### Title: Healthcare seeking and engagement after sexual assault

### Abstract

### Sexual assault, affecting up to 20% of women, is associated with chronic physical and emotional health disorders. While sexual assault victims/survivors are less likely to seek healthcare, less is known about the specific barriers and facilitators in healthcare seeking and engagement. The purpose of this study was to learn the barriers and facilitators from victims/survivors. Data was collected using semi-structured interviews. Constructivist coding was used in data analysis. Barriers were: reminders of sexual assault, male healthcare providers, and loss of control with disclosures. Facilitators were healthcare providers who were empathetic, knowledgeable, and female.

### Introduction

In the United States, up to 20% of women are sexually assaulted.1 As a result of SA, victims/survivors experience a myriad of severe physical and psychological health outcomes, such as significantly higher levels of unintended pregnancies, sexually transmitted infections, mental health disorders and substance abuse.2-4 Sexual assault victims/survivors are significantly more likely to be diagnosed with chronic health problems, such as asthma, chronic pain, obesity, and disability compared to non-victimized women. 4-7 Etiologies for these health disparities are multi-factorial, with a complex interaction between physical and psychological consequences of SA and decreased healthcare seeking and engagement. 8-9

Understanding how SA victims/survivors seek and benefit from healthcare is limited. The little that is known about healthcare seeking and engagement is primarily focused on medical forensic exams immediately following sexual assault. Most victims/survivors (79-84%) 9,10 do not seek care, despite that fact that this healthcare in the first five days after a sexual assault may help prevent un-intended pregnancies and STIs. 8-13 Barriers to seeking healthcare in this period include alcohol use, lack of awareness of the services, fear of legal repercussions, being assaulted by one’s partner, and being a racial or ethnic minority.10-13

Sexual assault victims/survivors are significantly less likely than their non-victimized counterparts to seek regular healthcare and more likely to perceive barriers to obtaining healthcare. Kapur and colleagues reported that SA victims/survivors were 1.5x less likely to have had a check-up (OR: 1.49, 95% CI 1.07–2.01).8 In addition, these women were almost three times more likely to site cost as a barrier to seeking healthcare (OR: 2.72, 95% CI: 1.70–4.34).8 Once sexual assault victims /survivors are in the healthcare office, they have more difficulty tolerating exams. In a survey comparing distress levels of SA victims/survivors vs. women who had not experienced sexual assault, SA victims/survivors reported the highest levels of examination related fear: χ2 = 18.8, p < .001; embarrassment: χ2 = 21.2, p < .001; and distress: χ2 = 18.2, p < .001. 14 Finally, SA victims/survivors have more difficulty establishing a collaborative relationship, sharing information, and sharing decision making with the healthcare provider.15-18For example, most SA victims/survivors do not disclose to their healthcare providers.15,16  Barriers to disclosure include: negative provider demeanor, feeling rushed, embarrassment, lack of privacy, perception that it is irrelevant to healthcare appointment, male healthcare provider, and lack of established relationship.19

Several critical gaps about SA victims’/survivors’ experiences with healthcare remain, such as the perceived impact of SA on regular preventive healthcare. In addition, there is a gap of knowledge about the facilitators and barriers of healthcare seeking and engagement.20 Such gaps require additional rigorous research, as access to and use of regular healthcare mitigates the harm from chronic illnesses 21,22 that disproportionally affect sexual victims/survivors. These knowledge gaps must be filled by studies that elicit the unique perspectives of these individuals and groups about health, subsequent to assaults.20

**Purpose.** The purpose of this article is to explore the facilitators and barriers to seeking regular preventive healthcare by victims/survivors of SA. In addition, clinical implications allow nurse practitioners (NPs) to provide compassionate, effective healthcare interactions in this population.

**Methodology**

**Design**

Constructivist grounded theory guided this qualitative research. Constructivist grounded theory is a useful methodology when little is known about the phenomenon.23  TheInstitutional Review Boards of the associated universities and agencies approved the study.

**Recruitment.**  Flyers about the study in diverse settings such as hair and nail salons, sexual assault service organizations, laundromats, and universities in two adjacent mid-size communities in the Midwest. Finally, a journalist featured the study in a local newspaper column with contact information for any potential participants.

**Setting.** The study occurred within two midsized Midwestern cities. Data collection (semi-structured interviews) were conducted in a mutually agreed upon confidential space, such as offices within community SA crises centers and on the grounds of a local university.

**Participants.** Criteria for participation were female, at least 18 years of age, self-identified history of SA after the age of 18, and ability to speak and understand English. Because there is a lack of research on the impact of time on health after SA, there were no time limits on the interval since SA and inclusion in the study.

**Data collection.** The primary investigator conducted the semi-structured interviews with 22 participants using an interview guide with questions based on facilitators and barriers of seeking and engagement in healthcare.24

**Analysis.** All of the interviews were digitally recorded and transcribed verbatim. The researchers utilized common constructivist grounded theory coding techniques of incident to incident, in vivo, and focused coding.3

**Findings**

**Sample Characteristics**

As apparent in Table 1, most of the participants were White, identified as straight/heterosexual and had completed at least some college. There was a wide range of incomes ($0-$96,000). All of the participants were assaulted by men; three participants were also assaulted by women.

**Table 1 here, please**

**Preventive and episodic healthcare utilization and engagement after assault**

While all of the participants expressed an understanding of the need for regular healthcare, desire for health, and relationships with healthcare providers, they faced significant barriers in seeking and engaging in healthcare. The overarching barrier was loss of agency over their physical and emotional responses to healthcare. For some participants in this sample, having a male healthcare provider exacerbated feelings of powerlessness. In addition, the women lacked agency over the consequences of disclosures of SA(s) and IPV to healthcare providers.

**Reminders of sexual assault(s) during healthcare**

Three women experienced visceral memories of their sexual assault(s) during healthcare. These experiences functioned as barriers to further healthcare seeking in diverse settings - from gynecological care, primary care, to dental care. For some women, like Helen (all names in this article are pseudonyms to protect the privacy of participants), the healthcare experiences reminded her of the sexual assaults she experienced:

you go to the dentist and you have no control…I had been known to just start bawling in the dentist chair, and at first, I didn't even know why. … I was at the dentist and there was a piece of cotton wad in my mouth, I flashed back to when a blanket or something had been stuffed into my mouth to keep me quiet… I've neglected my teeth for years...I learned to get a woman dentist too because men would trigger memories.

For other women, healthcare brought of memories not of the assault(s), but of the aftermath. Even though Adrian recognized the importance of gynecological healthcare, the reminders of SAs caused her to frequently cancel and delay necessary healthcare:

I actually had a scheduled pap smear for last week. I re-scheduled it. I have a lot of female issues…It’s not easy…. I remember the rape exams. I know that they mean well but…. you feel so dirty and you can’t… get rid of that feeling. And, then you’re making yourself more vulnerable to another stranger.

**Male healthcare providers**

For several (n=5), having a male healthcare provider exacerbated the physical and mental reminders of the abuse. Beth exemplified this, below:

I don’t have too much problem with a lady doctor, but when I have a man…. I had to go in there for a situation, and he had to look at my body. Lord, I had—oh, man. It was hard. … I left there and my whole body felt like, woo, I can’t even describe the feeling. It was horrible. …That’s the first and last time I ever let him touch me.

**Lack of control with disclosure of abuse**

Once participants sought healthcare, they experienced barriers to full engagement with their healthcare providers. This lack of engagement was demonstrated by participants not disclosing their abuse even though they felt that these experiences negatively affected their health. Alicia explained feared disclosing this sensitive information because she feared being judged: “I don’t just want to…get thrown into this category…I don’t know what people would think about me just seeing this checkbox.”

Often, when participants did disclose SAs or abuse, they lost their agency as healthcare providers labeled, blamed, and dismissed them. Arrica described this experience after she told her doctor that she was going to leave her husband who had physically, emotionally, and sexually abused her for years:

I went to the doctor’s and I said ‘I have to leave my husband.’ They said ‘Well, we’re gonna run some tests on you.’…and my thyroid was so off that they said (crying harder) ‘we recommend that you don’t leave yet, because maybe a lot of the problems you’re having is because of your thyroid.’…I had just gotten to point where I knew I had to go and then they told me that. I was put in that box again…I started suffering from being diagnosed with depression, which every female out there goes to see the doctor and gets diagnosed with depression… I was seen as the crazy woman.

Sarah felt that her physician exploited her sense of trust after she disclosed her SA.

I had one doctor – I told him and he just kind trying to use me like, and just trying to get me to do all kinds of un-necessary medical things so that he could get paid…He’d be calling me every week, telling me I needed something tested, or different things, blood levels, and thyroid…

While these participants felt safer by not disclosing, they all felt that healthcare providers should ask about sexual and intimate partner violence. Alicia said “I definitely want people to ask.” Gabby, who was physically, emotionally, and sexually abused by her husband for almost two decades wishes that her dentist had inquired about her abuse, even if she was not ready to disclose:

I got hit in the mouth, I had to go to the dentist. I wish the dentist had asked more questions. You know, …being ashamed, I don’t know if I would have been really able to share much. But if the opportunity would have been there, maybe I might have.

**Facilitators**

Several participants did begin seeking and engaging in regular healthcare after their SAs. For some participants, the first encounter after their SAs with an empathetic and knowledgeable healthcare provider positively influenced future healthcare seeking and engagement. Other participants found that after initially experiencing disempowering and traumatizing healthcare, they eventually found healthcare providers who increased their feelings of empowerment and engagement. Additionally, some participants found that the ability to choose a female healthcare provider facilitated healthcare seeking and engagement.

**Empathetic and knowledgeable healthcare providers**

Empathetic and knowledgeable healthcare providers facilitated healthcare seeking and engagement the first time some participants sought healthcare after their assaults. Sometimes healthcare providers offered more support than family or friends. Melanie explained this below:

when I told my mom,– she said ‘I knew that this was going to happen to you.’…I was pissed off. …I drove all the way out to [physician’s office]. He’s kind of a father figure. He was very supportive. when I told him he said…‘Can I just tell you that I’m mad that this just happened to you?’ That was very helpful.

Although Carmen did not plan to disclose her recent SA, her physician gently probed, which resulted in Carmen’s access to helpful resources like the SA services organization:

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

Although several participants initially avoided healthcare after they experienced traumatizing healthcare experiences, some eventually found empathetic healthcare providers with whom they could seek and engage in healthcare. Sarah did eventually find a supportive doctor who facilitated her sense of comfort and agency:

I’ve told my [new] doctor what happened and so, she’s very careful,…She says, ‘I’m going to do this as gentle as possible.’ She talks me through each step. It’s just really helpful that way.

**Female healthcare providers**

Just as male healthcare providers served as barriers to healthcare seeking and engagement, female providers facilitated these behaviors. Several quotes in the barriers section illustrated the impact of gender in healthcare seeking and engagement. Beth, who experienced severe reactions to her male healthcare provider when he looked at her body, can tolerate breast and pelvic exams when her healthcare provider is female “I don't have a man doctor no more, so….I do breast exam once a year, and pelvic exam…”   
Even participants who were sexually assaulted by women preferred female healthcare providers.

**Discussion**

While this study consisted of a small number of participants, their experiences with SA and healthcare reflect national data. For example, most of the women in this study (n=19) were assaulted by men they knew. National studies demonstrate that most SAs are committed by men who are known by the victims/survivors.9,25 This study also offers new knowledge about the role of healthcare providers in facilitating improved healthcare access healthcare access and engagement of SA victims/survivors.

A key finding in this study was a feeling of agency that women experienced over their bodies and their healthcare. The participants felt a loss of this agency when they were confronted with triggers and reminders of their assaults. They also experienced a sense of powerlessness when their healthcare providers exploited their sense of trust after they disclosed their histories of IPV and SA. In contrast, healthcare seeking and engagement were facilitated by situations in which the participants felt a sense of agency – an ability to choose their healthcare providers, collaboration during exams, and helpful responses to disclosure of SAs.

**Clinical Implications**

Clinical implications of this study are discussed within a trauma informed framework. According to the Substance Abuse and Mental Health Services Administration (SAMHSA)26 trauma informed care (TIC):

1. Realizes the widespread impact of trauma and understands potential paths for recovery;

2. Recognizes the signs and symptoms of trauma in patients

3. Integrates knowledge about trauma into policies, procedures, and practices; and

4. Seeks to actively resist re-traumatization

There are several ways that NPs can recognize and respond to the trauma of SA. For the first tenant of TIC, understanding the widespread impact of trauma, NPs need to be aware of the high prevalence of SA(one out of every five women).1 In addition, integrating universal screening for a history of trauma and/or trauma related disorders for their patients is vital. 27 While universal IPV screening is recommended,28 there is no recommendation for universal screening of SA. Several IPV screening instruments include questions about sexual abuse (see Basile & Hertz, 2007 29 for review), but women who are assaulted outside of a romantic relationship may be missed. Berry and colleagues (2016)19 also reported that most SA victims/survivors approve of screening for this history. Because many SA victims/survivors do not acknowledge their assaults,30 more inclusive language such as “bad sex, or unwanted sexual experience” may increase acknowledgement. While screening for SA and IPV is important, NPs must understand the risk that some patients experience in revealing this information.

The disclosure of SA and IPV increased the sense of vulnerability for the participants. Despite the fact that most of the participants (n=15) thought that their sexual assault negatively affected their health, more than a quarter (n=8) did not disclose this violence to their healthcare providers. Other researchers have described fears of judgement and loss of privacy as barriers to SA disclosure. 19 NPs should communicate their commitment to confidentiality to their patients.

NPs can realize potential paths for recovery in several ways. The strategic availability of posters and brochures with resources for IPV and SA can be placed around healthcare settings so that women can access this information discreetly. 31 In addition, NPs should be aware of services for SA in their area. In this study, access to these resources was critical. Table 2 lists national resources for SA. The RAINN organization has up to date information on local resources for SA.

Recognizing signs and symptoms of trauma in patients and resisting re-traumatizing were closely related in this sample. Some patients might not understand themselves why they are reacting to healthcare. Other participants identified that being naked reminded them of their SAs and aftermath. One intervention is to allow patients to remain clothed when possible.32 Remaining fully or partially clothed allows patients to feel less exposed.32  In addition, checking in during exams was critical to avoid re-traumatizing patients. Sarah explained how having a physician who checked in through her exams made her much more comfortable. Gentle assessments were also important to survivors of gendered violence in previous studies.32, 33

Having male healthcare providers was traumatizing for some of the participants, similar to other research.33 While allowing patients to choose their healthcare providers may facilitate healthcare seeking and engagement, it is not always possible. Female patients appreciate being offered the choice of having a chaperone during pelvic exams, even if they choose not to utilize them.34 Some researchers35 suggest that the preference that women have for female healthcare providers may have more to do with the egalitarian practice style, which is more common with women. Allowing the patient to remain dressed, as discussed earlier, helps equalize the power imbalance between patient and provider.32 Shared decision making is also a key component of a more egalitarian relationship.32

The relationship between a NP and patient takes time, especially with vulnerable patients. NPs typically spend more time with their patients than other healthcare providers 36,37 Victims/survivors of SA value time and relationships with their healthcare providers.23,33 In addition, more time during visits allows patients to ask questions and truly understand their health and recommendations of the healthcare providers.36

**Table 2 here please**

**Limitations**

The self-selection of the sample is a limitation in this study, as victims/survivors who volunteered to be a participants may be different than those who did not. The sample was homogenous in terms of race, language, and geography, limiting its application to women of other cultural backgrounds. The sample size (N=22) is small, but it is within the normal range for qualitative research.38  Additional research, including interventional, mixed methods, and longitudinal designs will continue to guide NPs on the best ways to provide evidence based care for this population.

**Conclusion**

The results of this study highlight the need for health care providers to be aware of barriers of healthcare seeking and engagement for SA victims/survivors. Practicing TIC facilitates healthcare utilization and engagement. In addition, NPs should be familiar with local and national resources for their patients.

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