



Gender-Based Violence

Physicians' Perceived Roles, as Well as Barriers, Toward Caring for Women Sex Assault Survivors



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A B S T R A C T

Background: Sexual assault (SA) affects about 40% of women in the United States and has many mental and physical health sequelae. Physicians often do not address SA with patients, although SA survivors describe a desire to talk to physicians to obtain additional help. Little information exists on how providers perceive their roles regarding caring for women SA survivors and what barriers they face in providing this care.

Methods: We performed a qualitative study using semistructured one-on-one interviews with 16 faculty physicians from five specialties: obstetrics and gynecology ($n = 4$), internal medicine ($n = 4$), family medicine ($n = 1$), emergency medicine ($n = 3$), and psychiatry ($n = 4$). Interviews were conducted between July 2011 and July 2012, transcribed verbatim, and coded using a constant comparative approach. Once a final coding scheme was applied to all transcripts, we identified patterns and themes related to perceived roles and barriers to caring for SA survivors.

Results: Physicians described two main categories of roles: clinical tasks (e.g., testing and treating for sexually transmitted infections, managing associated mental health sequelae) and interpersonal roles (e.g., providing support, acting as patient advocate). Physician barriers fell into three main categories: 1) internal barriers (e.g., discomfort with the topic of SA), 2) physician–patient communication, and 3) system obstacles (e.g., competing priorities for time).

Conclusions: Although physicians describe key roles in caring for SA survivors, several barriers hinder their ability to fulfill these roles. Training interventions are needed to reduce the barriers that would ultimately improve clinical care for SA survivors.

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Sexual assault (SA) is a prevalent problem that affects over 40% of women in the United States population (Breiding et al., 2014). SA is defined by the Department of Justice as “any type of sexual

contact of behavior that occurs without the explicit consent of the recipient.” Rape falls under the umbrella of SA and is defined by the Department of Justice as “penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.” In the United States, 19.3% of women experience rape during their lifetime, with an 11.5% prevalence of completed rape (Breiding et al., 2014). In addition, 43.9% of women have experienced sexual violence in a form other than rape during their lives (Breiding et al., 2014). In 2014, the White House Council on Women and Girls issued a national call to improve prevention and intervention for rape and SA, highlighting this issue as a national priority (Rape and Sexual Assault, 2014).

There are numerous mental and physical health sequelae from SA. Women who have experienced SA have a higher risk of

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asthma, diabetes, irritable bowel syndrome, headache, chronic pain, dyspareunia, poor sleep, and overall poor physical and mental health (DeLahunta & Baram, 1997; Breiding et al., 2014). Posttraumatic stress disorder is 2.4 to 3.5 more likely in women who have experienced one SA and 4.3 to 8.2 for women who have experienced more than one SA (Walsh et al., 2012). Additionally, survivors of SA use more medical and mental health care services (Basile & Smith, 2011), which is associated with higher health care costs. The latest study estimating national costs for SA was published in 1996 and estimated that rape in the United States accounted for \$127 billion dollars per year, in 1993 dollars. Most of this cost is attributed to health care costs (Miller, Cohen, & Wiersema, 1996). More recent regional reports estimated that SA cost the state of Minnesota \$8 billion in 2005 (or \$1,540 per resident; *Costs of Sexual Violence in Minnesota, 2007*) and the state of Utah \$4.9 billion in 2011 (\$1700 per resident; *Utah Violence and Injury Protection Program Costs of Sexual Violence in Utah, 2015*).

Given this high prevalence, associated medical conditions, and higher health care use, health care providers certainly encounter women with a history of SA. Appropriate identification of SA and provision of support, treatment, counseling, and referrals could potentially mitigate the sequelae. Studies indicate that women, including those who have experienced SA, felt comfortable with their health providers screening for SA and believe that discussing SA with their physicians and learning about the sequelae and available community resources and hotlines can help to them recover (Berry & Rutledge, 2016; Friedman, Samet, Roberts, Hudlin, & Hans, 1992; Littleton, Berenson, & Radecki Breitkopf, 2007). However, although women feel physicians can help them to deal with SA, physicians often do not bring up SA with their female patients (Friedman et al., 1992; Littleton et al., 2007). Few studies have explored what prevents health providers from addressing SA with their women patients. In particular, there is little literature exploring physicians' perceptions of caring for SA survivors.

To be able to design interventions and strategies that will improve providers' care of women SA survivors, we must first understand the perspectives of providers regarding working with this issues and these patients. The objective of our study was to gain a deeper understanding regarding what physicians feel are their roles and responsibilities in caring for women SA survivors and what challenges they face in providing this care.

Material and Methods

We chose a qualitative study design using semistructured individual interviews with physicians. Qualitative research methods allow a deeper and more descriptive exploration into the attitudes and perceptions of providers than quantitative approaches (Giacomini & Cook, 2000; Sandelowski, 2000). Our primary focus was on physicians' experiences, perceived roles, and challenges identifying and caring for women SA survivors. We focused on their perceptions of care for women SA survivors because the issues regarding perceived roles and challenges in providing for male or child SA survivors are likely different.

We recruited physicians from the five specialties that would most likely address and manage issues related to adult SA: internal medicine, family medicine, psychiatry, obstetrics and gynecology (OB/GYN), and emergency medicine. We focused on faculty physicians because we were interested in the perspectives of those who have a responsibility to teach and train residents and medical students. All faculty of our medical school are

based in the same health system in a city. This health system includes multiple hospitals and clinics all located in various neighborhoods in the same mid-sized metropolitan area and provides both inpatient and outpatient clinical services. Our sampling process focused primarily on ensuring representation from each of the five clinical specialties listed.

We recruited participants by speaking with the head or designated faculty leader for each department to obtain support for the study. These departmental heads and leaders then informed the faculty of the study by sending an email describing the study and inviting study participation to the departments' faculty. Participation was not compensated. Interested faculty then contacted us via email to schedule interviews. The main principle guiding the sample size in qualitative studies is "thematic saturation," a process by which a researcher collects and analyzes data until he or she is not learning anything new (Crabtree & Miller, 1992; Patton, 1999, 2014). During the time period available for subject recruitment (July 2011–July 2012), 16 faculty members contacted us: four from psychiatry, three from emergency medicine, four from internal medicine, one from family medicine, and four from OB/GYN. Although we had noted redundancy in our interviews by the 10th interview, we interviewed all 16 physicians who communicated interest to respect their willingness to contribute and to ensure inclusion of their perspectives. Interviews were conducted in a private room the physicians selected.

After obtaining verbal consent, we conducted individual semistructured interviews. Verbal consent was obtained instead of written consent to help protect the identities of the participants. We sought this exception to allow participating faculty members the security that no one aside from the primary interviewer (P.A.) would know of their participation. We felt that this would encourage more open and forthright responses. Immediately before the interview, participants filled out a questionnaire that included demographics, training experiences, and their frequency of asking patients about SA. The interview was conducted using an in-depth field guide that covered the following: what roles health care providers should have in caring for SA survivors, how SA is addressed in their practice or department, past stories of survivors, challenges in asking about an SA history and in counseling, and what situations or for what specific complaints they would ask about an SA history. Interviews were recorded using a digital voice-recorder and transcribed verbatim. This paper focuses on the portions of the interview that addressed what physicians perceived as their roles regarding SA survivors and the barriers to performing these roles. The study was approved by the Institutional Review Board at the University of Pittsburgh.

All interviews were transcribed and transcriptions reviewed by the interviewer (P.A.) for accuracy. We performed the qualitative analysis of the transcripts using an iterative constant comparison approach to develop the codes with both investigators coding separately and then meeting to compare codes and interpretations (Patton, 2014). Codes were created using an editing approach without application of a pre-determined coding scheme (Crabtree & Miller, 1992). We chose this approach to performing this content analyses because we did not have any preexisting hypothesis of how physicians would respond to our open-ended questions (Hsieh & Shannon, 2005). Once the final coding scheme was developed, the two investigators compared their coding on 6 of the 16 transcripts (37.5%). No major differences in interpretation occurred, so no third arbitrator was needed. Codes were examined to identify

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