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Sexual Assault: Disclosure, Healthcare Barriers and Facilitators, and Interventions

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Abstract

Sexual assault is apparent across the globe. Sexual assault victims and survivors face many barriers that decrease disclosure to healthcare providers leading to it becoming underreported. These barriers can be alleviated with interventions implemented by healthcare providers to ease the process of disclosure. Victims and survivors also face barriers seeking post-assault, follow-up, and mental healthcare. Researchers have described the barriers that sexual assault victims and survivors face accessing healthcare in the immediate period after assault, but less research has focused on healthcare beyond this period. Recognizing these barriers gives the opportunity for healthcare providers to remove them and make healthcare more accessible and comfortable. The purpose of this study was to determine 1). the barriers and facilitators to healthcare access and utilization beyond the immediate aftermath for sexual assault victims and survivors 2). determine the barriers and facilitators to disclosure of sexual assault to healthcare providers and 3). assess the test-retest reliability of the questionnaire. Data was collected through an electronic anonymous survey. Each participant completed the survey twice, between one and four weeks apart. Barriers to disclosure include thinking the healthcare provider could not help, the lack of screening, worried about reaction, and embarrassment and shame. Barriers and facilitators to healthcare were categorized using the Ecological Model of Well-Being. The mesosystem level focuses on the community and organizations, this is where the healthcare system is located and is the focus of this paper.

Keywords: sexual assault, healthcare, barriers, facilitators, disclosure

Sexual Assault: Disclosure, Healthcare Barriers and Facilitators, and Interventions

Sexual assault is prominent all over the world. According to the World Health Organization (WHO), (2021) it is estimated that one out every three women globally has experienced sexual assault in their lifetime. Although sexual assault is common, it remains underreported. Sexual assault impacts a person's physical, mental, and emotional health. The reaction to disclosure of sexual assault can also greatly impact how a survivor views themselves and their experience (Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010). Healthcare providers need to understand the impact disclosure has on victims and survivors and create a supportive and conducive environment to allow disclosure to occur. Sexual assault victims and survivors also face various barriers that impact their ability to seek healthcare services directly following assault and later after. Healthcare providers need to be advocates for survivors and develop interventions to overcome barriers to healthcare.

Background

A thorough literature review was conducted to gain further knowledge regarding barriers to disclosure, barriers to healthcare, and interventions with sexual assault survivors. The Western Michigan University Library, Google Scholar, and CINAHL were used to obtain the following pieces of literature. The journal articles are from 2001 to 2021.

Barriers to Disclosure

Lanthier, Du Mont, and Mason (2018) explain that despite the high prevalence of sexual assault, it remains underreported directly following the assault. Baker, Campbell, and Straatman (2012) identify that many sexual assault victims and survivors are hesitant to disclose their experience due to barriers they may be facing. The disclosure to a healthcare provider about sexual assault is uncommon. Mason and Du Mont (2015) explain that roughly only 6% to 27%

of women disclose their sexual assault to their healthcare provider. Myths and stereotypes regarding sexual assault are a social and emotional barrier because they can cause negative responses by formal resources (Baker et al., 2012). Formal resources can be considered health services, police, or campus security. These negative responses in turn, create feelings of shame, embarrassment, and guilt for the survivor that can be avoided by not disclosing (Baker et al., 2012, Berry & Rutledge, 2016, Lanthier et al., 2018, Mason & Du Mont, 2015, Ullman et al., 2008, & Wadsworth et al., 2019).

An additional barrier is re-victimization, this can be caused by the re-telling of a sexual assault experience or victim blaming (Baker et al., 2012). Campbell et al. (2001) defines secondary victimization as, "the victim-blaming attitudes, behaviors, and practices engaged in by community service providers, which further the rape event, resulting in additional trauma for rape survivors" (p. 1240). This can cause an added amount of trauma for a sexual assault victim or survivor. Healthcare providers need to be aware of their reactions and responses because blaming, shaming, or silencing can cause secondary rape or victimization where the victim is retraumatized (Wadsworth et al., 2019).

Ullman et al. (2008) explain that a stereotypical sexual assault including violence, weapons, injuries, and strangers has an increased link to disclosure to both informal and formal resources. Other factors that influence a person disclosing their assault include younger age, White, and a low socioeconomic status. A survivors health outcome can be directly associated with the reaction to their disclosure. A negative reaction leads to psychological distress and poor physical health (Ullman et al., 2008). Negative reactions occur more frequently after a violent assault or to an ethnic minority woman (Ullman et al., 2008).

The concern that confidentiality will be broken, and more people will find out about their assault also impedes disclosure of a sexual assault (Baker et al., 2012, Berry & Rutledge, 2016, & Mason & Du Mont, 2015). More barriers to disclosure include fear of retaliation, lack of knowledge of available care, lack of culturally competent services, and negative emotions of self (Baker et al., 2012). Another barrier to disclosure to healthcare providers is the lack of screening leading survivors to think it is irrelevant information (Berry & Rutledge, 2016, Lanthier et al., 2018, & Wadsworth et al., 2019). Additional barriers include lack of time, feeling rushed and having a male healthcare provider (Berry & Rutledge, 2016 & Wadsworth et al., 2019).

Orchowski and Gidycz (2015) reveal that sexual assault is prominent on college campuses but is seldom disclosed to formal resources. Some barriers to disclosure on college campuses include feelings of shame and embarrassment, believing the assault was not significant, fear that confidentiality will be broken, not wanting to cope with it, and denial (Mennicke et al., 2021). Another barrier is associated with rape myths and victim blaming. Mennicke et al. (2021) found that there were three reasons for barriers to disclosure: individual, interpersonal, and organizational. Individual reasons include minimization, discomfort, self-reliance, and negative beliefs regarding rape. Interpersonal reasons are associated with retaliation of the perpetrator. Organizational reasons include not knowing there were resources available, fear of medical examinations, the involvement of drugs or alcohol, and society's beliefs about rape (Mennicke et al., 2021).

Berry and Rutledge (2016) conducted a study to determine the number of women being screened for sexual assault and what are facilitators to disclosure. Their research showed that out of 143 women, 71.3% had never had a healthcare provider screen them for sexual assault and only 12 women had been screened by more than one healthcare provider (Berry & Rutledge,

2016). Over 60% of women believed their healthcare provider could assist them after disclosure (Berry & Rutledge, 2016). When directly screened for sexual assault 82.5% of women would disclose, whereas only 24.6% would disclose with no screening. With this knowledge, screening for sexual assault would help ease the process of disclosure (Berry & Rutledge, 2016).

Healthcare Provider Barriers to Disclosure

Healthcare providers have their own biases that pose barriers to disclosure by victims and survivors. Using a qualitative design, Amin, Buranosky, and Chang (2017) investigated barriers for physicians providing care for sexual assault survivors. They found three distinctive barriers in their study: internal barriers, communication challenges with patients, and system-imposed obstacles.

Internal barriers involve the fear of a patient disclosing a sexual assault, having to emotionally handle a sexual assault survivor, and biases about sexual assault (Amin et al., 2017). The study showed that numerous healthcare providers did not feel prepared to respond to a sexual assault disclosure which caused them to feel uncomfortable. Some healthcare providers explained that they only have a short period of time with the patient, so they do not want to open an extensive conversation causing them not to screen for sexual assault (Amin et al., 2017). Healthcare providers reported an emotional burden when caring for sexual assault victims and survivors either by taking on those negative emotions or the fear of making a patient feel worse by screening.

Participants also reported communication as a barrier. These problems include language differences, lack of comfort about discussing sexual assault, and challenges when there is a lack of disclosure of sexual assault (Amin et al., 2017). With a language barrier, a translator is present which can cause the healthcare provider and patient to be uncomfortable asking or

disclosing a sexual assault. Participants reported lack of disclosure as an additional barrier. For example, when patients with various signs of sexual assault do not disclose it makes it hard for healthcare providers to help (Amin et al., 2017).

The two system obstacles that block healthcare providers from properly caring for sexual assault survivors are lack of time and competing demands (Amin et al., 2017). The lack of time and having to prioritize the care when having an increasing number of demands can hinder healthcare providers from screening for sexual assault (Amin et al., 2017).

Post-Assault Healthcare Barriers

It is recommended to seek healthcare at an emergency department or rape crisis center within 72-120 hours after the assault for prompt prevention of pregnancy, STIs, and evidence collection (Munro-Kramer, Dulin, & Gaither, 2017). Frequently survivors do not seek any care after their assault, one study showed only 18% sought out medical care following the assault (Munro-Kramer et al., 2017). A common barrier to seeking post-assault medical attention are myths that influence how a person perceives their own assault experience. Additional barriers include cost, decreased availability of resources and the stigma for seeking these resources. Emotional barriers that prevent women from seeking care include shame and guilt, as well as not even recognizing their experience as a sexual assault (Munro-Kramer et al., 2017).

Zinzow et al. (2012) highlight that only 21% of women sought post-assault healthcare services. The barriers for the immediate period after assault include, substance use, lack of knowledge of available services, fear of legal consequences, being assaulted by a significant other, and being a minority (Wadsworth et al., 2019).

Follow-Up Healthcare Barriers

Follow-up healthcare can be defined as healthcare services after the post-assault period of 120 hours but focusing on the healthcare sought out months after the assault. Access to healthcare is not readily available to sexual assault survivors due to numerous reasons. In a study of (N=37) sexual assault victims and survivors, Gilmore et al. (2019) analyze the types of barriers that block survivors from follow-up healthcare. There are systemic, logistical, and attitudinal barriers. Systemic barriers include lack of childcare, lack of transportation, and decreased access to services (Gilmore et al., 2019). Logistical barriers are associated with financial issues, and for regular healthcare visits, cost can interfere with seeking out healthcare.

Attitudinal barriers are associated with emotions, stigma, and trust. The most common attitudinal barrier is the idea that people want to handle their problem by themselves (Gilmore et al., 2019). Wadsworth et al. (2019) discuss that fear of breast and pelvic exams can be another barrier survivors endure because it can remind them of their assault. Additional attitudinal barriers were found during an interview study with 22 women. The main barrier faced by these women was feeling a loss of control over their physical and emotional reactions to healthcare services (Wadsworth et al., 2019). This idea can be by feeling powerless or looked at by male healthcare providers, similar to how assault can make a victim or survivor feel. An additional barrier was healthcare experiences reminding the victim or survivor of their sexual assault. Three participants attributed this occurring during gynecological, primary, and dental care (Wadsworth et al., 2019).

Mental Healthcare Barriers

There are various long-term psychiatric effects that can occur after sexual assault. Gilmore et al. (2021) identify the long-lasting psychiatric effects of sexual assault, which include post-traumatic stress disorder (PTSD), depression, substance use disorder, and suicidal ideations. If

sexual assault survivors are provided access to adequate treatment these psychiatric effects can be prevented and managed (Alvidrez et al., 2011).

Gilmore et al. (2021) acknowledge that there are instrumental and attitudinal barriers that cause victims and survivors to not seek mental health treatment. Instrumental barriers consist of lack of knowledge regarding services, issues with finances, and lack of time and convenience (Gilmore et al., 2021). Lack of insurance is a barrier that prevents sexual assault victims and survivors from getting the healthcare they need. Uninsured victims and survivors endure a greater number of barriers that can be stigma and non-stigma related (Gilmore et al., 2021). Attitudinal barriers are those related to emotions that revolve around stigma, negative beliefs about mental healthcare, self-reliance, and the belief their problem is not enough (Gilmore et al., 2021). It is believed that attitudinal barriers arise due to social norms regarding sexual assault.

It has been identified that mental health treatment is not often sought out after sexual assault especially for ethnic minority women (Alvidrez et al., 2011). A study was performed to understand what barriers are present for ethnic minority populations from seeking mental health treatment after sexual assault and how to prevent these barriers from occurring (Alvidrez et al., 2011). Each participant received a case manager to assist with medication management and 16 free sessions of psychotherapy. Transportation assistance was provided, and childcare programs were recommended (Alvidrez et al., 2011). The results showed that Black women did not have as high of participation rates as White women in the free mental health treatment that was provided (Alvidrez et al., 2011). This is not due to a lack of need for mental health treatment, Black women had a more substantial history of trauma (Alvidrez et al., 2011). Even with the attempt at reducing barriers Black women may face, they still may have these present.

Research

Importance

This research is essential because sexual assault victims and survivors have higher rates of chronic health issues, including pain disorders, obesity, chronic pelvic pain, gynecological issues, and gastrointestinal disorders then women who have not been sexually assaulted (Irish, Kobayashi, & Delahanty, 2010) & Wadsworth et al., 2019). There is little research as to why sexual assault victims and survivors have an increased risk of facing these chronic health issues. This research seeks to assess one piece of this large question: What are the barriers to healthcare assess and utilization that sexual assault victims and survivors experience? Specifically, this research focuses on the mesosystem barriers, such as negative interactions with healthcare providers.

Purpose

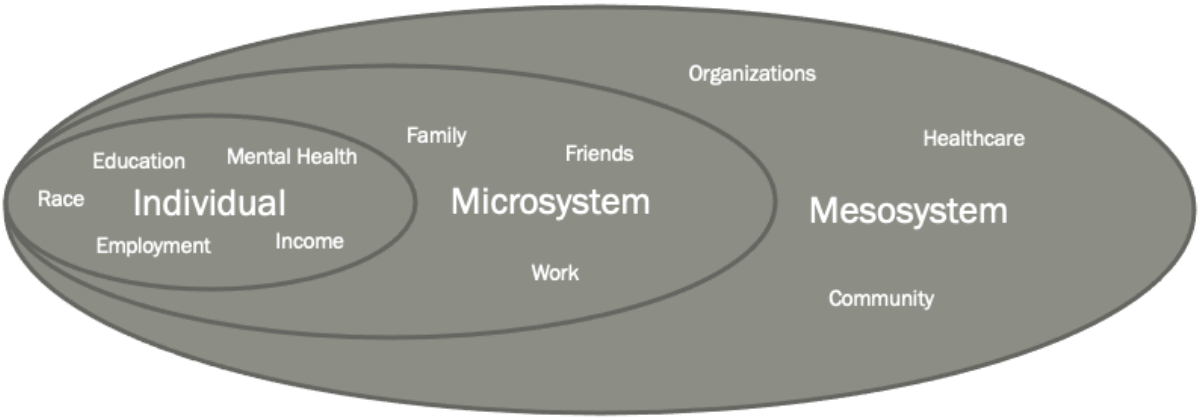
The purpose of this study was to determine barriers and facilitators for preventive healthcare of sexual assault victims and survivors. In addition, this study will assess the test-retest reliability of the questionnaire. Test-retest reliability is important to ensure that answers remain the same over a period, in this research, seven to 14 days.

Method

Participants were asked to take a 61-question electronic survey using Qualtrics twice; once, and then again 2 weeks later. The test-retest format was used to recognize if there were changes in answers between the two weeks, but the range of time was one week to four weeks. The questions were formatted as closed-ended with responses using the Likert scale. There were eight categories of questions: 1). demographic questions, 2). self-perceived health subscale, 3). healthcare seeking actions, 4). unmet healthcare needs subscale, 5). barriers and facilitators to healthcare, 6). engagement with healthcare provider subscale, 7). disclosure subscale, and 8).

sexual assault history subscale. Posters about the survey were posted at the YWCA and the Sexual Assault Services of Calhoun County, organizations that serve victims and survivors of sexual assault. The survey was also posted to Facebook to get participants involvement. The focus of this study was on women. Barriers to healthcare are categorized by individual, microsystem, and mesosystem using the Ecological Model of Well-Being as depicted in Figure 1. This research focuses on the mesosystem level centered around barriers associated with healthcare.

Figure 1: Ecological Model of Health



Participants

There were 19 participants that all had a history of sexual assault. Each participant was asked to choose a four-letter code to remember to use on their next survey to indicate which results correspond with each other. All the participants were female, mostly white, mostly non-Hispanic, mostly heterosexual, and ranging in age from 20 to 66.

Results

Demographics

The participants were asked various questions about their demographics. The data for the 19 participants is portrayed in Table 1.

Table 1: Demographic Data

Characteristics	n (%)	Mean	Range
Race			
Black	2 (10.5%)		
American Indian/ Alaskan	2 (10.5%)		
White	14 (73.7%)		
Not indicated	1 (5.3%)		
Ethnicity			
Hispanic	5 (26.3%)		
Non-Hispanic	14 (73.7%)		
Gender & Sex			
Gender identity	19 (100%)		
Sex assigned at birth	19 (100%)		
Sexual orientation			
Asexual	1 (5.3%)		
Bi-sexual / Pan-sexual	3 (15.7%)		
Gay / Lesbian	1 (5.3%)		
Straight / Heterosexual	14 (73.7%)		
Age (years)		28.2	20-66
Education			
Professional /Graduate school	2 (10.5%)		
College Graduate	4 (21.1%)		
Some college	9 (47.3%)		
High School / GED	4 (21.1%)		
Health Insurance			
Medicaid / Medicare	10 (52.7%)		
Private	6 (31.6%)		
None	3 (15.7%)		
Income (yearly)			
< 20,000	8 (42%)		
20,000-34,999	4 (21.1%)		
35,000-49,999	2 (10.5%)		
50,000-74,999	4 (21.1%)		
>75,000	1 (5.3%)		

Self-Perceived Health Subscale

The women were asked what they rate their general and emotional health from poor to excellent. Most of the women perceive their general health to be good to excellent. No women consider their general health poor. On the other hand, the emotional health varied, and the same number of women viewed their emotional health as very good, good, or fair. This shows that women perceive their general health better than their emotional health. The health subscale data is illustrated in Table 2.

Table 2: Self-Perceived Health

Health Subscale	General Health n (%)	Emotional Health n (%)
Excellent	5 (26.3%)	3 (15.7%)
Very Good	3 (15.7%)	5 (26.3%)
Good	7 (36.8%)	5 (26.3%)
Fair	4 (21.1%)	5 (26.3%)
Poor	0 (0%)	1 (5.3%)

Healthcare Seeking Actions

The participants were asked questions regarding seeking healthcare, including how often they get a regular checkup, where do they go for their healthcare, how often do they go for health problems, and if they seek healthcare less or more after their sexual assault. Most of the participants (n=10 52.6%) have had a checkup within the last year. Healthcare is most sought out at a regular healthcare office (n=14 73.7%). Participants answered equally whether they seek healthcare same as before the assault or more often after the assault (n=7 36.8%). The healthcare seeking data is represented in Table 3.

Table 3: Healthcare Seeking Actions

Healthcare Seeking Actions	n (%)
Last Checkup	
Within the last year	10 (52.6%)
Between 1-3 years	5 (26.3%)
More than 3 years ago	4 (21.1%)
Where is healthcare sought out	
Regular healthcare office	14 (73.7%)
Urgent Care	4 (21.1%)
Emergency department	1 (5.3%)
How often for health problems	
Fewer than once a year	7 (36.8%)
1-2 times a year	7 (36.8%)
Every few months	5 (26.3%)
Every few weeks	0 (0%)
Once a week or more	0 (0%)
Seeking healthcare after assault	
Same as before	7 (36.8%)
Less often	5 (26.3%)
More often	7 (36.8%)

Unmet Healthcare Needs Subscale

Participants were asked if they had trouble receiving various healthcare needs. The unmet healthcare needs data is depicted in Table 4.

Table 4: Unmet Healthcare Needs

Unmet Healthcare Needs	n (%)
Primary Care	
Yes	10 (52.6%)
No	9 (47.3%)
Mental Healthcare	
Yes	8 (42%)
No	11 (58%)
Gynecological Care	
Yes	11 (58%)
No	8 (42%)
Dental Care	
Yes	6 (31.6%)
No	13 (68.4%)
Specialist Care	

Yes	6 (31.6%)
No	13 (68.4%)

Barriers and Facilitators to Healthcare

Access to healthcare is an issue that many sexual assault victims and survivors face. The participants were asked what barriers block them from receiving the healthcare they need. The barriers are categorified using the Ecological Model of Well-Being: individual, microsystem, and mesosystem. Wadsworth, Krahe, and Searing (2018) describe the individual level as the "Demographic characteristics such as education level, marital status, employment, income, race, and ethnicity" and "personality characteristics (such as mental health conditions) and coping mechanisms" (p. 39). The microsystem level includes family, friends, and work factors. The mesosystem level is characterized by communities and organizations (Wadsworth et al., 2018). The data for barriers and facilitators to healthcare is presented in Table 5.

Table 5: Barriers and Facilitators to Healthcare

Barriers and Facilitators to Healthcare	**n (%)**
Individual Barriers	
My high co-pays or deductibles prevent me from getting the healthcare I need.	
Very often to always	3 (15.7%)
Sometimes	4 (21.1%)
Rarely to never	12 (63.2%)
Feeling embarrassed or ashamed prevents me from getting healthcare I need.	
Very often to always	4 (21.1%)
Sometimes	8 (42%)
Rarely to never	7 (36.8%)
I avoid necessary healthcare because it reminds me of being sexually assaulted.	
Very often to always	9 (47.3%)
Sometimes	3 (15.7%)

Rarely to never	7 (36.8%)
Lack of transportation prevents me from getting the healthcare that I need.	
Very often to always	5 (26.3%)
Sometimes	7 (36.8%)
Rarely to never	7 (36.8%)
Individual Facilitators	
I listen to music before or after healthcare visits to make me feel less nervous.	
Very often to always	6 (32.6%)
Sometimes	6 (32.6%)
Rarely to never	7 (36.8%)
I meditate or do deep breathing exercises before or after healthcare visits to make me feel less nervous.	
Very often to always	10 (52.7%)
Sometimes	5 (26.3%)
Rarely to never	4 (21.1%)
I use alcohol, marijuana, or other drugs help me to relax before or after my healthcare visits.	
Very often to always	5 (26.3%)
Sometimes	4 (21.1%)
Rarely to never	10 (52.7%)
Microsystem Barriers	
A lack of childcare prevents me from getting the healthcare I need.	
Very often to always	1 (5.3%)
Sometimes	10 (52.7%)
Rarely to never	7 (36.8%)
My partner prevents me from getting healthcare I need.	
Very often to always	1 (5.3%)
Sometimes	5 (26.3%)
Rarely to never	13 (68.4%)
I have enough time off from work to get the healthcare I need.	
Very often to always	4 (21.1%)
Sometimes	4 (21.1%)
Rarely to never	11 (58%)
Microsystem Facilitators	
I bring a friend or family member with me to healthcare visits to make me less	

nervous.	
Very often to always	7 (36.8%)
Sometimes	8 (42%)
Rarely to never	4 (21.1%)
Mesosystem Barriers	
Bad experiences with healthcare provider(s) in the past make it hard for me to get the healthcare I need.	
Very often to always	5 (26.3%)
Sometimes	8 (42%)
Rarely to never	6 (32.6%)
Mesosystem Facilitators	
Appointment times/office hours make it easy to get the healthcare that I need.	
Very often to always	11 (58%)
Sometimes	5 (26.3%)
Rarely to never	3 (15.7%)

Engagement with Healthcare Provider Subscale

Participants were asked to rate aspects about their experiences with their healthcare provider from never to always. The data for healthcare providers' experiences is illustrated in Table 6.

Table 6: Engagement with Healthcare Provider

Engagement with Healthcare Provider	**n (%)**
I have enough time to talk with my providers.	
Very often to always	9 (47.3%)
Sometimes to Never	10 (52.7%)
I do not tell my healthcare providers all of my concerns because I am worried about how they would react.	
Very often to always	8 (42%)
Sometimes to never	11 (58%)
It is hard to talk with my healthcare providers about my questions when they seem like they do not care about me.	
Very often to always	7 (36.8%)
Sometimes to never	12 (63.2%)
Shame or embarrassment prevents me from sharing	

all of my health concerns with my healthcare providers.	
Very often to always	5 (26.3%)
Sometimes to never	14 (73.7%)
I know that my healthcare provider will keep my information secret, so I do not worry about asking embarrassing questions.	
Very often to always	3 (15.7%)
Sometimes to never	16 (84.3%)
I withhold information from my healthcare provider because I worry they will share the information with others.	
Very often to always	2 (10.5%)
Sometimes to never	17 (89.5%)
Having female healthcare providers helps me talk about tough topics with them.	
Very often to always	5 (26.3%)
Sometimes to never	14 (73.7%)

Disclosure Subscale

Participants were asked if they disclosed their sexual assault in certain healthcare settings. The results for disclosure situations in healthcare are presented in Table 7. Participants were also asked about what barriers there are to disclosure. The barriers to disclosure are presented in Table 8.

Table 7: Disclosure Situations in Healthcare

Disclosure Situations in Healthcare	n (%)
Emergency or urgent care	
Yes	11 (58%)
No	8 (42%)
Mental healthcare visit	
Yes	12 (63.2%)
No	7 (36.8%)
Check-up	
Yes	11 (58%)
No	8 (42%)
Problem visit	

Yes	12 (63.2%)
No	7 (36.8%)
Prenatal care	
Yes	7 (36.8%)
No	12 (63.2%)
Dental care	
Yes	6 (32.6%)
No	13 (68.4%)
Specialty care	
Yes	10 (53.7%)
No	9 (47.3%)

Table 8: Barriers to Disclosure

Barriers to Disclosure	n (%)
When I told my healthcare provider(s) about my sexual assault(s), they were helpful	
Agree to strongly agree	11 (58%)
Undecided	7 (36.8%)
Disagree to strongly disagree	1 (5.3%)
I did not tell my healthcare provider(s) about the sexual assault(s) because I did not think they could help me.	
Agree to strongly agree	8 (42%)
Undecided	6 (32.6%)
Disagree to strongly disagree	5 (26.3%)
I did not tell my healthcare provider(s) because they did not ask me.	
Agree to strongly agree	8 (42%)
Undecided	7 (36.8%)
Disagree to strongly disagree	4 (21.1%)
I did not tell my healthcare provider(s) about the sexual assault(s) because of a lack of time.	
Agree to strongly agree	6 (32.6%)
Undecided	5 (26.3%)
Disagree to strongly disagree	8 (42%)
I did not tell my healthcare provider(s) about my sexual assault(s) because I was worried how they would react.	
Agree to strongly agree	11 (58%)
Undecided	5 (26.3%)
Disagree to strongly disagree	3 (15.7%)
I did not tell my healthcare provider(s) about the sexual assault(s) because I was embarrassed or ashamed.	

Agree to strongly agree	12 (63.2%)
Undecided	2 (10.5%)
Disagree to strongly disagree	5 (26.3%)

Sexual Assault History Subscale

Participants were asked questions regarding their sexual assault and intimate partner violence history. They were asked the number of times before the age of 18, the number of times after the age of 18, and how long ago the most recent assault was. Most of the participants had experienced sexual assault more than once, under and over the age of 18. Half of the participants revealed they have been sexually assaulted within the last year. The participants were also asked questions regarding how their partner treats them. This was than translated to the HITS score. The HITS tool screens for a partner hurting, insulting, threatening, and screaming at someone. A score above 10.5 indicates intimate partner violence (Rabin, Jennings, Campbell, & Bair-Merritt, 2010). The mean HITS score was 14.9 indicating a high number of participants may be facing intimate partner violence. Table 9 presents the sexual assault history results.

Table 9: Sexual Assault History

Sexual Assault History	n (%)	Mean	Range
How often have you experienced sexual assault when you were younger than 18?			
0-1	4 (21.1%)		
2-5	7 (36.8%)		
6-10	2 (10.5%)		
11-15	1 (5.3%)		
16 or more	5 (26.3%)		
How often have you experienced sexual assault when you were 18 or older?			
0-1	6 (32.6%)		
2-5	8 (42%)		
6-10	2 (10.5%)		
11-15	3 (15.7%)		

16 or more	0 (0%)		
How long ago was your most recent sexual assault?			
3 months – 1 year	9 (47.3%)		
1-2 years	4 (21.1%)		
2-5 years	4 (21.1%)		
5-10 years	1 (5.3%)		
10 years or more	1 (5.3%)		
How often does your partner physically hurt you?			
Fairly often to frequently	2 (10.5%)		
Sometimes	3 (15.7%)		
Rarely to never	14 (73.6%)		
How often does your partner insult or talk down to you?			
Fairly often to frequently	1 (5.3%)		
Sometimes	6 (32.6%)		
Rarely to never	12 (63.2%)		
How often does your partner threaten you with harm?			
Fairly often to frequently	2 (10.5%)		
Sometimes	5 (26.3%)		
Rarely to never	12 (63.2%)		
How often does your partner scream or curse at you?			
Fairly often to frequently	3 (15.7%)		
Sometimes	4 (21.1%)		
Rarely to never	12 (63.2%)		
HITS Score		14.9	4-25

Test-Retest Correlation and Significance

The test-retest correlation is to determine if answers from participants stay the same over a period, in this case it is aimed at two weeks. The test-retest stability was evaluated using the research sample of 19 participants, looking at time one and time two ranging between seven to 14 days. The mean correlation for all questions was 0.41. This meets the criteria of moderate test-retest correlation (Risco et al., 2020). The test-retest correlation is depicted in Table 10. The test-retest significance determines that participant responses were not totally due to chance.

Anything below 0.05 is considered significant for this research. The test-retest significance is presented in Table 11.

Table 10: Mesosystem Barriers and Facilitators Correlation and Significance

Mesosystem Barriers and Facilitators Engagement with HCP	Correlation	Significance
I have enough time to talk with my healthcare provider(s).	0.6980	0.0010
I do not tell my healthcare providers all of my concerns because I am worried about how they would react.	0.5140	0.0240
I know that my healthcare provider(s) will keep my information secret, so I do not worry about asking embarrassing questions.	0.4070	0.0840
I withhold information from my healthcare provider(s) because I worry that they will share the information with others.	0.5360	0.0180
Having female healthcare provider(s) helps me to talk about tough topics with them.	0.5920	0.0080
Bad experiences with healthcare provider(s) in the past make it hard for me to get the healthcare I need.	0.5350	0.0180

Table 11: Sexual Assault Disclosure Correlation and Significance

Sexual Assault Disclosure	Correlation	Significance
Did you tell your healthcare provider about your sexual assault(s) in the following situations? - While in emergency room or urgent care	0.4540	0.0510
Did you tell your healthcare provider about your sexual assault(s) in the following situations? - During a mental healthcare visit (social worker, psychologist, psychiatrist, etc.)	0.5350	0.0180
Did you tell your healthcare provider about your sexual assault(s) in the following situations? - During prenatal care	0.5680	0.0110
Did you tell your healthcare provider about your sexual assault(s) in the following situations? - During dental care	0.5000	0.0350
Did you tell your healthcare provider about	0.4500	0.0700

your sexual assault(s) in the following situations? - During specialty care		
When I told my healthcare provider(s) about my sexual assault(s), they were helpful.	0.3000	0.2260
Did you tell your healthcare provider about your sexual assault(s) in the following situations? - While in emergency room or urgent care	0.4540	0.0510

Discussion

Healthcare Seeking

Healthcare seeking actions varied for sexual assault survivors. Data revealed that almost 50% of sexual assault survivors have not received a checkup within the last year. The lack of checkups can be attributed to seeking healthcare less often after the sexual assault for more than 25% of participants. Short et al. (2021) and Wadsworth et al. (2019) explain that the utilization of healthcare following a sexual assault is uncommon. In contrast, Irish et al. (2010) found that individuals who have been victims or survivors of sexual assault seek healthcare more often, spending more than $150 dollars a year than those with no sexual assault. Berry and Rutledge (2016) also indicate that after a sexual assault, victims and survivors seek healthcare more than before.

Healthcare is essential for sexual assault survivors, and the data found in this study shows it is not being actively sought out. This is important because if sexual assault victims and survivors are not seeking preventative and regular healthcare, they are at a greater risk of developing chronic health problems that can be attributed to a lack of screening.

There are numerous types of healthcare that people should routinely use. Among types of healthcare, primary and gynecological care were the most troublesome to seek for over 50% of

participants. The lack of availability of healthcare can be due to a multitude of barriers. Healthcare barriers, as well as facilitators can be categorized as individual, microsystem, and mesosystem.

Mesosystem Barriers and Facilitators

Mesosystem barriers correspond with the community and organizations, including healthcare. The research revealed that previous negative experiences with healthcare providers are a barrier to seeking healthcare for almost 75% of participants. Campbell, Dworkin, and Cabral (2009) describe that sexual assault victims and survivors who do not receive necessary medical services attribute those as hurtful experiences. Campbell et al. (2009) also discuss that victim blaming and secondary victimization fall under the mesosystem category. These can be inferred to be negative experiences with a healthcare provider. One mesosystem facilitator for participants was the available appointment times or office hours make it easy to get care.

Engagement with Healthcare Provider

There are common concerns to engaging with healthcare providers. Participants concerns included lack of time, worried about provider's reaction, and a lack of caring attitude from provider. Previous literature has shown that lack of time is barrier for sexual assault victims and survivors (Wadsworth et al., 2019 & Berry & Rutledge, 2016). Amin et al. (2017) also discuss that lack of time is a barrier for healthcare providers to start conversations regarding sexual assault. There is also research consistent with the finding of fear of negative reactions from healthcare providers (Baker et al., 2012, Berry & Rutledge, 2016, Lanthier et al., 2018, Mason & Du Mont, 2015, Ullman et al., 2008, & Wadsworth et al., 2019).

Disclosure

Sexual assault disclosure can occur in a variety of healthcare situations. The most common healthcare situations where survivors disclosed their sexual assault were in the emergency room or urgent care, mental healthcare visits, check-ups, and problem visits. The two most uncommon healthcare situations for survivors were prenatal and dental care.

There are barriers that block survivors from disclosing their sexual assault to healthcare providers. The most common barriers faced by participants include thinking a healthcare provider could not help, the lack of screening, worried about the healthcare providers reaction, and embarrassment and shame. Lack of screening has been identified as a barrier by additional researchers (Lanthier et al., 2018, Wadsworth et al., 2019, & Berry & Rutledge, 2016). As well as, worrying about a healthcare provider's reaction and feelings of shame and embarrassment are common barriers supported by various research literature (Baker et al., 2012, Berry & Rutledge, 2016, Lanthier et al., 2018, Mason & Du Mont, 2015, Ullman et al., 2008, & Wadsworth et al., 2019). Although there are many barriers, 11 of the 19 participants acknowledged their healthcare provider was helpful after disclosure.

Clinical Implications

This research focuses on the barriers to disclosure and healthcare seeking for sexual assault victims and survivors and what healthcare providers can do to remove and fix these barriers.

Participants noted that one barrier to disclosure was the lack of knowledge that healthcare providers can help after an assault. Healthcare providers can make patients aware that they are a resource by letting them know verbally or by posting signs in their office. An additional barrier to disclosure was that participants were not being asked by their healthcare providers about sexual assault. When patients are not asked about sexual assault, they assume that the

information is not relevant for a healthcare provider (Berry & Rutledge, 2016, Lanthier et al., 2018, & Wadsworth et al., 2019). Although, this is relevant information because healthcare providers can give victims and survivors a variety of resources (see Appendix C). Healthcare providers can alleviate this barrier by improving their sexual assault screening and including it at every appointment because it can happen at any time. Regular screening with direct questions added to the routine assessment gives patients the ability and time to discuss their sexual assault (Lanthier et al., 2018). By asking more frequently, patients can become more comfortable in knowing that the provider is a trusting source.

Lessing (2005) clarifies that adolescents are less likely to spontaneously disclose their assault. Healthcare providers can ease the disclosure process by directly asking questions about sexual assault. One study Lessing (2005) acknowledged showed that in an outpatient setting, disclosure increased by 25% when patients were directly asked about having a history of sexual assault. The adolescent patient should be comfortable before asking them about sexual assault. This can be done by letting them know other people have experienced sexual assault which can decrease feelings of isolation. This can help facilitate conversation about sexual assault where they may feel safe to disclose with their healthcare provider. Questions regarding changes in sexual activity and behaviors should be asked at every appointment as they help decrease delayed disclosure (Lessing, 2005).

Healthcare providers can also learn the common signs and symptoms of sexual assault (see Appendix B). Lanthier et al. (2018) and Lessing (2005) expresses the significance of identifying common signs and symptoms of sexual assault. Some of these include, “sleep disturbances, decrease in appetite, self-blame, decreases in self-esteem, relationship difficulties, phobias, motor behavior difficulties, suicidal and homicidal ideation, and somatic reactions”

(Lessing, 2005, p. 21). Emotional and behavioral issues like depression, suicide attempts, personality disorders, problems academically, substance abuse, running away, or regression should indicate a healthcare provider to delve deeper as they could be a response to assault (Lessing, 2005).

The other two barriers, worried about healthcare providers reaction and feeling embarrassed or ashamed can be associated with each other. They can be alleviated by implementing more extensive training on how to properly respond and approach this sensitive topic. Mason and Du Mont (2015) discuss an online curriculum that was developed to improve communication and care. They focused on healthcare providers self-assessment regarding their own values, beliefs, and experiences (Mason & Du Mont, 2015). The online curriculum includes three competencies: "know (factual knowledge), know oneself (self-reflection), know how (procedural knowledge)" (Mason & Du Mont, 2015, p. 159). There was also an interactive portion included in the online curriculum to gage if the competencies were met (Mason & Du Mont, 2015). The two main themes present were: creating a supportive environment and responding appropriately. Different types of healthcare providers took this curriculum and had shown positive effects with patients. Healthcare providers noted this curriculum as excellent and a great resource (Mason & Du Mont, 2015).

Healthcare providers need to recognize and work through their own biases, so they can provide non-judgmental care to their patients. Lanthier et al. (2018) discuss helpful and unhelpful responses to disclosure. A helpful response includes validation of the disclosure, providing emotional support, and accessible resources (see Appendix A). Sherman (2019) also includes that empowerment is essential when responding to a disclosure to improve patient autonomy. Munro-Kramer et al. (2017) discuss how validation and reducing stigma can improve

patient interactions. There are numerous qualities of an unhelpful response, including blame, minimizing, dismissing, treatment the survivor differently, a cold demeanor, and doubting (Lanthier et al., 2018).

Creating a therapeutic environment that is private, safe, and supportive facilitates patients in disclosing their sexual assault (Lanthier et al., 2018 & Sherman, 2019). Demonstrating patient-centered care allows the patient to be involved in their decision-making process giving them the opportunity to disclose. Culturally competent care is important to implement after the disclosure to maintain care appropriate to their culture (Lanthier et al., 2018).

The research showed that feelings of shame and embarrassment are a common individual barrier to survivors seeking healthcare. As noted above, creating a non-judgmental attitude and environment are keys at establishing a trusting relationship that is welcoming for a patient. The other individual barrier found in the study was that healthcare is a reminder of the sexual assault. This barrier can be reduced by healthcare providers by careful explanations of procedures and allowing patients as much time as they need to feel safe (Sherman, 2019) (see Appendix C).

The mesosystem barrier was not seeking healthcare due to previous negative experiences with a healthcare provider. This can also be alleviated by creating and maintaining a safe therapeutic environment (see Appendix C). There are also many resources available for healthcare providers regarding education, training, and advocacy for sexual assault victims and survivors (see Appendix D).

Gilmore et al. (2019) illustrate that technology has the power to reduce barriers accessing healthcare after receiving post-assault care at a sexual assault medical forensic examination (SAMFE). mHealth is a previously known electronic application that can be accessed on cellphones, tablets, and computers that can be used almost instantly, any location, freely,

privately and is individualized to the survivor (Gilmore et al., 2019). mHealth overcomes the barriers of time, transportation, high costs, stigma, and cultural issues. Another study created a Prevention for Post Rape Stress video and was presented to survivors receiving care at a SAMFE. This video has been proven to be effective at decreasing substance abuse and psychiatric symptoms (Gilmore et al., 2019).

Gilmore et al. (2019) designed a new application based on the ideas of mHealth, called SC-Safe, that provides five intervention modules and includes referral for treatment. The five interventions teach users about alcohol and substance use, suicide prevention, posttraumatic stress and depressive symptoms, general adaptive coping skills, and physical health (Gilmore et al., 2019). The app provides information regarding follow up appointments. A referral can be made if testing and more formal treatment is necessary.

Munro-Kramer et al. (2017) identified that a one-stop shop can alleviate barriers to healthcare. The one-stop shop is aimed at creating one safe place that provides all resources and referrals and advising what is confidential and non-confidential for the campus to disclose. An aspect of one-stop shops is that they would provide survivor control and agency. This is achieved through individualizing care to each survivor and providing resources that are applicable to them (Munro-Kramer et al., 2017).

The use of electronic applications and a one-stop shop can be used with the thought that it can increase the seeking of preventive and follow-up healthcare for sexual assault victims and survivors. Supportive healthcare in the post-assault period could influence their healthcare seeking behaviors.

Limitations

There are multiple limitations to this study. One limitation is that it was a relatively small sample with only 19 participants. There were geographic limitations, participants were only from one state. Another limitation is that there were some incongruencies in responses between the original test and the retest. An additional limitation to this study was that most of the participants identified as white and heterosexual. The participants were also only women leaving other genders out of the research.

Research Implications

Further research needs to be conducted on why sexual assault victims and survivors are not seeking follow-up and preventative healthcare services. For future research, a bigger population from a larger geographic location would be useful to be able to have a greater comparison. Further research should have a more diverse sample including all genders, races, ethnicities, and sexual orientations. All genders are affected by sexual assault and further research should be done to gain knowledge on the barriers for all people. New research should examine correlations between the perception of one's health, demographic characteristics, and additional barriers with healthcare seeking.

Conclusion

The literature review conducted recognizes the barriers to disclosure and healthcare for sexual assault victims and survivors while providing information on interventions to implement to alleviate them. The study emphasizes these barriers are present. From the data, healthcare providers should improve sexual assault screening techniques and create a comfortable, nonjudgmental, safe environment for patients to help remove these barriers.

References

Alvidrez, J., Shumway, M. Morazes, J., & Boccellari, A. (2011). Ethnic disparities in mental health treatment engagement among female sexual assault victims. *Journal of Aggression, Maltreatment & Trauma, 20*(4), 415-425. Doi: 10.1080/10926771.2011.568997.

Amin, P., Buranosky, R., & Chang, J. C. (2017). Physician's perceived roles, as well as barriers, towards caring for women sex assault survivors. *Women's Health Issues, 27*(1), 43-49. Doi: 10.1016/j.whi.2016.10.002.

Baker, L. L., Campbell, M., & Straatman, A. (2012). Overcoming barriers and enhancing supportive responses: The research on sexual violence against women. Centre for Research & Education on Violence Against Women & Children, Western Education. Retrieved from https://www.vawlearningnetwork.ca/our-work/reports/report_2012_1.html.

Berry, K. M. & Rutledge, C. M. (2016). Factors that influence women to disclose sexual assault history to health care providers. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 45*(4), 553-564. Doi: 10.1016/j.jogn.2016.04.002.

Campbell, R., Dworkin E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence & Abuse, 10*(3), 225-246. Doi: 10.1177/1524838009334456.

Campbell, R., Wasco, S. M., Ahrens, C. F., Sefl, T., & Barnes, H. E. (2001). Preventing the "second rape": Rape survivors' experiences with community service providers. *Journal of Interpersonal Violence, 16*(12), 1239-1259. Doi: 10.1177/088626001016012002.

Gilmore, A. K., Davidson, T. M., Leone, R. M., Wray, L. B., Oesterle, D. W., Hahn, C. K., Flanagan, J. C., Gill-Hopple, K., & Acierno, R. (2019). Usability testing of a mobile health intervention address acute care needs after sexual assault. *International Journal of Environmental Research and Public Health, 16*(17), 3088. Doi: 10.3390/ijerph16173088.

Gilmore, A. K., Leone, R. M., Hahn, C. K., Oesterle, D. W., & Davidson, T. M. (2021). Barriers to accessing mental health care after a sexual assault medical forensic examination. *Journal of Forensic Nursing, 17*(2), 84-92. Doi: 10.1097/JFN. 0000000000000321.

Irish, L., Kobayashi, I., & Delahanty, D. L. (2010). Long-term physical health consequences of childhood sexual abuse: A meta-analytic review. *Journal of Pediatric Psychology, 35*(5), 450-461. Doi: 10.1093/jpepsy/jsp118.

Jacques-Tiura, A. J., Tkatch, R., Abbey, A., & Wegner, R. (2010). Disclosure of sexual assault: Characteristics and implications for posttraumatic stress symptoms among African American and Caucasian survivors. *Journal of Trauma and Dissociation, 11*(2), 174-192. Doi: 10.1080/15299730903502938.

Lanthier, S., Du Mont, J., & Mason, R. (2016). Responding to delayed disclosure of sexual assault in health settings: A systemic review. *Trauma, Violence, & Abuse, 19*(3), 251-265. Doi: 10.1177/1524838016659484.

Lessing, J. E. (2005). Primary care provider interventions for the delayed disclosure of adolescent sexual assault. *Journal of Pediatric Health Care, 19*(1), 17-24. Doi: 10.1016/j.pedhc.2004.06.010.

Mason, R. & Du Mont, J. (2015). The development of a novel curriculum to address past sexual assault. *International Journal of Medical Education, 6*, 158-160. Doi: 10.5116/ijme.5643.a0d0.

Mennicke, A., Bowling, J., Gromer, J., & Ryan, C. (2019). Factors associated with and barriers to disclosure of a sexual assault to formal on-campus resources among college students. *Violence Against Women, 27*(2), 255-273. Doi: 10.1177/1077801219889173.

Munro-Kramer, M. L., Dulin, A. C., & Gaither, C. (2017). What survivors want: Understanding the needs of sexual assault survivors. *Journal of American College Health, 65*(5), 297-305. Doi: 10.1080/07448481.2017.1312409.

Orchowski, L. M. & Gidycz, C. A. (2015). Psychological consequences associated with positive and negative responses to disclosure of sexual assault among college women: A prospective study. *Violence Against Women, 21*(7), 803-823. Doi: 10.1177/1077801215584068.

Rabin, R. F., Jennings, J. M., Campbell, J. C., & Bair-Merritt, M. H. (2010). Intimate partner violence screening tools. *American Journal of Preventative Medicine, 36*(5), 439-445. Doi: 10.1016/j.amepre.2009.01.024. \

Risco, E., Sauch, G., Albero, A., Acar-Denizli, N., Zabalegui, A., Kostov, B., Amil, P., Alonso, A., Rios, A., Martin, J., & Fabrella, N. (2020). Spanish validation of the "User Reported Measure of Care Coordination" questionnaire for older people with complex, chronic conditions. *International Journal of Environmental Research and Public Health, 17*(6608), 1-13.

Sherman, M. D. (2019). Communication tips for caring for survivors of sexual assault. *Family Practice Management, 26*(4), 19-23. PMID: 31287273.

Short, N. A., Lechner, M., McLean, B. S., Tungate, A., Black, J., Buchanan, J., Reese, R., Ho, J., Reed, G., Platt, M., Riviello, R., Rossi, C., Nouhan, P., Phillips, C., Martin, S. L., Liberzon, I., Rauch, S. A. M., Bollen, K., Kessler, R. C., McLean, S. A. (2021). Health

care utilization by women sexual assault survivors after emergency care: Results of a multisite prospective study. *Depression and Anxiety, 38*(1), 67-78. Doi: 10.1002/da.23102.

Ullman, S. E., Starzynski, L. L., Long, S. M., Mason, G. E., & Long, L. M. (2008). Exploring the relationships of women's. sexual assault disclosure, social reactions and problem drinking. *Journal of Interpersonal Violence, 23*(9), 1235-1257. Doi: 10.1177/0886260508314298.

Wadsworth, P., Krahe, E., & Searing, K. (2018). An ecological model of well-being after sexual assault: The voices of victims and survivors. *Family and Community Health, 41*(1), 37-46. Doi: 10.1097.FCH.0000000000000168.

Wadsworth, P., Krahe, E., & Searing, K. (2019). Healthcare seeking and engagement after sexual assault. *Journal for Nurse Practitioners, 15*(2019), 801-805. Doi: 10.1016/j.nurpra.2019.07.022.

World Health Organization. (2021, March 9). *Devastatingly pervasive: 1 in 3 women globally experience violence*. Retrieved from https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence.

Zinzow, H. M., Resnick, H. S., Barr, S. C., Danielson, C. K., & Kilpatrick, D. G. (2012). Receipt of post-rape medical care in a national sample of female victims. *American Journal of Preventative Medicine, 43*(2), 183-187. Doi: 10.1016/j.ampre.2012.02.025.

Appendix A

Helpful Responses to a Sexual Assault Disclosure

Appendix B

Signs of Sexual Assault

Signs of Sexual Assault

RESOURCE:
https://www.rainn.org/national-resources-sexual-assault-survivors-and-their-loved-ones

- Sleep disturbances
- Decrease in appetite
- Decrease in self-esteem
- Relationship difficulties
- Self-blame
- Phobias
- Suicidal/ homicidal ideations
- Somatic reactions

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(Lessing, 2005, p. 21)

Appendix C

Supporting Sexual Assault Victims and Survivors

Appendix D

Sexual Assault Resources for Healthcare Providers

Sexual Assault Resources for Healthcare Providers

Academy on Violence and Abuse

Organization of healthcare professionals researching and educating on the effects of violence and abuse.

abusehttps://www.avahealth.org/welcome.html

Futures Without Violence

Train healthcare professionals on improving responses to violence and advocate for healthy relationships.

https://www.futureswithoutviolence.org/

International Association of Forensic Nurses

Provides information on how to become a SANE, local SANE programs, and education and training.

https://www.forensicnurses.org/

Centers for Disease Control and Prevention

Educates on sexual violence prevention and information regarding STI treatment.

https://www.cdc.gov/violenceprevention/sexualviolence/

National Sexual Violence Resource Center

Has a guide on interventions and recommendations for care for sexual assault survivors.

https://www.nsvrc.org/publications/assessing-patients-sexual-violence-guide-health-care-providers

RISE

Helps healthcare providers navigate conversations about sexual assault with patients and responding to disclosures.

https://www.riseslo.org/resources_for_healthcare_providers.php

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