Barriers to care for sexual assault survivors of childbearing age: An integrative review

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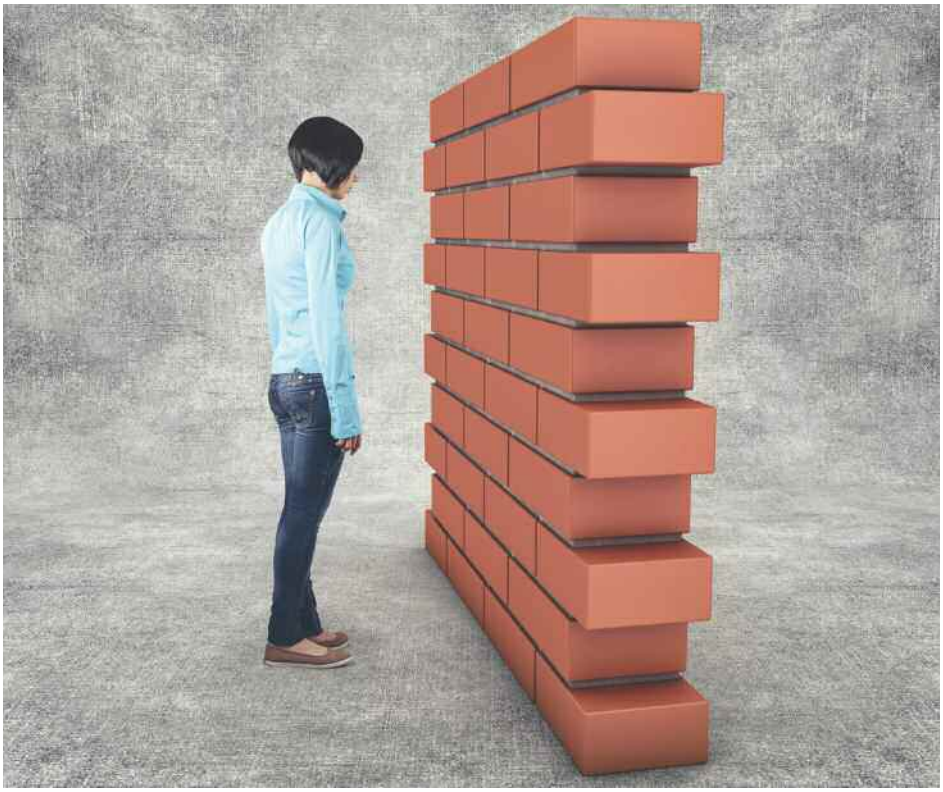
Research indicates that only a small fraction of sexual assault survivors seek comprehensive care—including physical and mental healthcare, forensic evidence collection, victim services, and legal support—after the assault. This integrative review was conducted to identify barriers that may be keeping sexual assault survivors of childbearing age from receiving such comprehensive care.

KEY WORDS: **sexual assault, barriers to care, comprehensive care**



For women in the United States, one of the most likely causes of severe psychological trauma is sexual assault, defined as unwanted sexual contact in any form that occurs without a person's consent.[1,2] Survivors of a completed rape have a 32%-80% incidence of posttraumatic stress disorder (PTSD), versus a rate of 9%-15% in the general population.[3-6] In addition to psychological harm, sexual assault survivors may experience physical consequences such as bodily injury, sexually transmitted infections (STIs), and pregnancy. In the immediate aftermath of a sexual assault, about half of survivors show evidence of physical trauma, up to 30% contract an STI, and 5% become pregnant.[7,8] Furthermore, survivors are up to 9 times more likely than the average woman to attempt suicide.[9] Despite these potential health risks, a major gap exists between reported rates of sexual assault and rates of comprehensive care seeking following the assault.

Statement of the problem

In this country, 1 of every 4-5 women is raped in college,[10,11] and lifetime prevalence of rape is 1 in 6-10 women.[1,12] Following sexual assault, women may have

a need for comprehensive care provided at a rape crisis center or hospital emergency department (ED)—ideally by a specially trained sexual assault nurse examiner (SANE). Recommended comprehensive care following a sexual assault includes treatment of physical injuries and other sequelae, pregnancy prevention, STI screening and treatment, psychological support and care for potential PTSD, forensic evidence collection, victim services, and legal support.[1,13-16]

Many sexual assault survivors do not receive the comprehensive care they need. In one analysis of post-assault care seeking, only one-third of rape survivors sought assistance from one or more of the following: the legal system, the medical system, the mental healthcare system, a rape crisis center, and/or the religious community.[17] Another report indicated that 4 million U.S. women have not received medical attention focused on preventing or treating the physical and emotional effects of rape.[8]

The study

The author conducted an integrative literature review to ascertain the barriers that may be keeping childbearing-age women from seeking comprehensive care following sexual assault. The review was focused on survivor, advocate, healthcare provider (HCP), police, and student perspectives.

Method—Five steps were used: problem identification, literature search, data evaluation, data analysis, and presentation.[18] An integrative review was appropriate because of the mix of quantitative and qualitative data that were available.[18,19]

Problem identification. The author analyzed empirical studies and national surveys completed between 1990 and 2012. The research question guiding the review was "What are the barriers that may prevent sexual assault survivors of childbearing age from receiving comprehensive care?"

Literature search. The review was conducted at a university library using the search terms *sexual assault, rape, barriers to care, barriers, inhibitors, impede, comprehensive care, health care,* and *health care access*. The search utilized a variety of databases. National surveys were identified separately by searching national websites. Only studies whose purpose was to identify barriers to care for sexual assault survivors of childbearing age were included. These studies had to be written in English in the form of scholarly works, dissertations, or qualitative or quantitative research. Excluded were papers unrelated to the research question, commentaries, literature reviews, and papers not written in English.

> Following sexual assault, women should receive comprehensive care at a rape crisis center or hospital ED.

The initial search elicited 220 articles with the following distribution: Cochrane Database of Systematic Reviews (n = 3), CINAHL (n = 12), EMBASE (n = 101), ISI Web of Knowledge (n = 52), PubMed (n = 37), and PsycINFO (n = 15). Many of these 220 articles were duplicates, and only 11 met all inclusion criteria. By hand-searching the references of these 11 articles, the author found 1 additional article for inclusion, resulting in a total of 12 empirical articles. In addition, 4 national surveys described in 6 different reports met inclusion criteria.

Data evaluation and analysis. Data extraction for the 4 national surveys and 12 empirical studies was conducted with use of a table to identify key components. The author extracted data about the sample, study design, outcomes measured, instruments utilized, results related to the research question, validity, and notes. Results related to the research question were reviewed for common themes using a technique similar to the constant comparative method of analysis outlined by Glaser.[20] This technique entailed reading through the results to glean general thoughts, followed by a line-by-line review to evaluate for general themes using a color-coding system. Further review elicited core themes. The data were reviewed again to find commonalities in themes among the studies. Finally, the data were compiled into overarching themes related to the research question and assessed for the information they represented.

Whittemore and Knafl[18] noted that the diverse array of primary sources in an integrative literature review increases the

Table 1. Summary of barriers to care from national survey studies

Author(s), year, study	Study characteristics, total sample size	Results
Kilpatrick et al, 1992[22] *National Women's Study*	Two-year longitudinal study with a cross-section of the U.S. adult female population (n = 2,008) and an oversample of women aged 18-34 (n = 2,000); N = 4,008	Rape survivors feared STIs, HIV/AIDS, becoming pregnant, their family or others finding out, others thinking that the assault was their fault, and/or their identity becoming public knowledge.
Resnick et al, 2000[8] Additional analysis of the *National Women's Study*	Secondary analysis of 2-year longitudinal study[22] with a subgroup of women who completed Wave 3 data collection; focused on factors influencing why respondents did not receive medical care; N = 3,006	Respondents identified concerns about rape-related STIs, HIV/AIDs, and pregnancy; and voiced fears of others knowing, being blamed, and/or having their names made public.
Tjaden & Thoennes, 2006[1] *National Violence Against Women Survey*	Used a computer-assisted telephone interviewing system to conduct interviews with men (n = 8,000) and women (n = 8,000); purpose was to measure the extent of violence against women; N = 16,000	The three most common reasons for not reporting a rape to the police included fear of the rapist, feeling ashamed or embarrassed, and that the incident was minor and not a crime or a police matter.
Fisher et al, 2000[10] *National College Women Sexual Victimization Survey*	Randomly selected national sample of college women surveyed about sexual victimization that occurred since they had begun school; N = 4,446	Most respondents cited that they did not want to report the incident to police because they were concerned about their family or others finding out, lack of proof that the incident happened, fear of reprisal by the assailant, anticipation that the police would not view the incident as serious enough, and/or fear of being treated hostilely by the police.
Kilpatrick et al, 2007[23] *Drug-Facilitated, Incapacitated, and Forcible Rape: A National Study*	National telephone sample of U.S. women (n = 3,001) and college women (n = 2,000); focused on barriers to reporting to the police; N = 5,001	Fifty percent or more of the survivors reported barriers of reporting to the police related to not wanting family or others to know about the rape, fear of retaliation by the assailant, and lack of proof; other barriers included fear of bad treatment by the criminal justice system, lack of knowledge about how to report, lack of certainty that a crime was committed, and belief that the event was not serious enough to warrant reporting.
Wolitzky-Taylor et al, 2011[2] Additional analysis of *Drug-Facilitated, Incapacitated, and Forcible Rape: A National Study*	Secondary analysis of national telephone sample of U.S. women[23]; N = 3,001	Overall reported prevalence of rape has not significantly changed in the last decade. Most commonly cited reasons for not reporting to the police were fear of reprisal, not wanting family or others to know, fear of the justice system, and not knowing how to report.

complexity in evaluating the quality of the literature. Also, in an integrative review with a diverse collection of studies, various threats to internal validity must be addressed.[19,21] These threats were determined by assessing the studies' methodology and data relevance.

Results—

National surveys. Four national surveys were reported in 6 different studies (*Table 1*).[1,2,8,10,22,23]

Empirical studies. *Table 2* lists the 12 empirical research studies that met inclusion criteria. As shown in *Table 3*, these studies used a cross-sectional methodology[24-29] or a descriptive or exploratory qualitative methodology.[30-35] All of the studies'

Table 2. Summary of empirical research studies

Author(s) and year Population, sample size, study design Outcome measures	Results	Validity	Notes
Jones et al, 2009[24] Community-based women presenting to a sexual assault clinic or emergency department; N = 152; cross-sectional survey Reasons women gave for declining to report sexual assault to the police	I do not want the assailant going to jail*, Police would be insensitive or blame me*, I know the assailant*, I was involved in illegal activity during assault, I am afraid of going to court/trial, Some people will not believe me, I have no support from friends/family, I have had a bad experience with police in the past, My family or friend(s) will be upset, It would be just his word against mine, Others will think I am responsible, I am concerned that others will find out about the assault, The details of the assault are unclear, I feel partially responsible, I have a criminal record or am on probation, I feel ashamed or embarrassed, I feel anxious, I am afraid of the assailant, I have been raped/assaulted before, Friend/family told me not to report (** indicates a statistically significant reason*)	*Strengths:* Utilized a standardized data abstraction form for data collection, used a pre-tested questionnaire, and addressed potential limitations. *Limitations:* Cross-sectional	Surveyed women already attaining medical care post-assault on why they would not report sexual assault to the police. Of the 424 eligible women, 75% did report to the police.
Kelleher & McGilloway, 2009[30] Irish women who had worked in the sexual violence sector; N = 18; exploratory qualitative study Barriers to services	Survivors' shame and guilt, naming/acknowledging of the incident, societal myths around rape	*Strengths:* Interviewed a range of sexual-assault service providers; findings are consistent with past studies *Limitations:* Small sample size	Perceptions of gaps from service providers
Logan et al, 2004[32] Women with victimization (sexual & physical) histories; N = 128; exploratory qualitative study Barriers to health/mental health and criminal justice services using the health services utilization literature's four dimensions of affordability, availability, accessibility, and acceptability	Affordability: cost Availability: limited services, difficulty obtaining an appointment, *limited police availability* Accessibility: lack of awareness of services/*lack of knowledge*, bureaucracy, lack of qualified and consistent providers, fragmented services, lack of transportation, *lack of priority*, *good ol' boys network* Acceptability: embarrassment/stigma/*blame*, lack of efficacy, confidentiality concerns, lack of perceived need for help, gender/power issues, perpetrator retaliation, lack of resources ** Italics indicates barriers specific to the criminal justice system.*	*Strengths:* Large sample size for qualitative study with a fairly heterogeneous sample that increases generalizability *Limitations:* Focused on perceptions of barriers to care, not observed barriers to care for physical and sexual violence	Provided service use for participants over last 5 years, but did not specify about immediate post-assault service use
McGrath et al, 1997[25] Physicians, residents, nurse midwives, nurses, and social workers in a Level 1 trauma center, tertiary care pediatric emergency department, and women's urgent care in New England; N = 207; cross-sectional survey Barriers to screening and intervention for domestic violence and sexual assault	Frustration that survivors would return to their abusive partners for sexual assault (52%), not enough time to handle cases effectively (55%), lack of experience (80%), concern about misdiagnosis (74%), personal discomfort (63%), concern about invading family privacy (57%), unavailability of 24-hour access to the social worker (48%), lack of police response (53%), reluctance to become involved in the justice system (40%)	*Strengths:* Open- and closed-format questions; addressed limitations of limited demographic data *Limitations:* Cross-sectional; addressed sexual and physical interpersonal violence	Perceptions of gaps from service providers

Table 2. Summary of empirical research studies (continued)

Author(s) and year Population, sample size, study design Outcome measures	Results	Validity	Notes
Logan et al, 2005[31] Women recruited from rape crisis centers in urban and rural areas; N = 30; exploratory qualitative study Barriers to health services, mental health services, and the criminal justice system using the health services utilization literature's four dimensions of affordability, availability, accessibility, and acceptability	Affordability: cost Availability: limited services, *limited police availability* Accessibility: lack of awareness of services, misperceptions of services, bureaucracy, staff incompetence, lack of resources, *politics, lack of priority* Acceptability: shame and blame, lack of sensitivity, community and family backlash, confidentiality concerns, loss of trust, *revictimization by the system, lack of efficacy, fear and misperceptions, fear of perpetrator retaliation, police and criminal justice attitudes* **Italics indicates barriers specific to the criminal justice system.*	*Strengths:* Results consistent with researchers' past work, participants from urban and rural locations increase generalizability *Limitations:* Relatively small sample size	Did not assess service use of participants
Muganyizi et al, 2011[33] Rape survivors and the men and women who supported them during the process of seeking care in Tanzania; N = 30 (10 rape survivors and 20 supporters); ground theory qualitative Experiences and responses of raped women and their supporters while seeking legal or healthcare services	Two broad themes emerged with six categories describing them: *Walking a path of anger and humiliation*: (1) subjected to unreliable services, (2) caught in a messed up system, (3) meeting unprofessionalism and irresponsibility, (4) realizing it is all about the money *Managing in the contemporary world:* (5) negotiating truths, (6) knowing what to do	*Strengths:* Theoretically grounded, focus on raped women and their supporters *Limitations:* Relied on raped women who attended help centers, constrained to one geographic location	All participants had sought and accessed services
Nasta et al, 2005[26] Undergraduate women from a private Northeastern university; N = 234; cross-sectional survey Barriers to resource use	Concerns surrounding confidentiality (93%), issues of fear (92%), embarrassment or guilt (92%)	*Strengths:* Attained a fairly heterogeneous sample from within one location and addressed social desirability bias *Limitations:* Cross-sectional	Among sample, 38% were sexual assault survivors. Utilization of services among survivors was reported as 22% for on-campus services and 6% for off-campus services.
Prospero & Vohra-Gupta, 2008[27] Undergraduate college students from a university in the southern region of the United States; N = 200; cross-sectional survey Reasons for intimate partner violence (physical, psychological, and sexual) victims not using mental health services	Embarrassment (19%), expense (16%), ineffectiveness (14%), social stigma (9%)	*Strengths:* Attained a fairly heterogeneous sample from within one location and addressed social desirability bias in limitations *Limitations:* Addressed interpersonal sexual and physical violence and was cross-sectional	Among the sample, 46% were survivors of sexual victimization. Of the respondents who reported some form of victimization (physical, psychological, or sexual), only 16% received mental health care.

Table 2. Summary of empirical research studies (continued)

Author(s) and year Population, sample size, study design Outcome measures	Results	Validity	Notes
Sable et al, 2006[28] Students from a Midwestern university; N = 215; cross-sectional survey Perceived barriers to care for sexual assault and rape survivors	*For male survivors:* shame, guilt, and embarrassment; confidentiality concerns; fear of not being believed *For female survivors:* fear of retaliation; financial dependence on perpetrator/ perpetrator interference in seeking help; does not want family member or friend to be prosecuted; lack of resources to obtain help; cultural or language barriers to obtaining help	*Strengths:* Used a survey instrument formulated from qualitative interviews and pre- testing *Limitations:* Convenience sample of students in the same class and did not identify whether respondents were survivors or not	Did not assess survivor status or service use of sample
Ullman & Townsend, 2007[34] Rape victim advocates from a large Midwestern city; N = 25; qualitative: grounded theory exploratory study Barriers advocates face in their work and how those barriers affect survivors' ability to receive support	*Societal attitudes:* denial of rape; race and class biases; gender and sexual orientation biases; disabilities biases *Organization barriers:* lack of funding; environmental factors; professionalism issues; racism *Staff burnout* *Direct service barriers:* access and availability barriers; lack of resources, secondary victimization	*Strengths:* Fairly heterogeneous sample increasing generalizability among rape victim advocates and results consistent with past research *Limitations:* Limited geographic applicability	Perceptions of gaps from service providers
Walsh et al, 2010[29] Undergraduate college students at a public New England university, including some who were survivors of unwanted contact (n = 127), survivors of unwanted intercourse (n = 26), or friends of survivors (n = 253); N = 1,230; cross-sectional survey Knowledge and likely use of the sexual assault center	Reasons for not using the sexual assault center: *Given by survivors of unwanted sexual contact:* incident was not perceived to be serious enough to warrant the use of services (70%); experience was a private matter (40%) *Given by survivors of unwanted sexual intercourse:* experience was a private matter (73%); shame or embarrassment (50%); incident not perceived to be serious (48%); concern about others finding out (39%); concern about negative consequences for perpetrator (33%); fear of not being believed (30%); hard to trust stranger for help (29%); fear of being blamed for the incident (23%); thought people would tell them what to do (20%) *Given by friends of survivors:* experience was a private matter	*Strengths:* Attained a fairly heterogeneous sample from one institution and provided definitions with survey questions *Limitations:* Cross-sectional; only addressed a small number of correlates related to knowledge of barriers to care	Among the survivors of unwanted sexual contact, 97% reported that they did not use any services. Among the survivors of unwanted sexual intercourse, 94% reported that they did not use any services.
Young, 2002[35] Sexual assault service providers (law-enforcement, social workers, and health-care providers) from the southern United States; N = 17; descriptive qualitative study Existing barriers to reporting sexual assault	*External Barriers:* reporting process; service provider doubts of the validity of the accusation; lack of services, including limited hours of availability; community and/or family response; reluctance of the service providers to be involved in the sexual assault cases *Internal Barriers:* acquaintance with the perpetrator; fears of the perpetrator, the forensic examination, and public exposure; feelings of vulnerability, guilt, humiliation, or embarrassment; impaired cognitive ability due to drinking, drugs, or mental retardation	*Strengths:* Interviewed a variety of sexual assault service providers *Limitations:* Low generalizability due to failure to expound on characteristics of sample and due to limited geographic location	Perceptions of gaps from service providers

research questions elicited the barriers that prevented sexual assault survivors of childbearing age from accessing community services such as police reporting,[24] mental healthcare,[27] medical care,[25] and sexual assault centers.[26,29]

Themes. Several themes

describing barriers to care emerged. These themes, subdivided into personal and environmental factors, are described in detail using the results from all 18 studies—that is, the 6 reports on national survey data and the 12 empirical studies.

PERSONAL FACTORS. The overarching theme of personal factors encompassed barriers to care inherent to a survivor herself. This broad theme included three subfactors: emotional states, fear of external exposure, and lack of knowledge.

Emotional states. Certain emotional states experienced by a woman after a sexual assault could preclude her from seeking physical, mental, or legal care. These emotional states were identified in 11 (61%) of the 18 studies.[1,22,24,26-32,35] Emotional states most commonly cited as barriers were shame,[24,28-31] embarrassment or humiliation,[1,24,26-29,32,35] guilt,[26,28,30,35] and self-blame.[22,26]

Fear of external exposure. Fear of external exposure was described in 12 studies (67%).[1,2,8,10,23,24,26,28,29,31,32,35] Fears cited by survivors included bad treatment by the criminal justice system,[2,10,23] not being believed,[24,28,29] lack of confidentiality,[22,24,26,28,29,31,32] going to trial,[24] the assailant,[1,2,10,23,24,28,31,32,35] and public exposure.[8,29] Fears related to the assailant involved fear of retaliation[1,10,23,24,28,31,32,35] and, conversely, the possibility of jail for the assailant because the survivor had some type of relationship with the assailant.[24] Fear of public exposure was often cited by members of groups such as immigrants, persons with disabilities, sexual minority members, and racial minority members.[28] Many of these women feared that their minority status would bring them greater stigma and potentially unfair treatment.

Lack of knowledge. Lack of knowledge regarding post-assault services was identified as a barrier to care in 6 studies (33%).[2,23,27,28,31,32] This knowledge deficit encompassed factors such as not knowing which services were needed,[31,32] where or how to get services,[2,23,28,31,32] and how to pay for services.[27,31,32]

ENVIRONMENTAL FACTORS. The broad theme of environmental factors captured barriers to care due to outside forces and not within a survivor's immediate control. These factors were noted in 11 of the 18 studies and included themes of structural/organizational barriers and societal rape myths.

Lack of knowledge regarding post-assault services was identified as a barrier to care.

Structural or organizational barriers. Barriers to comprehensive care can include factors related to how these services are accessed. Structural/organization barriers were elicited from 6 studies (33%).[25,31-35] For instance, many survivors cited a lack of availability or limited services as a barrier to receiving care.[31-33,35] Organizational barriers reported by HCPs included inexperience in treating sexual assault survivors, inadequate time, and personal discomfort.[27] Rape victim advocates noted insufficient funding resources as barriers that might compromise survivors' ability to receive support.[33,34]

Societal myths. Twelve studies (67%) noted the perpetuation of rape myths by society as a factor in preventing survivors from accessing care.[1,10,23,24,25,27,29-32,34,35] Many of these myths are propagated through biases related to race, gender, disability, sexual orientation, and class.[34] Subsumed within this category is survivors' perception of the social stigma attached to naming the incident and the belief that the assault was not serious enough to warrant using services.[1,10,23,27,29] Societal myths noted by persons in the service sector included police attitudes, including blame and insensitivity[24,31,32] and doubt about the validity of the sexual assault accusations.[35] Some HCPs perceived that survivors would return to partners who had perpetrated the assault.[25]

Discussion—This review has shown that from survivor, advocate, HCP, police, and student perspectives, numerous barriers to care—encompassing both personal and environmental factors—may prohibit a woman of childbearing age from seeking care after a sexual assault. The overarching theme of personal factors comprised the survivor's emotional state, her fear as it related to external exposure of the survivor and the assailant, and a lack of knowledge about post-assault services. These results coincide with past research, which has shown that many survivors, especially members of ethnic minorities, lack awareness about post-assault services such as rape crisis centers.[17] The broad theme of environmental factors includ-

Table 3. Summary of research methods used in the empirical studies

Study	Method			Population			Barriers to reporting/seeking care from:		
	Qualitative/ Quantitative	Survivors	Students	Healthcare providers	Service providers – social workers & advocates	Police	Criminal justice services	Healthcare services	Not specified (broad service use)
Jones et al., 2009[24]	Quantitative	X					X		
Kelleher & McGilloway, 2009[30]	Qualitative			X	X				X
Logan et al, 2004[32]	Qualitative	X					X	X	
Logan et al, 2005[31]	Qualitative	X					X	X	
McGrath et al, 1997[25]	Quantitative			X	X			X	
Muganyizi et al, 2011[33]	Qualitative	X			X		X	X	
Nasta et al, 2005[26]	Quantitative	X	X				X	X	
Prospero & Vohra-Gupta, 2008[27]	Quantitative	X	X					X	
Sable et al, 2006[28]	Quantitative		X				X		
Ullman & Townsend, 2007[34]	Qualitative				X				X
Walsh et al, 2010[29]	Quantitative	X	X						X
Young, 2002[35]	Qualitative			X	X	X	X		

ed subthemes of structural/organizational barriers and societal myths. Past research has shown that survivors needed to sit for extended periods of time while they waited to be seen by HCPs who did not have training on the physical or mental aspects of performing a forensic exam.[36] In addition, rape myths are known to affect how a survivor deals with an assault, including acquisition of care.[37,38] The themes subsumed under environmental factors are long-standing issues that must be addressed using a team approach to improve acquisition of comprehensive care by sexual assault survivors.

Limitations. This review could not completely separate the research articles that dealt with sexual assault and intimate partner violence. One person may be a survivor of both crimes within the same relationship; therefore, many researchers combine the topics. All data were collected via cross-sectional surveys or qualitative interviews and are thus correlational in nature. These data are subject to the possible weaknesses of responses affected by social desirability bias (wherein a respondent wishes to please a researcher) and complicated by the stigma of the topic itself and by problems of recall of traumatic events post-assault.

A limitation specific to the studies in this review was the potential for limited generalizability due to homogenous samples, small sample sizes, and failure to expound on study characteristics. However, the four studies that enrolled college students had fairly heterogeneous samples in terms of age and ethnicity,[26,27,29] and most qualitative studies had heterogeneous samples as evidenced by demographic variables and identified themes consistently reported within their study samples.[31,32,34]

Because a validated and psychometrically sound barriers-to-care scale for sexual assault survivors does not exist, all of the cross-sectional studies used questionnaires specifically created for the purposes of their study. These surveys may not have captured the full range of barriers to care perceived by these survivors.

Strengths. This integrative review demonstrates many strengths within this body of literature. The barriers identified within each individual study, when compared as a group, were consistent. Furthermore, the studies sampled a wide range of individuals. This broad range of participants, coupled with the large geographic region they represent, provides strong evidence for the overall generalizability of the results. Finally, the exploratory and descriptive natures of the included studies have served the purpose of identifying which barriers to care exist for sexual assault survivors of childbearing age.

Implications for practice and research

For nurse practitioners (NPs) working on the front line with survivors of sexual assault, one way to begin to overcome barriers to care is to change the societal atmosphere that perpetuates rape myths. Underlying this atmosphere are patriarchal attitudes and a history of male dominance, both of which support the perpetuation of sexually violent behaviors.

Nurse practitioners need to identify and treat survivors of sexual assault, an all-too-common crime. NPs should consider using screening techniques to identify these survivors, which could simply involve asking about sexual trauma in childhood and adulthood. NPs must also be aware of potential psychological and physical manifestations of past sexual assault, including increased mental health complaints and somatic symptoms, in order to identify *hidden* survivors who may not freely disclose their history. Universal screening for sexual assault is controversial because of the paucity of research regarding the benefits of early identification and of treatment once a survivor is identified.[39] However, NPs do have a responsibility to understand their patients' histories and their healthcare needs.

Universal screening for sexual assault is controversial.

In addition, NPs and other HCPs, mental HCPs, and members of the legal system need to know about structural barriers that may exist within their professional realm. One way to surmount these barriers is to promote and expand the use of SANE programs in all EDs. These programs, in which specially trained nurses address survivors' emotional and medical needs while performing high-quality evidence collection, are a viable alternative to the traditional medical system.[13]

Nurse practitioners need to advise survivors of their options for pregnancy prevention, STI testing, care of physical injuries, and mental healthcare. And for survivors who have not yet sought post-assault care, NPs can place useful, easy-to-read brochures in public locations such as lavatories, homeless shelters, and community centers. NPs can get brochures and pamphlets from organizations such as the **National Sexual Violence Resource Center**[A] or the **Rape, Abuse & Incest National Network**[B]. Additional research is needed to determine the resources that survivors would find most valuable, as well as the easiest ways in which these resources could be provided. For instance, would survivors prefer to receive information about community resources at HCP visits, when they fill prescriptions (e.g., for contraceptives), or through other sources?

Conclusion

Educating women about available resources and recommended care after a sexual assault can help remove personal barriers to care. However, NPs must keep in mind that the community is responsible for minimizing structural barriers. Community members must work together to

prevent the occurrence of sexual assault; to provide resources on care, social support, and legal advocacy for instances in which sexual assault has occurred; and to continue to speak with community allies and survivors to determine their needs.

Michelle L. Munro is a research fellow at the University of Michigan School of Nursing in Ann Arbor. **The author states that she does not have a financial interest in or other relationship with any commercial product named in this article.**

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References

1. Tjaden PG, Thoennes N. *Extent, Nature, and Consequences of Rape Victimization: Findings from the National Violence Against Women Survey*. Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice; 2006.

2. Wolitzky-Taylor KB, Resnick HS, McCauley JL, et al. Is reporting of rape on the rise? A comparison of women with reported versus unreported rape experiences in the National Women's Study – replication. *J Interpers Violence*. 2011;26(4):807-832.

3. Breslau N, Peterson EL, Schultz LR. A second look at prior trauma and the posttraumatic stress disorder effects of subsequent trauma: a prospective epidemiological study. *Arch Gen Psychiatry*. 2008;65(4):431-437.

4. Foa EB, Rothbaum BO. *Treating the Trauma of Rape: Cognitive Behavioral Therapy for PTSD*. New York, NY: The Guilford Press; 1998.

5. Kilpatrick DG, Saunders BE, Amick-McMullan A, et al. Victim and crime factors associated with the development of crime-related post-traumatic stress disorder. *Behav Ther*. 1998;20:199-214.

6. Resnick HS, Kilpatrick DG, Dansky BS, et al. Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *J Consult Clin Psychol*. 1993;61(6):984-991.

7. Holmes MM, Resnick HS, Kilpatrick DG, Best CL. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. *Am J Obstet Gynecol*. 1996; 175(2):320-325.

8. Resnick HS, Holmes MM, Kilpatrick DG, et al. Predictors of post-rape medical care in a national sample of women. *Am J Prev Med*. 2000; 19(4):214-219.

9. Goodman LA, Koss MP, Russo NF. Violence against women: physical and mental health effects. Part I: research findings. *Appl Prevent Psychol*. 1993;2(2):79-89.

10. Fisher BS, Cullen FT, Turner MG. *The Sexual Victimization of College Women*. (No. NCJ 182369). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 2000.

11. Koss MP, Gidycz CA, Wisniewski N. The scope of rape: incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *J Consult Clin Psychol*. 1987;55(2):162-170.

12. Basile KC, Chen J, Black MC, Saltzman LE. Prevalence and characteristics of sexual violence victimization among U.S. adults, 2001-2003. *Violence Vict*. 2007;22(4):437-338.

13. Ahrens CE, Campbell R, Wasco SM, et al. Sexual assault nurse examiner (SANE) programs: alternative systems for service delivery for sexual assault victims. *J Interpers Violence*. 2000;15:921-943.

14. Campbell R, Bybee D, Ford K, Patterson D. *Systems Change Analysis of SANE Programs: Identifying the Mediating Mechanisms of Criminal Justice System Impact*. (No. 226497). Washington, DC: U.S. Department of Justice; 2008.

15. Campbell R, Patterson D, Lichty LF. The effectiveness of sexual assault nurse examiner (SANE) programs: a review of psychological, medical, legal, and community outcomes. *Trauma Violence Abuse*. 2005;6:313-329.

16. U.S. Department of Justice, Office on Violence Against Women. *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*. (NCJ 206554); 2004. http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf

17. Campbell R, Wasco SM, Ahrens CE, et al. Preventing the "second rape": Rape survivors' experience with community service providers. *J Interpers Violence*. 2001;16(12):1239-1259.

18. Whittemore R, Knafl K. The integrative review: updated methodology. *J Adv Nurs*. 2005;52(5):546-553.

19. Cooper HM. *Synthesizing Research: A Guide for Literature Reviews*. 3rd ed. Thousand Oaks, CA: Sage Publications; 1998.

20. Glaser BG. *Advances in the Methodology of Grounded Theory: Theoretical Sensitivity*. Mill Valley, CA: Sociology Press; 1978.

21. Kirkevold M. Integrative nursing research—an important strategy to further the development of nursing science and nursing practice. *J Adv Nurs*. 1997;25:977-984.

22. Kilpatrick DG, Edmunds C, Seymour A. *Rape in America: A Report to the Nation*. Charleston, SC: National Victim Center & the Crime Victims Research and Treatment Center, Medical University of South Carolina; 1992.

23. Kilpatrick DG, Resnick HS, Ruggiero KJ, et al. *Drug-Facilitated, Incapacitated, and Forcible Rape: A National Study*. (Document No. 219181); 2007. https://www.ncjrs.gov/pdffiles1/nij/grants/219181.pdf

24. Jones JS, Alexander C, Wynn BN, et al. Why women don't report sexual assault to the police: The influence of psychosocial variables and traumatic injury. *J Emerg Med*. 2009;36(4):417-424.

25. McGrath ME, Bettacchi A, Duffy SJ, et al. Violence against women: provider barriers to intervention in emergency departments. *Acad Emerg Med*. 1997;4(4):297-300.

26. Nasta A, Shah B, Brahmanandam

S, et al. Sexual victimization: incidence, knowledge and resource use among a population of college women. *J Pediatr Adolesc Gynecol*. 2005;18(2):91-96.

27. Prospero M, Vohra-Gupta S. The use of mental health services among victims of partner violence on college campuses. *J Aggression Maltreat Trauma*. 2008;16(4):376-390.

28. Sable MR, Danis F, Mauzy DL, Gallagher SK. Barriers to reporting sexual assault for women and men: Perspectives of college students. *J Am Coll Health*. 2006;55(3):157-162.

29. Walsh W, Banyard V, Moynihan M, et al. Disclosure and service use on a college campus after an unwanted sexual experience. *J Trauma Dissociation*. 2010;11(2):134-151.

30. Kelleher C, McGilloway S. 'Nobody ever chooses this ...': a qualitative study of service providers working in the sexual violence sector - key issues and challenges. *Health Soc Care Community*. 2009;17(3):295-303.

31. Logan TK, Evans L, Stevenson E, Jordan C. Barriers to services for rural and urban survivors of rape. *J Interpers Violence*. 2005;20(5):591-616.

32. Logan TK, Stevenson E, Evans L, Leukefeld C. Rural and urban women's perceptions of barriers to health, mental health, and criminal justice services: implications for victim services. *Violence Vict*. 2004;19(1):37-62.

33. Muganyizi PS, Nyström L, Axemo P, Emmelin M. Managing in the contemporary world: Rape victims' and supporters' experiences of barriers within the police and the health care system in Tanzania. *J Interpers Violence*. 2011;26(16):3187-3209.

34. Ullman S, Townsend S. Barriers to working with sexual assault survivors: a qualitative study of rape crisis center workers. *Violence Against Women*. 2007;13(4):412-443.

35. Young CL. Barriers to reporting sexual assault as identified by sexual assault service providers: a qualitative study. Unpublished Doctor of Nursing Science Dissertation. Memphis, TN: University of Tennessee Health Science Center; 2002.

36. Ledray LE. *Sexual Assault Nurse Examiner Development & Operation Guide*. NCJ 170609; 1999. http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf

37. DuMont J, Miller KL, Myhr TL. The role of "real rape" and "real victim" stereotypes in the police reporting practices of sexually assaulted women. *Violence Against Women*. 2003;9(4):466-486.

38. McGee H, O'Higgins M. Garavan R, Conroy R. Rape and child sexual abuse: what beliefs persist about motives, perpetrators, and survivors? *J Interpers Violence*. 2011;26(17):3580-3593.

39. Basile KC, Smith SG. Sexual violence victimization of women: prevalence, characteristics, and the role of public health prevention. *Am J Lifestyle Med*. 2011;5:407-417.

Web resources

A. http://www.nsvrc.org

B. https://rainn.org