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RESEARCH

Factors That Influence Women to Disclose Sexual Assault History to Health Care Providers

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ABSTRACT

Objective: To examine women's experiences with sexual assault screening by health care professionals and identify factors that influence women to disclose their sexual assault history to providers.

Design: Cross-sectional descriptive survey with correlational analysis.

Setting: On-line survey distributed nationally.

Participants: One hundred forty-three women.

Methods: Participants were recruited through social media; the authors e-mailed organizations across the nation and asked them to share links to a Facebook page connected to the survey. Descriptive statistics, Spearman's rho, and contingency tables were calculated, and qualitative content analysis was performed by thematic analysis.

Results: Most ($n = 103$, 72.5%) participants reported that they felt comfortable with being asked about sexual assault, but only 41 (28.7%) participants were screened for sexual assault by health care professionals. Positive attitude and increased comfort level with screening were associated with increased intention to disclose past assault ($p < .05$). A total of 113 (82.5%) women reported intentions to disclose sexual assault to a provider if asked, whereas only 35 (24.6%) women would voluntarily disclose. Women identified prevention of medical and physical consequences as main facilitators to disclosure, and provider attitude and demeanor as the main barriers. Sixty-nine (48.9%) participants were victims of sexual assault. Women with a history of sexual assault were no more likely than women not victimized to have been screened for sexual assault.

Conclusion: Study findings suggest that women are often not screened for sexual assault despite being receptive to inquiry. Health care professionals often do not identify those who have been sexually assaulted because they do not ask. Thus, many victims do not receive needed sexual assault resources and support.

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Sexual assault is prevalent and underreported across the globe. According to the World Health Organization (2013), between 6% and 59% of women worldwide are victims of sexual violence, with ranges attributed to variations in definition and type of data collected. Young women are disproportionately victimized and often suffer silently with complex short- and long-term sequelae, including posttraumatic stress disorder, depression, anxiety, increased suicide risk, eating and sleeping disorders, chronic pain, substance use, and increased revictimization (ACOG, 2014; Black et al., 2011).

Results from the National Intimate Partner and Sexual Violence Survey indicated that more than one in four American women (27.3%) and one in nine men (10.8%) experienced some form of unwanted sexual contact in their lifetimes, and 80% of female victims stated that their first rape was before age 25 years (Black et al., 2011). It was estimated that more than 23 million American women were raped in their lifetimes, and 98% of perpetrators were male (Breiding et al., 2014). The public burden of sexual assault is difficult to evaluate because of the numerous physical and mental comorbidities that result from sexual trauma.

The high prevalence of sexual assault indicates that clinicians are likely to care for survivors on a daily basis. Sexual assault victims tend to seek health care more often than others, and researchers found that most providers do not

Women often suffer silently from the devastating effects of sexual assault with long-term sequelae that include depression, anxiety, posttraumatic stress disorder, and chronic pelvic pain.

routinely screen for sexual violence (Friedman, Samet, Roberts, Hudlin, & Hans, 1992; Littleton, Berenson, & Breitkopf, 2007). On the contrary, sensitive and timely inquiry can reduce adverse medical sequelae by promoting identification of sexual assault victims for early intervention and access to resources (National Sexual Violence Resource Center, 2011). The limited research on sexual assault screening practices among health care professionals in primary care settings leads to a gap in knowledge about whether women are being screened or would benefit from routine sexual assault screening.

Background

Statistics on sexual assault may be grossly underestimated because of the sensitive nature of the topic and inconsistent definitions in state laws and organizations; the term *rape* is often used interchangeably with *sexual assault*. Rape is considered sexual assault; however, not all sexual assault is rape. For the purpose of our study, we defined *sexual assault* in accordance with the American College of Obstetricians and Gynecologists (ACOG; 2014), which recognizes the comprehensive range of attempted and completed unwanted sexual contact. Therefore, we defined *sexual assault* as intentional unwanted or forced completed or attempted sexual contact, to include vaginal, oral, or anal intercourse or object penetration.

Prevention at all levels is critical to decrease sexual violence. The White House Council on Women and Girls (2014) has called for necessary support in policy, research, education, and practice to address sexual assault through prevention efforts and for reauthorization of the Violence Against Women Act. Researchers have linked younger age and alcohol use to increased risk of victimization, and this connection has led to targeted primary prevention through programs such as *Safe Dates, Shifting Boundaries* and bystander intervention training (DeGue et al., 2014). Extensive efforts have also been evaluated in provision of immediate postassault care in a safe environment that is respectful and restores control to survivors (McGregor, Mont, White, & Coombes, 2009). When women disclose a history of stressful life experiences to health care providers (HCPs), a supportive response by the provider is part of recovery for survivors to effectively process information; however, research is limited on secondary prevention through routine sexual assault inquiry by HCPs in primary care (Foynes & Freyd, 2013).

Sexual assault screening has been inconsistently recommended by professional organizations and is often classified with intimate partner violence screening. The American Medical Association (2008) and ACOG (2014) recommend routine sexual violence screening of all women, but *routine* is not defined or standardized. The United States Preventive Services Task Force (2013) includes sexual violence screening under intimate partner violence screening and has not recommended sexual assault screening. The World Health Organization (2013) does not recommend universal sexual assault screening but rather promotes improved identification and follow-up care of sexual assault survivors with an emphasis on better training for health care professionals to recognize signs and symptoms of violence.

Case-based screening of proposed high-risk populations may miss identification of many survivors (Sims et al., 2011). Older women continue to suffer from mental health disorders related to past sexual assault, and Starzynski and Ullman (2014) suggested that this group reports more positive perceptions of mental health services after disclosure. Numerous studies have been done on the closely related topic of intimate partner violence screening; however, an intimate partner does not always perpetrate sexual assault, so sexual assault demands distinct screening tools (Basile, Hertz, & Back, 2007). Also, researchers have found that sensitive inquiry may provide relief from a sense of sharing, but minor upset and retraumatization from violence surveys are a concern that warrants attention in consideration of routine sexual assault screening (McClinton Appollis, Lund, de Vries, & Mathews, 2015).

Authors of studies on violence screening found that lack of knowledge, negative attitude, and perceived barriers, such as discomfort with the topic and time pressure, appeared to decrease providers' abilities and readiness to perform screening (Van den Ameele, Keygnaert, Rachidi, Roelens, & Temmerman, 2013). In addition, some