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"Some Things Stick": Secondary Traumatization among Police Officers and Medical Personnel Meeting with Raped Women

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Abstract. Professionals who work with traumatized individuals can develop secondary traumatization (ST). Little research has focused on ST among police officers and medical personnel, who meet with raped women. Based on focus groups with these professionals (*N*=28), a deductive thematic analysis was conducted with a focus on ST. Informants described listening to stories with traumatic content and they showed signs of cognitive and emotional changes. They also described a lack of support, forcing them to find both constructive and destructive ways of coping on their own. Negative effects may lead professionals to continue working without understanding how they are affected. This can hinder professionals from taking care of themselves as well as from offering proper treatment to the victims they meet.

In the last two decades, there has been a significant amount of research that focus on victims of trauma (e.g. Salston & Figley, 2003). In comparison, little research has focused on professionals who engage by working with those traumatized and who listen to stories with traumatic content. Sexual abuse and rape are traumas that affect many women, and it contributes to psychological distress (La Bash & Papa, 2014). Victims frequently report traumatic responses such as fear, anxiety, depression, suicidal thoughts, sleeping disturbances, and intrusive memories of the abuse (Wilson & Miller, 2016). In addition, post-traumatic stress disorder (PTSD) has been found to be prevalent among these victims (e.g. Pegram & Abbey, 2019).

Meeting with victims, and listening to their stories about sexual abuse, are often associated with emotional distress, discomfort, and uncertainty in the professional (e.g. Rudolfsson & Tidefors, 2013). Being exposed to the woman’s distress and traumatic material involves a risk, where the professional can develop clinical symptoms similar to those experienced by the victim herself. Besides the effect on the professional her/himself, there is a risk that these effects hinder the professional from engaging empathically with the victims they meet (e.g. Bride, Radey & Figley, 2007).

There have been numerous attempts to explain the negative effects on the professional her/himself when interacting with traumatized individuals (Salston & Figley, 2003). Previous research has been established focusing health care personnel (e.g. Beck, 2011) and other helping professions such as social workers (e.g. Caringi et al., 2017), and mental health professionals (e.g. Ivicic & Motta, 2017). However, few studies focus on first responders, such as police officers and medical personnel, meeting with raped women in acute situations. Thus, this study aimed to gain a deeper understanding of what negative psychological effects can be distinguished among police officers and medical personnel, who meet with raped women, and how they cope with such difficulties.

Victims of sexual abuse

Sexual abuse, including rape, are traumatic events that cause physical and psychological distress in victims (e.g. Elklit & Christiansen, 2013). According to Swedish legislation, rape is defined as: intercourse or other sexual action that, considering the degree of violation, is to be conceived equal with intercourse, towards a person against her/his will, against a person who is unable either to comprehend or consent, or against a person who is in a position of

dependence to the perpetrator (Criminal code, chapter 6, § 1). In prior studies, women who have been raped have reported feelings of guilt, self-blame, and loneliness, as well as having sexual difficulties during sexual activity, actualizing feelings of shame or flashbacks of the abuse (e.g. Wilson & Miller, 2016). Furthermore, symptoms of PTSD have been found to be prevalent in victims (e.g. Wilson & Scarpa, 2017). According to the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5), these symptoms include: 1) *intrusion* (i.e. distressing recollections, dreams and feelings as if the event is recurring), 2) *avoidance* (i.e. of thoughts, feelings, activities, places or people that remind them of the trauma), 3) *negative alterations* in cognitions and mood (i.e. negative assumptions of the world, self-blame etc.) and 4) *hyper-arousal* (i.e. sleep difficulties, irritability and difficulties concentrating) (American Psychiatric Association, 2013).

Although rape and sexual offenses are traumatic crimes that cause psychological distress, a majority of all sexual offenses do not come to the attention of public authorities. According to a report from the Swedish National Council for Crime Prevention (Brå), the unknown number of sexual offences in Sweden, as in many other countries, is difficult to estimate (2019a). In the Swedish Crime Survey (SCS), six percent of the population reported having been subjected to one or more cases of sexual abuse, which corresponds to approximately 482,000 individuals. Out of these reports, only 22,500 sexual offences were officially reported to the Police, where 7,960 cases were classified as rape. These reports almost solely consisted of crimes against women (2019a).

Previous research has shown different factors that can affect the victim's propensity to report (Maddox, Lee & Barker, 2011). It has been well established that a close relationship with the perpetrator minimizes the victim's tendency to report sexual abuse (e.g. Felson, Messner, Hoskin & Deane, 2002). Furthermore, the relationship to the perpetrator also affects whether or not the victim identifies the sexual abuse as a rape (e.g. LeMaire, Oswald & Russel, 2016). Other important factors that affect victim's propensity to make a report include feelings of shame and guilt, fear of not being believed, not feeling like the crime can be proven, fear of revenge, threats to disclose, and an unwillingness to let others know due to the stigmatizing effect of having been raped (e.g. Sarkar & Sarkar, 2005).

In cases where women have reported a rape, these victims report having received both positive (i.e. comfort, emotional support, empathy) and negative (i.e. blame, doubt, withdrawal) reactions from professionals (Ahrens, Cabral, & Abeling, 2009). Positive reactions to a disclosure has been associated with improved psychological health among victims (Campbell, 2005). However, negative reactions, such as victim-blaming and skeptical reactions from professionals, has been shown to have a harmful effect on the victim's psychological health, causing increased symptoms of depression and post-traumatic stress (Ahrens, Stansell, & Jennings, 2010). These negative reactions to a victim's disclosure has also lead to victim's reluctance to seek help again (Campbell, 2005). Hence, meeting with women who have been raped puts high demands on the professional to show emotional support and empathy. Thus, it remains important to investigate why some professionals instead display negative reactions toward rape victims, and if the ability to show support and empathy might be hindered by secondary traumatization.

First responders

Previous research has mainly focused on the prolonged exposure to traumatic material among professionals, such as therapists or social workers, who have had long-term contact with traumatized individuals (e.g. Zeidner, Hadar, Matthews & Roberts, 2013). However, fewer studies have focused on the impact on first responders, who are frequently and routinely

exposed to traumatized individuals through short-term contact. First responders, such as police officers and medical personnel, working at emergency units, are often the first to meet the traumatized individual in the acute situation. Hence, both police officers and medical personnel are at risk of experiencing potentially traumatic events across their careers (e.g. Kerswell, Strodl, Johnson & Konstantinou, 2019). Although some individuals do not report prolonged negative effects on mental health, previous research has found that first responders are at prominent risk of developing PTSD, depression, anxiety, and substance-related disorders throughout their careers (Thornton & Hendeon, 2016). Studies have also shown that health care personnel are more resilient when compared to the Police. This has been explained through that more precautions that are taken to create support systems and interventions for health care workers in their work environments, in order to help those who may be impacted by meeting traumatized individuals (Osofsky, Putnam & Lederman, 2008).

Professionals' variability of mental health following a traumatic event have also been linked to different psychosocial and demographic variables (Kerswell et al., 2019). Personal history of trauma, social support, coping strategies, gender, and length of service are variables that can affect the outcome (e.g. Ménard et al., 2016). For example, some studies have found risk-differences based on gender where female police officers showed a higher risk of developing PTSD and depression (Beck, 2011), while other studies did not find any gender differences in PTSD-rates among police officers (Pole et al., 2001). In line with the above, studies among medical personnel have also recognized that women are at higher risk for PTSD (Carmassi et al., 2018). Furthermore, Kerswell and colleagues (2019) explored whether a longer length of service among police officers could be associated with greater symptoms of post-traumatic stress, however, no significant correlation could be observed. In addition, Máirean and Turliuc (2013) explored whether length of service correlated to trauma symptoms among 76 medical workers and physicians from intensive care units, however, no significant correlations were observed. Contradictory to these findings, Carmassi and colleagues (2018) found that medical personnel who were older and had a greater length of service reported higher rates of PTSD-symptoms compared to those who were younger. Potentially, this could be linked to the elders' lower education.

Although previous research has shown that both police officers and medical personnel are at risk of developing symptoms of trauma, little is known about *how* these professionals get affected when meeting with women who have been raped.

Secondary traumatization

Encountering victims of sexual abuse and being exposed to the content of victims' stories has been described as a difficult task (Viviani, 2011). Not only is it difficult to acknowledge the existence of sexual abuse as a phenomenon, but it is also difficult to compare it to other traumatic events, since the professional's own sexuality is more likely to be actualized (Tidefors & Drougge, 2006). As an association with sexuality is likely to be made (Tidefors & Drougge, 2006), a deeper identification with the content of these stories might develop, which can make the encounter particularly complex for the professional (Pearlman & Saakvitne, 1995). As mentioned in the introduction, professionals who are exposed to a victim's distress and stories with traumatic content may be at risk of developing clinical symptoms similar to those experienced by the victim her/himself (Bride et al., 2007). In literature, this is referred to as secondary traumatic stress, compassion fatigue, burnout, or vicarious trauma (Figley, 1995; Joinson, 1992; Newell & MacNeil, 2010; McCann & Pearlman, 1990). Some researchers differentiate between these terms, while others use them interchangeably (Salston & Figley,

2003). Consequently, descriptions and prior research of these terms will be outlined below in order to address what the definitions have in common, as well as what differentiates them.

Secondary traumatic stress. Figley (1995) defined secondary traumatic stress (STS) as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other" (p. 7). Furthermore, STS has been defined as the "stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 10). Thus, individuals who are in contact with traumatized individuals can develop a traumatic response without having experienced the traumatic event themselves (e.g. Baird & Kracen, 2006). The symptoms experienced by the professional, are almost identical to symptoms associated with PTSD (e.g. Baird & Jenkins, 2003). The only factor that differs STS from PTSD is that the professional experiences the trauma indirectly, by listening to stories with traumatic content (Figley, 1995). Turgoose and colleagues (2017) explored the prevalence of STS among police officers. A sample of 142 specialist police officers who worked with victims of sexual abuse completed measures of STS. Around 26% of the respondents indicated on moderate to severe STS, which is slightly higher than prevalence rates established in prior research on professionals (Turgoose et al., 2017).

Compassion Fatigue. While STS addresses some symptoms of trauma, compassion fatigue may result in different ones (Meadors, Lamson, Swanson, White & Sira, 2009). Joinson (1992) was the first to introduce the phenomenon known as compassion fatigue (CF) when assessing how nurses were experiencing burnout after hospital emergencies. Nurses reported symptoms such as depression, anger, apathy, and exhaustion (Joinson, 1992). Figley (1995) described compassion fatigue as a more "friendly term" for professionals who suffered from STS (p. 14). In addition, Figley (1995) established that if these symptoms last for more than 30 days after being exposed one suffers from CF. In comparison to STS, CF is described as the consequence of working with traumatized individuals combined with an empathic response for the other (e.g. Adams et al., 2006). Previous research has frequently stated that empathy plays a central role in psychotherapy when establishing a therapeutic alliance, i.e. the relationship between a client and a therapist (Gibbons, 2011). The importance of empathy has also been addressed in other helping professions, besides therapy work (May, 2013). In addition, perceived empathy by the police officer correlates with the likelihood of victims of sexual abuse being more likely to disclose her experiences (e.g. Maddox et al, 2011). Since there are low conviction rates of rape cases, partly due to the common lack of physical evidence and witnesses in these cases (Brå, 2019b), Turgoose and colleagues (2017) suggest that the lack of being able to offer the victim juridical restitution can be a contributing factor of compassion fatigue or burnout among police officers.

Burnout. Burnout has been a broadly researched phenomenon, particularly among nurses. Burnout overlaps with both CF and STS in that they are all characterized by the professional being emotionally exhausted (e.g. Maytum et al., 2004). However, burnout can also occur in professions that do not entail exposure to victims of trauma (Osofsky et al., 2008). Stamm (2010) describes burnout as both psychological and emotional exhaustion in terms of hopelessness and difficulties dealing with ones work efficiently. Furthermore, burnout is associated with a reduced sense of professional accomplishment, cynicism, and inefficacy (Turgoose et al., 2017). However, unlike STS and CF, rather than operational factors such as dealing with victims and trauma, much of the mental exhaustion in burnout has been found to be associated with work related stressors such as time pressure, conflicts at work, and lack of supervision (e.g. Meadors et al., 2009). Consequently, Adams and colleagues (2006) suggest that burnout is a critical feature of STS and CF, however, both related to and independent of one another.

Vicarious traumatization. McCann and Pearlman (1990) explored the psychological effects on therapists who empathically engaged with traumatic material by treating victims of

sexual abuse, by using a constructionist self-development theory. They identified changes in worldview, cognitive schemas (i.e. an alteration in a person's beliefs, assumptions and expectations about oneself, others, and the world), and belief systems that were stable over time. These changes were later defined as vicarious traumatization (VT) (Cohen & Collens, 2013). Pearlman and Saakvitne (1995) associated VT with disruptions in five areas; safety, trust, esteem, intimacy, and control. These five areas all represent a psychological need and prevents the individuals' belief in a just world (Lerner, 1980). Without a belief in a just world, the individual may develop negative worldviews, which in turn can lead to depression, cynicism, and pessimism (McCann & Pearlman, 1990). The impact of VT has been investigated in different professions, such as therapists (e.g. Cohen & Collens, 2013); sexual assault nurse examiners/SANEs (e.g. Raunick, Lindell, Morris & Backman, 2015), and domestic violence agency staff (Baird & Jenkins, 2003). For example, Raunick and colleagues (2015) compared levels of VT among SANEs with other women's health nurses through the Trauma and Attachment Belief scale. SANEs reported significantly higher levels of trauma-related cognitive disruption than other women's health nurses (Raunick et al., 2015).

In summary, previous research clearly indicate that professionals who interact with traumatized individuals are at risk of experiencing symptoms of traumatic stress, disrupted cognitive schemas, and general distress (Bride, 2007). Although there are details separating the definitions to describe this, many similarities can be distinguished which has led researchers to sometimes use the terms interchangeably. However, many researchers use secondary traumatization as a generic term for the phenomena described above (Greinacher, Derezza-Greven, Herzog & Nikendei, 2019). Thus, in this study, the term to describe the trauma experienced by the professional will be secondary traumatization.

Aim and Specific research questions

Previous research highlights the need for more qualitative studies that address the concerns raised regarding secondary traumatization of police officers and medical personnel meeting victims of rape (Turgoose et al., 2017). Consequently, the aim of this study was to gain a deeper understanding of how police officers and medical personnel experience meeting with women who have been raped; what psychological effects of these meetings that are described. Furthermore, the study aimed to explore how police officers and medical personnel talk about managing these difficulties. Specific research questions are: What emotional and/or cognitive changes and difficulties do police officers and medical personnel describe when meeting with raped women? How do police officers and medical personnel describe coping with emotional and cognitive changes and/or difficulties? What support do police officers and medical personnel describe that they need?

Method

Six focus groups, with two to six informants per group, and one interview, were conducted.

Informants

Twenty-eight informants participated in the study: sixteen police officers and twelve informants working as assistant nurses, nurses, and medical doctors.

Among the police officers, eleven women and five men participated. Police officers' age ranged from mid-twenties to late fifties, and their police working experience ranged from just over two years to over thirty years. Eleven police officers worked as first responders and five as investigators of serious crimes.

Among the medical personnel, all informants were women. Medical personnel's age ranged from mid-twenties to just over fifty, and their working experience ranged from two years to over ten years. Four of the medical personnel worked as nurses, four as assistant nurses, and four as medical doctors (MD). To protect the informants' confidentiality, no further information is given.

Procedure

This study is part of a larger research project titled "Female rape victims: Quality of initial police and medical care contact". The project is funded by the Swedish Crime Victim Compensation and Support Authority (project id: 252342801), and led by principal investigator Ph.D. Lisa Rudolfsson. Besides the focus on police officers and medical personnel, forthcoming are studies on the experiences of women who have reported that they have been raped and/or sought medical care after being raped. The studies have been ethically reviewed and approved by the regional ethical board in Gothenburg (ref. no. 883 18).

Police officers were recruited through gatekeepers within the Swedish Police Authority, who forwarded a letter of inquiry in different police districts in Sweden. The inquiry described the aim of the overall project and the aim of the focus group study, that participation was voluntary and anonymous. Participants who were interested in participating in a focus group were urged to contact Lisa Rudolfsson, who then gathered participants at a time that suited them all. In two of the focus groups, administrators within the Police Authority gathered the participants and found a time when they all could get together in a focus group. Two focus groups were conducted at the University of Gothenburg and one focus group was conducted at the Police departments where the participants worked. One participant was the only one at her department who wanted to participate and, hence, an interview was conducted at the Police department where the informant worked.

Medical personnel were recruited in a similar manner: gatekeepers were contacted who then forwarded the letter of inquiry to personnel on different gynecological emergency healthcare units in Sweden. Participants who were interested in participating in a focus group were urged to contact Lisa Rudolfsson, who then gathered participants at a time that suited them all. Two focus groups were conducted at the hospitals where the informants worked, and two at the University of Gothenburg. In two of the groups only nurses and assistant nurses participated, and in two focus groups only medical doctors participated.

The focus groups, and the interview, lasted for 1.5 to 2 hour each. All focus groups and the interview were moderated by Lisa Rudolfsson. Focus groups and interview were audio recorded and transcribed verbatim, including non-verbal communication, by Lisa Rudolfsson.

Interview

The question guide for both police officers and medical personnel started with asking the informants to introduce themselves and to share how long they had worked as police officers/medical personnel. After this, participants were instructed to share a memory of a meeting with a raped woman. The following questions comprised of how often they, as professionals, had met with raped women, and whether they perceived there to be any typical

situations in which they as professionals met with raped women. Other examples of questions were if there was something in these meetings that they perceived as difficult, and what professional practices that they perceived to be helpful for the woman. Questions were also asked about guidelines, their education and perceived need for support. As the informants discussed these questions, a number of follow up questions were asked, e.g. "how did that make you feel", and "can you give an example of that". All focus groups ended with asking the informants if there was something that they felt had been lacking in the discussion, how the they perceived talking about this topic in a focus group, and how they thought they would feel afterwards. All informants were urged to contact Lisa Rudolfsson, if they thought of something in hindsight that they wanted to elaborate on or if they felt a need discuss the feelings evoked by participating in the focus group. For complete question guides, in Swedish, see appendix A, and B.

Analysis

The material was analyzed using deductive thematic analysis (Braun & Clarke, 2006; 2018), which can be described as top down. A deductive thematic analysis is driven by a theoretical interest, in this case secondary traumatization. Only the parts of the material relating to informants' descriptions of emotional and/or cognitive changes and difficulties, ways to manage these difficulties, and descriptions of need of support were analyzed. The deductive form of thematic analysis tends to provide less of a rich description of the overall data and more of a detailed analysis of some aspect of the data (Braun & Clarke, 2006). Furthermore, the analysis was based on a critical realistic perspective, and the data was analyzed mainly on a semantic level. With a critical realistic perspective, one can only interpret the statements of others. This means that social structures and practices are conceptually dependent, and that the informants and the interview as well can be influenced by the author (Stoehrel, 2007). As mentioned above, the data was analyzed mainly on a semantic level where signs of emotional and cognitive effects were sought. In particular, the analysis was specifically focused on identifying signs of PTSD, since these symptoms are a central part of secondary traumatization (Baird & Kracen, 2006)

The transcripts were first read and re-read to ensure the context of extracted material. Initially, the whole data set was given equivalent attention in order for complete consideration to be given to the repeated patterns within the data. Ideas concerning the structure of the data were reviewed and discussed. The codes that were identified, reflected features of the data that was relevant to the research questions. Thereafter, different codes that were similar within the data were combined. All initial codes pertinent to the research questions were incorporated into a theme. Codes were first organized into three themes: 1) what happens in the encounter with a raped woman 2) what happens within the professional in these meetings and, 3) how do informants talk about their need of support. The coded data was then reviewed and discussed to investigate whether the themes captured and fit the data set. Themes that did not have enough data to support them were incorporated in a higher level of consolidated themes. The themes were then reviewed to ensure that all relevant initial codes were represented in the thematic structure.

A final structure including two themes emerged: 1) The hazards of emotional overload 2) Making me another. Sub-themes were created to give structure to the material, and all data extracts were reviewed in relation to main themes. Finally, the data extracts were reviewed to find the quotes that best capture the essence of each main- and subtheme. The quotations have been lightly edited and abbreviated in order to facilitate reading.

Results

The aim of this study was to gain a deeper understanding of how police officers and medical personnel experience meeting with women who have been raped; what psychological effects of these meetings that is described. Furthermore, the study aims to explore how police officers and medical personnel talk about managing these difficulties. The following text presents the main- and subthemes that emerged in the analysis. Results are summarized in *Table 1*.

Table 1. Main- and subthemes.

Main theme	Subtheme
The hazards of emotional overload	*Moved by empathy* *If it were me* *I am left alone*
Making me another	*I am emotionally exhausted* *The world is not a safe place*

The hazards of emotional overload

All informants gave detailed records of the trauma experienced by the women they had met. They described how encounters with raped women made them feel a strong sense of empathy for the victims, which affected them in a personal manner. The informants also talked about how they often felt concern for the victim during their interrogation or during the medical examination, and how they sometimes perceived it as if their work made the woman re-live her trauma. Some informants also described identifying with the victim; thinking of how they would feel if they themselves were victimized. This caused them to reflect on how they as victims would feel meeting with someone from their own profession. Another reoccurring topic for discussion was the informants talking about how they could feel powerless when meeting with victims. Police officers talked about the lack of physical evidence and rape cases boiling down to he-said-she-said situations. Both police officers and medical personnel talked about how they often knew beforehand that the woman they met would probably not get legal justice. All informants described how feeling powerlessness could lead to frustration, and both police officers and medical personnel emphasized a lack of emotional and structural support to cope with these feelings.

Moved by empathy. Although the informants stressed the ability to feel empathy for the woman as a prerequisite for being able to offer a good-enough treatment, they also described how they at times could become almost too empathic.

> *"(1) Sometimes you even feel too much, it's like 'ugh', almost as if you get caught in your own emotions /…/*
>
> *(2) I don't think you could keep working with this if you didn't have the capacity for that kind of empathy (agreements)."* – Police, female and male

The informants also described how meeting with raped women sometimes made them feel overwhelmed with emotions, leading to insecurity as to what were the best actions to help

the woman. Informants described how being overwhelmed in that way could lead to difficulties to be professional and to keep a personal distance. Some described feeling so moved by the victims' stories that they were not able to shake off the feelings that the victims had enticed on them, causing them to carry the woman's hurt with them.

> *"It's not just a job. You cannot shake this off. And you go home and like (sounds like crying) cause it stays with you. Although I'm not working that case anymore, I still think about it..."* – Police, female

The informants discussed how they could become so overwhelmed with emotions that the boundary between professionalism and privacy became blurred.

> *"One meeting was with a patient who had been here several times, and who uses sex as self-harm /.../ and that meeting… it really affected me. She feels so damn bad. /.../ somehow we understood each other, and so the meeting became something more than just a professional meeting. This, being professional versus personal, it's for better or worse… but I do think that you can be both professional and show empathy, well, even though that boundary is crossed sometimes."* - Assistant nurse, female

Mainly the informants working as police officers, talked about how their work entailed listening to stories of sexual violence in graphic details, making them remember the stories significantly well. When victims gave details about their reactions and feelings during the abuse, the informants talked about it as almost impossible not to get emotionally involved and believing that the stories told were true.

> *"I was working a case, not that long ago, where she… described that… well, she said, 'I had a hard time breathing, I usually do, but that time I didn't even care if I kept breathing or not'. And when you're that graphic, you just have to believe her (agreements)."* – Police, female

In addition, the informants talked about meeting with the victim's relatives as sometimes affecting them in the same way.

> *"I mean, this father; it really cut to the core. His daughter was here and she had been raped. I don't know if it was an assault or what it was, but she was quite young. And he sat in the corridor and he just broke down, crying intensively. You could really hear the grief and the frustration as he hadn't been able to save her. And it was awful… He just sat there… and cried."* - Assistant nurse, female

Other informants expressed that meeting with the victims instead became memories, which they stored far in the back of their mind. They expressed that they sometimes experienced unexpected and intrusive memories from past meetings with victims, even months after the actual meeting.

> *"For the most part, I don't think that it affects me that much. Rather, I try to put it in a box somewhere at the back of my mind. And then, well, memories can reappear in different situations even though you may not remember the patient /.../ then suddenly, after several months, it pops."* – MD, female

Informants described how different women evoked different kinds of emotions within them. Many described getting more emotionally involved when they met with a raped woman who came from a socially vulnerable group, for example meeting with women who struggled with addiction and homelessness making them even more vulnerable. For some informants,

such meetings led to existential thoughts about the different conditions of the women they met and themselves.

> *"Yes, we really lead such different lives and, probably, that's what gets me as well. Also, she reminded me of other women I have met who live under similar conditions. It's almost like a double vulnerability, homelessness, addiction, and being exploited in different ways. And then this happens because they are 'easy victims'. So yes, meeting with her really got to me."* – Police, female

Mainly the informants working as medical personnel, talked about how meeting with women who did not even have the basic necessities, such as proper clothing, could make them get more emotionally involved. This made the meetings stay with them for a long period of time.

> *"And the worst thing was taking her clothes as evidence, cause she didn't have other clothes. She had nothing, except for what she was wearing, so we had to give her clothes from the hospital. And I thought to myself 'this woman doesn't even, she can't even keep the only clothing she has'. She didn't even get to keep her underwear cause we had to take them as well… Such meetings, they really stick."* – MD, female

Some informants seemed to remember the women they had felt unable to help particularly, others most notably remembered the women they had been able to make a difference for.

> "*I stayed with her for several hours… and she was really distraught which affected me. /…/ The relief came, later that night, when the prosecutor made the decision to bring the suspect in. She had lived with this for seven years, and that arrest drastically changed her life. She really made an impression."* – Police, female

Many of the informants talked about the concern they had for the women they met. Police officers discussed how they, during interrogations, had to make the woman go through the abuse once again. Some described a wish for interrogations not to go on for too long, as the woman often did not have the strength to go through details while in a highly emotional state. If the interrogations became too long, the informants described it as a struggle for themselves to stay focused as well.

> *"It's as they say, a ketchup effect. And how do you make the decision to stop the interrogation? Cause you think 'by God, we will have to be here for hours and hours'. And in some ways, you have to keep it short for her sake as well. She might not have the strength to manage a hearing, cause first she needs to be allowed to just tell and to be upset, and then you have to write everything down in some kind of structure… and, still, you may want to limit the time. Cause oftentimes they have this <u>huge</u> need to tell and to let it go."* – Police, female

If it were me. When reflecting on how it could be for a raped woman to go through an interrogation or a medical examination, mainly female informants discussed how they could picture themselves in the victim's position. Some informants talked about how meeting with women who reminded them of themselves made the informants more emotionally involved, identifying with the victim. In these discussions, some informants talked about it as a coincidence that it was not them who themselves had been raped.

> *"(1) Cause if it can happen to them, you kind of wonder why it hasn't happened to you… you compare yourself to those who have the same age and who also are*

'normal' so to speak… or at least 'normal' enough to make you think that it's just a coincidence that it wasn't you. /.../

(2) Cause I feel like, all women can be unfortunate enough to get raped (agreements) It can happen to any of us any day, cause we really are not safe anywhere, men are not as subjected to it as we are…that's the truth." – Nurses, female

When the informants talked about ways in which they identified with the victim, they also tried to understand what the victim could have been thinking and feeling during the rape, and they reflected on how they would react if they were to find themselves in the same situation.

"As a victim, first you try to talk yourself out of the situation and then you try to winkle in different ways and kind of… well, the last thing you resort to is to act more physical. Well, in the end, you just surrender and you think, 'if I just keep calm and close my eyes this will be over soon' (agreements). Cause you realize that you won't, you won't get out of this (agreements)." – Police, female

The informants discussed their own view on sexuality as something consensual and beautiful. Mainly the female informants, related to their own sexual experiences, such as sexual debut, and talked about how some young raped women had been robbed of something the informants themselves had been given.

"I remember my own first sexual experience very well and I wanted it. It's like, that is taken away from them." - Assistant nurse, female

The informant's also talked about sexuality as something intimate that one should share with someone you trusted and knew well.

"Yes! In general, it's very intimate. After all, having sex with someone is something you do in private, like; you don't do it in public. You should want it for yourself and you should be allowed to choose it yourself. It's supposed to be something nice and something you want." – Assistant nurse, female

When the informants identified with the victim, they also described thinking about how it would feel to meet with themselves as professionals. They reflected on what kind of experience the victim previously could have of meeting with professionals, or which professional the victims would be most comfortable meeting. Female police officers described using the term "we" to make the victim feel safe with them.

"With everything that relates to violence against women, I think it works by talking about it as a 'we'…That you say, 'we are not supposed to put up with this, we don't deserve this, we should be treated better'. Then she feels, or at least I've perceived it that way, that it makes the girls feel strengthened." – Police, female

The informants working as police officers further discussed whether they were more likely to send a female or a male officer to respond to a raped woman. Although stressing that there were no guidelines on this within the Authority, some informants described that, as most perpetrators are men, the victim would probably feel more comfortable meeting with a female professional.

"I really don't know if there is… well, it's not regulated that it would be better to send a woman, but it seems like common sense." – Police, male

Both female and male informants also talked about how it was probably easier for a female professional to understand the victim's experiences.

"*It might be easier for a woman to understand. Like, they can think, 'what if that was me… who had been through this'."* – Police, female

The informants working as police officers compared their own profession to those of medical personnel. They then talked about how, while meeting with a female police officer could be important, meeting with a female gynecologist was probably even more important. Medical personnel also tried to put themselves in the victim's position thinking about how it would be to meet with the Police. They talked about how police officers sometimes acted unaware of the impact their presence could have, barging in at the hospital when they accompanied a woman there. Some informants discussed how they, themselves, would feel walking in to their unit in the company of police officers.

"(1) But if you were to come here, walking through the corridor where you've never been before, being accompanied with two police officers… everyone looking at you. I imagine, you would feel so guilty (agreements).

(2) It's like a 'walk of shame' coming here with cops… like, it creates such a stir." – Nurses, female

I am left alone. The informants described how they often felt like they were left alone with their emotions. They described feeling powerless in relation to the woman's scarce possibilities to get juridical justice, and they described it as if they were letting the woman down. Mainly police officers talked about how they imagined that the woman had gathered courage to make a report, and how the informants had to disappoint her by not being able to take her case to court.

"I imagine they will have gathered courage to come here, they might even realize their own… guilt, or they blame themselves, and they still manage to turn to the legal system… and they hit the ceiling right away. Like, 'nothing will come out of this'. Well, they've worked so hard to do something that is basically doomed from the start." – Police, male

Some informants described how the powerlessness they experienced was also sometimes perceived as shared with the woman. Although they tried their best, the informants described the woman as having a preconceived notion of being let down; something that often turned out true.

"Many come here with that perception from the get-go, like, 'this is going to lead to nowhere'. And you have to tell them that 'we do the best we can, cause we do try!' We pull all the strings we have." – Police, female

The informants working as police officers described feeling powerless in regards to working within the legal system. They talked about how their work was almost in vain and that they did not want to overwork a case, as they knew beforehand that the case would not go to trial.

"Sometimes I feel like, there's no need to put too much effort in to a case that we know is going to be dropped anyway." – Police, female

Informants working as medical personnel expressed resignation when not being able to conduct certain examinations (i.e. testing for drugs) without the woman first making a police report. In such cases, if the woman did not want to file a police report the informants described it with sadness that they could not help the woman in the way they wanted to, nor in the way she asked them to.

"(1) It's not very nice having to tell a patient who has been sexually abused, and who has memory gaps; thinking she was drugged. And you may think so yourself, but you cannot offer her a drug-test, cause that costs money /…/

(2) She will have to file a police report to have one.

(1) So, that's crap and it makes you feel awful." – Nurses, female

In some instances, the informants projected their frustration on to the woman herself. Informants working as police officers sometimes expressed frustration toward the woman during the interrogation processes, especially in situations where the woman did not want to go through a medical examination.

"That's hard, and you have to work with yourself (agreements) when you have a woman or a girl in front of you that has been molested and she refuses to go through an examination… I mean, the enormous amount of frustration where you just 'damn! If we are to work this, there are no witnesses, there's nothing, <u>this</u> is what we have to do and now you don't want to!' I mean, I understand them, it's hard to be examined and everything, but for <u>me</u>, there's an extreme frustration. I mean, you're almost pissed, you don't show it, but the feeling is that you're pissed off. Like, 'damn' (sighs, others agree)." – Police, female

When talking about their work, all informants also discussed being lonely in terms of a lack of support. Several police officers described that although supervision and de-briefing in group-settings were available they were not always available in the situations where they most needed them.

"We have debriefings and such, but we don't always have them in situations where you meet women who, where there is an <u>extreme</u> amount of emotions; an extreme amount of emotions that you're just supposed to receive." – Police, female

Although several informants described getting support from colleagues, others described a lack of emotional support even within the collegiate. They described how they often talked about interesting cases, but that they rarely spoke about what it meant to carry the burden of a victim's story within them.

"We probably don't talk that much with each other about this. We may talk about interesting cases, dodgy assessments, but this really isn't an assessment; it's not decision-making in that way. Rather, this is something that we just do, something that needs to be done. In that way, it's not medically interesting and consequently, in our culture we don't talk about it. We talk about the cases where there's something new to learn." – MD, female

The informants working as medical personnel described that there was supposed to be designated time within their workday to separate and reflect. However, they also talked about how this time did not exist in reality, especially during weekends or nightshifts.

"(1) On weekdays, on our schedule, you should be able to distance yourself and reflect, but during the weekends, or on evening-shifts, the time to do that just isn't there.

(2) No, and that's hard I think. When there's a lot at work and you're assigned a difficult patient, well, there's no time to talk about that." – Nurses, female

Some informants also talked about a lack of support outside work, where their partner did not want to listen to sad stories.

> *"And like, you come home and your partner doesn't want to talk about it; because it is awful… And then, who are you to talk to? There's a need to talk about it, and there's a need for someone reacting to it."* – Nurse, female

The informants working as police officers talked about how support-groups and supervision were mainly available for officers working as investigators. The officers working as first responders described it as their personal responsibility to ask for support; something they all found hard to do.

> *"(1) The strange thing is… if you're at a department handling these cases there's a structure in place that takes care of it, educates and such… but for us, working as first responders, that structure doesn't exist /../*
>
> *(2) Rather, it's up to us, I mean, the Authority makes it our responsibility (agreements) saying 'it's your job to notify us if you need any support'*
>
> *(1) That's the easy way out.*
>
> *(2) But in reality, you cannot ask for that support."* – Police, females

The informants described that being a first responding police officer also meant being new to the field, not knowing if they as police officers were allowed to show emotions.

> "*(1) As a newcomer, there's a lot of other things stealing your attention. You're young and you haven't figured out if it's okay to get affected (agreements). I think you have to allow yourself to be affected. Many of us think that we can just shake this off*
>
> *(2) Yes, it's kind of typical to say 'I have no need to talk', and then others follow 'me neither'."* – Police, females

Furthermore, several police officers described that as the supervision took place in group-settings, they felt that it was hard to express their personal experiences and feelings. Some informants described how they lacked individual guidance in personal issues that was difficult to share with colleagues.

> *"I mean, I like my colleagues, I like working with them and whatnot, but I don't interact with them privately. And supervision isn't just about our work; it's about me as an individual, my feelings, and so on. At first, I was skeptical thinking 'am I supposed to share my inner thoughts with others?' cause those kind of feelings belong to <u>me</u> /…/ I think it would have been a good idea to meet more often, and that you were allowed to get individual counseling at times; so that you can actually talk about how you feel".* – Police, female

The informants talked about how specific units within the Authority varied in what one could share with others. However, a general culture was described where police officers were supposed to handle their emotions on their own, not sharing what was hard with others.

> "*(1) And it can become somewhat of a culture of silence... I mean, our groups really differ, how much you're allowed to share and how much you're supposed to keep quiet.*

(2) If I'm a police officer, I might be expected to think 'I'm supposed to be able to handle this'. Like, 'why am I reacting this way when I'm supposed to handle this?'." – Police, females

One of the police officers described how he had filed a report on work-related injury and demanded rehab after working a rape case. He described asking for help as a taboo within the Authority, and how colleagues had seen him as weak for not coping.

"I filed a complaint about that, and I've been going to rehab after that and I'm going to continue doing so. And it's like, it's kind of a taboo, like 'what's wrong with him?' and 'he can't take the pressure', and such." – Police, male

Police officers also talked about the lack of resources as a hinder for being professional when meeting with victims. They described an idle talk about future improvements that all fell short and left them disappointed.

"I mean, like, there's a lot of fancy talk, giving us hope… I've actually written about this… cause at our station, the environment just isn't suited for victims. /.../ And, I mean, men and women who have been subjected to crimes, rape in particular. Just the way we photograph, it's just, we're not being professional at all. We don't have the resources to be professional… and yet, we make them, we encourage them to file a report cause we're supposed to, but we haven't got the environment to actually take care of it. I mean, the prerequisites just aren't there." – Police, female

Police officers expressed concern regarding the lack of basic amenities in the interrogation rooms, such as a water dispenser or a coffee machine. The informants working as investigators of serious crimes described how some victims they had met did not want to go into the interrogation room, expressing how they could not stand the environment. These informants all described how there was a lack of insight within the Authority on the importance of the room.

"*(1) Sometimes, the victim doesn't want to set foot in our interrogation rooms, cause they can't stand the environment.*

(2) I get that, the rooms are, to say the least, Spartan and no fun. At least, now, we can offer them a cup of coffee or hot chocolate

(3) or water.

(1) Actually, I couldn't find any the last time I was there.

(2) I have to say, our interrogation room is under all criticism and they've always been like that. I mean, interrogations are our most important evidence, and they're not taken seriously by the Authority (agreements)." – Police, females and male

In addition, the informants working as police officers talked about the difficulties of getting supplementary education.

"It's not that the Authority actually offers, I mean, it's not easy to get an education (agreements). There's very few offered, and let's say that there's 30 spots open, and all the police officers in Sweden attempts to get one. It's not enough. And also, the Authority cannot afford to send this and this, and the staff isn't enough to get away; they can't afford to send someone from that particular division and so on." - Police, female

Informants also described how an intensive workload affected the quality of their work, taking a toll on both the victim and themselves.

> *"There are these nightmare scenarios where you've running between patients the whole evening /.../ yes, I've had two rape cases within one shift. In such cases, you barely have the time to eat /.../ One case just comes after the other, and I mean it's not fair on us either, cause what quality of work can we actually offer the victim in such cases? What quality of an investigation can we offer when you're so tired that you don't have the energy to write things down. Everything's just spinning for you."* – Police, female

Medical personnel, also talked about an intensive work load and how they oftentimes wanted to stay with the victim, but that they were not able to, as other patients needed their attention.

> *"(1) Oftentimes, what you really want is to be able to stay with the patient to support her, especially when she doesn't have anyone accompanying her and she doesn't want to be alone. But it's close to impossible stay with just one patient, when there are other things that you must tend to.*
>
> *(2) Yes, you can see that they're not doing well, but you can't stay with them. You just don't have the time, that's awful."* – Assistant nurses, female

Many informants described how the extensive workload affected their physical and mental health. Many of them also described how colleagues of theirs units had left, as the lack of the pre-requisites needed to partly offer a good-enough treatment of the victim, partly to take care of themselves was not there.

> *"If you apply for our department, you usually stay. And those who don't, they leave because they can't take it. I mean, they're exhausted. Not because they don't appreciate their job, but because they can't stand the extensive workload. And then there's something wrong."* – Police, female

Making me another

Both police officers and medical personnel described how their work had changed them. Several informants discussed how they sometimes felt emotionally exhausted. They also described having difficulties mobilizing energy to do their work, such as conducting interrogations or performing a gynecological examination. Furthermore, some informants expressed a fear of growing cold and becoming numb when meeting with victims, while other informants described how their approach to victims had already changed. They described how these meetings once had a strong emotional impact on them but how they no longer were affected by them. All informants also discussed how the meetings with raped women had contributed to changes in their perceptions of the world. Instead of viewing the world as just, the informants had an increased awareness of the evils of man. Some informants described that they had become increasingly wary of men in general. They also described finding it difficult to accept the randomness of some people being unfortunate enough to get raped. The informants sometimes talked about a fear of themselves, or others in their vicinity, being raped and expressed how they dealt with these thoughts by acting differently in their daily lives. Furthermore, the informants expressed that their changes in perceptions of the world had caused them to, sometimes, go beyond their professional role when trying to help victims.

I am emotionally exhausted. Several police officers described how they during an interrogation could become so engaged in the victim that they felt exhausted afterwards. They also described that while the victim could go home afterwards, the informant was left with more work, having to type the interrogation.

> *"You get very emotionally involved /.../ Sometimes, you're completely washed out afterwards (agreements). You're completely washed out, cause you're all focused on getting as much information as possible. And sometimes you think, 'who in God's name is going to print this out?'."* – Police, female

Medical personnel also described feeling exhausted, although not as often as police officers. Mainly, informants working as medical personnel talked about this in relation to victims only barely remembering details from the abuse. They described how women could come in, only having a hunch that they had been victimized. In such situations, informants described it as a struggle to mobilize the energy for a medical examination, and some described the examination as pointless for both the victim and themselves.

> *"(1) They have this feeling that something happened at the party, but they can't remember. I mean, if you actually knew that nothing happened it would be so much easier to just let it go, and spare her the traumatic experience of an examination.*
>
> *(2) I don't blame them, but the whole situation's just much more complicated when they don't know what happened.*
>
> *(1) Yes, and it's also hard to gather the energy, it's hard to find motivation.*
>
> *(2) Yes, I understand what you mean.*
>
> *(1) It's much more exhausting, both on the patient and on me."* – MDs, female

Some informants talked about a fear of growing cold and numb. They described a lack of being able to reflect on how meeting with raped women actually affected them. Meeting with raped women had become just a part of their daily work, making it a routine.

> *"(1) I mean, it's a constant flow and the time to stop to think how all this is affecting me just isn't there. And you don't want to become numb to it; that's something that you definitely don't want to become*
>
> *(2) No, I don't think we will, but sometimes it's just a part of our everyday life. You have to receive and receive and it's like 'okay so you've been raped, we have a routine for this'."* – Nurses, female

Although acknowledging a fear of losing their empathic response, many informants also admitted that their approach to these victims actually had changed over time. With experience, the focus on being professional, as opposed to emotional, had increased making the informants more goal-focused.

> *"I think of how I used to handle these errands earlier in my career as opposed to now. The first times I think I put, I mean I got really emotionally involved. And I thought it was troublesome, cause I didn't know the line between being objective, doing my job, being professional, and at the same time showing empathy. It's still a balancing act, but I've noticed a tendency towards me becoming a bit more correct, goal-focused, handling the task at hand."* – Police, female

The focus on professionalism seemed to sometimes make the informants overly pragmatic, viewing the woman as a crime scene. The focus became on gathering evidence to catch the perpetrator and less on meeting the woman in her vulnerable state.

> *"I may be pragmatic, but I see her as a crime scene, cause she is one. After all, a crime has been committed on her so to say. But I also think it's important that we do a good job when meeting with her, so that we can capture as much DNA as possible in order for them to catch the perpetrator. Cause if we don't find the evidence, there may be nothing for them to look for and then he goes free. So, I think it's important to be thorough and make sure everything's done properly."* - Assistant nurse, female

The world is not a safe place. Mainly the informants working as medical personnel described that ever since they started working with victims, they had become increasingly wary of men in general and how they could not help viewing most men as potential rapists.

> *"In some ways, I think of all men as potential rapists."* – Nurse, female

Other informants described that early on working with victims they had felt hatred towards most men, due to the hurt they caused their patients. However, several informants described that, with experience, the anger had diluted.

> *"Well I mean, the first time while working here it was just like I went into a total darkness and I actually hated <u>all</u> men. I saw every man as a potential rapist and just became this complete man-hater (agreements) Cause I saw what all of these women went through… however, it has started to calm down, you kind of learn to handle it."* – Nurse, female

One informant, working as a nurse, talked about how her increasing suspicion towards men had even made her think about changing her sexual orientation. As a result, of viewing men as dangerous, she imagined she would feel safer in sexual encounters with women.

> *"(1) I have to say, I've actually considered dating women instead. I would never put myself in, I don't know how to say this…. But let's say, I'm very aware of the risks meeting with men*
>
> *(2) yes, so <u>very</u> much aware."* - Nurse and Assistant nurse, female

When thinking of different encounters with raped women, although acknowledging that they had come to accept that bad things happen, many of the informants found it hard to accept that some of the women they met had sad life stories, in which the rape was just one of many tragic events.

> *"(1) A person's whole life story, that*
>
> *(2) yes, that's exactly it*
>
> *(1) it hits you. /…/ I mean, you're able to accept that occasionally sad things happen, but it's harder to accept that (sighs) some have such tragic lives."* – MDs, female

In one discussion, two of the informants working as medical personnel talked about their fantasies of confronting the perpetrator, revenging their patients.

> *"Like this 14-year old that I told you about; I wrote the forensic certificate and I got the whole interrogation-script. And in that, was the name of the guy and everything was written down so I got this (laughs), I started fantasizing of looking him up;*

turning into this masked revenger attacking him. I didn't do it, though (giggles)." – MD, female

Both police officers and medical personnel described how they had come to avoid certain people, places, situations, and activities out of fear of being reminded about the women they had met. One of the informants, working as an investigator of serious crimes said that some of her interests had changed over time. Where she once enjoyed documentaries or detective novels, she could now only stand stories of romance and happy endings.

"It shows in the way I've changed since I started working with this. That I'm, I'm totally boring to take to a movie theatre or those kind of thing. I never go to the movies anymore, but if I'm to watch a movie it has to be a feel-good. I mean, I don't even watch documentaries anymore. And like, before I used to read… well… fact books, but now I don't even read detective novels anymore. Cause I only want happy-endings and, and love. /…/ The glass is full… I mean, I can't take it no more." – Police, female

Mainly the informants working as medical personnel described avoiding certain places and situations they perceived as high-risk. Some described that they no longer went to certain restaurants, clubs, or gender-mixed toilets mainly due to having listened to patients describing that they had been raped in such places. Some informants described that they would never even consider taking a cab, because of the stories they had listened to.

"I never take a cab. I've only taken a cab once since I started working here, and that was to get to the ER when I was sick... If I've been out, I'd rather take the bus even though it takes me much longer to get home. I mean, this is our reality, we see it on a daily basis and of course, it affects you. I know I'm a bit paranoid, but I know what this society is like." – Nurse, female

When discussing the aftermaths of meeting with raped women, several informants said that they also had more concern that they themselves or someone they knew could get raped. They talked about different ways in which they tried to care for others' and their own safety. Some informants described that they constantly texted their friends to see how things were going if they were out on a date.

"I have friend, who's gotten married and had children through dating-apps, but what we see here are not those fairytale-cases (agreements) 'How are you doing? Is he kind?' I actually bombard my friends with texts if they're on a date, just to make sure everything's okay." – Assistant nurse, female

If using a dating-app, the informants discussed how they first tried to gain more information about the man they were in contact with, making sure that he was safe to meet.

"Also, with the information you can find on these apps, I try to find out more, like 'what do I actually know about this man?' (agreements) And I know it makes me sound kind of like a stalker, but I have to act that way; for my own safety." – Assistant nurse, female

Both police officers and medical personnel described situations in which they had gone beyond their professional role to help victims. Some informants described themselves almost as social workers; making contacts with for example women's shelters.

"I've contacted women's support organizations. If someone is insecure and in need… so that they find someone to talk to. People working at women's support organizations are usually good at that." – Police, male

One informant, working as medical personnel, described a situation in which there was no possibility for the victim to get help from others, due to social vulnerability and a lack of social network. Thus, the informant described how she had decided to get in the cab with the woman and escort her to make sure that she got home safe. In hindsight, the informant contemplated about her own safety in such situations.

"We had a patient who were under threat, she lived in a women's shelter… and it was late at night, there was no one who could accompany her back to the shelter; she had no one, no social networks. /…/ She was scared shitless /…/ It actually ended up with me going with her…to the shelter /…/ and when I got home afterwards, I was thinking to myself, 'I did this out of pure compassion' but also, 'how involved should we actually become?'." – Nurse, female

Many informants also described how they tried to take responsibility for what happened to the victim after their work was done.

"I mean, for example, how do you send a person home after an interrogation? I usually think… well, 'you can't', you don't want to send this woman home alone… Like, 'you can't go home', or 'who is meeting you at home? What are your thoughts on, what are you going to do after this?' /…/ Cause, after the interrogation my life continues as usual, but she's just told me about the worst thing that's ever happened to her. You can't just say 'thank you, bye-bye! Have a good time!' I mean, it doesn't work that way." – Police, female

Discussion

The victim's initial meeting with a professional after a sexual abuse or rape is considered crucial for her ability to process what has happened (Rudolfsson & Tidefors, 2015). Comforting reactions, where professionals show empathy and support to a disclosure, has been associated with improved psychological health among victims (Campbell, 2005). However, negative reactions from professionals, such as being cold or disbelieving have been shown to exacerbate the psychological suffering within the victim (Ahrens, et al., 2010). Thus, the initial meeting with a professional is of great importance as to how the raped woman continue to process what has happened, and if she chooses to seek help again (Campbell, 2005). In order for professionals to be able to show empathy and support, we must first explore how the professionals themselves experience the initial meeting with raped women, and how the professional's own feelings might affect their response to victims. Hence, the aim of this study was to gain a deeper understanding of how police officers and medical personnel experience meeting with women who have been raped; what psychological effects of these meetings that are described. Furthermore, the study aimed to explore how police officers and medical personnel talk about managing these difficulties.

The informants described how they were exposed to highly emotional and traumatic stories by listening to the women they met. The informants talked about how they were moved by empathy, causing them to sometimes feel overwhelmed with emotions. The encounters with raped women were also described as affecting the informants in a personal manner, leading to difficulties being professional as they sometimes found it difficult to keep a personal distance. Some informants described identifying with the victim, which further caused them to reflect on how they as victims would feel meeting with someone from their own profession. Informants

also expressed feeling left alone. They talked about feeling powerless, as they often knew beforehand that the woman they met would probably not get legal justice. All informants emphasized a lack of emotional and structural support to cope with these feelings. Not only did these meetings cause informants to feel moved by the stories, they also described how their work changed them into becoming another. Both police officers and medical personnel addressed how they often felt emotionally exhausted, having difficulties mobilizing energy to do their work. Some informants also talked about a fear of growing cold and becoming numb, while others described how their approach to victims had already changed. Furthermore, all informants discussed the perception of the world not being a safe place. Instead of viewing the world as just, the informants had an increased awareness of the dark sides of Society and the evils of man. These changes in perception of the world had caused the informants to act differently both in their work as well as in their daily lives.

Although police officers and medical personnel differ in some aspects, many similarities can be found. Both police officers and medical personnel are first responders, and all informants had at least two years of working experience. Therefore, all informants had been exposed to traumatic material when meeting with raped women. The regular experience of working with victims and listening to stories with traumatic content may overwhelm the professional's capacity to adapt and cope, leading to psychological changes (Kerswell, et al., 2019). Hence, all negative emotional aspects described above can both increase the risk and be presented as consequences of secondary traumatization. In order to gain a deeper understanding of how emotional and cognitive changes were identified within the professionals, these aspects will be further discussed below. The consequences of lacking support and issues of gender will also be examined.

Emotional changes and perceived difficulties

All informants described how their encounters with raped women affected them emotionally, making them feel a strong sense of empathy with the victim. All informants gave detailed records of the stories they had listened to and they all stressed the empathic response as a prerequisite for being able to offer a good-enough treatment. In previous research, the importance of empathy has been addressed when meeting with victims of rape (Maddox et al., 2011). In addition, empathy has been defined as a strong predictor of helping behavior, which elicits motivation to reduce the suffering of others (Pavey, Greltemeyer & Sparks, 2012). Furthermore, empathy has been linked with positive interpersonal and intrapsychic outcomes, such as increased social engagement with others (Tone & Tully, 2014). Although empathy is described as an essential resource when meeting with victims (Figley, 1995), empathic reactions to other's distress can increase the emergence of internalizing problems within the professional (Tone & Tully, 2014). Many of the informants described that they often felt overburdened with empathy. Consequently, questions arises as to how much empathy the professional can feel for the victim before the empathy becomes too big of a burden for the professional to bare.

Several informants described that meetings with raped women made them exhausted, taking a toll on both the victim and themselves. Meanwhile, some informants expressed that feelings of exhaustion caused a fear of growing cold and numb, while other informants admitted that their approach to victims had actually already changed. With experience, several informants had become less emotional and more goal-focused, leading some informants to become overly pragmatic by viewing the woman less as a human and more as a source of evidence. The emotional exhaustion might have caused these informants to become more cynical than before (Maytum et al., 2004). Running out of empathy and showing tendencies of

cynicism, might explain why some informants talked about viewing the victim as a crime scene. Dehumanizing the other may also be viewed as a way of distancing oneself from the pain and vulnerability experienced by the victim (Vahali, 2015). In addition, Vahali (2015) suggests that all humans have a tendency to create distance from what is perceived as unbearable within the self as well as in the other. Thus, the more goal-focused the informants become, the less they need to pay attention to their own or others emotions. Not only does running out of empathy risk cheating the victim of adequate treatment, but it might also affect the victim's perception of the professionals; making them less willing to seek help in the future. A lack of reflection of the personal consequences of interacting with traumatized individuals, might lead professionals to continue working without understanding how these meetings affect them. In the long run, this risk affecting professionals in a way that hinders them from offering proper treatment to the victims they meet as well as denying themselves from dealing with their own emotions.

The strong engagement with the victim can be seen as a result of the professional identifying with the victim (Bride et al., 2007). Identifying with the victim's position can contribute to a greater motivation to continue this work. Identification might also contribute to the victim feeling seen and understood by the professional. However, in this study, informants seemed to sometimes over-identify with the victim. Both police officers and medical personnel described how they could picture themselves in the victim's position in different ways; both in relation to themselves being raped and also regarding being a victim and meeting a professional. Some informants also described how victims sometimes reminded them of themselves, for example when the victim was in the same age or came from similar conditions. This way of identifying with the victim can contribute to professionals experiencing both feelings and symptoms similar to the victim herself (Turgoose et al., 2017). This in turn, might contribute to professional's developing mental illnesses, such as PTSD or depression, through their meetings with raped women (Bride et al., 2007).

Listening to stories about rape can also actualize thoughts and feelings regarding the professionals' own sexuality (Tidefors & Drougge, 2006). One might assume that this can be exacerbated if there is a higher level of identification with the persons involved in a rape. Furthermore, Pearlman and Saakvitne (1995) discuss intimacy as one of the areas that can become disrupted for professionals working with traumatized individuals. In this study, mainly female informants described being able to picture themselves in the victim's position. Previous research show that aspects of gender might affect the professionals' reactions to disclosure (e.g. Hetherton & Beardsall, 1998). Although the male informants in this study did not elaborate on this in particular, there might be a risk that male professionals come to identify with the position of the perpetrator (Etherington, 2009). The lack of statements regarding identification among male informants, in this study, can be understood through the perceived threat of identifying with the position of a perpetrator. The actualization of the professionals own views of sexuality, might have an impact on both informants' conceptions on the stories told, as well as contribute to difficulties working with victims of sexual abuse. This might also be a contributing factor to the previously noted tendency for female professionals to be expected to offer care for victims of sexual abuse, in a higher degree than their male colleagues (e.g. Rudolfsson, 2015). It can also further our understanding of how informants in this study stated that it was "common sense" to try to send a female professional to respond to raped women.

Identifying with the perpetrator may contribute to feelings of guilt for what the victim has been put through (Asker, 2019). Identification with the perpetrator can also be actualized in the female informants as they expressed concern for the victims during an interrogation or medical examination, because of how they often times perceived their work as causing the victim to re-live the rape. Identification might not only actualize being a perpetrator, but it may also actualize feelings of being a victim. Using sexual diction in these meetings with raped women, perpetrators, or even with each other within the work environment might also affect

the possibility of connecting to the traumatic stories of the victims. In that sense, identification can cause difficulties in remaining professional. The burden of feeling like your work-efforts forces the woman to relive her trauma can be assumed to be a heavy burden to carry.

The informants in this study showed some indication as to the effects on their own sexuality, for example by thinking of changing their sexual orientation. However, it remains to be understood in what ways professionals' own sexuality can become actualized in these meetings, and how their work might affect their own personal sexual relationships.

Cognitive changes and its consequences

Both police officers and medical personnel described how they had become increasingly aware about the dark sides of Society and that the world is not a safe place. Several informants described that since they started working with victims, they had become increasingly wary of men in general, and some even described viewing all men as potential rapists. Furthermore, some informants talked about how they felt that it was difficult to accept that some women lived such sad and violent lives. Change in worldview and cognitive schemas have been identified as a symptom of secondary traumatization (McCann & Pearlman, 1990). When the perspective of the world changes within a professional, it can become difficult for the professional to hold the idea that humanity is generally good. This can lead to an internal conflict of whether the world is good or bad, since the professional observes more of the evils of mankind. Furthermore, if man is considered evil, then there is a risk that life can feel meaningless (Palmer, 2019). To manage these inexplicable thoughts about meaninglessness, it is common to become cynical (McCann & Pearlman, 1990); something some of the informants in this study showed tendencies of. Being ruthless, insensitive, and skeptical towards the world and sometimes towards the victims, can be seen as comforting to the professional as it provides them with some kind of meaning and explanation in regards to the evils of world (Pearlman & Saakvitne, 1995). Consequently, the informants' being exposed to the victims' traumatic stories can be viewed as a relatively unbearable situation. Continuously listening to stories about rape and violence might not only lead to emotional changes, but also to an altered perception of thoughts in regards to the informants' own safety and control.

Due to an increased insight about the informants own risk of being subjected to rape, the informants described avoiding certain places, situations, and hobbies. Furthermore, some informants also described how memories could pop up unexpectedly even months after a meeting. Such changes in perceptions of the world, avoidant-strategies, and intrusive thoughts are similar to victims diagnosed with PTSD (APA, 2013). The fact that professionals also have the same feelings and changed cognitive schemas can be seen as a confirmation that the stories the informants listen to is reflected in their own lives through the fear of becoming victims themselves. One of the police investigators also talked about how some of her interests had changed over time, where she no longer enjoyed documentaries and only could stand watching movies with romance and happy endings. Although this can be related to the over-exposure to traumatic material, it may also be seen as a sense of survival debt within the professional; a debt or guilt for not having suffered the trauma themselves (Palmer, 2019). This might cause professionals to find it difficult to enjoy the pleasures and comforts of their own lives.

As a way of balancing the injustice in the world, some informants fantasized about revenge. This can be viewed as a way for the informants to gain personal control. In relation to this, Pearlman and Saakvitne (1995) describes that interactions with victims may disrupt the professional's sense of control. The informants described feeling frustrated and helpless regarding what the victims had been subjected to. In one way, this might function to motivate the informants to help the woman, in other ways it can also be seen as a way for the informant

her/himself to gain some kind of control over the victims' future. This might help the professional to gain a higher sense of being able to contribute something meaningful through their work, which in turn can make the informant feel less helpless and more successful in their work.

Several informants admitted that they sometimes had gone as far as to help victims outside of their professional duty. They described how they contacted women's shelters for the victims to talk about their experiences, while some informants had even followed the victim home in order to make sure they she was safe. Going outside of one's professional duties can be seen as benevolent and empathic, however, it may also contribute to an increased sense of control within the professional her/himself; a sense of control about being able to make a difference for the victim, making the professional to feel more competent. It may also be considered to motivate professionals to continue their work with raped women. On the contrary, the feeling of not being able to make a difference for the victim might increase the risk of secondary traumatization. However, going beyond the professional role might also contribute to too much of an engagement in the professional's work, which can further add to the pre-existing difficulties in creating boundaries between victim and professional (Palmer, 2019).

Lack of structural and emotional support

The informants described how they often felt like they were left alone in their work. They described feeling powerless in relation to the woman's scarce possibilities to get juridical justice. Oftentimes, the informants described how their own feelings of powerlessness were shared with the victims they met. Previous research show that experiencing feelings of powerlessness is common among professionals working with raped women (e.g. Martin, 2005). The feelings of powerlessness can be based both in the lack of abilities to offer the victim juridical justice (Turgoose et al., 2017), but it can also represent a feeling that is projected on the professional by the victim (Liotti, 2014). Although powerlessness can be viewed as an empathic, powerlessness can also create difficulties in showing empathy (Turgoose et al., 2017). Both police officers and medical personnel expressed that they often felt frustrated describing their work as almost in vain and they talked about working in headwind. Thus, we can assume that there is a reduced sense of professional accomplishment. This in turn, may cause a sense of hopelessness dealing with ones work effectively (Stamm, 2010). In the end, victims risk not getting the help they need from professionals, which in turn might confirm the victims' ideas of not deserving restitution (e.g. Zinzow & Thompson, 2011). However, frustration and hopelessness can also affect the professionals' motivation to continue offering care for the women they meet.

To work with something that, as described by the informants, is doomed to fail can also affect both the propensity for professionals to ask for support as well as the willingness to receive support offered. Both police officers and medical personnel described a lack of structural and emotional support. They also talked about how, although supervision in group-settings was offered, they were not always available in the situations where they most needed it. Supervision is one way to support professionals in coping with their work situation and, thus, a means to prevent secondary traumatization (Bégat & Severinsson, 2006). Furthermore, Severinsson and Hallberg (1996) stated that supervision can help healthcare professionals to maintain their ability to take action under stress, having more work motivation, and to have a more tolerant attitude toward patients. Previous research show that the risk of secondary traumatization can be reduced when professionals have access to professional support (e.g. Salston & Figley, 2003). Personal and professional supervision has also been considered as crucial for reducing symptoms of secondary trauma (Salston & Figley, 2003). The combination

of an ability to discuss the stories listened to with colleagues, attending training workshops, limiting workload, spending time with family or friends and supervision has been considered as most helpful (Pearlman, 1999). Thus, supervision and support from employers affects the quality of the treatment that professionals are able to offer to the women they meet (Johnson, 2015).

Furthermore, previous research show that victims of major traumas experience positive growth and positive mental health outcomes when feeling adequately treated by professionals (Linely & Joseph, 2004). However, in this study, both police officers and medical personnel described a lack of structural and emotional support in their work. For example, they talked about how they rarely spoke about what it means to carry the burden of a victim's story within them. Furthermore, the informants described that there was a lack of structural support, and that the intensive workload they were under affected the quality of their work. A lack of supplementary education was also discussed, and some informants expressed concern regarding the lack of physical resources as a hinder for them being professional when meeting with victims. Previous research have shown that being dissatisfied with your work and weak organizational commitment, risk making the professional not fully invested in their work; in some cases, this might even make the professional retire prematurely (Kop, Euwema, & Schaufeli, 1999). Furthermore, lack of support has been shown to increase the risk of secondary traumatization among professionals (Kerswell et al., 2019). However, it remains to further explore how the lack of emotional and structural support among professionals is perceived by the women who seek their help.

We must also address the fact that the informants in this study, mainly the police officers, described that in order to get supervision it was their personal responsibility to ask for it; something they found hard to do. The lack of being able to ask for support can be a sign of a culture of silence within the Police Authority, where officers are expected to be tough and cope on their own. However, there is a lack of research on how Police culture might affect officers' possibilities to display emotions towards one another. According to Jordan (2001), emphasizing with victims can be viewed as a deviation from objectivity. Thus, this might be a reason as to why police officers in this study did not feel like they could show in what ways they were affected by the victims they met. Since there is a lack of research on this phenomenon, we can assume that the culture of silence can lead professionals to feel lonely in their work, possibly leading them to believe that they are the only ones who feel and think a certain way when meeting with victims. This might also contribute to feelings of shame within the professional, as s/he is not mentally strong to deal with the emotions provoked in meetings with raped women. Possibly, this can also make the professional not even reflecting or understanding why s/he experiences certain psychological reactions. There is a general understanding of the macho-culture within the Police Authority causing professionals to try to handle their emotions on their own (e.g. Rich & Seffrin, 2012). One example of this, that was found in this study, was one of the police officer who had filed a report on work-related injury. He described that asking for emotional support was a taboo within the Authority and described how colleagues saw him as weak for not coping on his own.

If there is no room to discuss personal experiences, the professional will not only feel as if they are overreacting and that their experiences are not important, they may also never receive the reassurance that their feelings are normal and okay. In that way, cultures of silence might be considered a risk factor to secondary traumatization. Cultures of silence could also be distinguished on a latent level the informants working as medical personnel as they also described a lack of emotional support. These informants talked about how they often came to discuss interesting cases with colleagues, but that they rarely talked about what it meant to carry the burden of the victim's story within them. In the focus groups with medical personnel, the informants sometimes seemed to talk about the women they met as cases. On a latent level of

interpretation, this can be seen as a sign of a culture of silence; they did not focus on the meeting with the victim but instead on routines to handle a group of patients. Previous studies have shown that social support is a variable that can affect a professional's mental health after listening to a traumatic event (Kerswell et al., 2019). Consequently, although there may be a more open culture within the health care system to talk about your own feelings in meetings with the victim there are other, structural factors, that might make it difficult to do so. One of these factors include lack of time to reflect, which may cause the informants to still find it difficult to express their feelings with colleagues.

Issues of gender

There are several dimensions relating to gender that need to be addressed. First, there was an uneven distribution of males and females where a majority of the informants in this study were female, among the informants working as medical personnel all informants were women. This may cause difficulties generalizing the findings to include both men and women professionals. However, the majority of professionals within the Police and health care field who work with, and interrogate victims of rape, are women (Rich & Seffrin, 2012). In addition, the informants all talked about it being more suitable for a female professional to attend to female rape victims. Thus, the gender disparity in this study corresponds to what reality is like. However, the disproportion might affect the male informants' possibilities to express their thoughts and feelings about their work, not the least, as the interviewer was also female.

Most victims of rape are females (e.g. Brå, 2019a), which may also further our understanding of how female professionals might resonate more with these victims, possibly making female professionals more motivated to work with victims of sexual abuse. In several countries, assignments to conduct rape interviews are often based on the professionals' gender (e.g. Hodgson & Kelley, 2002), and in this study the informants described it as common sense to assign a female professional to respond to a raped woman. Furthermore, victims of rape have also reported that they prefer meeting with a female professional, and that they feel more comfortable discussing the intimate details of a sexual assault with another woman (Temkin & Krahé, 2008). Consequently, there seems to be a general assumption that women share a common understanding of rape, which results from shared socialization influences (Martin, 2005). Previous research have also shown that female professionals are sometimes expected to take on a greater care-responsibility, show more concern, and be more supportive of female victims (e.g. Rudolfsson, 2015). In this study, both female and male informants described a higher identification between victims and female professionals, as well as it making more sense for the female professional to respond to raped women. Therefore, we can assume that there is a higher risk for female professionals to be supposed to respond to victims of rape, making them more exposed. This may confirm the finding in previous research that female professionals are at higher risk of developing PTSD-symptoms, when compared to their male colleagues (Carmassi et al., 2018). Although the informants in this study gave statements that support the existence of secondary traumatization, we cannot assure that this is the case in reality for each one of them. However, based on previous research, the informants' statements still confirm both symptoms and reactions that are similar to those who have been secondary traumatized.

Methodological reflections

As the aim of this study can be seen as explorative, a deductive thematic analysis was conducted. This way of analyzing the material enables the ability to identify and interpret themes based on the theoretical interest. Although there are disadvantages with this method, as with other methods, it is also important to acknowledge its advantages. Thematic analysis is a flexible approach and provides rich and complex account of data (Braun & Clarke, 2006). Furthermore, thematic analysis is a useful method for examining the perspective of different research participants, highlighting similarities and differences, and generating unanticipated insights. Thematic analysis is also useful for summarizing key features of a large data set, as it forces the author to take a well-structured approach to handling data, helping to produce a clear and organized final report. This method also enables an analysis of the data on a latent level (Braun & Clarke, 2006).

It must also be mentioned that the research project in which the material was gathered, did not specifically aim to focus on professionals' psychological effects of meeting with raped women. Rather, the focus was on the treatment of raped women and how professionals perceive their work as either helping or hindering the victims' ability to process what has happened. The focus on signs of secondary traumatization was therefore not in the question guide, rather, the focus of this study was an attempt to view the transcripts from a different perspective.

Furthermore, we must address the fact that there were two different professions included in this study. Police officers and medical personnel are different professions where one aims to care for the patient and the other aims to investigate what actually happened. Consequently, police officers' work is not a caring profession and they are supposed to question all allegation as well as be able to attend to both victim and suspect. Because medical personnel aim to care for their patients, we can assume that there might be a general idea of caring for one another at work. Thus, there might exist a bigger acceptance for medical personnel to show vulnerability. The duties of a police officer are different, which might make comparisons between the professions hard to do.

The different professions also require different job assignments and guidelines regarding the treatment of raped women. While medical personnel aim to care, police officers aim to question the statements of both victim and suspect, leading to differences in knowledge of how to care for these victims. Hence, it might be questioned whether the findings in this study is applicable to both police officers and medical personnel. In the analysis, quotes were selected on the premises of them representing a general finding. In the cases of a finding pertaining to one profession more than the other, this was emphasized. However, both police officers and medical personnel are among the professionals exposed to traumatic content when meeting with raped women, and hence, we can assume that the findings are at least to some degree representative for both professions.

In addition, we must address that the study was based on focus groups. Since the professionals talked about their experiences in focus groups, we might miss important information that might have been revealed if conducting individual interviews. However, in comparison to individual interviews, the interaction between individuals can contribute to a higher degree of debates and stimulate participants to remember experiences to a greater extent (Millward, 2006). Furthermore, focus groups offer the opportunity to gain new knowledge, which makes this method suitable for more exploratory studies (Yardley, 2000). However, the dynamics in the focus groups can affect how open the informants are with sharing personal experiences. Just as supervision in group-settings can make it hard for participants to disclose personal information, the focus groups can work in the same way. Furthermore, informants who had a longer working experience might have a louder voice in focus groups; possibly taking more time from other informants. It should also be noted that the Swedish Police Authority has

a history of senior police officers ranking higher, which may also have caused the informants who had not been working as a police officer for as long time to feel hindered in what they were able to share in the focus groups.

In order for informants to be able to share their experiences and discuss new aspects, the interview guide was semi-structured and contained broad questions and the follow-up questions were based on what the informants chose to share. Although the questions asked were broad, previous research has shown that informants have tendencies to express thoughts and opinions that they think the researcher wants to hear (e.g. Randall, Prior & Skarborn, 2006). This corresponds to the critical realistic perspective where the informants might be influenced by the researcher as well (Stoehrel, 2007). Thus, we must stress the possibility that the moderator, who comes from the psychological field, could have affected what the informants chose to share.

Clinical implications

From a clinical perspective, meeting with raped women and listening to stories with traumatic content can affect the professional in different ways. Working with these victims without reflecting on personal consequences can lead professionals to continue working without understanding how these meetings affect them. This in turn, may hinder professionals from offering proper treatment to victims as well as denying themselves from dealing with their own emotions. Thus, meeting with raped women can contribute to professional's developing mental illnesses, such as PTSD or depression.

This study attempted to contribute with a deeper understanding of how police officers and medical personnel might be affected from working with raped women. Previous research has mainly focused on professionals who have had long-term contact with traumatized individuals. However, this study indicates that first responders, who are frequently and routinely exposed to traumatized individuals through short-term contact, might also be affected in negative ways. The lack of emotional and structural support is, thus, an important factor to have in consideration regarding police officers and medical personnel who work with raped women, as this lack risk hinders professionals from doing their work effectively. They described a lack of resources and support is also at risk for becoming detrimental for the women who rely on these first responders, as it can affect whether they decide to seek help again and, thus, get an improved psychological health. The need for social support and supervision by employers is therefore crucial in order for these professionals to come home from work and although feeling that some things stick, being able to cope with what has affected them constructively.

Implications for further research

- Semi-structured, individual interviews can be used as a complement to focus group studies, in order for informants to open up about more personal aspects, such as in what ways first responders own sexuality may become actualized when meeting with raped women and how their work might affect their own personal sexual relationships.
- Further, investigate how to help police officers and medical personnel cope in constructive ways, giving them tools of how to build more resistance to these psychological effects.
- Further exploration of how macho-culture and cultures of silence might affect police officers specifically.

- Suspicion towards the victim might be a risk, or a consequence, of secondary traumatization. Therefore, there is a need to explore how professionals' suspicion might affect meeting with victims.
- Forthcoming, are studies on how raped women experience meeting with police and medical personnel.

Concluding remark

Police officers and medical personnel are at risk of developing secondary traumatization. If we do not discern the potential effects by exposing oneself to victims and traumatic content, we might miss the psychological consequences that develop among professionals. Consequently, there will exist a group of professionals who are not able to meet the victims who seek their help at their full potential. Therefore, we must always have in consideration how to take care of those who's responsibility it is to take care of us.

Finally, many thanks to the informants for sharing their thoughts and experiences in an open-minded way.

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Appendix A

Frågeguide, Fokusgrupper
Polis

- Presentationsrunda: Berätta vad Du heter, hur länge Du har arbetat som polis och om något minne Du har från när Du har tagit emot en polisanmälan från en kvinna som har blivit utsatt för våldtäkt.

- Hur vanligt skulle ni säga att det är att man som polis tar emot anmälan om våldtäkt från kvinnor?
- Finns det någon ”typisk situation” i vilken man som polis tar emot en anmälan om våldtäkt?
- Finns det någon ”typ av” våldtäkt / ”typ av” brottsoffer som är lättare eller svårare att möta?
- Finns det någonting i dessa möten som ni har upplevt fungerar extra bra?
- Finns det något i dessa möten som är svårt?

- Har ni gått någon utbildning kring bemötande av personer som har utsatts för sexualbrott?
- Har ni tagit del av de riktlinjer som finns inom Polismyndigheten kring bemötande av personer som har utsatts för sexualbrott?
    - Finns det någonting i riktlinjerna som ni tycker har varit hjälpsamt i ert arbete?
    - Finns det någonting i riktlinjerna som är svårt att förstå/är svårt att förhålla sig till?
    - Finns det någonting ni tycker saknas i de riktlinjer som finns idag?

- Känner ni er trygga i situationen?
- Finns det någonting jag har glömt att fråga er, eller som är viktigt för mig att veta?
- Avslutningsrunda: Hur har det känts att sitta här och prata om detta idag? Hur tror ni att ni kommer att känna efteråt?

Följdfrågor

- Kan du ge något exempel på det?
- Hur kändes det/vad tänkte du då?
- Är det som [xx] berättar, något ni andra också upplevt?
- Håller ni med om det som [xx] berättar – varför/varför inte?

Appendix B

Frågeguide, Fokusgrupper
Medicinsk personal

- Presentationsrunda: Berätta vad Du heter, hur länge Du har arbetat som [läkare/sjuksköterska/undersköterska/barnmorska] och om något minne Du har från när Du har tagit emot en kvinna som har blivit utsatt för våldtäkt i ditt yrke som [yrkesgrupp].

- Hur vanligt skulle ni säga att det är att man som [yrkesgrupp] tar emot våldtagna kvinnor inom vården?
- Finns det någon ”typisk situation” i vilken man som [yrkesgrupp] tar emot en våldtagen kvinna inom vården?
- Finns det någon ”typ av” våldtäkt / ”typ av” vårdsökande kvinna som är lättare eller svårare att möta?
- Finns det någonting i dessa möten som ni har upplevt fungerar extra bra?
- Finns det något i dessa möten som är svårt?

- Har ni gått någon utbildning kring bemötande av våldtagna kvinnor?
- Har ni tagit del av de riktlinjer som finns inom sjukvården kring bemötande av våldtagna kvinnor?
    - Finns det någonting i riktlinjerna som ni tycker har varit hjälpsamt i ert arbete?
    - Finns det någonting i riktlinjerna som är svårt att förstå/är svårt att förhålla sig till?
    - Finns det någonting ni tycker saknas i de riktlinjer som finns idag?
- Av vem och hur fattas beslut kring om kvinnan behöver samtalsstöd?

- Känner ni att ni är trygga i situationen?

- Finns det någonting jag har glömt att fråga er, eller som är viktigt för mig att veta?
- Avslutningsrunda: Hur har det känts att sitta här och prata om detta idag? Hur tror ni att ni kommer att känna efteråt?

Följdfrågor
- Kan du ge något exempel på det?
- Hur kändes det/vad tänkte du då?
- Är det som [xx] berättar, något ni andra också upplevt?
- Håller ni med om det som [xx] berättar – varför/varför inte?