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

### Abstract

### Sexual assault, affecting up to 20% of women, is associated with long term chronic physical and emotional health disorders. The causes of poor health are multifactorial, such as a complex interaction between physical consequences of abuse, psychologically mediated physical responses and/or hypo-thalamic-pituitary-adrenal axis (HPA) dysfunction, high risk behaviors, and decreased and/or ineffective healthcare seeking and utilization. Little is known about the barriers and facilitators to healthcare seeking and engagement. This manuscript presents research completed with women who experienced adult sexual assault, and offers their perspectives on barriers and facilitators to healthcare seeking and engagement.

### Introduction

 Sexual violence presents a significant health hazard for women. In the United States, up to 20% of women are sexually assaulted during their lifetimes. 1,2 As a result of sexual assault, victims/survivors (this combination term is used to be inclusive of all women who have experienced sexual assault) experience a myriad of severe and negative physical and psychological health outcomes, such as significantly higher levels of unintended and unwanted pregnancies sexually transmitted infections, post-traumatic stress disorder, depression, anxiety, and substance abuse. 3-5 In addition, 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. 5-7 The etiologies for these health disparities are multi-factorial, with a complex interaction between physical consequences of abuse, psychologically mediated physical responses and/or hypo-thalamic-pituitary-adrenal axis (HPA) dysfunction, high risk behaviors, and decreased and/or ineffective healthcare seeking and utilization. 8-9

Understanding` about how sexual assault victims/survivors seek and benefit from healthcare is limited. The little that is known about healthcare access and utilization is primarily focused on the immediate period following sexual assault. Most victims/survivors do not seek this care, despite that fact that access to healthcare in the first five days after a sexual assault may help prevent un-intended pregnancies and STIs. 2,10

Sexual assault victims/survivors are significantly less likely than their non-victimized counterparts to seek regular and preventive healthcare and more likely perceive barriers to obtaining health care. 9,11 Once sexual assault victims /survivors are in the healthcare office, they have more difficulty tolerating pelvic and breast exams. 11,12 Finally, sexual assault victims/survivors have more difficulty engaging with in their healthcare, 9,11 characterized by a collaborative relationship, information sharing, and shared decision making between healthcare provider and patient. 13,14

Several critical gaps about sexual assault victims’/survivors’ experiences with formal healthcare remain, such as the perceived impact of sexual assault on regular and episodic preventive healthcare. In addition, there is a gap of knowledge about the facilitators and barriers of healthcare seeking and engagement. Such gaps in knowledge require additional rigorous research, as access to and use of regular, preventive healthcare mitigates the harm from chronic illnesses like hypertension, diabetes, and obesity 15,16 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.

**Purpose.** The purpose of this article is to illustrate the facilitators and barriers to seeking regular preventive and episodic healthcare by victims/survivors of sexual assault. In addition, the insights gained from this work form the basis for nurse practitioners to provide compassionate, effective healthcare interactions in this population.

**Methodology**

**Design**

Constructivist grounded theory guided this research. According to Charmaz (2014),17 constructivist grounded theory is an especially useful methodology when little is known about the phenomenon. In this methodological approach, the socio-political context is critical to creating a credible and useful theory. 17 TheInstitutional Review Boards of the associated universities and agencies approved the study.

**Recruitment.**  Flyers about the study in diverse settings such as healthcare facilities, hair and nail salons, restaurants, laundromats, and universities in two adjacent mid-size communities in the Midwest. In addition, the researchers worked with several community organizations that served women in various capacities, such as shelters, counseling organizations, and job training to share information about the study. 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 between October 2014 and April, 2015 in a mutually agreed upon confidential space, such as offices within community rape crises centers, houses of worship, and on the grounds of a local university.

**Participants.** Criteria for participation were willingness to participate, female, at least 18 years of age, self-identified history of being sexually assaulted 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 sexual assault, there were no time limits on the interval since sexual assault and inclusion in the study.

**Data collection.** The primary investigator conducted each of the semi-structured interviews with 22 participants using an interview guide with questions based on facilitators and barriers of wellbeing, such as accessing and engagement in healthcare. 18

 **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. 17 Inter-rater reliability on coding was 91% to 96%.

 **Findings**

**Sample Characteristics**

As apparent in Table 1, most of the participants were White, identified as straight/heterosexual, had children, had completed at least some college, and worked in paid positions. There was a wide range of incomes ($0-$96,000). Most of the women in this study (n=19, 86%) were assaulted by someone they knew. 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 collaborative relationships with healthcare providers, they faced significant barriers in seeking and engaging in healthcare. The overarching barrier was a loss of agency or control 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 sexual assault(s) and intimate partner violence to healthcare providers.

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

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, 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 then the next time… I was at the dentist and there was a piece of cotton wad in my mouth, I flashed back to when a blanket or a sheet or something had been stuffed into my mouth to keep me quiet…So, I didn't know all those years. I've neglected my teeth for years cause I had so much fear. I wouldn't even be able to go to work the next day cause it would trigger so many repressed memories…. I learned to get a woman dentist too because men would trigger memories.

For other women, like Adrian, 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 sexual assaults caused her to frequently cancel and delay necessary healthcare:

I actually just had a scheduled pap smear for like last week. And, I re-scheduled it. I have a lot of female issues. I have polycystic ovarian syndrome, I have endometriosis…I’ve had cryo surgery on my cervix for pre-cancerous cells when I was 23 or 24. I’ve had laparoscopic surgery But, it’s not easy. I don’t think it’s fun for anybody, whether you have a history of abuse or not. I’m uncomfortable. I don’t know when you put that up against what I’ve been through versus like, a rape kit exam, which is what it triggers back to, I think, a lot of it. I remember the rape exams. I know that they mean well, and that they’re there to collect evidence….I mean, you feel so dirty and you can’t, you can’t get, you just 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), but not all participants, 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 a man doctor, the last couple years I had a man doctor. And—and I had to go in there for a situation, and he had to look at my body. And 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. And—and I’m like okay, I can’t keep doing this, you know. But 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 (n=8) even though three quarters of the sample (n=15) felt that these experiences negatively affected their health. Alicia explained that she feared disclosing this sensitive information because she did not know how others would view and judge her:

 if I were to go to the doctor, and fill out a form, I would not want to put ‘yes.’ …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 sexual assaults or abuse, they lost their agency as healthcare providers labeled, blamed, and dismissed them. Arrica’s quote demonstrates this process, as her physicians encouraged to stay in her physically, sexually, and emotionally abusive marriage after she disclosed.

I went to the doctor’s and I said ‘I – I have to leave my husband.’ And 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 right 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 completely seen as the crazy woman.

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

I mean I had one doctor – I told him and he just kind of like was trying to use me like, you know, ‘people who have been raped are more likely to have this disease so we better like test you for it,’ and just like 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, at that time…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**

Fortunately, several participants did begin seeking and engaging in regular, preventive healthcare after their sexual assaults. For six participants, the first encounter after their sexual assaults with an empathetic and knowledgeable healthcare provider positively influenced future healthcare seeking and engagement. After initially experiencing disempowering and traumatizing healthcare, five women did find healthcare providers with whom they could feel empowered and engaged in their own health. Five women 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. For some participants, their healthcare providers offered more support than their 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 literally just got up, got into my car and started driving. I drove all the way out to [physician’s office]. He’s kind of a father figure. He was very supportive. In fact, 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.

Melanie also described feeling comfortable and in control during regular pelvic exams and procedures (she was undergoing fertility treatments to donate her eggs to an infertile couple) “it was a pelvic exam every other day. Like, get in those stirrups – you’ve gotta be comfortable.”

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

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

Although several participants initially avoided healthcare after they experienced traumatizing healthcare experiences, three participants eventually found empathetic healthcare providers with whom they could seek and engage in healthcare. As soon as she was able to leave her ex-husband, Arrica found a new group of healthcare providers she simply described as “wonderful.” After leaving this doctor, Sarah did 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, and …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 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…”
Preference for female healthcare providers was evident even in women who were sexually assaulted by women. Anita, who was sexually assaulted by both women and men, did not hesitate when asked about what facilitates seeking regular, preventive care “I always ask for a female doctor.”

**Discussion**

While this study consisted of a small sample size, their experiences with sexual assault 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 sexual assaults are committed by men who are known by the victims/survivors. 2,19 However, this study offer also offers new knowledge about the role of nurse practitioners and other healthcare providers to facilitate improved healthcare access and engagement of sexual assault victims/survivors.

The most significant factor in healthcare seeking and engagement for participants in this study was a feeling of control or agency over their bodies, their health and healthcare. The participants felt a loss of control or power when they experienced 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 intimate partner and sexual violence. In contrast, healthcare seeking and engagement were facilitated by situations in which the participants felt a sense of agency and control – an ability to choose their healthcare providers, collaboration during exams, and helpful responses to disclosure of sexual assaults. Nurse practitioners can facilitate empowerment and a sense of agency in sexual assault victims and survivors in several ways: allowing patients to choose their healthcare providers, collaborating equitably with patients, providing opportunities for disclosure of sexual assault and intimate partner violence, and offering resources.

Allowing patients to choose their healthcare providers may facilitate healthcare seeking and engagement. Five participants said that they avoided male healthcare providers because they triggered feelings of helplessness, however, they did not feel triggered by female healthcare providers. Jannseen and Lagro-Jannssen (2012) 20 suggest that the preference that women have for female healthcare providers may have more to do with the egalitarian or democratic style of communication, which is more common with women than men.

Nurse practitioners can practice a more egalitarian style in several ways. Taking the time to talk with patients during their visits was important to the participants in this study. The relationship between a nurse practitioner and patient takes time, especially with vulnerable and marginalized patients. 21,22 Nurse practitioners typically spend more time with their patients, which enables them to develop relationships with their patients, resulting in higher satisfaction and better health outcomes. 21

Taking the time to talk with patients who have experienced gendered violence may be especially important. Other studies have shown that survivors of intimate partner violence value time and relationships with their healthcare providers. 23,24 Allowing more time during visits also allows patients to ask questions and truly understand their health and recommendations of the healthcare providers. 23 Increased time spent with patients as well as the presence of a relationship increases the likelihood of disclosure of sexual assault and IPV. However, nurse practitioners must be cognizant of the risks to patients who disclose.

 The disclosure of sexual assault and intimate partner violence increased the sense of vulnerability and helplessness for the participants. Despite the fact that most of the participants (n=15) thought that their experiences of sexual assault negatively affected their health, more than a quarter (n=8) did not disclose this violence to their healthcare providers. Alicia feared that writing this intensely private information on a form would result in others being able to see this information and “throw” her in a category. The concern over loss of privacy and judgement, in person and on paper, have been described by other researchers as barriers to IPV disclosure. 24,25 Nurse practitioners should communicate their commitment to confidentiality to their patients.

Despite this reluctance to disclose, a third of participants (n=7) also voiced their approval for questions about past sexual assaults/abuse by healthcare professionals. This pattern is similar to universal screening for IPV in the healthcare environment. Even when IPV victims/survivors do not disclose, most approve of universal screening. 24,26,27 While universal IPV screening is recommended because the benefits outweigh the harms, 28,29 there is no such recommendation for universal screening of sexual assault. Several IPV screening instruments include questions about sexual abuse (see Basile & Hertz, 2007 30for review), but women who are assaulted outside of a romantic relationship may be missed. The strategic availability of posters and brochures with resources for IPV and ASA can be placed strategically around healthcare settings so that women can access this information discreetly. 31 Because many sexual assault victims/survivors do not acknowledge their sexual assaults as such, 19 more inclusive language like “bad sex, hook up sex, or unwanted sexual experience” may increase acknowledgement and help seeking. 32

Some of the participants, like Beth, felt especially vulnerable when they were naked. Reeves and Humphries (2017) 23 suggest nurse practitioners and other healthcare practitioners allow patients to remain clothed when possible. 23 Remaining fully or partially clothed allows patients to feel less helpless and exposed. 23

Checking in during exams was critical for the participants in this study. Sarah explained how having a physician who checked in and talked her through her exams made her much more comfortable. Frequent, gentle assessments were also important to survivors of gendered violence in previous studies. 23 Table 2offers suggestions for nurse practitioners to increase the comfort level of sexual assault victims / survivors during healthcare encounters.

**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 victims/survivors who did not. The sample was homogenous in terms of race, language, and geography, which limits 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.33  While the participants in this study felt triggered during pelvic exams, similar to other studies, 11,12 the participants in this study also described feeling triggered and out of control when they were treated by dentists or simply viewed by healthcare providers. Because of the qualitative, cross sectional nature of this study, it is not possible to infer that the higher prevalence of chronic health conditions 5-7 in sexual assault victims / survivors is due to healthcare avoidance. Longitudinal research that utilizes mixed methods will assist in determining this relationship.

References

1. Centers for Disease Control. Centers for Disease Control and Prevention. The national intimate partner and sexual violence survey. 2010. Retrieved from http://www.cdc.gov/ViolencePrevention
/pdf/NISVS\_FactSheet-a.pdf. Accessed 18 March, 2019.
2. Tjaden, P, & Thoennes, N. Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey. 2006. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/210346.pdf>. Accessed 1 February, 2018.
3. Basile, KC, Smith, SG, Liu, Y, Kresnow, M, Fasula, AM, Gilbert, L, & Chen, J. Rape-related pregnancy and association with reproductive coercion in the U.S. *AJPM* 2018; 55(6), 770-776. doi: 10.1016/j.amepre.2018.07.028
4. Brookmeyer, KA, Beltran, O, & Abad, N. Understanding the effects of forced sex on sexually transmitted disease acquisition and sexually transmitted disease care: Findings from the national survey of family growth (2011–2013). *STD.* 2017; 44(10), 613-618. doi: 10.1097/OLQ.0000000000000651
5. Santularia, J, Johnson, M, Hart, L, Haskett, L, Welsh, E, & Faseru, B. Relationships between sexual violence and chronic disease: A cross-sectional study. *BMC Public Health.* 2014; 14(1286), 1-7. doi: 10.1186/1471-2458-14-1286.
6. O’Brien, BS & Sher, L. Military sexual trauma as a determinant in the development of mental and physical illness in male and female veterans. *J Adolesc Med Health.* 2013; 25, 269-274. doi: 10.1515/ijamh-2013-0061.
7. Pandey, N, Ashfaq, SN, Dauterive, EW, MacCarthy, AA, & Copeland, LA. Military sexual trauma and obesity among women veterans. *J Womens Health*. 2018; 27(3), 305-310. doi: 10.1089/jwh.2016.6105
8. Mokma, TR, Eshelman, LR, & Messman-Moore, TL. Contributions of child sexual abuse, self-blame, posttraumatic stress symptoms, and alcohol use to women’s risk for forcible and substance facilitated sexual assault. *J Child Sex Abus.* 2016; 25, 428-448. oi: 10.1080/10538712.2016.1161688.
9. Kapur, NA & Windish, DM. Health care utilization and unhealthy behaviors among victims of sexual assault in Connecticut: Results from a population-based sample. *J Gen Intern Med.* 2011; 26(5):524–30. doi: 10.1007/s11606-010-1614-4
10. Mengeling, MA, Booth, BM, Torner, JC, & Sadler, AG. Post sexual assault healthcare utilization among OEF/OIF servicewomen. *Med Care.* 2015; 53: S136–S142.
11. Ackerson, K. Personal influences that affect motivation in pap smear testing among African American women. *JOGNN.* 2010; 39(2), 136-146. doi: 10.1111/j.1552-6909.2010.01104.x
12. Weiflauf, JC, Frayne, SM, Finney, JW, Moos, RH, Jones, S, Hu, K, & Spiegel, D. Sexual violence, posttraumatic stress disorder, and the pelvic examination: How do beliefs about the safety, necessity, and utility of the examination influence patient experiences? *J Womens Health.* 2010; 19(7), 1271-1280. doi: 10.1089/jwh.2009.1673.
13. [Carman, KL](https://www.ncbi.nlm.nih.gov/pubmed/?term=Carman%20KL%5BAuthor%5D&cauthor=true&cauthor_uid=23381514) [Dardess, P](https://www.ncbi.nlm.nih.gov/pubmed/?term=Dardess%20P%5BAuthor%5D&cauthor=true&cauthor_uid=23381514), [Maurer M](https://www.ncbi.nlm.nih.gov/pubmed/?term=Maurer%20M%5BAuthor%5D&cauthor=true&cauthor_uid=23381514), [Sofaer, S](https://www.ncbi.nlm.nih.gov/pubmed/?term=Sofaer%20S%5BAuthor%5D&cauthor=true&cauthor_uid=23381514), [Adams, K](https://www.ncbi.nlm.nih.gov/pubmed/?term=Adams%20K%5BAuthor%5D&cauthor=true&cauthor_uid=23381514), [Bechtel, C](https://www.ncbi.nlm.nih.gov/pubmed/?term=Bechtel%20C%5BAuthor%5D&cauthor=true&cauthor_uid=23381514), & [Sweeney J](https://www.ncbi.nlm.nih.gov/pubmed/?term=Sweeney%20J%5BAuthor%5D&cauthor=true&cauthor_uid=23381514). Patient and family engagement: a framework for understanding the elements and developing interventions and policies. *Health Aff.* 2013; 32(2):223-31. doi: 10.1377/hlthaff.2012.1133.
14. Jerofke‐Owen T, Dahlman J. Patients’ perspectives on engaging in their healthcare while hospitalised. *J Clin Nurs*. 2019; 28:340–350. doi: <https://doi-org.libproxy.library.wmich.edu/10.1111/jocn.14639>
15. Ho, AK, Thorpe, CT, Pandhi, N, Palta, M, Smith, MA, & Johnson, HM. Association of anxiety and depression with hypertension control: A U.S. multidisciplinary group practice observational study. *J Hypertens Manag*. 2015; 3, 2215–2222, doi:10.1097/HJH.0000000000000693
16. Lachin, JM, White, NH, Hainsworth, DP, Sun, W., Cleary, PA, & Nathan, DM. Effect of intensive diabetes therapy on the progression of diabetic retinopathy in patients with type 1 diabetes: 18 years of follow-up in the DCCT/EDIC. *Diabetes.* 2015; 64, 631-42. doi: 10.2337/db14-0930.
17. Charmaz, K. *Constructing grounded theory.* 2014; 2nd ed; London, UK: Sage.
18. Centers for Disease Control and Prevention. Wellbeing concepts. 2013. Retrieved from <http://www.cdc.gov/hrqol/wellbeing.htm>. Accessed 27 February, 2019.
19. Littleton, H, Grills, A, Layh, M, & Rudolph, K. Unacknowledged rape and re-victimization risk: Examination of potential mediators. *Psychol Women Q.* 2017; 41(4) 437-450. doi 10.1177/0361684317720187
20. Janssen, SM & Lagro-Janssen, AL. Physician's gender, communication style, patient preferences and patient satisfaction in gynecology and obstetrics: A systematic review. *Patient Educ Coun*. 2012; 89(2), 221-226. doi: 10.1016/j.pec.2012.06.034
21. Judge-Ellis, T, & Wilson, TR. Time and NP practice: Naming, claiming, and explaining the role of nurse practitioners. *JNP*. 2017; 13(9), 583–589. doi https://doi.org/10.1016/j.nurpra.2017.06.024
22. Zervopoulos Siomos, M, Perlia Bavis, M, Swartwout, K, Danko, K, & Delaney, KR. Nurse practitioner training with the underserved: Building a skilled workforce. *JNP.* 2016; 12(2), e37–e43. https://doi.org/10.1016/j.nurpra.2015.08.034
23. Reeves, EA & RN, Humphreys, JC. Describing the healthcare experiences and strategies of women survivors of violence. *J Clin Nurs*. 2018; 27:1170–1182. doi: 10.1111/jocn.14152
24. Wadsworth, P, Degesie, K, Kothari, C, Moe, A. Intimate partner violence during the perinatal period. *JNP* 2018; *14*(10), 753-759. https://doi.org/10.1016/j.nurpra.2018.08.009
25. Catallo, C, Jack, SM, Ciliska, D, & MacMillan, HL. Minimizing the risk of intrusion: A grounded theory of intimate partner violence disclosure in emergency departments. *J Adv Nurs*. 2013; 69: 1366-1376. doi: 10.1111/j.1365-2648.2012.06128.x
26. Ben Natan, M, Ben Ari, G, Bader, T, & Hallak, M. Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective. *Int Nurs Rev.* 2012; 59: 108–114. https://doi.org/10.1111/j.1466-7657.2011.00931.x
27. Wadsworth, P, Kothari, C, Lubwama, G, Brown, C, & Frank-Benton, J. (2018). Health and healthcare from the perspective of intimate partner violence adult female victims in shelters: Impact of intimate partner violence, unmet needs, barriers, experiences, and preferences. *J Fam Med Community Health.* 2018; 41(2), 123-133. doi: 10.1097/FCH.0000000000000186.
28. American College of Obstetricians and Gynecologists. Committee Opinion 554 reproductive sexual coercion; https://www.acog.org/-/media/Committee-Opinions/Committee-on.../co554.pdf?. 2013. Accessed 1 March 2019.
29. Emergency Nurses Association, International Association of Forensic Nurses. (2013). Joint position statement intimate partner violence. Retrieved from: <https://www.ena.org/SiteCollectionDocuments/Position%20Statements/Joint/IPV.pdf>. Accessed 1 February 2019.
30. Basile KC, Hertz MF, Back SE. Intimate partner violence and sexual violence victimization assessment instruments for use in healthcare settings: Version 1. Atlanta, GA; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. 2007.
31. Decker, MR, Frattaroli, S, McCaw, B, Coker, AL, Miller, E, Sharps, P, . . . Gielen, A. Transforming the healthcare response to intimate partner violence and taking best practices to scale. *J Womens Health.* 2012; 21(12), 1222-1229. doi:10.1089/jwh.2012.4058
32. Cleere, C, & Lynn, SJ. Acknowledged versus unacknowledged sexual assault among college women. *J Interpers Violence.* 2013; 28(12), 2593-2611. doi: 10.1177/0886260513479033.
33. Creswell, JW. *Qualitative inquiry and research design.* 3rd ed. Los Angeles, CA: Sage; 2013.