informed by intersectionality, this manuscript centered voices of African American women that received healthcare services in an acute/hospital setting after experiences of sexual assault, and gathered nurses' perspectives on their interactions with survivors in acute/hospital settings. Ultimately, we provided recommendations based on women's voices that incorporated anti-oppressive practices into nursing practice, education, and policy in order to create a safe space for disclosure and treatment for African American women survivors of SA.

Manuscript 3: The 4th Step: Creating a Space for Safe Disclosure and Treatment for African American Women Survivors of Sexual Assault

This manuscript focused on the voices of African American women and the perspectives of nurses practicing in acute/hospital settings. This manuscript was formatted to the author's guidelines for *Journal of Advanced Nursing,* our targeted journal for publication. In this manuscript, we defined the 4th step as the process African American women underwent when disclosing to nurses. We delineated this 4th step process at the individual, institutional, and public level as the means necessary to create a safe space and treatment for African American women survivors of sexual assault. We provided recommendations that incorporated anti-oppressive practices into nursing practice, education, and policy to support ultimately a cultural shift that responded to African American women survivors of sexual assault and their healing.

The 4th Step: Creating a Space for Safe Disclosure and Treatment for African American Women Survivors of Sexual Assault

Abstract

For African American women, disclosure of a sexual assault to a nurse and access to help through the healthcare system was a process informed by the racialized and gendered social context that they navigated every day. Legacies of historical oppression interfaced with the realities of institutional and systemic racism to serve as important barriers that women navigated if nurses and the healthcare system were to be a part of their journey towards healing. This manuscript was based on a qualitative study conducted with African American women in urban metropolitan cities in the upper Midwest with 30 survivor participants and 16 nurse participants. Using thematic analysis, we found the 4th step, which was part of the process leading to disclosure for African American women who experienced sexual assault, was the central theme. The 4th step included (a.) establishing a relationship, (b.) creating a therapeutic space, (c.) providing non-judgmental care, (d.) ensuring a culture of transparency, (e) standing in solidarity, and (f) communicating empathy. The healthcare system was an integral part of the healing journey for women who experienced sexual assault. Eliminating barriers for African American women's access to healthcare necessarily involved addressing systemic oppression to ensure that women felt valued in society and in every interaction within the healthcare system in order to facilitate safe disclosure of sexual assault. Incorporating anti-oppressive practices, or practices disrupting the perpetuation of oppression, across nursing had the potential to create a cultural shift whose response to African American women survivors of sexual assault facilitated healing at the individual, institutional, and societal level.

"The process begins with the individual woman's acceptance that American women, without exception, are socialized to be racist, classist and sexist, in varying degrees, and that labeling ourselves feminists does not change the fact that we must consciously work to rid ourselves of the legacy of negative socialization."

-bell hooks

Background

It is estimated that 1 in 5 Black women experienced sexual assault (U.S. Department of Justice, 2013; The National Center on Violence Against Women in the Black Community, 2018). More recent research found that within a sample of 168 urban African American[5] women, 53.7% of women reported having experienced rape and of these women, 73.4% reported being raped before the age of 18 (Basile et al., 2016).

African American women were the least likely ethnic group to report sexual assault (Ullman & Townsend, 2007; Williams, 2013). "For every Black woman who report[ed] rape, at least 15 Black women d[id] not report" (National Center on Violence Against Women in the Black Community, 2018). Sexual assault was widely recognized to be underreported among Black women; however, previous studies also showed that when Black women disclosed, often they received more negative responses (Ullman et al., 2008). As Ullman and Filipas (2001) explained, "ethnic minority women…may be likely to face disbelief, blame, and stigmatizing responses from those to whom they disclose[d], given the racist attitudes shown towards these women by the dominant society" (p.379).

[5] In this study, a woman identifying as African American is one whose ancestors were enslaved and forcibly brought to the United States during the Trans-Atlantic slave trade. Such women moved with their families to urban metropolitan environments such as Milwaukee and Chicago, during what is known as the great migration, to escape the oppression associated with sharecropping, which was the predominant economic system in the south, following the abolition of slavery.

The stigma that ethnic minority women faced when disclosing an experience of sexual assault is referred to as "double stigma" (Alvidrez et al., 2011; Munroe, 2015). For African American women, this stigma was partly the result of the perpetuation of White supremacist ideologies generated by those in positions of power within classist, racist, and sexist systems of oppression. The assumptions informed by these ideologies became internalized within key institutions that women needed to navigate in order to begin their healing journey, including healthcare and law enforcement. The historical legacy of slavery and how sexual assault manifested within that legacy also informed African American women's experiences of not only sexual assault itself but the barriers that exist for seeking help. Angela Davis (1981) summarized, "In the same way that rape was an institutionalized ingredient of the aggression carried out against the Vietnamese people, designed to intimidate and terrorize the women, slaveowners encouraged the terroristic use of rape in order to put Black women in their place (p. 27).

This "double stigma" and the possibility of encountering unfair, unjust treatment affected Black women's ability to access healthcare and safely disclose experiences of sexual assault. Many women turned to informal supports, friends, and family for help after experiences of sexual assault (Alvidrez et al., 2011; Finfgeld-Connett, 2015; Munroe, 2015; West et al., 2014). While informal supports may be helpful to women in rendering emotional support and perhaps safety, women needed healthcare for purposes of obtaining not only mental health support but also for injuries sustained, prophylaxis for sexually transmitted infections, and prevention of pregnancy. Ultimately, it was nurses' and healthcare workers' denial of SA that lead to many women not utilizing healthcare as a resource. As Ullman & Townsend (2007)

explained, “the high prevalence of rape in combination with widespread denial of this problem contribute[d] to the under resourcing of agencies that serve[d] victims” (p. 421).

Given the complexity of the social context that African American women navigated in the US in relation to sexual assault, disclosure to a nurse was a process rather than a singular individual phenomenon. Essentially, disclosure to a nurse was taking a stand to challenge institutional and systemic legacies of oppression. These legacies of oppression continued shaping contexts casting African American women as “unrapable”, and denigrating their humanity and dignity as African American women. In this manuscript, the complexity of a woman’s decision to disclose, and what disclosure represented in challenging individual, institutional, and systemic histories, was referred to as the 4th step. One survivor participant coined this term in her attempt to describe this complicated and courageous process.

Examining African American Women’s Experiences With Nurses After Sexual Assault

Women who formally disclosed sexual assault within the healthcare system held a unique position that is both ‘patient’ in the medical world and ‘victim’ in the legal world (Mulla, 2014). As Mulla (2014) stated, “the courtroom [wa]s present in the emergency room not simply as a space, but as an agency that structure[d] the examination” (p.8). Although this may be recognized by those who sought healthcare services, there was a paucity of literature that studied both voices of African American women survivors of sexual assault and the nurses entrusted with their care. Understanding the interactions that occurred within the nurse-patient relationship between African American women and nurses was essential to improving the care of African American women survivors of sexual assault. Our goal in this manuscript was to analyze and speak to the role of nurses in addressing sexual assault in healthcare as well as in society more broadly. By hearing from both African American women survivors of sexual

assault and the nurses with whom they interacted, and by focusing on their actual interactions within a hospital or healthcare setting, we presented recommendations for integrating anti-oppressive practices (AOP) across nursing practice, education, and policy.

Anti-Oppressive Practice is Anti-Violence Work in Nursing: A Need for Collaboration

Anti-oppressive practice (AOP) involved the interruption of actions that justified the perpetration of violence and the sustenance of systems of oppression (Hutchinson, 2015). A concept created by social movements focused on advancing human rights, anti-oppressive practices were valuable in addressing the needs of African American women who experienced sexual assault because this concept challenged social structures and practices that perpetuated oppression across multiple axes (including gender and race). Anti-oppressive practices also called us to recognize how power dynamics emerged and sustained themselves within a given sociopolitical and historical context. This understanding was critical in recognizing the historical and systematic ways that made African American women vulnerable to experiences of sexual assault, and denied them protection and help following such experiences. It was essential that all nurses reckoned with their professional role and position of power if the nursing profession were to uphold its commitment to honor professional ethical codes of conduct in an effort to protect, promote, and restore patient health and well-being (American Nurses Association, 2015; Hutchinson, 2015). In this regard, nurses had the capacity to promote the health and well-being of some while hindering that of others.

Further, nurses needed to utilize their positions of power to reallocate resources as necessary for improving health and well-being. Nurses needed to establish themselves as leaders committed to creating social change that ultimately leads to the provision of inclusive patient-centered care in collaboration with patients. This included care that prioritizes the needs of the

most marginalized populations of women who were historically underserved and even harmed during the provision of care following a sexual assault; women who were disproportionately affected by sexual assault and who hesitated to access services because of medical mistrust and historical realities of oppression. At the center of historical oppression, disproportionate experiences of sexual assault, and substandard nursing care were African American women in the US.

Nurses Perspectives & History in Addressing Sexual Assault

Sexual assault was a major public health problem associated with a myriad of negative health outcomes for those affected. Many nurses were, however, underprepared and lacked appropriate training to provide basic care to survivors of sexual assault (Alhalal, 2020; Plichta et al., 2006). The topic of addressing sexual assault, as an imperative and prevalent health concern, was rarely discussed to the point of it being a taboo topic in nursing. Many healthcare providers, including nurses, reported experiencing discomfort when discussing SA with patients (Auten et al., 2015; Jackson et al., 2009; Van den Ameele et al., 2013). In addition to feeling discomfort discussing sexual assault, many nurses were reluctant to provide care to survivors of SA because of limitations related to time and/or resources needed to adequately care for survivors, or the belief that their expertise was not applicable to caring for survivors of sexual assault (Maier, 2012; Martin, 2005; Plichta et al., 2006).

Although the research showed that many nurses were reluctant to work with survivors, nurses had a history of advocating for survivors, and this advocacy informed current standards of practice required to care for survivors of sexual assault. To begin, it was nurses who recognized the failure of healthcare services to comprehensively address the healthcare needs of sexual assault survivors in the 1970's. During this time, there were a number of social movements,

such as the third wave feminist women's movement and the crime victim movement, occurring in the United States. These movements raised awareness and called for action against the prevalence of SA in women's lives and the poor treatment received by those who sought justice through institutions such as healthcare and law enforcement. For the nursing profession specifically, it was these movements that led to the creation of a professional association focused on the skills required to effectively respond to sexual assault survivors, known as the International Association for Forensic Nurses (IAFN).

While this was a welcome development, currently, there were fewer than 3,000 certified sexual assault nurse examiners (SANE) in the US (population of approximately 329.5 million people), in a reality where "every 68 seconds an American is sexually assaulted" (International Association of Forensic Nurses, 2021; RAINN, 2021, para. 1; U.S. Census, 2019).

As the largest profession in healthcare, taking a stance in support of providing quality nursing care in response to sexual assault upheld nurses' responsibility to support patients in achieving and maintaining the best health outcomes (AACN, 2019). Additionally, the nursing profession had the ability to influence a cultural shift that promoted responses that do not inflict violence or harm, thereby minimizing further trauma for women with histories of SA. As van der Kolk (2007) stated, "the issue of responsibility, individual and shared, [wa]s at the very core of how society define[d] itself" (p. 29). The work encompassing the nursing profession was hinged on relational interactions with patients, families, and communities and the profession defined itself as a profession committed to "values, moral norms, and ideals" that supported changing "aspects of social structures that detract[ed] from health and well-being" (American Nurses Association, 2015, p. 9). The nursing profession needed to assume responsibility and accountability for upholding an obligation and commitment to responding to survivors of sexual

assault in ways that did not inflict further trauma. In critically reflecting on nurses' obligations and commitments, it was essential that nurses committed to fully engaging and integrating anti-oppressive practices throughout their praxis if the profession were to effectively provide healthcare services that comprehensively facilitated healing for all people who experienced sexual assault.

Methodology

This study used qualitative inquiry to gain a deep understanding of the role of nurses in addressing sexual assault within healthcare, and within society more broadly. Qualitative inquiry was appropriate in generating new knowledge, especially considering that responses to experiences of sexual assault within the US were complex, and required recognizing social context in order to fully understand the interactions between nurses and survivors of sexual assault. Using critical ethnography, and informed by intersectionality, we examined the power dynamics within the nurse-patient relationship by listening to African American women survivors of sexual assault, as well as nurses with experience caring for survivors of sexual assault. Intersectionality helped us understand women's experiences of sexual assault, as well as their experiences navigating the healthcare system on account of their racial and gender identity.

Recruitment for survivor participants involved responding to a flyer distributed in various sister circles[6], shelters, churches, or through advocate referrals. This flyer included the objective of the study, as well as the contact information for the Principal Investigator. For women to participate, they: (a.) were 18 years or older of age; (b.) self-identified as an African American woman; (c) had an experience of sexual assault at some point in their life prior to recruitment;

[6] Sister circles refer to support groups that foster interpersonal connections and community support for African American women (Neal-Barnett et al., 2011).

(d.) were proficient in English; and (d.) received care at an acute care or hospital setting in the US; and (e.) had experience discussing experiences of sexual assault with a nurse at some point in their lives. We excluded from participating women with severe intellectual and mental disabilities. We recruited nearly half of survivor participants through snowball sampling.

We conducted interviews with 30 women survivors of sexual assault individually over a period of seven months (between February and August of 2021) online via Zoom because the study occurred during the COVID-19 pandemic. Interviews conducted via Zoom recorded only audio, and on average, lasted 1.15 hours. Women who participated received a $40 Amazon gift certificate, and an additional $25 Amazon gift certificate if they referred other participants to the study.

We recruited nurses by a flyer distributed through a state-wide directive of forensic nurses or through snowballing. Inclusion criteria for nurse participation required nurses: (a.) had recent experience practicing in an acute care or hospital setting within the past year; (b.) held a valid RN license in the United States at the time of practice; (c.) were proficient in English; and (d.) encountered in their practice African American women who experienced sexual assault. We excluded nurses practicing outside of the US within the past year since our focus was on examining interactions between nurses and African American women survivors of sexual assault.

We held four focus groups (with two participants per focus group) and nine individual interviews with nurse participants during the same timeframe as women survivor participants (between February and August of 2021). Using in-depth semi-structured interviews, we interviewed participants online via Zoom. Interviews with nurses lasted approximately one hour. Nurses received a $25 Amazon gift card as a token of our appreciation for participating and an additional $25 Amazon gift card when they referred other participants for the study.

Ethical Considerations

We obtained IRB approval for the study through the University of Wisconsin—Milwaukee. Participation in the study was voluntary, and participants were allowed to withdraw from the study at any time. Participants were able to refrain from responding to any questions that they were uncomfortable answering. Participation in the study required completing written informed consent prior to participating. To maintain confidentiality, all identifying information was removed; electronic data were stored on a password-protected, encrypted computer, and paper data were stored in a locked file cabinet in a locked office.

Sample

In this study, we interviewed a total of 30 women and 16 nurses (See Table 1.). Of the women interviewed, all identified as African American cisgender women and ranged in age from 23 to 40 years old (with a mean age of 29 years old). On average, 73.3% of women reported being single. Most resided in an urban metropolitan city in the upper Midwest. This predominantly included Milwaukee, Cook County (Chicago), and Dane County (Madison). 56.7% of women reported being employed and 63% averaged an annual income of less than 30 thousand a year. Women mostly reported being self-employed, but some were employed in healthcare, accounting, and the service/food industry. In this sample, women's level of education averaged 14.3 years of education that ranged from middle school (8^{th} grade level) to a master's degree (18 years of education). Less than half of the women (43% of women) reported having health insurance when accessing healthcare following an experience of sexual assault (See Table 1 for participant demographics).

Nurses participating ranged from 30 to 58 years of age with a mean of 38.5 years of age. Half of the nurses sampled were White, followed by African American (31.25%). 75% of the

sample of nurses reported currently practicing in Milwaukee County. Nurses' years of experience as a Registered Nurse ranged from 4 to 34 years (with a mean of 16.375 years of experience). Of those years of experience, nurses reported a range of 2 to 30 years of experience practicing in acute care or hospital settings (with a mean of 15.8125 years of experience in acute care). Although the majority of nurse participants reported specializing in forensic nursing (68.75%), nurses also reported specializing in Labor and Delivery, Critical Care Nursing, and Emergency Nursing. 75% of nurses participating reported receiving prior education focused on providing care to sexual assault survivors that included two 40-hour Sexual Assault Nurse Examiner courses of didactic training in pediatric and adult populations (See Table 1 for nurse demographics).

Data Analysis

We conducted individual and focus group interviews online via Zoom, although we offered the option to interview in-person. After conducting individual and focus group interviews, we transcribed recordings, and removed all identifying information. The data were analyzed using thematic analysis, a systematic approach to identifying and interpreting patterns and meaning in the data obtained (Ritchie et al., 2014).

Trustworthiness

Described as the "degree of confidence in data, interpretation, and methods used to ensure the quality of a study", trustworthiness provided assurance that the knowledge generated was indeed representative of the people or phenomena examined (Connelly, 2016, p. 1). In this study, trustworthiness was ensured through credibility, dependability, and transferability.

Credibility

As the Principal Investigator and first author, credibility was enhanced through my experience practicing as a Sexual Assault Nurse Examiner for the past three years. This specialization in an area of nursing knowledge focused on providing comprehensive care for those who experience interpersonal violence, aided my ability to more accurately analyze data collected, and to interpret the findings in a way that recognized the implications of sexual assault on health outcomes for survivors.

Secondly, by engaging in reflexivity, which involved recording first impressions of each individual and focus group interview conducted, I recognized patterns in the data while minimizing any biases as a researcher and scholar (Shenton, 2004).

Dependability

We established dependability through an audit trail created to track and account for the implementation and "operational details of data gathering" (Shenton, 2004, p. 71-72).

Transferability

Transferability was ensured by confirming results obtained with two fellow Sexual Assault Nurse Examiners with over 10 years of experience. In addition to peer debriefing, detailed demographic data was gathered from both participant groups (survivor and nurse participants) in order to provide sufficient context for future researchers to transfer the findings of this study to the contexts in which they practiced and served survivors of sexual assault.

Results

The 4th Step

The 4th step referred to disclosure to a nurse as a process, a process that entailed a vulnerable reality for African American women. The process of coming forward about an experience of sexual assault challenged histories of oppression that denied African American

women the basic human right of protection at the individual, institutional, and societal levels. The subthemes identified for creating a safe space to disclose are identified within this 4th step, and organized based on (1.) individual interactions between women and nurses, (2.) the healthcare institution, and (3.) the public. Subthemes identified included: (i) establishing a relationship, (ii) creating a therapeutic space, (iii) providing non-judgmental care, (iv) ensuring a culture of transparency, (v) standing in solidarity, and (vi) communicating empathy.

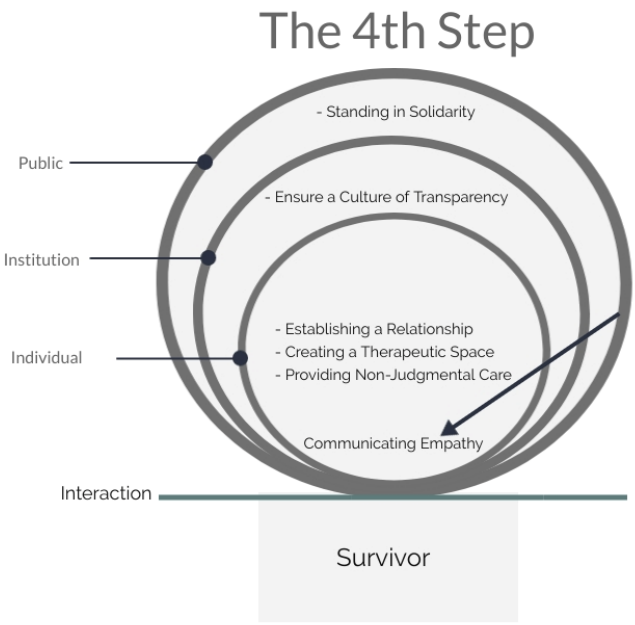

Figure 5. The 4th Step

It was important to recognize that the 4th step starts with women coming to terms with the trauma of sexual assault experienced. As one survivor participant explained in describing disclosure to a nurse as the 4th step, "…to talk about it with a nurse. [Wa]s like the 4th step. You know what I mean? Like, you gotta admit that something happens yourself and sometimes you t[old] a peer."

This was reiterated by another 26-year-old survivor employed in the service industry who stated, “Some people are so reluctant to accept the situation that has already happened, so they should be patient. When dealing with different people.”.

Similarly, a 23-year-old survivor participant who received services from a Sexual Assault Nurse Examiner following sexual assault stated “… I feel like they [nurses] need[ed] for recognition …I mean, the nurses should be aware that it's quite not an easy task for these women to come out”.

The difficulty of the process of accessing healthcare services and disclosing was also discussed by a 32-year-old survivor participant who stated, “When the sexual assault happened, I feared I was in a dilemma of whether to go or not. But eventually I did…it took a lot of courage”.”

Individual interactions between women and nurses

Within individual interactions between women and nurses, we found three subthemes necessary in the creation of a safe space to allow for the 4th step to occur. These subthemes included: establishing a relationship, creating a therapeutic space, and providing non-judgmental care.

Establishing a Relationship

Establishing a relationship involved creating rapport through healthy interactions between survivors and nurses. One 26-year-old survivor reported struggling with substance abuse following her sexual assault as a child. She accessed nursing services only after experiencing SA again in college. She shared, “There weren’t a lot of nurses, I happened to get this one nurse. She was a lady, a Black African woman. And at first…she created a rapport,

very good rapport with me. So, I think that's why I was able to open up and tell her everything. I didn't hide anything from her".

The importance of establishing a relationship from the beginning of the nurse-patient relationship was iterated by some nurses. For example, one 41-year-old African American nurse with 19 years of experience in forensic nursing stated:

> With sexual assault patients, we ha[d] to understand that we ha[d] to move from that norm to really building a relationship of trust and helping that patient understand what their options [we]re, and they ha[d] choices and they g[ot] to decide how we move[d] through this process.

The value of establishing a relationship specifically with African American survivors of sexual assault was also noted by a 48-year-old nurse with 17 years of experience practicing in forensic nursing and labor and delivery. She explained her experience caring for an African American woman who was in police custody following an experience of sexual assault:

> Being calm and supportive with her, I think really was helpful for her at the moment, at least to get enough information to help her with what I could. I could have easily saw her and been like, yep, I can't work with her, she's, you know, like belligerent or whatever she's swearing. I d[id]n't tolerate swearing. You know there's that whole thing when people g[o]t…I [saw] it in the ER like don't use that language with me. Well, you know I didn't do any of that.

A 34-year-old survivor participant, who first experienced sexual assault in foster care at the age of 6 and again at 33 years of age, iterated the importance of establishing a relationship so that disclosure and thereby healing could take place:

> That support [went] a long way for a woman of color, 'cause we're usually in our community, looked at as being the backbone and being so strong. Like I said like that, that to me, was just a unique need was that, that having somebody should be there…Like I said, sometimes you're you bec[a]me weak and that's all that you can really. That's all you really need[ed]. Somebody that's there [wa]s somebody that underst[ood] you. It's simple things like that's a need for me as a Black woman because sometimes you can't even get that from your own family and stuff.

Creating a Therapeutic Space

After establishing a relationship, it was essential that nurses created a therapeutic space in which survivors knew they were believed and heard.

The normalcy of not being believed by nurses was expressed by a 47-year-old Caucasian nurse with 14.5 years of experience as a forensic nurse examiner and 26 total years of acute care experience. She reflected on her experience caring for an African American woman who was frequently seen in the emergency department, and who was brought to the emergency department after the police found her being sexually assaulted in a public stairway:

> Because of her history with the department…One of the nurses…Which [wa]s something that [wa]sn't uncommon that we hear[d], and I [was] sure that like… Probably many people involved in this [said] that. D[id] you believe it's real or d[id] you believe it happened…? It sa[id] it was because she was…known for having mental health issues, known for having substance abuse issues and, uhm, you know in my mind I thought had somebody not walked in and witnessed this…How would she have been treated?

A 28-year-old survivor participant reflected on what was most helpful receiving care from a nurse after sexual assault, “First of all [was] believing. My nurse believed me.”

Five survivors reported experiencing not being believed by a nurse. Among these was a 26-year-old woman who shared her experience:

> She did not want me to say what really happened. She had her own conclusions and that made me feel so demeaned…It was not so fine for me. I could not speak what was in my heart. I could not explain because she already made conclusions that definitely this d[id] not happen. So you had your own issues that led to the incidence, the incidence... She was so judgmental. I could not speak…t was not so good. I actually left the room and went to seek help from someone else. I could not stand the judgement, so I left.

Not being believed led to one survivor explaining why she did not disclose her experiences of sexual assault to nurses:

> I d[id]n't know…I guess I just felt like it. It's just I [was] not believed anyway and they're already [holding] assumptions and biases and stereotypes anyway. So like let them think whatever the hell they want[ed] to think and I just want[ed] to get what I gotta get done and get out of here.

Not being believed was a component of not being heard, and that compromised the ability of a nurse to create a therapeutic space. As one participant discussed in relation to where nurses could improve:

> OK, maybe they [nurses] can improve on the way to handle the survivors like taking their time. Tr[ied] to sympathize with them when they [we]re telling their stories. And also be there for them like. Be…upfront in helping them. Feel like…they can pick themselves up again. And still go on with their…their lives.

The importance of listening was iterated by another 23-year-old survivor participant who was sexually assaulted during a house party at 18 years of age, “They should be friendly and

humble and encourage them because some of them [we]re maybe in a situation that they have even lost like what's the meaning of life in their life?".

Nearly half of nurses interviewed recognized the importance of listening to survivors as a crucial element to supporting African American women after experiences of sexual assault. A 58-year-old nurse with 30 years of experience practicing in emergency and forensic nursing discussed the importance of listening during an experience of caring for an African American woman who had a key inserted during a sexual assault. Of this experience she said:

> I put the speculum in. I didn't see anything. I went 360 degrees around the cervix, could not feel anything, patient insisted looked me in the eye, grabbed my hand. There were mental health issues, but there was still a communication that [happened] between my patient and I that I had to listen…I had to validate, OBGYN came down. They did 360 degrees. Completely dismissed the patient. I took the patient over to to go to the bathroom. She again grabbed my hand and said "[nurse] there [wa]s something inside of me". I…went over to X-Ray and I said "I don't have an order. I need a flat plate of her abdomen." There was a key in her.

In reflecting on the experience this nurse explained, "The listening and believing is completely outside of every box. Every learned thing in humanity. Uhm, it's it's the ability to really, really get on a ride with somebody and just really be present and really listen."

Providing Non-Judgmental Care

Providing non-judgmental care was required for nurses to be able to provide a safe space for African American women following experiences of sexual assault. To the study participants, non-judgmental care meant attending to survivors' needs in a way that did not allow for assumptions or biases to impede the delivery or quality of nursing care. One nurse said:

> …when you're supporting a sexual [assault survivor] you should not judge them first thing. OK. And that is something that I'll still talk and talk[ed] about it. They should not judge a victim or should not blame them.

A 28 year-old survivor participant expressed how she feared judgmental encounters with healthcare providers after she experienced an attempted sexual assault while waiting for the bus. She explained how the fear of receiving judgmental care initially deterred her from accessing healthcare services:

> At first this sexual assault affected me in many ways. For example, OK. I was in shock and denial, whereby I [asked] myself, why me or why did? Why did I use this route so that I can make it this sexual assault or why did I use this route so that I can meet this person? Who was attempting to sexually assault me…and I was in fear whereby…I was in silence I felt that I should not open up. And yeah, I should not open up because I feared how are these people [healthcare providers] going to to check me? Or how are they [healthcare providers] going to [we]re they going to judge me? Or what [we]re they going to do to me?

Ultimately, this particular survivor participant decided to access healthcare. She went on to describe how she encountered a nurse who provided judgmental care that was re-traumatizing:

> For me on the way she [nurse] approached me, I didn't like it because she [nurse] was like like she was judging me. She was asking me for something like what were you wearing during that time? Was it because of maybe alcohol consumption…which I thought that it's like she's blaming me for the act. Yeah, I felt that she's blaming me for that for the act. Or like I [was] the cause of the sexual assault, of which at that point, I

th[ought] that…they were like traumatizing me because she was asking what were you wearing or so it means that my dressing code that led to these sexual assault, so for me I thought that was not the case or that was not the way to console.

Another example of encountering judgmental care was noted by a 32-year-old survivor participant who stated, "My experience getting the services that I needed has not always been easy. It [was] tough. But I think I maneuver[ed] that way to like get the services I need[ed] because I met a lot of people who [we]re quite judgmental".

Initially this participant accessed healthcare services through a clinic after experiencing sexual assault. She explained, "When I got there I got a very rude nurse. I don't know if she had a bad day, but that wasn't an excuse to like treat someone so badly she…she actually like wanted like brushed me off like I didn't like deserve the services. At this point I was very vulnerable, so I didn't expect that".

Afterwards, the survivor participant called a friend who transported her to a hospital 20 minutes away. She related how services at the hospital were more helpful in that, "just [were] human to me, not pushing me away. Not being afraid of what I [was] gonna say to them. So they were motivating me to say everything that had happened".

The fear of encountering judgmental care due to one's racial identity was discussed by fully half of survivor participants. For instance, a 25-year-old survivor participant said, "… when I first I went to seek…some health services I had that in my mind. I knew now I [was] Black and I [was] going to experience some sort of racism, discrimination. They may not attend to me. They may judge me.".

For one survivor participant, the anticipation of experiencing judgmental care after disclosing sexual assault was the reason why she did not disclose to nurses. She stated, "[I]

guess it's just the reality, but…I d[id]n't know how much they [nurses] actually believe[d] that sexual assault happen[ed] to Black women".

Women were concerned about encountering bias on account of their identity as Black women. The impact of these biases on the quality of care came up for a 39-year-old Biracial nurse with 17 years of experience in critical care, perioperative, and forensic nursing. She spoke about a case where she recognized the bias of nurses who were responsible for the care of an African American woman who had experienced sexual assault:

> That reminded me of a recent case that I had with a Black woman who had experienced sexual assault. And she had mental illness. Um...was homeless at the time and was seeking shelter. And the Advocate was able to guide her through how to get shelter and we were successful in that. I went to the emergency room nurse and I said, you know, we were able to locate shelter for her. Transportation has been arranged. And I said the only thing she would like is her IV taken out. And she [ER nurse] said "you can do that… it's just like you guys are so much better at that anyway". [The forensic nurse said,] "What do you mean?" And she's [ER nurse was] like "just dealing with them". And I said "Don't do that. Don't do that." And it made me like, reflect and say if you can't take an IV out of the patient then how can I trust you with them after experiencing a traumatic experience, and how can I even trust that they will get to me? Uhm, like you won't believe them. You won't acknowledge them.

Four survivor participants also reported encountering judgmental interactions at the individual level with nurses, which led them to terminate their encounter with either the provider or the health agency after accessing healthcare services.

> First you ha[d] to find someone who is very understanding. Second, she must be willing to like internalize what you are saying to her. She must not be fearing what will be the consequences. She just need[ed] to be there for you, so for her I don't know. She didn't like feel that compassionate towards me. And I found it like, really a hard time being that place sucks that I… I just walked out.

Similarly, another 30-year-old survivor participant discussed how she left the first healthcare facility she accessed:

> When I went to the hospital, I also had some hard time because at first the nurse who interacted with was so rude to me. Because it's just a uh nearby Health Center where I live. So the nurse knew…my friend before I disclosed who assaulted me, but then…would not believe. He was telling me that I was making up stories. I was so devastated. I was so frustrated. I had to change the health facility even to another one.

Part of providing non-judgmental care was respecting the autonomy of African American women. As one 41-year-old African American nurse participant with 19 years of medical-surgical and forensic experience explained:

> I th[ought] giving a patient an open and safe space and saying that to that patient at least letting the patient know that you ha[d] choices. This [wa]s your space. You g[ot]t to decide what happen[ed] next…or what d[id] not happen. As long as that patient [wa]s an adult. I [was] very clear with patients and not just my sexual assault patients [but] with patients…taken care of with domestic violence 'cause those bring some of the same stigma.

Interactions between women and the healthcare system

Sexual assault survivors and nurses interviewed also iterated how interactions between women survivor participants and the healthcare system impacted the process of the 4th step. In analyzing the data, we found it essential that nurses created a culture of transparency between women and the healthcare system. Ensuring a culture of transparency meant providing the same pattern of quality-care at each interaction between African American women and the entire healthcare system.

Ensuring a Culture of Transparency

Nearly half of the survivors discussed reluctance when accessing healthcare services after experiences of sexual assault due to prior experiences of mistreatment at healthcare institutions. For example, one 23-year-old survivor shared:

> … you fe[lt] it's it's difficult to go and share your issue with the nurse because…We experience[d] our mishandle. You're being…mishandled in these hospitals. Maybe we fear[ed] to go and face them because. They will face[d] a lot of rejection, mistreatment and all that kind of stuff. Maybe they need[ed] to improve on how they are treating their patients in making them want to come back another day.

A forensic nurse discussed the delivery of poor-quality care to African American women in the healthcare system:

> …for the Black women that I [took] care of, I'll give you an example of this case. The patient was assaulted by an ex-boyfriend in her home. Uhm, she called police to come and help her. Police came and helped her. They put her in the back of their squad car. They interviewed her for four hours. She [wa]s brought to the emergency department. She [wa]s seen in triage. She [wa]s triaged by the nurse. Which mean[t]

> that a medical exam or medical screening exam was done in triage. And I …received the call 20 minutes after the patient got to the emergency department and when I got to the emergency department her respirations were 56. I put a pulse ox on her and her pulse ox was 82 and and I found out the elements of the of the assault was. That the perpetrator had his knee on her chest during the assault. And I brought the patient directly into… where she had a chest X ray and had pneumothoraces. So my experience is working with specifically Black women. I have seen multiple times where the ball was dropped. This patient was brought into a cop car, sat in a cop car with…pneumothoraces brought into triage, triaged by a nurse and a medical screening exam done and it was not caught and then I was the third person and just the forensic nurse.

Because of the expectation of receiving poor quality care, four survivor participants discussed accessing healthcare services after being sexually assaulted but not disclosing. A 26-year-old survivor who experienced sexual assault twice shared that although she accessed healthcare services after both sexual assaults, she only disclosed the second time after sustaining severe physical visible injuries:

> …It happened twice, so the first encounter I didn't disclose it to someone, but now the second one I had to disclose because besides being raped, I had also gotten some injuries on my back because the perpetrator was…So violent with me…that…I had some back issues and we had a battery outright. I was like a cracked bone on the lower back.

Similarly, one participant shared that during her 5-year marriage, she had "more than 10" experiences of being sexually assaulted by her then husband. The 29-year-old survivor participant shared her experience accessing healthcare services to attend to severe physical injuries sustained after being beaten and sexual assaulted by her then husband:

…so once I got to the hospital was asked like…what had happened to me...I just didn't go too direct and say that I was beaten. I just said there was so much in pain and my teeth had fallen off. My fingers had bent.

The delivery of poor-quality care that failed to meet the needs of African American women survivors was demonstrated in this situation that one forensic nurse encountered when emergency personnel missed signs of strangulation that resulted in brain injury:

The patient that I saw…had the severe sexual assault and physical assault she was…held in her apartment from by an ex for numerous days, was assaulted in front of her 3-year-old son. And eventually got help through, like a code word with her mother who had called. Uhm, when she was brought to the hospital…she had been strangled multiple times. Feet not touching the floor, incontinence of urine and stool, classic signs of strangulation severity was high. Um, she began to show symptoms of a brain injury…began vomiting, so we that was also a good learning experience from both sides to see that sometimes these symptoms are not recognized by emergency personnel and then also, they're not believed necessarily or the right questions [we]ren't asked.

A 40-year-old emergency room nurse with 10 years of experience in emergency nursing expressed the lack of training to appropriately care for sexual assault survivors:

I th[ought] it always made me a little uncomfortable taking care of sexual assault patients just because I never knew if what I was saying was not appropriate, but like comforting enough, and I th[ought] because everybody experience is so different. That from my understanding, they're just happy to know that someone care[d] about them, but yet [was] I providing them with the right resources when they're done?.

A forensic nurse explained how adequately meeting the healthcare needs of African American women who experienced sexual assault required a shift in healthcare culture.

> …one great thing that I was taught …[was] being able to see beyond the injury and see beyond the algorithm of the collection of forensic evidence but, the ability to see the patient and be present to the patient [wa]s something that [wa]s unless you're doing that, you're going to miss. You're going to miss…things that can really improve a culture. A healthcare culture, and I th[ought] that's the most important takeaway that I really just wanted to communicate with you about how important it [wa]s that nurses really be versed in how to care for populations that have experienced and live[d] in violence every single day and how it [wa]s our job to figure out how to better create these relationships and better earn the trust of these populations to move forward.

Interactions between women and the public

Women and nurses interviewed discussed the importance of standing in solidarity with African American women who experienced sexual assault.

Standing in Solidarity

Standing in solidarity entailed nurses taking a publicly unified stance against the sexual assault perpetuated against African American women. For example, one 28-year-old who shared having experienced multiple sexual assaults for nearly ten years, and accessing hospital services for abortion services as a result said:

> I realized they weren't as receptive, especially to…me. Now like a Black American…So…from my point of view, I th[ought] they didn't believe in me at first.

Yeah, so that was really painful. That was really really painful because it…forced me to shut down.

This was reiterated by another 23-year-old survivor, “I fe[lt] like most women…[we]re afraid of speaking out when they faced these things because they they assume[d] that the nurses will will just ignore them. Being a Black woman [wa]s not easy. We face[d] a lot of rejection out here”.

One forensic nurse spoke to the importance of recognizing the unique needs of African American women:

> …[African American women’s] experiences [we]re different. Be it with healthcare, their community, their resources [we]re different. Uhm, due to inequity. Uhm, so you ha[d] to acknowledge who they [we]re. You can't treat everybody the same. You can't, you know, see everything as you know, colorblind. It's not. We ha[d] differences. This [wa]s America and and we ha[d] to acknowledge it. I think that's the first, you know, step [wa]s like you have to acknowledge that this person [wa]s different. Even if she's you know. If it's a Black nurse and a Black patient. You ha[d] to acknowledge that that's who they [we]re, that's part of treating them as a whole being that's a part of who they [we]re.

Similarly, another 48-year-old Caucasian forensic nurse shared how she recognized the importance of understanding the context in which African American women navigated society. She shared an experience providing care to an African American woman in custody who experienced sexual assault:

> Black women who've experienced sexual assault. Need. Everything that all victims of sexual assault…require[d], however, I th[ought] you need[ed] to also acknowledge them

> as Black women, period…I was telling her…She was going into custody after this and like let's just get, you know I can do this for you. We can collect some evidence, give you some meds you know, and then you can be out of here. She wanted to leave. She was going to the detention facility next door across the street. And she suddenly busted out, like when I said that she's like, I'm afraid. If I go there that I won't come back out alive. And that struck me. It was at the time when there was a lot of deaths of incarcerated people. Strangely, you know they would be howling and then they died and there was. We'd hear[d] about it in the news or whatever. Of course, people of color.

Although some nurses recognized the importance of understanding the context that African American women navigated, this was not the case for all nurses. One emergency room nurse stated, "I'm just going to say like as a White woman…I can't say like what a Black woman need[ed] specifically 'cause I'm not… I'm not Black."

Survivors also spoke about the context that they navigated as Black women. One survivor iterated this, "I th[ought] the way that a nurse integrate[d] that analysis into their life [wa]s going to impact the way that they are received in the way that they receive[d], like survivors of sexual assault and sexual violence".

Another participant explained the importance of standing in solidarity with African American women publicly:

> What nurses can actually do is…improve[d] on how they respond[ed] to these people [African American women survivors] not discriminating. No racism. Yeah, just treat[ed] them like any other person. Who [came] yeah, especially that [wa]s the main area 'cause the few cases [we]re. Had most of them will just talk of the discrimination,

how they're not received. Well, how some nurses [we]re so judgmental. So, 'cause now somebody t[old]. Yes I got the medication. Yes, I got what I needed, but then these people just judged me so. We'll get the medication, but you still fe[lt]. You were not helped enough yeah. Yeah, so I th[ought] the main area [wa]s that. Of how they treat[ed] them, the discrimination patterns.

Three participants discussed the importance of nurses providing public support and how prior relationships with nurses made it easier to access healthcare following sexual assault. For instance, one survivor shared how her decision to seek healthcare services after experiencing sexual assault was largely due to being friends with an emergency room nurse in the hospital where she sought services:

I think first [wa]s the fact that I kn[e]w my friend and not like…we've just met. …we d[id]n't get to meet often but… At least having someone to like access healthcare and besides, this healthcare d[id]n't come mainly in terms of sexual assault, even other things. So I fe[lt] like this time round knowing someone really matters and also having a strong support system within you, because as in as much as you kn[e]w the friend as a nurse. At at times, if you d[id]n't have the right support system back home or back in the relationship that you [we]re in, it could be very very hard.

Another participant expressed that she only sought services at a hospital due to her prior relationship with a nurse from her community. When asked would she have sought healthcare services after experiencing sexual assault if she did not have the relationship with the nurse, she stated:

> I d[id]n't think so. I th[ought] [I'd] shy away from saying some things…Because now I d[id]n't want to be judged, I d[id]n't want to have people against me. I d[id]n't want to be feeling uncomfortable and at the same time it's a very emotional state.

Communicating Empathy

Finally, communicating empathy was iterated by both survivor and nurse participants as a necessary component to support African American women's disclosure at the individual, institutional, and public levels. Communicating empathy involved demonstrating an understanding of the trauma encountered.

A 26-year-old survivor participant spoke of the importance of empathy at the individual level, "It [wa]s very devastating if you g[o]t someone who d[id]n't understand you, someone judgmental, or someone dismissing, or denying allegations. It could be hard, especially if you [we]re dealing with professional nurses, which who at times [were] very rude".

Similarly, a forensic nurse described the harm of interactions that lacked empathy at the institutional level:

> I think what [wa]s most frustrating [wa]s when you ha[d] regular police officers that c[a]me in and [we]re just not even or being, so like disrespectful and disregarding. That these women [we]re coming forward as a minor, as like a wave [wa]s convenient. And not taking them seriously, and almost like shaming them. But just like that they were, they had other things going on. Well, this [wa]s just a convenient way to stop the process of wanting to either being going, going to booking, or being charged with something.

At a public level, one survivor's story demonstrated the importance of empathy. As a minor, this survivor experienced multiple sexual assaults from a former foster parent. She

discussed how after being beaten, sexually assaulted, and locked in a room, she escaped to a neighbor's house who then escorted her to the hospital:

> I th[ought] they should be…sympathizing with…the patients, especially if it's a case of a minor... These [nurses] should be very prudent and very confidential in their work. They should be people who ha[d] a heart because once you…under[went] such a situation, it [wa]sn't very easy, so you ha[d] to have someone to like lean on, and these nurses really play[ed] a supportive role

Because of the supportive care this survivor received from nurses, as well as the support she received from her neighbors in the public realm, she was placed in a new foster family:

> They [African American women] needed a place where…a safety, like for me [I] needed a home that [wa]s safe. I need[ed] friends around me. I also need[ed] people who trust me. I d[id]n't need some, some more external forces that d[id]n't believe me because that would be depressing, and it could worsen the situation.

One 26-year-old survivor participant who experienced empathy after disclosing to an emergency department nurse, explained how disclosing and the response of empathy facilitated her healing process, "…even for someone who [wa]s not ready to disclose their experience yet, at least they kn[e]w how they can handle you so that you can get to a point to where you'll be able to comfortably disclose your situation, and they'll take you through a healing journey. You know, healing [wa]s a process. It's not a one-time thing".

Similarly, another 28-year-old survivor participant shared her experience of receiving empathetic responses after disclosing to a Sexual Assault Nurse Examiner. "I…found out that asking for help is not a sign of weakness. And it t[ook] strength and courage to reach out. Yeah, and by doing so, will help me heal from more trauma".

Discussion

As the largest workforce in healthcare, nurses played an important and influential role in shaping the culture within healthcare institutions and society at large. The following section delineated recommendations for nursing practice, education, and policy.

Practice

As survivor participants voiced within this study, African American women were often hesitant and anticipated encountering harmful interactions with individual nurses, the healthcare system, and society members following their experiences of sexual assault. For African American women, who may come from an oral tradition where communications travel throughout one's community as well as across generations (Banks-Wallace, 2002), experiences of receiving substandard care affect not only one woman's disclosure and access but also the disclosure and access of other women in their community and so on into the future.

It was imperative that all practicing nurses (and nurses preparing to enter practice) who interacted with African American women, incorporated anti-oppressive practices within their nursing practice. This included engaging with and understanding the impact of historical context on present day power dynamics informing women's experiences. This included the power dynamics of women's encounters with perpetrators, as well as the power dynamics within the nurse-patient relationship, the healthcare institution, and other areas of society. Attaining understanding was critical because it enabled nurses to take accountability in recognizing how acts of violence, such as sexual assault, are perpetuated and supported through the responses of individual nurses, healthcare institutions, and broader society.

Secondly, many survivor participants discussed the positive impact of encountering diversity within the nursing workforce and how this fostered a safe environment for disclosure and receiving quality nursing care. Diversified workforces communicated a clear message about

the value of inclusion and safety to the diverse population of patients the nurses served. Nevertheless, the current nursing workforce, which is predominantly White, continued to have the responsibility of ensuring they provided quality and safe nursing care to diverse clientele.

Although many nurses voiced the importance of diversifying the workforce, some also discussed their limited interactions with the populations they served. Segregation in urban metropolitan areas had important implications for relationship building and for learning to communicate effectively and transparently with diverse populations. It was essential that nurses fostered relationships within and across the communities they served, particularly in racially segregated metropolitan areas.

Thirdly, incorporating anti-oppressive practices into nursing practice also required nurses to integrate taking a stance in opposition to the oppressive violence perpetuated towards specific communities and across the public. Since nurses protected and promoted the health of those they served, they had a responsibility to call out violence as a public health problem, and to invest in and protect communities where African American women belong. By leading this charge against oppression and violence, nurses contributed to the creation of a more just system where women felt safe to access care and to disclose their experiences of sexual assault.

Education

Considering the impact of past and current nursing practice on African American women's experiences, it was imperative to include nursing students in anti-oppressive practices. Engaging nursing students in anti-oppressive practices fed into creating a societal cultural paradigm shift because nurses set the foundation for adequately caring for African American women survivors of sexual assault. Simply, nursing students became nurse practitioners. Nurse educators provided tools that enabled nursing students to critically reflect on the historical

context of the populations they served. Incorporating discussions about the history, especially nursing and healthcare institutions' role in perpetuating violence, and contrasting with examples of nurses who facilitate trajectories of healing for African American survivors of sexual assault was tantamount to nurse educators' success in shaping future health outcomes.

The knowledge base informing the education of nurses should be generated from the lived experiences of members of communities that had systemically been predisposed to sexual assault while also experiencing barriers to care as a result of marginalization. This might include integrating emancipatory theoretical foundations into nursing education. This would enable future nurses to develop a critical lens in understanding historical contexts and their impact on the inequities we see today, and to understand the relationship between violence and oppression.

Policy

Nurses were a part of the healthcare institution, and this institution contributed to the suffering of African American women and their communities, whether through unethical acts (like in the case of the Tuskegee study) or through the perpetuation of health inequities resulting from systemic racism. It was important that healthcare providers interacting with African American survivors of sexual assault were conscious about creating a relationship and a space that facilitated healing. The policies guiding the practice of healthcare professionals in the various healthcare organizations also needed to incorporate anti-oppressive practices that ensured the creation of safe spaces for disclosure and healing to occur.

Survivor participants called attention to the importance of receiving care from a nurse with specialty training specific to caring for survivors of sexual assault. Despite the national policies requiring healthcare organizations to screen patients for safety concerns related to violence, in reality, outside of the forensic nursing specialty, there were limited training

opportunities provided in acute care settings for nurses and healthcare workers. It was essential to provide nurses with educational opportunities that prepared them to respond to disclosures of sexual assault. In addition, nurses who specialized in providing care to sexual assault survivors should be readily available within acute care facilities across the nation.

Some survivor participants shared their experiences of not being screened when accessing healthcare. Creating and ensuring the implementation of policies within healthcare organizations that ensured the screening and safe response to disclosures of experiences of violence, such as sexual assault, communicated a commitment to recognizing and addressing violence as a public health concern. Furthermore, healthcare institutions should partner with the communities they served to develop and provide options of care that use an integrative framework. Integrative healthcare frameworks were an approach to providing care that recognized and treated every person holistically, tailoring care to meet individual needs, centering care around the patient's decisions, to support wellness and to prevent disease (Kania-Richmond & Metcalfe, 2017). Providing an integrative approach within healthcare institutions that served sexual assault survivors not only aided in establishing a coordinated partnership with community-based providers who have been engaged in addressing sexual assault in the community, but also provided opportunity to improve access and quality of care delivered by fostering long-term relationships within communities where African American women reside (Zweig et al., 2021).

Ultimately, the knowledge base of nurses offered an opportunity of supporting sexual assault survivor's trajectories towards healing. For survivors of sexual assault, facilitating healing trajectories required that interactions with nurses were healthy. For African American women sexual assault survivors, these healthy interactions best occurred when nurses adopted

and engaged in anti-oppressive practices. The nursing profession had an important role to play in advocating for quality care that supported African American women's health following sexual assault within their individual practice, as team leaders within healthcare institutions, and in the pubic where nurses were committed to serve.

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Tables

Table 1. Participant demographics.

Women participant demographic		Nurse participant demographic	
Age		Age	
18-24	3	30-37	3
25-30	16	38-44	4
31-35	10	45-51	5
36-40	1	52-58	2
		Not Answered	2
Ethnic Identity		Ethnic Identity	
African American	30	African American	5
		Caucasian, Non-Hispanic	8
		Biracial	1
		Not Answered	2
Marital Status		Current Employment Status	
Single	22	Employed	16
Married	8		
Zip Code of Residency		Zip Code of Practice	
Rural Wisconsin	4	Massachusetts	1
Madison, Wisconsin	2	Milwaukee, Wiscosin	9
Milwaukee, Wisconsin	4	Milwaukee County, Wisconsin	3
Chicago, Illinois	5	Madison, Wisconsin	1
Cook County, Illinois	11	Rural Wisconsin	1
Winnebago County, Illinois	1	Cook County, Illinois	1
Lee County, Illinois	1	Lake County, Illinois	1
Atlanta, Georgia	2		
Type of Employment		Years of Experience as RN	
Cashier	2	1-5	1
Waiter	1	6-10	4
Cosmetics	1	11-15	1
Food Industry	2	16-20	4
Accountant	2	21-25	3
Healthcare	2	26+	2
Sales	1	Not Answered	1
Social Work	1		
Self-Employed	5		
Unemployed	13		
Annual Income		Years of Experience in Acute Care	
Below 20K	7	1-5	2
21-30K	9	6-10	3
31-40K	6	11-15	2
41-50K	3	16-20	3
51+	3	21-25	2
Not Answered	2	26+	3
		Not Answered	1

Highest Level of Education		Specialty Area of Practice	
Middle School	1	Emergency Nursing	5
High School	3	Forensic Nursing	11
Diploma	2	Critical Care Nursing	1
Associate	5	Perioperative	1
Bachelors	16	Med-Surg	2
Masters	3	OB/Labor & Delivery	3
		Reproductive Endocrine	1
		Intensive Care Unit 1	
		Unspecified 1	
Health Insurance		Prior Education Providing Care to Sexual Assault Survivors	
Yes	13		
No	17		
		SANE-A 12	
		SANE-P 12	
		Emergency Continuing Education 1	

Chapter VI: DISCUSSION AND SYNTHESIS

This qualitative study used critical ethnography to explore interactions between African American women who experienced sexual assault (SA) and nurses practicing in acute care hospital settings. The purpose of exploring these interactions was to better understand what prevented or led to secondary victimization for African American women survivors of sexual assault during their interactions with nurses in acute care hospital settings. By centering the voices of African American survivors of sexual assault, we sought to create a space in which the voices of survivors were heard and to contribute to the development of interventions grounded in the unique sociocultural needs of African American women survivors of sexual assault. Our analysis, which was informed by Black Feminist Thought and Intersectionality, iterated the importance of recognizing the ways that socially constructed ideas of race and gender informed present-day responses towards African American women when they experienced sexual assault.

Although the literature showed the harmful impact that secondary victimization (SV) had on survivors of sexual assault, specifically within healthcare, no studies to date focused on the interactions between African American women survivors of sexual assault and nurses in acute care/hospital settings. This study generated new knowledge that helped us understand how secondary victimization by nurses mimicked and extended from US history. Throughout US history, society, institutions, and individuals denied African American women protection and invalidated their experiences of SA on account of their gender and racial identity. Secondary victimization of African American women survivors of SA was racialized and gendered, echoing society's call to dehumanize African American women. SV usurped these women's right to healing opportunities that arise from healthy nurse-patient relationships.

In this chapter, we discussed the findings of this study as well as the study's strengths and limitations. We also discussed the implications that this study had on considerations for policy and nursing practice.

Synthesis of Findings

Within this dissertation, there are three manuscripts that demonstrated the need to develop and implement nursing interventions tailored to meet the unique needs of African American women who experienced sexual assault. As the findings of this dissertation demonstrated, African American women survivors of sexual assault often encountered responses that deemed them as unworthy of protection when interacting with healthcare providers. The frequency of these harmful responses within nurse-patient relationships (as well as relationships with other healthcare providers), reflected and continued the historical legacy of ideologies that cast African American women as less than human on account of their gender and racial identity.

The first manuscript in this dissertation, which was included in Chapter II, was published in *Advances in Nursing Science* in 2021 and was entitled: The Role of Hegemonic Masculinities in the Lives of Ethnic Minority Women. This manuscript was a historical analysis of the role of hegemonic masculinities in shaping ethnic minority women's experiences of sexual assault. Four themes were identified: social order hierarchies, "othering" dynamics, economic labor divisions, and negative media/mass communication depictions. These findings, informed by intersectionality, spoke to the historical acceptability of the use of sexual violence against ethnic minority women. Acknowledging these histories better enabled nurses and allied health professionals to help patients who navigated multiple systems of oppression when they sought healthcare services after experiences of SA. Healthcare professionals who understood the

history helped to shift societal attitudes by addressing and opposing the hegemonic masculinities that support ongoing violence against women in the United States.

The second manuscript was a thematic analysis of 30 semi-structured interviews conducted with African American women survivors of sexual assault. The goal of this manuscript was both to gather voices of African American women who interacted with nurses and healthcare providers in hospital settings after they experienced of sexual assault, and to inform practice, education, and policy that mitigated and prevented SV. The findings of this analysis indicated that over half of the survivors (N=17) faced invalidating or dehumanizing treatment when accessing healthcare services following SA. Studying women survivors' responses led to the identification of four types of dehumanizing treatment: discrediting, dismissing, shaming, and blaming.

Women survivors discussed how their realities as African American women resulted in poor treatment and management by nurses and allied healthcare professionals and poor health outcomes. Many women survivors recounted interactions with general healthcare providers, not just nurses, that negatively impacted their mental and physical health. It was important that healthcare professionals utilized an anti-oppressive framework to provide safe care to African American women. Incorporating an anti-oppressive framework ensured the workforce was prepared and ready to prevent re-traumatization, or secondary victimization, for African American women seeking healthcare services after experiences of sexual assault.

Although African American women were disproportionately at risk for violence, they were also hesitant to access care and to disclose to healthcare professionals about their experiences of violence. Women who participated in this study requested nurses receiving specialty training to care for them as survivors of sexual assault. By incorporating specialty

training in nursing education, nurses more effectively screened and cared for women who experienced violence.

Additionally, policies to address violence needed to account for the sociohistorical context wherein institutions such as healthcare and law enforcement deprived African American women of protection from sexual assault. For example, current policies often carried caveats to report to law enforcement in order to receive support. Such policies needed reframing to provide alternative options that minimize the role of law enforcement in women's healing. The creation of interdisciplinary services that include nursing, mental health, and advocacy in collaboration with community-based organizations was another avenue that needed exploration.

The final manuscript in this dissertation was a thematic analysis of data collected with African American women survivors of sexual assault (N=30) and nurses (N=16). The goal of this research was to understand the interactions between African American women survivors of sexual assault and nurses who cared for them. In analyzing the data, we noted ways to improve the quality and delivery of nursing care provided to African American women survivors of sexual assault, and spoke to nurses' ability to improve healing outcomes in healthcare and in society.

After hearing from African American women about their experiences interacting with nurses after sexual assault, the final manuscript provided recommendations for nursing practice, nursing education, and healthcare policy that integrated anti-oppressive practices. The role of sexual assault nurse examiners (SANEs) in leading interdisciplinary teams to provide care, particularly in community settings, and how this might be accomplished from a practice perspective also needed to be explored. This was especially true in the case of African American

women who were unlikely to access care at hospital settings but were perhaps more amenable to seeking services from a community-based agency.

Since many African American women expressed anticipating encountering harmful interactions with nurses individually, as well as from the healthcare establishment and broader society, it was imperative that all nurses reflected on their position of power. Nurses needed to consider how they their position of power can either support or hinder best health outcomes for African American women's healing trajectories after their experiences of sexual assault.

By incorporating anti-oppressive practices into nursing practice, education, and policies, power dynamics can be accounted within the nurse-patient relationship. The sociopolitical environment informed power dynamics throughout US history and into present day. This understanding was essential to nurses taking responsibility individually and as a profession in actively resisting actions that perpetuate sexual violence in the lives of African American women.

Many survivor and nurse participants discussed the need for diversity in the nursing and healthcare workforce. Propagating diversity communicated a desire and commitment to include the diverse populations who nurses serve. In addition to intentional efforts to diversify the workforce, nurses and healthcare institutions can be committed to fostering genuine relationships with the communities they served, particularly in segregated urban metropolitan areas.

Integrating anti-oppressive practices into nursing practice enabled nurses to advocate, publicly and within their nursing care, against oppression and violence against African American women. Having nurses committed to investing in the protection of communities where African American women resided allowed for the creation of systems and relationships where women felt safe to access care and to disclose experiences of sexual assault.

The integration of anti-oppressive practices needed to extend beyond current nurses to include those entering the practice as well as nursing school students. Nurse educators can be prepared to enable students to reflect on the historical contexts that inform current dynamics between nurses and the populations they serve. By providing spaces for nursing students to engage in critical reflection on the power dynamics of their future roles, health outcomes and advocacy can be improved while opposing practices that perpetuated sexual violence.

Finally, policies guiding healthcare professionals at every level of the healthcare organization needed to incorporate anti-oppressive practices in order to ensure that safe spaces for disclosure and healing can occur. The final manuscript discussed national requirements to screen patients for safety concerns related to violence, yet healthcare institutions nationwide provided often limited training to workforce outside the specialized realm of forensic nursing. Providing educational opportunities for nurses ensured preparing safe space for disclosure and healing for survivors of sexual assault. We found all acute care settings across the nation should have specialty forensic nurses available to meet patients' needs.

Lastly, establishing and maintaining partnerships between healthcare organizations and communities in which survivors of sexual assault are a part of, will require the use of an integrative framework. Meeting individual needs called for integrative frameworks for providing care that treated each patient holistically, tailoring their care to meet their individual needs (Kania-Richmond & Metcalfe, 2017). Integrative frameworks gave patients' the decisions. This facilitated wellness in the prevention of disease because it options and empowerment enabled them to utilize resources enabled them to heal. These resources and empowerment came from communities where the survivors resided. In fostering a coordinated partnership between healthcare organizations and community-based providers, including word of mouth and person-

to-person relationships, issues of access and improving quality of care delivered were mitigated by fostering long-term relationships with communities.

Strengths of Dissertation

The strengths of this study included African American women centered in their true voices. Analyses provided context and deepened the women's truth. The interactions between nurses and African American women following violence were known to harm the patients. No studies conducted thus far focused on examining secondary victimization from the perspective of African American women who accessed acute care/hospital settings after sexual assault. We documented this known truth, a truth that received no formalized research, in our records. As we examined the nurse-patient relationship from the nurses' perspectives, we found a number of recommendations for helping nurses help their cares heal.

Limitations

There were limitations to the study. One was the majority of nurse participants reported specializing in forensic nursing (68.75%). This was not representative of the entire experience of African American women who survive sexual assault and who interact with predominantly non-forensic nurses through the course of their treatment. We likely did not appreciate the extent to which non-nurse and non-medical employees, emergency room nurses, acute care nurses, nurses working in obstetrics/gynecology clinics, and other hospital settings impacted the healing rate of survivors of sexual assault.

Policy & Practice Recommendations

In this section, we discussed recommendations for practice and policy based on the findings of our research.

The Definition of Sexual Assault

Our first recommendation was for nurses to understand the definition of sexual assault. African American women limited their access to necessary healthcare interventions due to the normalization of violence through socialization and social processes that accepted rape (Hlavka, 2014). Rape culture included ideologies that gave some members of society the expectation that consent was not necessary, or that women as sexual objects were promiscuous or readily accessible. The result was the social acceptance of sexual assault in normative male behavior and justifying the use of force in a patriarchal society benefitting men (Read: White; Judeo-Christian; heterosexual men). (Giroux, 2017). As members of this society, nurses must be educated and be opposed to this legacy of violence.

For example, the legal definitions of sexual assault reflected the belief systems of the historically dominant group (Scully, 1994). By law, rape and sexual assault were considered "a crime against property, not a crime against a person" (National Research Council, 2014, p. 24). This definition strengthened patriarchal control and disavowed women's value outside of their ability to reproduce. Literally, a woman was only considered a sexual victim if she were unmarried, virgin, and the assault occurred through penile/vaginal penetration. These ideologies led to the basic elements of rape law, culminating in what was known as the Model Penal Code. The model code defined rape as "sexual intercourse with a female not his wife" through use of force or threat to severe harm (National Research Council, 2014, p. 24). The code's verbiage yielded some power to women. Not enough. According to the Moral Penal Code, in order to be considered felony of the first degree, rape needed to result in bodily injury, the victim and offender were not social companions and/or had no history of sexual activity together (National Research Council, 2014).

These historical definitions translated into modern day ideologies that recognized "*real rape*" cases only when they presented a stereotypical script of what "normally" occurred during a rape (Archambault et al., 2011; Muehlenhard & Peterson, 2004). Examples of the stereotypic rape script included perpetrator-victim dynamics where the perpetrator was a stranger to the victim, a hand weapon was used, and the assault resulted in physical injuries (Archambault et al., 2011; Hlavka, 2014; Muehlenhard & Peterson, 2004). In reality, most cases of rape and SA were committed by people known to the victim, there was no weapon, and the victim frequently escaped the assault without physical signs of injury (Archambault et al., 2011).

These legal definitions about rape, rape victims, and rapists continued to dictate legal practice in a way that narrowed the definition of rape. The experiences of victims of sexual assault, however, rarely looked like this definition. Failing to respect the vast spectrum of sexual victimization took power from women as well as impacted prosecution outcomes (Archambault et al., 2011; Muehlenhard & Peterson, 2004). As a result, rape and SA are the most common and underreported violent crimes in the US, and annual successful prosecution in cases of rape and SA continued to be significantly low in comparison to reported and charged cases of rape and SA (U.S. Department of Justice, Bureau of Justice Statistics, 2008; U.S. Department of Justice, Bureau of Justice Statistics, 2011).

Legal definitions of rape and sexual assault evolved, but patriarchal designs continued to impact verbiage and outcomes on victim's health and prosecution of violent offenders. Varying from state to state, the inconsistent definitions of rape and sexual assault reflected the struggle to embody the true dynamics of the reality of sexual victimization (National Research Council, 2014).

Understanding Oppression in Nursing: Racism, Sexism & All Other -isms

Our second recommendation for practice is the need for nurses to recognize and understand the way in which oppression operates to perpetuate unequal opportunity for best health outcomes. This includes recognizing factors that perpetuates ongoing violence within the nurse-patient relationship. Historical sociopolitical factors within the environment that create barriers to access and the delivery of safe and quality care are also important to understand. By understanding the ways in which oppression operates, nurses are better able to engage and resist various forms of oppression (i.e. racism, sexism, etc.) within their own practice. Additionally, as nurses understand the way in which oppression operates, they will be better prepared to approach patients in a way that does not place the blame of their experiences on the patient.

Violence Against Women Act (VAWA)

Originally passed in 1994, the Violence Against Women Act was passed in response to the recognition of "domestic violence and sexual assault as crimes", and to provide resources for communities responding towards such violence (Violence Against Women Act, 2020). The Office on Violence Against Women (OVW) was created to provide federal support for women who had experienced violence. Every five years the VAWA requires reauthorization, which provides "special interest groups, and the general public time to reflect about the current need for legislation" (Modi et al., 2014, p. 253). With each reauthorization there have been changes associated with the VAWA. The following section highlights some of these changes.

Reauthorization of Violence Against Women Act 2005

The reauthorization of the VAWA 2005 aimed to be more inclusive in its legal protections and services by creating provisions that specifically sought to protect immigrant survivors of sexual assault, trafficking, and domestic violence (Conyers, 2007). Under section 801 of the VAWA 2005, immigrants who experience trafficking are offered increased protection

by “reuniting them with their children and family members living abroad” (Conyers, 2007, p. 459). Section 801 of the VAWA of 2005 also allows for relatives of those who have experienced violence to be able to remain in or come to the United States, without having to prove “extreme hardship”.

Furthermore, section 802 “creates an exception to the unlawful presence for survivors of severe forms of trafficking who demonstrate that their trafficking experience was “at least one central reason” for their unlawful presence in the United States” (Conyers, 2007, p. 459). This acknowledges that the reason for unlawful presence is related to the experience of being trafficked. Additionally, section 804 qualified immigrants for a T visa status if they are survivors of trafficking and, for example, are undocumented and willing to cooperate with law enforcement in the provision of evidence and information (Conyers, 2007).

There are limitations to this, as this reauthorization iterates the need for people experiencing trafficking to cooperate with law enforcement. If survivors are fearful of retaliation and refuse to cooperate with law enforcement, this limits their options in accessing services that could facilitate and support their healing.

Healthcare Systems Response

The 2013 reauthorization of VAWA is unique in that it was the first-time best practices were funded and were focused on improving interdisciplinary community responses to people experiencing domestic violence, dating violence, sexual assault, and stalking. Under this reauthorization, interdisciplinary training was provided to professionals practicing in healthcare, public health, and other related health care professions. Secondly, under Title V, education programs were also offered to students of the health professions. Statewide interventions were also implemented to “improve the response of clinics, public health facilities, hospitals, and other

health settings to domestic violence, dating violence, sexual assault, and stalking" (Congress.gov, 2020, para. 26). Furthermore, under title V, there was expansion of the sexual assault forensic medical examination itself, and sexual assault programs. For example, those who received funds were required to "provide patient with advance notice about any circumstances under which information may be disclosed, such as mandatory reporting laws, and give patients the option to receive information and referrals without affirmatively disclosing abuse" (Congress.gov, 2020, para. 28). Although the 2013 reauthorization of VAWA has expanded funding for sexual assault forensic medical examinations and sexual assault programs, the availability of these programs as standard across healthcare organizations is limited.

Current Gaps in the VAWA

Although each reauthorization of the VAWA has come with improvements to offer protection for women who experience violence, including sexual assault, in the United States, there are areas where the VAWA still fails to offer protection for women. The following section details how the involvement of law enforcement, gaps in healthcare services, unregulated state kits in storage, expanding gun regulation, and an underemphasis on refugee health impedes VAWAs ability to protect *all* women.

Emphasis on Reporting Experiences of Sexual Assault

First, the VAWA mostly focuses on offering support services that involve reporting to law enforcement. Although, survivors have the right to an anonymous/unreported rape kit, these services are funded through the state in which they are collected. This emphasis on the "need" to report experiences of sexual assault to law enforcement overlooks the historical impact that legal institutions have had in controlling and regulating experiences of sexual assault, particularly in the lives of Black women.

Gaps in Healthcare Services

Screening for Sexual Assault

Although the VAWA has led to mandated practices within healthcare institutions, the details of these policies need to be clarified and further supported in order to be effective. For example, although the VAWA act requires healthcare workers to "screen individuals for intimate partner violence" and offer "local domestic violence services," there is no mandate that requires the screening of individuals who have experienced sexual assault. Further research on how these policies are currently implemented across various sites and sectors is necessary.

Specialized Training

Accurate screening of individuals who experience sexual assault requires specialized training and education of healthcare professions, many of whom are nurses. Incorporating specialized training and education into healthcare professional's education, such as nursing education is not iterated within the VAWA. Currently, every healthcare institution is required to have a person who is trained in administering a state kit for collecting state evidence. This, however, does not mean that this individual has specialty training in providing care to survivors of sexual assault. There are no minimum requirements for training and it is not clear as to the type of training required for a person to be considered as meeting the standard for evidence collection. Incorporating such training throughout nursing education and nursing training could help address this problem as well as address the individual beliefs and values that may be harmful in responding to individuals who have experienced sexual assault.

Encouraging Equal Access to Sexual Assault Service Programs (SASP)

As discussed earlier, the VAWA expands the ability for healthcare institutions to have Sexual Assault Services Programs (SASP), in which specially trained healthcare providers in the

area of violence are available. This, however, is not the standard across all healthcare organizations. For example, in my experience as a forensic nurse practicing in Milwaukee, Wisconsin, many survivors disclose and seek services in acute care settings that do not have a SASP. This then requires that either the patient be transferred to a hospital where there is a SASP, or the patient is left to find transportation to the local SASP. As a result, survivors of sexual assault often disclose in acute care settings without SASP, and are then unable to access the healthcare services offered in SASP.

Moreover, there is minimal focus on the interventions that could be made available as options for survivors of sexual assault besides evidence collection. This again demonstrates the way in which reporting to law enforcement is the primary emphasis throughout this policy.

Addressing Sexual Assault as a Taboo topic in Healthcare

A national policy that recognizes and addresses sexual assault as a pervasive public health issue impacting women's health would aid in establishing partnerships between healthcare institutions and survivors of sexual assault. It would also help in minimizing the idea of violence as a taboo topic. As Ullman & Townsend (2007) explains, "the high prevalence of rape in combination with widespread denial of this problem contributes to the under resourcing of agencies that serve victims" (p. 421).

Health care organizations are sometimes seen as "reluctant partners" in delivering services for SA survivors (Martin, 2005; Matthews, 2008). The notion of "reluctant partners" results from hospital policies that often focus on collecting evidence for legal purposes, rather than supporting health outcomes for SA survivors. Additionally, healthcare providers, including nurses, may view services available to SA survivors as a burden to provide, as they are seen as

preventing providers from completing the "real" or "urgent" work of caring for the sick" (Matthews, 2008, p. 245).

Underemphasis on Refugee Health

Finally, there is no inclusion or support provided through VAWA that focuses on supporting the complex and unique needs of refugees who experience sexual assault, or violence in general. A recent systematic review found that sexual violence was reported among refugee populations in 65% of studies conducted, with 89% of survivors being women (Araujo et al., 2019). In certain spaces, there is an increasingly large population of women who are identified as being at risk, and whose safety and well-being are continually under threat based on "gender, ethnicity, religion, culture, and power structure" (Johnson-Agbakwu et al., 2014). One example of this are Somali refugee women populations.

Constituting the largest group of refugees entering the United States in 2005, with over half residing in Minnesota since 2004, Somali refugees began entering the United States to escape civil war following the collapse of the Somalian government in the early 1990s (Nilsson et al., 2008; Herrel et al., 2010). Although there is a lack of data demonstrating the prevalence of sexual violence against women and girls in Somalia, "women in Somalia continue to be subject to high level conflict-related sexual violence and domestic violence, where rape is often used as a weapon of war" according to reports by UNICEF (Country Policy and Information Note, 2018, p. 13). In these reports, police and militia members have been found to perpetuate rape against women. Women displaced in Somalia are particularly vulnerable to sexual violence, such as "rape, abduction, forced marriage" and sex trafficking (Country Policy and Information Note, 2018, p. 13).

Understanding of prevalence and risk of sexual violence for refugee women prior to their immigration to the United States is important to emphasize, as this risk continues through their process of migration and after settling in the United States. Furthermore, similar populations to Somali refugee women who resettle in the U.S. and other western countries after fleeing armed conflict and persecution, are considered significantly at-risk for violence by the United Nations High Commissioner for Refugees (UNHCR). However, even with this understanding, little to no research has been conducted examining Somali refugee womens experiences of accessing healthcare services after sexual assault in Milwaukee, Wisconsin. We also know that refugee women consistently demonstrate high levels of trauma across a number of studies (Johnson-Agbakwu etal., 2014; Marshall et al., 2005; Sudhinaraset et al., 2017).

Young refugee women in particular are vulnerable to experiences of SA and/or IPV due to the migration process, which may also include sex trafficking, requiring "obstetric and reproductive health care (i.e. pregnancies, miscarriages, abortion care, access to contraception, etc.)" (Freedman, 2016; Sudhinaraset et al., 2017, p. 2). Based on one study examining refugee women's health profile in California, 1 in 3 women reported having experienced a traumatic event prior to migration. This included 17% of physical assaults, 11.7% experiencing captivity, 10.5% experiencing sexual assault, and 17.4% experiencing weapon assault (Sudhinaraset et al., 2017). Although limited research exists that examines SA and IPV among refugee women, we do know that prior traumatic experiences, such as SA occurring in childhood or adolescence in particular, increases one's risk for revictimization in adulthood (NSVRC, 2012).

Refugee women face unique challenges not only in relation to exposure to prior conflict-related trauma experienced before and during the migration process, but also due to vulnerabilities related to resettling. Some examples of challenges associated with resettlement

relate to the process of learning new social and cultural systems including a "lack of knowledge about resources or protections available in the receiving country, language and cultural barriers, and unstable economic circumstances" (Sudhinaraset et al., 2017). Additionally, evidence shows "that refugee women resettled in Western countries possess a tenfold risk of developing posttraumatic stress disorder (PTSD) symptoms" compared to "women of the same age in the general population" (Johnson-Agbakwu et al., 2014). The lack of research, limited funding for future research, and interventions specific to supporting refugee women's needs who experience sexual assault (and violence in general) has not been incorporated into the VAWA.

Title IX

Online platforms are essential tools for youth engagement in social activism, particularly in mobilizing policies that address college campus sexual assault. The largest national poll conducted found that 20 percent of young women will be sexually assault while attending college (Anderson & Clement, 2015). This estimate supports additional reports which found that 27.2% of college senior women reporting having had unwanted non-consensual sexual contact while attending college (Association of American Universities, 2015). Historically, university responses commonly disregard or provide minimal consequences to the perpetrator when survivors attending university report a SA. This results in significantly low reporting of sexual assault. The largest national report conducted among college campuses found "63.3 percent of students" reported or believed "it very or extremely likely that the report would be taken seriously by campus officials" (Association of American Universities, 2015).

Until the past decade, as a result of youth survivor's engagement, resistive strategies in the form of developing models for filing Title IX action lawsuits have gained national momentum to address this common public health issue. Under Title IX, educational institutions

receiving federal financial assistance, require that "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program" (U.S. Department of Education, 2018, para. 2).

A model for survivors was developed that guided them through how to file a Title IX in relation to sexual assault. The report became interwoven into the #MeToo movement which garnered national attention to the problem of sexual violence against college women. Andrea Pino, talked about first sharing "Me too. It happened to me too," after Annie Clark disclosed her experience of sexual assault while attending a university (Clark & Pino, 2018). After this initial exchange, Clark and Pino began to support other survivors filing Title IX claims across the nation due to university negligence following reported cases of sexual assault. Through the use of Twitter, Andrea recalls initial survivors seeking help through the use of the hashtag #MeToo after being victimized while attending higher education.

The combined national pressure through the filing of Title IX across the country in relation to sexual assault within higher education institutions, led to the formation of the "It's on Us" campaign and the White House Task Force to Protect Students from Sexual Assault under President Barack Obama (Coulter & Rankin, 2017). Under the Task Force, there was an urgency to focus on addressing sexual misconduct within institutions of higher education by developing resources, reports, and an online website called the "It's On Us" campaign. Through this initiative, recommendations and guidelines for creating solutions were established, along with a coordinated response to reports of sexual misconduct, and enforcement of campus policy and procedures related to sexual misconduct (The White House Washington, 2017). The implementation of the "It's On Us" campaign helped increase public awareness and to encourage bystander intervention in fostering a shift in social norms on college campuses.

Although online platforms have been used to support sexual assault survivors in discussing experiences and having a community of support, few tools have been developed to support sexual assault survivors' healthcare needs using online tools, such as an application (app). Given the sensitivity of opening up about experiences of sexual assault to others, online applications could potentially provide a space in which survivors can access available options and connect with others in a supportive and discrete manner.

This study with African American women and nurses has clear implications for nursing future research. First, future research should focus on interactions between survivors and nurses beyond emergency room and specialty forensic nursing. To date little research has been conducted examining interactions within the nurse-patient relationship beyond emergency room and forensic nursing specialties. Examining these interactions are important to gain a more accurate understanding of the interactions that are mitigating, preventing, or causing secondary victimization within nurse-patient relationships.

Secondly, future research is needed to explore the experiences of ethnic minority women that access healthcare services that are in positions that may place them at high-risk for experiences of sexual assault. This includes women that experience sex trafficking, substance abuse, and refugee women populations. By understanding interactions that ethnic minority women that are prone to past and ongoing trauma experience, we can better develop interventions to implement that reduce or eliminate further traumatization within nurse-patient relationships.

Considering the suffering that African American women have experienced dating back to the time in which enslaved women were brought to the shores of the Americas, and the suffering continued after slavery, sharecropping, and the great migration, it is nurses responsibility to

ensure that women are cared for to first prevent sexual violence, but that they also invest in African American communities to extend support and offer protection to women when sexual violence does occur in order to foster healing.

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Appendix A:

IRB Approval Letters

UNIVERSITY of WISCONSIN
UWMILWAUKEE
Department of University Safety & Assurances

Melody Harries
IRB Administrator
Institutional Review Board
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New Study - Notice of IRB Full Board Approval

Date: February 17, 2021

To: Lucy Mkandawire-Valhmu
Dept: Nursing

CC: Ashley Ruiz

IRB#: 21.191
Title: Examining Secondary Victimization Within the Nurse-Patient Relationship

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board at a fully convened meeting held **February 5, 2021**, your protocol has been approved as governed by 45 CFR 46.

In addition, your protocol has been granted **Level 2** confidentiality for Payments to Research Subjects according to UWM Accounting Services Procedure: 2.4.6.

This protocol has been approved on **February 5, 2021** for six months. IRB approval will expire on **August 5, 2021**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, a continuation for IRB approval must be filed by the submission deadline. If the study is closed or completed before the IRB expiration date, please notify the IRB by completing and submitting the Continuing Review form found in IRBManager.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. It is the principal investigator's responsibility to adhere to the policies and guidelines set forth by the UWM IRB, maintain proper documentation of study records and promptly report to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

This study may be selected for a post-approval review by the IRB. The review will include an in-person meeting with members of the IRB to verify that study activities are consistent with the approved protocol and to review signed consent forms and other study-related records.

As Principal Investigator, it is your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., FERPA, Radiation Safety, UWM Data Security, UW System policy on Prizes, Awards and Gifts, state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation and best wishes for a successful project.

Respectfully,
Melody Harries
Melody Harries
IRB Administrator

UNIVERSITY of WISCONSIN
UWMILWAUKEE
Department of University Safety & Assurances

Melody Harries
IRB Administrator
Institutional Review Board
Engelmann 270
P. O. Box 413
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Modification/Amendment - IRB Expedited Approval

Date: March 31, 2021

To: Lucy Mkandawire-Valhmu
Dept: Nursing

CC: Ashley Ruiz

IRB#: 21.191
Title: Examining Secondary Victimization Within the Nurse-Patient Relationship

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has received expedited modification/amendment approval for the following minor changes to approved research, as governed by 45 CFR 46.110:

- Adding procedures to allow virtual participation

IRB approval will expire on **August 5, 2021**. Before the expiration date, you will receive an email explaining how to either keep the study open or close it.

This study may be selected for a post-approval review by the IRB. The review will include an in-person meeting with members of the IRB to verify that study activities are consistent with the approved protocol and to review signed consent forms and other study-related records.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records and promptly reporting to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., FERPA, Radiation Safety, UWM Data Security, UW System policy on Prizes, Awards and Gifts, state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation, and best wishes for a successful project.

Respectfully,
Melody Harries

Melody Harries
IRB Administrator

UNIVERSITY of WISCONSIN
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Modification/Amendment - IRB Expedited Approval

Date: June 15, 2021

To: Lucy Mkandawire-Valhmu
Dept: Nursing

CC: Ashley Ruiz

IRB#: 21.191
Title: Examining Secondary Victimization Within the Nurse-Patient Relationship

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has received expedited modification/amendment approval for the following minor changes to approved research, as governed by 45 CFR 46.110:

- Adding incentive to flyer for survivors
- Increasing compensation
- Expanding recruitment from Milwaukee only to Wisconsin and Illinois

IRB approval will expire on **August 5, 2021**. Before the expiration date, you will receive an email explaining how to either keep the study open or close it.

This study may be selected for a post-approval review by the IRB. The review will include an in-person meeting with members of the IRB to verify that study activities are consistent with the approved protocol and to review signed consent forms and other study-related records.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records and promptly reporting to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., FERPA, Radiation Safety, UWM Data Security, UW System policy on Prizes, Awards and Gifts, state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation, and best wishes for a successful project.

Respectfully,
Melody Harries

Melody Harries
IRB Administrator

UNIVERSITY of WISCONSIN
UWMILWAUKEE

Department of University Safety & Assurances

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IRB Administrator
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Modification/Amendment – IRB Full Board Approval

Date: October 29, 2021

To: Lucy Mkandawire-Valhmu
Dept: Nursing

CC: Ashley Ruiz

IRB#: 21.191
Title: Examining Secondary Victimization Within the Nurse-Patient Relationship

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board at a fully convened meeting held September 3, 2021, your protocol has received modification/ amendment approval for:

- Expanding study nationally
- Increasing number of survivor participants
- Including Somali Black refugee women and women actively involved in sex trafficking
- Updating partner organizations for recruitment

Your protocol has also been granted approval to waive documentation of informed consent as governed by 45 CFR 46.117 (c) for women actively involved in sex trafficking.

Additionally, your protocol has been granted Level 3 confidentiality for Payments to Research Subjects per UWM Accounting Services Procedure: 2.4.6.

IRB approval will expire on **March 5, 2022**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, a Continuation for IRB Approval must be filed by the submission deadline. If the study is closed or completed before the IRB expiration date, please notify the IRB by completing and submitting the Continuing Review form in IRBManager.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records and promptly reporting to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., FERPA, Radiation Safety, UWM Data Security, UW System policy on Prizes, Awards and Gifts, state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Appendix B:

Screening Scripts

Thank you for your time and interest in participating in this study. This study focuses on exploring the interactions between nurses in acute care settings and sexual assault survivors who identify as Black women. To ensure you qualify to participate I'd like to ask you a few questions:

1. Are you over the age of 18?*

Survivor questions:

2. Do you identify as a Black?* (If no, refer to nursing questions)
3. Do you identify as a woman?*
4. Have you experienced sexual assault?*
5. Do you have experience interacting with nurses in acute care settings (i.e. hospitals) following experiences of sexual assault?*
6. Did you disclose being sexually assaulted when you accessed healthcare services (in an acute care setting)?*
7. If you received nursing services in an acute care setting following an assault, did you access services in Milwaukee, Wisconsin?*

*Must answer "yes" to questions 1 through 7 to be able to participate as a survivor

Nursing questions:

8. Do you have experience practicing in Milwaukee, Wisconsin in an acute care setting?*

9. Have you held a valid RN license in the state of Wisconsin while you practiced?*

10. Do you have experience encountering Black women who have experienced sexual assault while practicing?*

*Must answer "yes" to questions 1, and 8 through 10, to be able to participate as a nurse participant

Screening Script

Thank you for your time and interest in participating in this study. This study focuses on exploring the interactions between nurses in acute care settings and sexual assault survivors who identify as Black women. To ensure you qualify to participate I'd like to ask you a few questions:

8. Are you over the age of 18?*
9. Are you interested in participating as a nurse or as a survivor in this study?
10. Do you prefer participating in face-to-face interviews or virtual interviews?

Survivor questions:

11. Do you identify as a Black?* (If no, refer to nursing questions)
12. Do you identify as a woman?*
13. Have you experienced sexual assault?*
14. Do you have experience interacting with nurses in acute care settings (i.e. hospitals) following experiences of sexual assault?*
15. Did you disclose being sexually assaulted when you accessed healthcare services (in an acute care setting)?*

*Must answer "yes" to questions 1 through 7 to be able to participate as a survivor

Nursing questions:

8. Do you have experience practicing in an acute care setting?*

9. Have you held a valid RN license in the United States while you practiced?*

10. Do you have experience encountering Black women who have experienced sexual assault while practicing?*

*Must answer "yes" to questions 1, and 8 through 10, to be able to participate as a nurse participant

Screening Script at Inner Beauty

Introductory Script:

Hello my name is Ashley Ruiz. I'm a doctorate nursing student at UWM. I'm currently doing a study to hear from Black women their experiences interacting with nurses after having experienced sexual assault. Would you be interested in participating?

16. Are you interested in participating as a nurse or as a survivor in this study?
17. Are you over the age of 18?*
18. Do you prefer participating in face-to-face interviews or virtual interviews?

Survivor questions:

19. Do you identify as a Black?* (If no, refer to nursing questions)
20. Do you identify as a woman?*
21. Have you experienced sexual assault?*
22. Do you have experience interacting with nurses in acute care settings (i.e. hospitals) following experiences of sexual assault?*
23. Did you disclose being sexually assaulted when you accessed healthcare services (in an acute care setting)?*
24. Are you actively experiencing sex trafficking?

*Must answer "yes" to questions 1 through 6 to be able to participate as a survivor

Appendix C:

Interview Guide

Nurses in acute care questions:

The purpose of this interview is to better understand how nurses interact with survivors of sexual assault.

1. Describe your current or most recent position as a nurse practicing in acute care.
2. Describe a time in which you encountered patients that experienced sexual assault.
3. Tell me what sexual assault means to you.
4. Describe prior training you've received related to responding to survivors of sexual assault?
5. How do you feel these experiences prepared you to provide care for survivors? Tell me more about how you felt unprepared/prepared.
6. Describe a time when you provided care to a patient that identified as a Black woman who had experienced sexual assault?
7. Describe what was most helpful from the interventions you provided for this survivor in your experience of providing care to survivors of sexual assault? Tell me more about how this was helpful.
8. Describe what was least helpful for this survivor in your experience of providing care to survivors of sexual assault? Tell me more about how this was not helpful.
9. Tell me about the needs of Black women that experience sexual assault.
10. Describe what you think would be most beneficial to survivors while receiving nursing services?

Explanation of how the questions are ordered: These questions are ordered in a way to present opportunities for nurses to elaborate upon their experiences in relation to providing care for those sexually assaulted, beginning with explaining their current or most recent position as a Registered nurse practicing in acute care settings. From here, nurses are encouraged to describe a time in which they encountered a patient of sexual assault and to describe what the term 'sexual assault' means to them. After which, we ask nurses to reflect on training and/or education nurses received in preparation. By beginning with training and/or education or opportunities that have been available. From here, questions dive deeper into specific cases in which nurses may have provided care to sexual assault survivors that identified as Black women, and considers what was helpful or not helpful in providing care. The interview is concluded with a question meant to end the interview on a positive note. This question inquires of recommendations that nurses may be able to implement to best support survivors.

Sexual Assault Survivor questions:

The purpose of this interview is to better understand how nurses interact with survivors of sexual assault, specifically for Black women.

1. Tell me about your experiences accessing healthcare services.
    a. Tell me about a time you felt comfortable accessing healthcare services

b. Tell me about a time you didn't feel comfortable accessing healthcare services

2. Tell me about your experiences disclosing sexual assault to a nurse?
    a. What was that experience like?
    b. Where did this disclosure happen?
    c. Tell me about this experience
    d. Describe what was helpful in this experience
    e. Tell me what was harmful in this experience
    f. Tell me about something that the nurses did well or that you found really helpful in moving you towards healing?
3. Looking back on your experience of disclosing sexual assault to a nurse, what do you believe are the unique needs of Black women that experience sexual assault?
4. As a Black woman, what are the unique needs you have in relation to nursing care for sexual assault survivors.
5. Describe areas in which nurses can improve in meeting the healthcare needs of Black women survivors of sexual assault.
6. What has been or do you feel would be the most helpful component of nursing care that would help you and other survivors recovering from sexual assault?
7. Describe some things that have helped you survive your experiences as a Black woman.

Explanation of how the questions are ordered: Questions for survivors begin with presenting the purpose of these questions. I begin by asking participants to reflect on their experiences receiving healthcare services. This question is meant to build rapport, while also identifying what was helpful and/or harmful while receiving healthcare services. From here, I ask participants to reflect on their experiences disclosing sexual assault to nurses. This provides women with an opportunity to discuss what the experience was like, if it was helpful, and/or if it was harmful. This also presents an opportunity to identify where care was received in terms of healthcare specialty within acute care settings. This also presents an opportunity for participants to identify what was helpful from these interactions in healing. From here, I ask an open-ended question about what survivor's believe need to be unique in meeting the needs of sexual assault survivors from the position of a Black woman. The interview is concluded in a question that is designed to end on a positive note, that places the control back towards survivors, in which survivors provide recommendations for nurses to implement to best support survivors following sexual assault.

Appendix D:

Demographic Data

Sample size: 60 participants (30 Black women survivors of SA and 30 nurses practicing in acute care settings)

Recruitment location: social media, Aurora Sinai, Sojourner, Froedtert, Ascension, the ASHA Project, 16th Street Clinic, Health Connections Inc.

Anticipated sample demographics: I anticipate the sample of nurses I obtain to reflect the demographics of nurses in the state of Wisconsin. This means I assume a majority will be white women over the age of 25 years old. However, all nurses of ethnic/racial backgrounds and genders will be eligible to participate.

For survivor participants, I anticipate a majority of women to be African American, meaning descending from ancestors in slavery.

Completing Demographic Data: Nurse demographic data will be completed by nurses individually. Survivor demographpic data will be completed with the researcher, who will ask the demographic data information to survivors participating.

Pertinent demographic data to collect

Nurses demographic data to collect:

- Age _____
- Ethnic identity_____
- Zip code of practice _____
- Zip code of residency_____
- Religious Affiliation_____
- Current employment status_____
- Years of experience practicing as a registered nurse_____
- Years of experience in an acute care setting_____
- Type of specialty practicing in acute care _____
- Prior education/training providing care to sexual assault survivors_____

Patient demographic data to collect:

- Age_____
- Ethnic identity_____
- Marital status_____
- Zip code of residency_____
- Type of Employment_____
- Annual income_____
- Level of education_____
- Health insurance_____

Housing

- Have you ever experienced homelessness?
- Do you have a place of residency?
- Who lives at your place of residence?

Medical History

How many times have you been pregnant?_____
How many children are living?_____

Have you had any challenges with drug misuse? Y N Declined
Current medications:_____
_____
_____
_____

Have you noticed any difficulties with:
-Dissociating[7]
-Emotional numbing[8]
-Difficulty Sleeping
-Fatigue
-Nausea
Other:_____

Family History

Who did you grow up with?_____

Sexual Assault

Has your mother experienced sexual assault? Y N Declined
-grandmother Y N Declined
-great grandmother Y N Declined
-other:_____

Number of times the survivor experienced sexual assault_____
Year of first sexual assault_____
Most recent year of sexual assault_____

Whether or not survivors had access to receiving healthcare services after assault Y N
- if yes, what healthcare services were received after assault_____
-and in what healthcare setting were these healthcare services provided?_____
_____

Sex Trafficking

Have you ever been sex trafficked? Y N Declined

Incarceration

Have you ever experienced incarceration? Y N Declined
If yes, jail or prison?

[7] Dissociation is often a natural response to excess trauma and stress. Some describe this as gaps in their life when one can't remember what happened or one does ont remember information about oneself or things that happened in life. Some may feel like the world is 'foggy' or feels unreal, while others may feel they are looking at themselves from the outside.

[8] Emotional numbing is often temporary, and involves the inability to feel or express emotions

Appendix E:

Consent Form for Survivors

UNIVERSITY of WISCONSIN
UWMILWAUKEE

Informed Consent for Research Participation
IRB #: 21.191
IRB Approval Date: 1/26/21

Study title	Examining Secondary Victimization Within the Nurse-Patient Relationship
Researcher	Ashley Ruiz RN, PhDc (College of Nursing)

We're inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.

What is the purpose of this study?

The purpose of this study is to understand interactions between nurses and survivors of sexual assault.

What will I do?

If you agree to participate, we will meet at a time and place of your choice for an interview.). You may choose to participate in either a face-to-face or virtual interview. This interview may take approximately 1-3 hours, but may take longer depending on the information provided. If you agree, I will also voice record our interview.

- When we meet, I will ask you questions about your experiences receiving healthcare services.
- We will also discuss what it was like talking to a nurse about your experiences of sexual assault.
- We'll also talk about what was helpful or harmful about these experiences with a nurse.
- And we will discuss the unique healthcare needs of Black women that experience sexual assault and consider what nurses can do to improve meeting these needs.
- We will also discuss what has been helpful for you in surviving these experiences.
- After these questions, I will ask questions about your current and past life, family, and experiences.
- You may skip any questions you do not wish to answer and/or limit the information you provide to any topic

Risks

Possible risks	How we're minimizing these risks
Some questions may be personal or upsetting	• Participation in this study is voluntary. • You can skip any questions you don't want to answer. • You're welcome to take as many breaks as you need throughout the interview. • I will ask for your permission to record prior to starting the interview, and will stop the recording at any point you ask. • You may end the interview at any time.

	• We will provide you with a list of local resources available for support.
Breach of confidentiality (your data being seen by someone who shouldn't have access to it)	• All identifying information is removed and replaced with a study ID. • All electronic data will be stored on a password-protected, encrypted computer. • We'll store all paper data in a locked filing cabinet in a locked office. • Voice recordings will be destroyed after the interview has been made into a written transcript. • The data will be reviewed by our team to ensure the highest level of privacy for those that participate

There may be risks we don't know about yet. Throughout the study, we'll tell you if we learn anything that might affect your decision to participate.

Other Study Information

Possible benefits	• One benefit to participating in this study is that you will be provided a list of resources available to you to use as needed • Another benefit to participating in this study is that others will be able to learn
Estimated number of participants	Up to 100 participants that identify as Black women that have accessed healthcare services following experiences of sexual assault nationally
How long will it take?	1-3 hours
Costs	None
Compensation	Survivors will receive a $40.00 Amazon gift card
Future research	Only data that has de-identified information (presented anonymously) will be shared with other researchers through published reports or presentations.
Recordings	I will voice record the interview. These recordings will be used to write a transcript of the interview. This recording is necessary to be able to accurately recall your story. You can refuse to be recorded. I will then take some notes about your story.
Removal from the study	If you feel your safety is in jeopardy researches will remove you as a participant in this study. Furthermore, if you feel your participation in the study will be jeopardize you may remove yourself from participating in this study at any time. Additionally, if your participation in the study causes distress that is inconsolable the researchers will remove you as a participant in this study.
Funding source	Forest County Potawatomi Foundation & the International Association of Forensic Nursing

What if I am harmed because I was in this study?

If you're harmed from being in this study, let us know. If it's an emergency, get help from 911 or your doctor right away and tell us afterward. We can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.

Where will data be stored?	On my personal computer that is encrypted and password protected
How long will it be kept?	Until 12/31/2022

Who can see my data?	**Why?**	**Type of data**
The researchers (Ashley Ruiz and Dr. Lucy Mkandawire-Valhmu)	To conduct the study and analyze the data	• Your contact information to schedule interviews (name and number) • Demographic information • A voice recorded interview • The written transcript of the interview
The IRB (Institutional Review Board) at UWM The Office for Human Research Protections (OHRP) or other federal agencies	To ensure we're following laws and ethical guidelines	• Your contact information to schedule interviews (name and number) • Demographic information • A voice recorded interview • The written transcript of the interview
Anyone (public)	If we share our findings in publications or presentations	• Aggregate (as a collective or grouped) data • De-identified (no names, birthdate, address, etc.) • If we quote you, it will be listed as "anonymous"

Reporting

We are mandated reporters. This means that if we learn or suspect that a child is being abused or neglected, we're required to report this to the authorities. I am not required to report disclosures of an adult that has experienced sexual assault regardless of pregnancy status.

Contact information:

For questions about the research	Ashley Ruiz	414-630-7298/ruizam@uwm.edu
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	414-662-3544 / irbinfo@uwm.edu
For complaints or problems	Ashley Ruiz	414-630-7298/ruizam@uwm.edu
	IRB	414-662-3544 / irbinfo@uwm.edu

Signatures

If you have had all your questions answered and would like to participate in this study, sign on the lines below. Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time.

_____

Name of Participant (print)

_____ _____

Signature of Participant Date

_____

Name of Researcher obtaining consent (print)

_____ _____

Signature of Researcher obtaining consent Date

Appendix F:

Consent Form for Nurses

UNIVERSITY of WISCONSIN
UWMILWAUKEE

Informed Consent for Research Participation
IRB #: 21.191
IRB Approval Date: 1/26/21

Study title	Examining Secondary Victimization Within the Nurse-Patient Relationship
Researcher	Ashley Ruiz RN, PhDc (College of Nursing)

We're inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.

What is the purpose of this study?

The purpose of this study is to understand interactions between nurses and survivors of sexual assault.

What will I do?

You will be interviewed in a focus group of about 5 other people (also nurses**).** You may participate in a focus group that is face-to-face or held virtually. In this focus group, you and the other participants will discuss your experiences caring for sexual assault survivors, prior training received in preparation caring for sexual assault survivors, your experiences caring for Black women that have experienced sexual assault.

Risks

Possible risks	**How we're minimizing these risks**
Some questions may be personal or upsetting	You can skip any questions you don't want to answer.
Others in the focus group could share your responses	We ask everyone to keep everything said during the focus group confidential. However, we can't control what others say, so it is best not to share anything you don't want others to know.
Breach of confidentiality (your data being seen by someone who shouldn't have access to it)	• All identifying information is removed • We'll store all electronic data on a password-protected, encrypted computer. • We'll store all paper data in a locked filing cabinet in a locked office. • All voice recordings of the interview will be destroyed once they are written into a transcript • The data will be reviewed by our team to ensure the highest level of privacy for those that participate

There may be risks we don't know about yet. Throughout the study, we'll tell you if we learn anything that might affect your decision to participate.

Other Study Information

Possible benefits	• One benefit to participating is that this will help others to learn how to best support those that have experienced sexual assault
Estimated number of participants	30 nurses (6 focus groups)
How long will it take?	3 hours
Costs	None
Compensation	Nurses will receive a $25.00 Amazon gift card
Future research	Only data that has de-identified information (presented anonymously) will be shared with other researchers through published reports or presentations.
Recordings	I will voice record the interview. These recordings will be used to write a transcript of the interview. This recording is necessary to be able to accurately recall the groups experiences. If you do not wish to be recorded, we recommend you do not participate.
Funding source	Forest County Potawatomi Foundation & the International Association of Forensic Nursing

What if I am harmed because I was in this study?

If you're harmed from being in this study, let us know. If it's an emergency, get help from 911 or your doctor right away and tell us afterward. We can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.

Confidentiality and Data Security

We'll collect the following identifying information for the research: your name and phone number. This information is necessary in order to arrange a time to participate in the study.

Where will data be stored?	On my personal computer which is encrypted and password protected
How long will it be kept?	Until 12/31/2022

Who can see my data?	**Why?**	**Type of data**
The researchers (Ashley Ruiz and Dr. Lucy Mkandawire-Valhmu)	To conduct the study and analyze the data	• Your contact information to schedule interviews (name and number) • Demographic information • A voice recorded interview • The written transcript of the interview
The IRB (Institutional Review Board) at UWM	To ensure we're following laws and ethical guidelines	• Your contact information to

The Office for Human Research Protections (OHRP) or other federal agencies		schedule interviews (name and number) • Demographic information • A voice recorded interview • The written transcript of the interview
Anyone (public)	If we share our findings in publications or presentations	• Aggregate (as a collective or grouped) data • De-identified (no names, birthdate, address, etc.) • If we quote you, it will be listed as "anonymous"

Reporting

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For complaints or problems	Ashley Ruiz	414-630-7298/ruizam@uwm.edu
	IRB	414-662-3544 / irbinfo@uwm.edu

Signatures

If you have had all your questions answered and would like to participate in this study, sign on the lines below. Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time.

_____

Name of Participant (print)

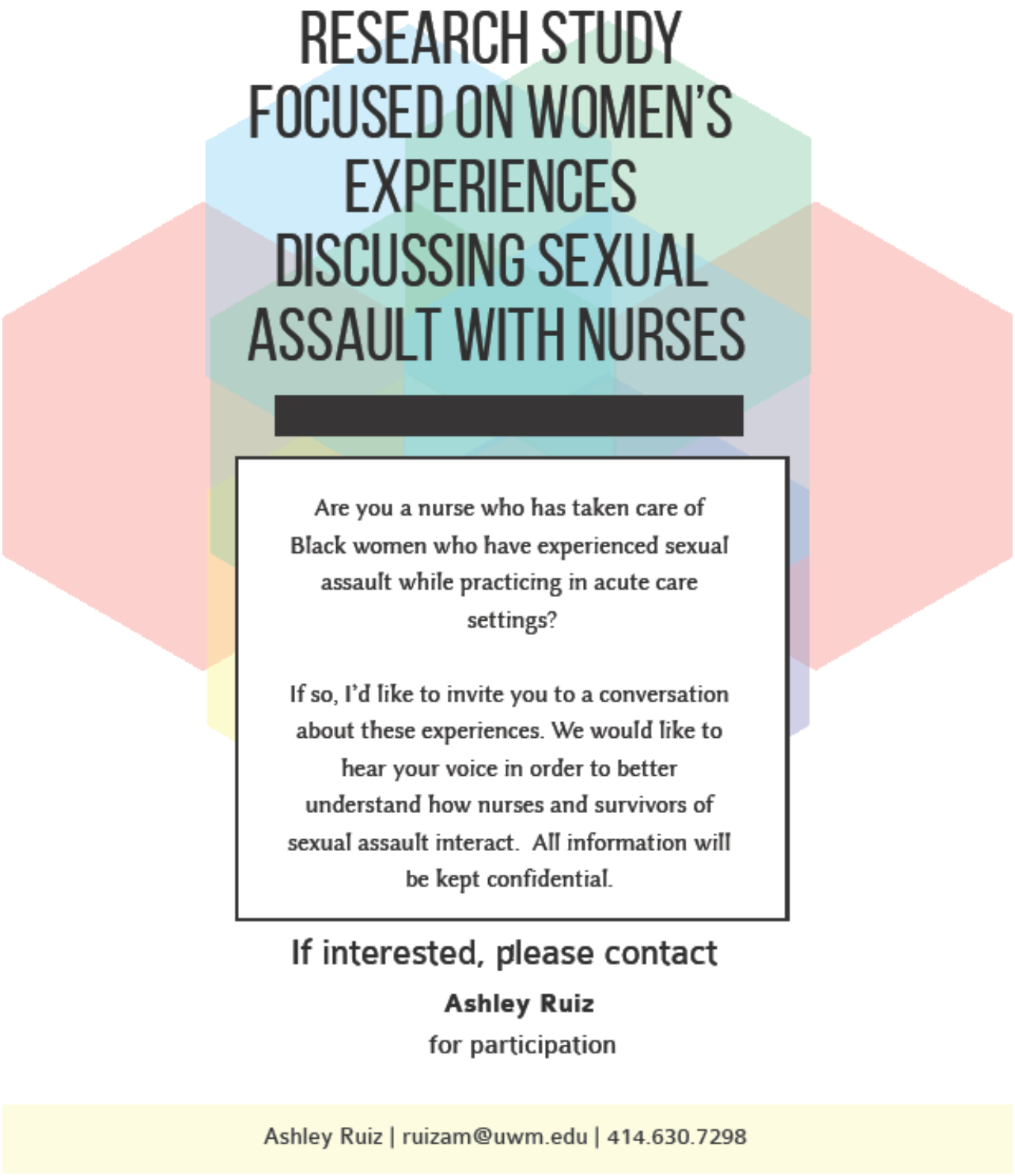
_____ _____

Signature of Participant Date

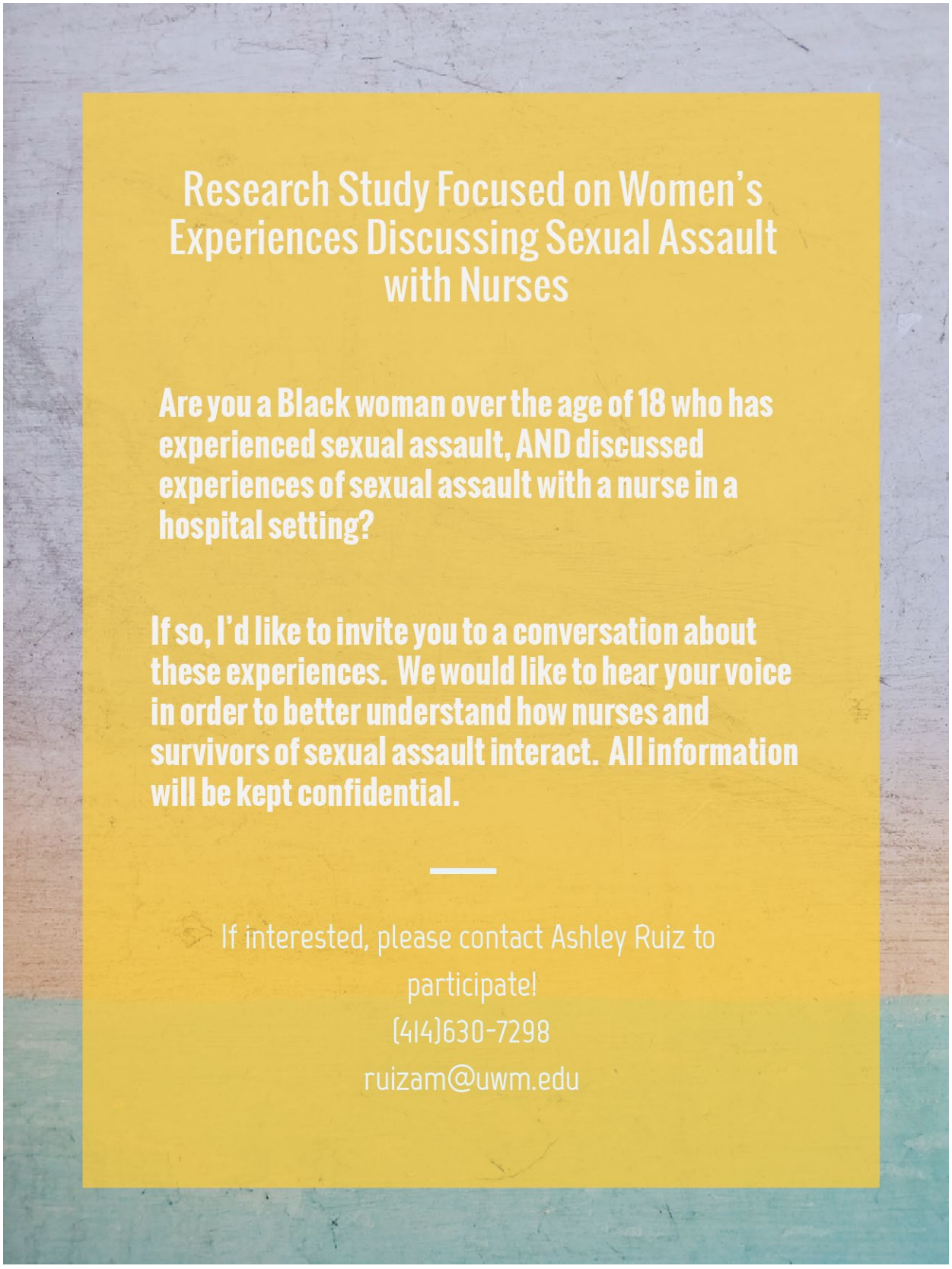
Name of Researcher obtaining consent (print)

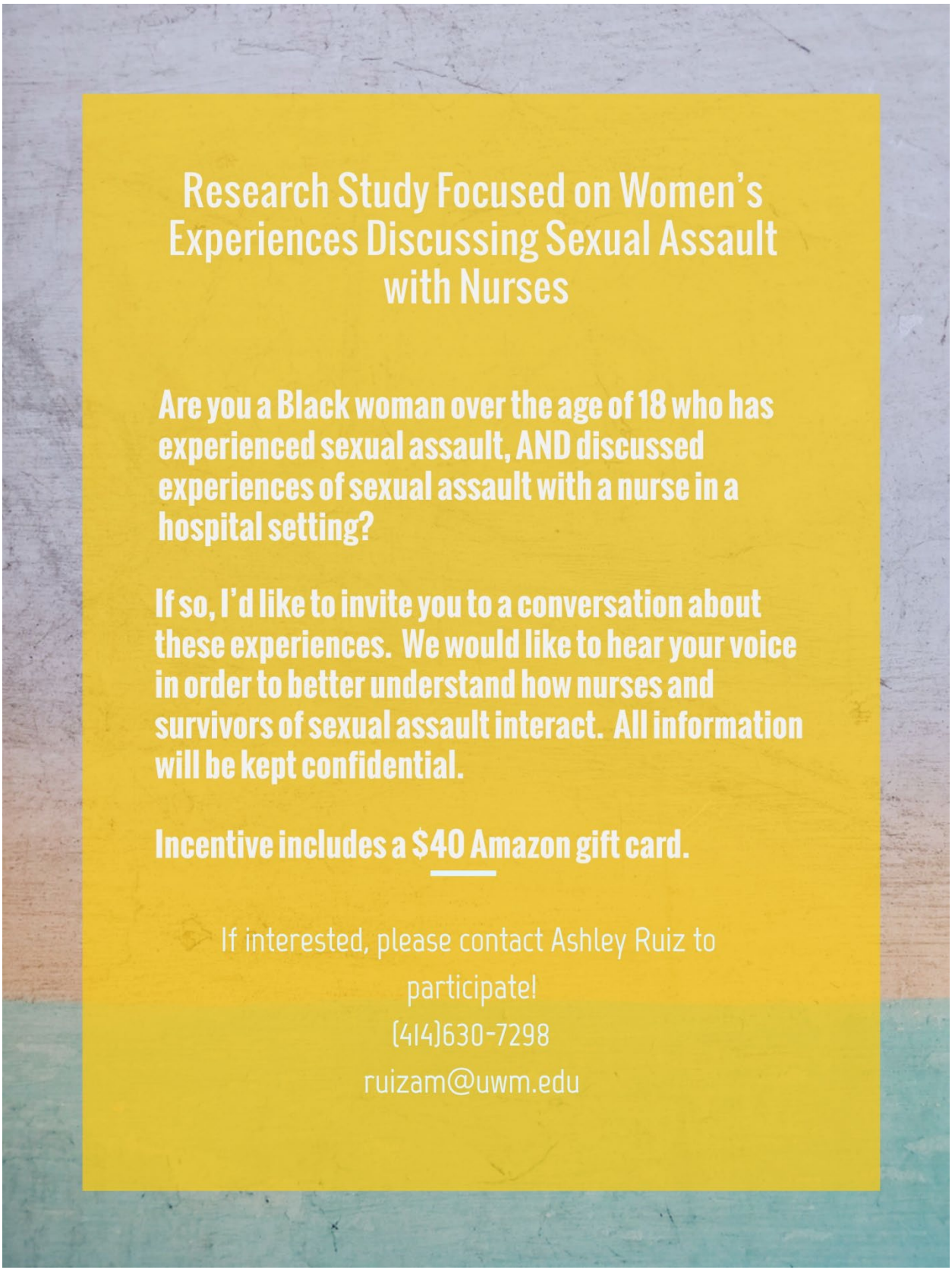
Signature of Researcher obtaining consent Date

APPENDIX G:


RESEARCH STUDY FOCUSED ON WOMEN'S EXPERIENCES DISCUSSING SEXUAL ASSAULT WITH NURSES
Are you a nurse who has taken care of Black women who have experienced sexual assault while practicing in acute care settings?
If so, I'd like to invite you to a conversation about these experiences. We would like to hear your voice in order to better understand how nurses and survivors of sexual assault interact. All information will be kept confidential.
If interested, please contact
Ashley Ruiz
for participation
Ashley Ruiz | ruizam@uwm.edu | 414.630.7298

APPENDIX H:


Research Study Focused on Women's Experiences Discussing Sexual Assault with Nurses
Are you a Black woman over the age of 18 who has experienced sexual assault, AND discussed experiences of sexual assault with a nurse in a hospital setting?
If so, I'd like to invite you to a conversation about these experiences. We would like to hear your voice in order to better understand how nurses and survivors of sexual assault interact. All information will be kept confidential.
If interested, please contact Ashley Ruiz to participate!
(414)630-7298
ruizam@uwm.edu


Research Study Focused on Women's Experiences Discussing Sexual Assault with Nurses
Are you a Black woman over the age of 18 who has experienced sexual assault, AND discussed experiences of sexual assault with a nurse in a hospital setting?
If so, I'd like to invite you to a conversation about these experiences. We would like to hear your voice in order to better understand how nurses and survivors of sexual assault interact. All information will be kept confidential.
Incentive includes a $40 Amazon gift card.
If interested, please contact Ashley Ruiz to participate!
(414)630-7298
ruizam@uwm.edu

APPENDIX I:

Code Book

Manuscript II: Dehumanizing

Survivor Transcription

Initial Data Management Highlighting Key of Dehumanizing	
	Blame +blam* +judg* +stigma* +attitude +criticize +demean +fault +responsible +guilty +proof
	Shame +embarrass* +found out +careless +shame* +ashame*
	Dismiss +believe* +support* +heard +valid* +overlook* +not receptive +push back +own agenda +assum* +non-emergency +didn't have to come +worth +importance/important +priority +don't care +attention
	Discredit + making up +actually believe* +change answer +did/didn't/not believe +scrutinized +framed +make it look

Code Book

Manuscript III: Dehumanizing

Survivor & Nurse Transcription

Initial Data Management Highlighting Key: The 4th Step	
	Establishing a relationship +left +approach +rapport +friend +having someone +attitude +came +knew +company +support
	Creating a therapeutic space +comfort* +home +trust +listen* +push back +help +positive +able to make it +impression +kind +gentle +pleasant +welcom* +heal* +hope +talk
	Providing non-judgmental care +judg* +assum* +heard +valid* +believe*
	Ensuring a culture of transparency +look like +divers* +inclusi*
	Standing in solidarity +integrate +critical +antiracis* +patriarch* +race/racism/racist +discrimination/discriminate*
	Communicating empathy +empath* +care +told/said +val* +being human

Appendix J:

CURRICULUM VITAE

Ashley Ruiz RN, PhDc

Place of birth: Oklahoma City, OK, USA

EDUCATION

University of Wisconsin—Milwaukee[9] **Doctor of Philosophy in Nursing**	**May 2022**
University of Wisconsin—Milwaukee **Bachelors of Science in Nursing**	**May 2015**
Madison College Associate Degree in Nursing	**Dec 2013**

Dissertation Title: Examining Secondary Victimization Within the Nurse-Patient Relationship

PROFESSIONAL EXPERIENCE

University of Wisconsin—Milwaukee *Position: Adjunct Professor*	**2021 to Present**
University of Wisconsin—Milwaukee *Position: Clinical Instructor*	**2019 to 2021**
Aurora Sinai Medical Center *Position: Sexual Assault Nurse Examiner*	**2019 to Present**
University of Wisconsin—Milwaukee *Position: Teaching Assistant*	**2018 to Present**
Aurora Memorial Hospital & Aurora Lakeland Medical Center *Position: Sexual Assault Nurse Examiner*	**2018 to 2019**
Columbia St. Mary's Hospital *Position: Charge Nurse*	**2016 to 2019**
Jewish Home & Care Center *Position: Registered Nurse Supervisor*	**2015 to 2016**
Camp Timberlane for Boys *Position: Registered Nurse*	**2014**

PROFESSIONAL LICENSURE & CERTIFICATES

Registered Nurse Licensure, *Wisconsin*, **Current**
Basic Life Support, *American Heart Association*, **Current**

[9] Anticipated completion May 2022

Graduate Certificate in Trauma-Informed Care, *University of Wisconsin Milwaukee*, **2020**

PUBLICATIONS

Deal, E., Hawkins, M., Del Carmen Graf, M., Dressel, A., **Ruiz, A.,** Pittman, B., Schmitt, M., Krueger, E., Lopez, A., Mkandawire-Valhmu, L., Kako, P. (2021). Centering our Voices: Experiences of Violence Among Homeless African American Women. *Violence Against Women*.[10]

Mkandawire, E., **Ruiz, A**., Gondwe, K., Mutsvangwa-Sammie, E., Kibicho, J., Anderson, A., Kirungi, J., Bisai, C., Dyke, E., Dressel, A., Gandidzanwa, C., & Mkandawire-Valhmu, L. (2021). Gender Barriers to Food Security and Nutrition: A Qualitative Analysis of Rural Central Malawi. *Appetite*.[11]

Hawkins, M., Wang, Y., **Ruiz, A.,** Weinhardt, L., Watson, R., Weitzel, J. & Lopez, A. (2021) Heart Attack Symptom Knowledge Among Hispanics in the United States, National Health Interview Survey 2014 and 2017. *International Journal of Health, Wellness, and Society.*[12]

Graf, MDC., **Ruiz, A**., Luebke, J., Olukotun, O., Kendrick, A., Shaw, L., Lopez, A., Snethen, J., Silvestre, E., Mkandawire-Valhmu, L. (2022) Application of Postcolonial Feminist Theory, Chicana Feminist Thought, and Black Feminist Thought in Analyzing the Mental Health Needs of Latina Migrant Farmworkers, *Advances in Nursing Science*. doi: 10.1097/ANS.0000000000000399

Ruiz, A., Luebke, J., Klein, K., Moore, K., Gonzalez, M., Dressel, A., Mkandawire-Valhmu, L. (2021). An Integrative Literature Review & Critical Reflection of Intersectionality Theory. Nursing Inquiry.

Ruiz, A., Luebke, J., Klein, K., Hawkins, M., Callari-Robinson, J., Mkandawire-Valhmu, L (2021). The Role of Hegemonic Masculinities in the Lives of Ethnic Minority Women. *Advances in Nursing Science*. 44(1).

Hawkins MM, Schmitt ME, Adebayo CT, Weitzel J, Olukotun O, Christensen AM, **Ruiz AM**, Gilman K, Quigley K, Dressel A, Mkandawire-Valhmu L. Promoting the health of refugee women: a scoping literature review incorporating the social ecological model. Int J Equity Health. 2021 Jan 23;20(1):45. doi: 10.1186/s12939-021-01387-5. PMID: 33485342; PMCID: PMC7825239.

Dressel, A., Mkandawire, E., Gondwe, K.W., Mkandawire-Valhmu, L., Nordin, S., Vilakazi, N., Scheer, V., Kako, P., Ngui, E., Neiman, T., **Ruiz, A**., Luebke, J., & Minjale, P. (2020). The Intersection of Food Insecurity and Health for Rural Malawian Women at End of Life. *International Journal of Palliative Nursing*. 26(7), 372–382. https://doi.org/10.12968/ijpn.2020.26.7.372

Mkandawire-Valhmu, L., Kendall, N., Dressel, A., Wendland, C., Scheer, V., Kako, P., Neiman, T., Valhmu, W., **Ruiz, A.,** Luebke, J., Merriman, A., Kishindo, L., & Egede, L. (2020). Women's work at end of life: The intersecting gendered vulnerabilities of patients and caregivers in rural Malawi. *Global Public Health*. https://doi.org/10.1080/17441692.2020.1730930

[10] Accepted for Publication, In-Press
[11] Currently under peer-review
[12] In-Press

Weitzel, J., Luebke, J., Wesp, L., Del Carmen Graf, M., **Ruiz, A**., Dressel, A., Mkandawire-Valhmu, L. (2020). The role of nurses as accomplices against racism and discrimination: An analysis of key resistance movements of our time. *Advances in Nursing Science.* 43(2).

Luebke, J., Hawkins, M., Lucchesi, A., Weitzel, J., Deal, E., **Ruiz, A.,** Jorns, J., & Mkandawire-Valhmu, L (2020). The Utility of Using a Postcolonial and Indigenous Feminist Framework in Research and Practice about Intimate Partner Violence against American Indian Women. *Journal of Transcultural Nursing*. (Accepted for Publication)

Wesp, L. M., Scheer, V., **Ruiz, A.,** Walker, K., Weitzel, J., Shaw, L., Kako, P. M., & Mkandawire-Valhmu, L. (2018). An Emancipatory Approach to Cultural Competency: The Application of Critical Race, Postcolonial, and Intersectionality Theories. *ANS. Advances in nursing science*, *41*(4), 316–326. https://doi.org/10.1097/ANS.0000000000000230

GRANT EXPERIENCE

National Institutes of Health Research Project Grant Program (R01). *Understanding Intersecting Realities/Complex Healthcare Needs of Black, American Indian, Hispanic/Latinx Cisgender Women who Trade Sex and are Involved in Substance Misuse in Midwestern Urban Metropolitan Areas.* **2021**[13]

International Association of Forensic Nurses Research Grant Award. *Examining Secondary Victimization Within the Nurse-Patient Relationship*. Awarded: $4,000. **2021**

National Institutes of Health Research Project Grant Program (R01). *Understanding Indigenous and Black Feminist Thought to Analyze the Impact of the COVID-19 Pandemic on the Help Seeking of American Indian and Black Women Experiencing Intimate Partner Violence in Wisconsin.* Awarded: $2.3 million. **2020**[14]

Diversity, Equity, and Inclusion Grant. *Addressing Racism and Promoting Equity through Policy and Practice in Nursing Education*. **2020**

AWARDS

Distinguished Dissertation Fellowship Award	**2022**
Graduate Student Excellence Fellowship Award	**2019-2020**
Simon-Ontscherenki & Nurses of West Allis Memorial Hospital Scholarship	**2019**
National Women's Studies Association Scholarship	**2019**
Milton & Joan Morris Doctorate of Nursing Practice School of Scholarship	**2019**
Chancellor's Graduate Student Award for Talented Students	**2016– 2019**

PROFESSIONAL PRESENTATIONS & CONFERENCES

Nursing Network on Violence Against Women International Conference **2022**
Podium presenter. "The 4th Step: Creating a Space for Safe Disclosure and Treatment for African American Women Survivors of Sexual Assault"

Population Health Presentation **2021- 2022**
Guest presenter at Edgewood College. "Sexual Assault Nurse Examiner"

Virtual Nursing Theory Week **2021**

[13] Lead in developing and writing the theoretical framework component of grant application

[14] Lead in developing and writing theoretical framework component of grant application

Podium presenter. *"Using Intersectionality Theory to Examine "Othering" Dynamics Occurring Within Hegemonic Masculinities"*

Acquired Immunodeficiency Syndrome Education & Training Center Program: Midwest **2020**
Guest presenter. *"The Intersection of Intimate Partner Violence, Sexual Assault, Trafficking, and Sexually Transmitted Infections/Human Immunodeficiency Virus Risk in Indigenous Women: Providing Survivor Led, Advocacy Driven, and Culturally Safe Care"*.

University of Wisconsin—Milwaukee, Nursing Student Association **2020-2022**
Guest lecturer. *"Sexual Assault Nurse Examiner (SANE)"*

American Nurses Association **2020**
How You Can Have a Direct Impact on Reducing the Devastating Racial Disparities of COVID-19

American Nurses Association **2020**
Caring for Covid-19 Patients: Disease Progression and Nursing Interventions You Need to Know

2nd Annual Nursing Theory Conference 2020
Paper presenter. *"Using Intersectionality Theory to Examine "Othering" Dynamics Occurring Within Hegemonic Masculinities"*

4W Summit on Women, Gender, and Well-Being, University of Wisconsin—Madison **2020**
Podium Presenter. *"Geographic and other Barriers that Impact Access to Care for Wisconsin American Indian Women Impacted by Gender Based Violence"*

Transcultural Nursing Society, Transcultural Nursing: Advancing Culture Care **2019**
Poster presentation. *"The Role of Hegemonic Masculinities in the Lives of Ethnic Minority Women"*

National Women's Studies Association **2019**
Poster presentation. *"Nurse Positionality in Developing Trauma-Informed Care Within the #MeTooMovement"*

¡Milwaukee Evaluation! Social Justice & Evaluation Conference **2019**

University of California Los Angeles, Thinking Gender Conference **2019**

University of Wisconsin—Milwaukee, Nursing Student Association **2019**
Guest lecturer. *"Forensic Nursing"*

University of Wisconsin—Milwaukee, Cultural Humility 2018

University of Wisconsin—Milwaukee, Nursing Student Association 2018
Guest lecturer. *"Forensic Nursing"*

National Criminal Justice Training Center 2018
Developing a Community Response for High-Risk Victims of Child Sex Trafficking and Exploitation

Wisconsin Center for Nurses Annual Conference 2018
Dealing with Health Disparities

4W Summit on Women, Gender, and Well-Being 2017
Podium presenter. *"Violence Against Women at End of Life in Rural Central, Malawi"*

Georgetown University (2016)
Social, Economic, and Financial Challenges in Health & Human Development

PROFESSIONAL AFFILIATIONS

American Nurses Association	**2018 to Present**
Wisconsin Nurses Association	**2018 to Present**
International Association of Forensic Nurses	**2018 to Present**
UWM Doctorate Student Nurse Association	**2017 to Present**
Sigma Theta Tau	**2019 to Present**
Transcultural Nursing Society	**2019**
National Women's Studies Association	**2018 to Present**

Graduate Organization of Asian Pacific Americans **2019 to Present**
Doctoral Nursing Student Organization **2017 to Present**

CONTINUING EDUCATION

National Training Standard for Sexual Assault Medical Forensic Examiners 2nd Edition: A Training Blueprint Webinar, *International Association of Forensic Nursing*, 2018
Sexual Assault Nurse Examiner Skills Fair, *Aurora Sinai*, 2018
Crime Victim Compensation/Sexual Assault Forensic Exam Fund Training, *Aurora Sinai*, 2018
Pediatric/Adolescent Online Training Continuing Nursing Education, *International Association of Forensic Nursing*, 2018
Adult/Adolescent Sexual Assault Examiner Continuing Nursing Education, *International Association of Forensic Nursing*, 2018
Wisconsin Child Abuse Network Webinar, *Wisconsin Child Abuse Network*, 2018
National Sexually Transmitted Disease Curriculum, *University of Washington School of Nursing*, 2018
Intimate Partner Violence Screening in Healthcare Setting, *International Association of Forensic Nursing*, 2018
Sexual Assault Services and Sexual Assault Response Team, *Ascension All Saints Racine*, 2018
Abuse Screening, Intervention and Documentation in Healthcare, *Tribal Forensic Healthcare*, 2018
Teaching Assistant Professional Development Certificate, *Center for Excellence in Teaching and Learning*, 2018
Collaborative Institutional Training Initiative Program Course, *University of Wisconsin Milwaukee*, 2017
Ethical Considerations in Healthcare, *Columbia St. Mary's*, 2016
Medical-Surgical-Telemetry Skills Fair, *Columbia St. Mary's*, 2016

STATE COALITION BOARDS

Statewide Human Trafficking Task Force Coalition, Ascension Wisconsin, 2018

PRECEPTORSHIP & CLINICAL EXPERIENCE

Mendota Mental Health Institution, *Civil Service Treatment Unit* 2013
St Mary's Hospital, *Cardiac Unit* 2013
Meriter Hospital, *Cardiac Unit* 2013
Meriter Hospital, *Acute Psychiatric Unit* 2013
Meriter Hospital, *Medical-Surgical/Orthopedic Floor* 2012
St. Mary's Care Center, *Skilled Nursing Rehabilitation* 2011

VOLUNTEER OPPORTUNITIES

Inner Beauty **2021**
Assisting access to basic necessities (such as clothing, food, etc) to women actively experiencing sex trafficking
Nursing Endeavor Program **2021**
Supporting first generation college students who are underrepresented minority students and/or economically disadvantaged students transition through the Bachelor of Science Nursing program by providing mentorship
University of Wisconsin Milwaukee **2020**
Evaluating 'diversity' and 'inclusion' competencies among admitting Nursing students through the Holistic Care Model
University of Wisconsin Milwaukee 2018
Critiquing poster presentations at Eta Nu Poster Symposium

Aurora Memorial Hospital & Lakeland Medical Center	2018
Providing community education and awareness about human-trafficking	
Ascension Columbia St. Mary's	2017 to 2018
Administering Varicella and Tuberculosis skin tests to staff	
RNRN Disaster Response Network	2016 to 2018