PERCEPTIONS OF PROVIDER-PATIENT COMMUNICATION
AMONG WOMEN WITH A HISTORY OF SEXUAL ASSAULT

By

Erika Anne Soderman

A Thesis Submitted to the Faculty of the
COLLEGE OF NURSING
In Partial Fulfillment of the Requirements
For the Degree of
MASTER OF SCIENCE
In the Graduate College
THE UNIVERSITY OF ARIZONA
2006
STATEMENT BY AUTHOR

This thesis has been submitted in partial fulfillment of requirements for an advanced degree at The University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this thesis are allowable without special permission, provided that accurate acknowledgement of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his or her judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: [signature]
ACKNOWLEDGMENTS

I would like to thank the Southern Arizona Center Against Sexual Assault for their support with this thesis and to all other sexual assault centers across the country for their assistance with sexual assault survivors.

I would like to thank my thesis chairperson, Dr. Elaine Jones, for her thoughtfulness and guidance throughout the genesis of this thesis. I would also like to thank committee members Dr. Judy Berg and Sharon Ewing for their contributions and continued support.
TABLE OF CONTENTS

LIST OF ILLUSTRATIONS.................................................................6
LIST OF TABLES.............................................................................7
ABSTRACT.......................................................................................8
CHAPTER 1: INTRODUCTION.............................................................9
  Significance..................................................................................10
  Background................................................................................12
  King’s Goal Attainment Theory..................................................13
  King’s Transaction Process Model.............................................14
CHAPTER 2: REVIEW OF LITERATURE.............................................17
  King’s Personal System: Personal Health....................................17
  King’s Interpersonal System: Provider-Patient Interaction...........22
  King’s Social System: Healthcare System..................................27
  Summary.....................................................................................31
CHAPTER 3: METHODOLOGY.............................................................33
  Research Design- The Case Study Overview...............................33
  The Case Study as an Illustrative Purpose..................................34
  The Case Study as a Disconfirmation of Universality..................34
  Research Questions......................................................................35
  Sample.........................................................................................35
  Human Subjects Protection........................................................36
  Participant Recruitment...............................................................36
  Data Collection............................................................................37
  Data Analysis..............................................................................37
  Trustworthiness..........................................................................37
CHAPTER 4: PRESENTATION OF FINDINGS AND DATA ANALYSIS....39
  Case Study Background...............................................................39
  Case Study Findings....................................................................40
  Case Study Discussion: King’s Transaction Process Model.........43
  Perception....................................................................................43
  Communication............................................................................44
TABLE OF CONTENTS – Continued

Interaction and Transaction................................................................. 45
King’s Personal System: Case Study Themes vs. Literature....................... 48
King’s Interpersonal System: Case Study Themes vs. Literature.................. 49
King’s Social System: Case Study Themes vs. Literature.......................... 50
Acknowledgment- Case Study............................................................... 51
Acknowledgement- Literature............................................................... 51
Physical Environment- Case Study......................................................... 52
Physical Environment- Literature......................................................... 52
Trust & Empathy Case Study................................................................. 53
Trust & Empathy Literature................................................................. 54

CHAPTER 5: CONCLUSION........................................................................ 56

Implications for Nursing Practice............................................................ 56
Theory Development................................................................................. 58
Study Limitations..................................................................................... 58
Recommendations for Future Research.................................................... 59
Summary................................................................................................. 60

APPENDIX A: HUMAN SUBJECTS COMMITTEE APPROVAL....................... 62

APPENDIX B: SACASA APPROVAL LETTER............................................ 64

APPENDIX C: SUBJECT CONSENT FORM.............................................. 66

APPENDIX D: RECRUITMENT FLYERS..................................................... 70

REFERENCES.......................................................................................... 73
LIST OF ILLUSTRATIONS

FIGURE 1, King's three interacting systems and transaction process model......16
LIST OF TABLES

TABLE 1, Literature vs. Case Study Findings.............................................. 47
ABSTRACT

The purpose of this study was to describe provider-patient interaction among women with a history of sexual assault. Researchers have found an association between a history of sexual assault with increased health care usage, chronic medical conditions, dissatisfaction with provider-patient interaction, and dissatisfaction with the health care system.

King’s Goal Attainment Theory and Transaction Process Model served as the organizing framework for the study. Emphasis was placed on the interplay between the personal, interpersonal, and social systems during the provider-patient interaction.

The case study found that disclosure vs. nondisclosure of a history of sexual assault during gynecologic exam may have directly affected patient satisfaction outcome. Provider acknowledgement, use of screening tools, physical environment, and provider professionalism influenced gynecologic exam outcomes. A combination of routine screening along with outlines set up by the American College of Obstetricians and Gynecologists (ACOG) may be beneficial during the gynecologic examination to ensure patient satisfaction.
CHAPTER 1

INTRODUCTION

The purpose of this study was to describe perceptions of provider-patient interaction among women with a history of sexual assault. This first chapter begins with basic definitions and significance of the provider-patient relationship for women with a history of sexual assault. Then, an overview (background) of the long term effects of sexual assault on women’s health will be presented. Finally, King’s Goal Attainment Theory (1981) will then be introduced and described as it applies to the subject of this study.

Health care providers for this study are defined as a medical practitioner (physician and/or nurse practitioner) who delivers health care services including identifying, treating, or preventing illnesses. Sexual assault is defined as forced vaginal, oral, or anal penetration against one’s will (Tjaden & Thoennes, 2000). There are an estimated 876,064 sexual assaults against women each year and many others who are sexually assaulted but do not report these experiences to police or other officials (Tjaden & Thoennes, 2000). There has been a great deal written about the medical care of patients in the immediate aftermath of sexual assault and about the long-term effects of sexual assault in every aspect of women’s later lives (Lang, Rodgers, Laffaye, Satz, Dresselhaus, & Stein, 2003; Stein, Lang, Laffaye, Satz, Lenox, & Dresselhaus, 2003; Krakow, Melendrez, Johnston, Warner, Clark, Pacheco, et al., 2002; Kimerling &
Calhoun, 1994; Plichta & Falik, 2001). However, healthcare providers are often unaware that a history of sexual assault may affect other areas of healthcare for patients in the years after the sexual assault. There is evidence that poor provider-patient interactions are detrimental to the health of women with a history of sexual assault (Campbell, et al., 2001; Plichta & Falik, 2001; Ulman & Filipas, 2001). These negative interactions occur when factors such as barriers to discussing sexual health, time constraints during appointments, lack of screening initiatives, and secondary victimization experiences occur when utilizing services (McNutt, 2000; Plichta & Falik, 2001; Campbell, et al., 2001).

Significance

This section will describe the impact of sexual assault on women’s healthcare utilization, physical health, and communication between provider and patient.

Many of the first experiences with service providers after sexual assault are within the healthcare system (Plichta & Falik, 2001). Study results have indicated that women who have experienced sexual assault were more likely than women without sexual assault histories to have multiple healthcare visits each year (Plichta & Falik, 2001; Stein, et al., 2004). Women with histories of sexual assault have been shown to have higher levels of worry or fear about illness and higher healthcare utilization as a form of medical reassurance about their symptoms (Stein, et al., 2004).

Healthcare is the most common form of service utilization in the years after sexual assault due to the physical somatization of symptoms resulting from psychological
stressors (Kimerling & Calhoun, 1994; Bohn & Holz, 1996; Stein, et al., 2004). The term “Thick chart syndrome” was used by Bohn & Holz (1996) to refer to the frequent healthcare visits with lengthy testing and unknown medical explanation for physical complaints experienced by women with history of sexual assault. Healthcare providers have noted a host of symptoms such as headaches, nausea, back pain, and allergies in this population (Kimerling & Calhoun, 1994). Bohn & Holz, (1996) described other somatic symptoms such as dysmenorrhea, nightmares and insomnia, and gagging and choking sensations for women who were strangled or forced to have oral sex during sexual assault. Chronic medical conditions such as pelvic pain, gastrointestinal illness, eating disorders, and sexual dysfunction associated with sexual assault often presented to healthcare providers on a longer-term basis (Schei, 1990; Kimerling & Calhoun, 1994; Drossman, Talley, Lesserman, Olden, & Barreiro, 1995). The effects of sexual assault on physical and psychological functioning results in higher health care usage, more medical visits, more medication usage, and higher levels of post-traumatic stress disorder (PTSD) (Suris, Lind, Kasner, Borman, & Petty, 2004). Treating PTSD related to a history of sexual assault was found to be associated with increased health care costs (Suris, et al., 2004).

Researchers have found numerous barriers in providers’ abilities to recognize underlying psychological problems in patients presenting with chronic physical complaints in the years after sexual assault (Plichta & Falik, 2001; Docherty, 1997). Factors such as providers’ lack of awareness of sexual assault history, discomfort in
addressing psychological issues, time constraints, and lack of violence or sexual assault screening inhibits detection and effects provider-patient communication (Plichta & Falik, 2001; Docherty, 1997; Parsons, Zaccaro, Wells, & Stovall 1995, McNutt, 2000).

Communication between provider and patient is essential to forming an appropriate diagnosis and treatment plan in all healthcare encounters. Recognizing, diagnosing, and referring to specialized psychological services can improve quality of care for women with a history of sexual assault. However, these actions are often not initiated by providers (Docherty, 1997; Parsons, et al., 1995). This oversight in recognition, diagnosis, and referral by the provider is counterproductive and costly for the healthcare system (Docherty, 1997; Stein, et al., 2004, Suris, et al., 2004). An association between sexual assault and higher healthcare utilization along with increased costs for medical services has been found by researchers (Suris et al. 2004). In the age of rising health care costs, appropriate diagnosis and intervention are at the forefront of practice (Kimerling & Calhoun, 1994).

Background

This section will present research regarding interactions between women with histories of sexual assault and the healthcare system. Secondary victimization experiences and its adverse psychological affects will be discussed.

Researchers have studied the effects of healthcare service utilization on patients with a history of sexual assault (Campbell, et al., 2001; Ulman & Filipas, 2001). One phenomenon, known as secondary victimization, is defined as “victim-blaming treatment
from system personnel” that can take the form of health care providers not finding the patient credible or truthful when disclosing sexual assault (Campbell, et al., 2001, p. 1239). Previous research has suggested that community help is often denied for women with sexual assault histories and the help that is received “often leaves them feeling blamed, doubted, and revictimized” (Campbell, et al., 2001, p. 1240). When these blaming behaviors happened, greater levels of post-assault psychological and physical health distress resulted in the years after sexual assault (Campbell, et al., 2001).

Researchers have found that over 90% of patients developed post-traumatic stress disorder (PTSD) immediately after the sexual assault (Ulman & Filipas, 2001). These findings suggest that if formal services such as healthcare were not accessed appropriately, greater PTSD symptoms developed and adversely affected the patients’ health status (Ulman & Filipas, 2001). The likelihood of having negative experiences with healthcare providers after sexual assault may impact the patient’s ability to recuperate both physically and mentally and may damage the provider-patient relationship.

King’s Goal Attainment Theory

This section will introduce and discuss the applications of King’s Goal Attainment Theory (1981) to provider-patient interactions within the health care system. King’s Transaction Process Model and Goal Attainment theory will provide the contextual and the conceptual systems for this study.
Imogene King’s Goal Attainment Theory (1981) was grounded in nursing practice. However, concepts and principles used in her theory may be applicable to other healthcare professionals who interact with patients. The focus of King’s theory is the provider-patient relationship and the creation of an interacting process with the common goal of health (King, 1981). For purposes of this paper, King’s references to “nurse” are changed to “provider” to reflect the contemporary healthcare system and the expanding roles of advanced practice including nurse practitioner providing primary healthcare.

According to King (1997), provider-patient interactions are purposeful. The interactions contain perceptions, purposeful communication, and valued goals. King’s (1999) conceptual system is composed of three entities; the personal system (or individual), the interpersonal systems (or groups), and the social systems (such as healthcare) (Figure 1). For this study, the individual is the woman with a self-reported history of sexual assault who has received healthcare from a primary provider. The interpersonal system refers to the woman’s interactions with the primary provider. Within these interpersonal transactions perception, communication, and interaction occur between provider and patient (Alligood & Tomey, 2002). The social system is the healthcare system in which the provider-patient interactions occur.

King’s Transaction Process Model

Through the inner workings of the personal, interpersonal, and social systems, King’s middle-range theory of Goal Attainment evolved to provide a structure for nursing discipline (King, 1999). Goal attainment refers to patient outcomes and can indicate a
measure of quality of care (King, 1999). The model known as the transaction process model within the goal attainment theory uses perception, communication, interaction, and transaction — key concepts in forming relationships and transacting between patient and provider (King, 1999). When a transaction occurs, each person interacts and perceives the other, self, and environment. Judgments are made. The outcome of the transaction occurs during goal attainment when mutual goals are set to attaining health (Figure 1).

According to King, goals cannot be achieved unless the provider and patient share their perceptions, feelings, values, and conclusions during the transaction process (1999). Both the patient and the provider have their own perceptions which are communicated through verbal or non-verbal communication during the patient-provider transaction. Both parties come up with their own judgments and conclusions as the end result of the transaction. Goal attainment or failure to attain the goal is reflected on the provider-patient communication and transaction.
The personal, interpersonal, and social systems interact when a patient receives healthcare. This interaction leads to a health care transaction in which communication is exchanged, perceptions are made, and goals (or outcomes) are attained.

The purpose of this study was to explore provider-patient interaction, transaction, communication, and perception among women with a history of sexual assault to develop evidence-based recommendations for providing healthcare that supports the provider-patient interaction. For this study, goal attainment may refer to a mutually tolerable provider-patient interaction which supports positive outcomes, or quality healthcare. King's transaction process model will be the structure by which the provider-patient transaction occurs. The results of the study will be used to develop new knowledge and recommendations for improved patient-provider interaction, transaction, communication, and perception for women with histories of sexual assault.
CHAPTER 2

REVIEW OF LITERATURE

The purpose of this chapter is to review literature about the healthcare experiences of women with a history of sexual assault. King’s Theory of Goal Attainment (1981) provides the concepts of personal, interpersonal, and social systems which interact when sexual assault patients receive health care. The key concepts in this theory when systems come together are interaction, transaction, and perception; leading to goal attainment.

The systems interacting and transacting with women with sexual assault histories stand as the organizing framework for this chapter. First, studies regarding the personal systems are presented, followed by interpersonal system studies, and finally issues related to the social system as the healthcare industry.

King’s Personal System: Personal Health

The personal system, according to King, incorporates concepts such as perception, self, body image, growth and development, and time and space (Alligood & Tomey, 2002). Health, both physical and mental, is an entity that directly influences the personal system. Personal health perceptions was the system of interest for this study.

Numerous studies have found adverse physical and mental health problems for women who have experienced sexual assault. Researchers have found reproductive health problems, menstrual pain, irregular menses, increased substance abuse, riskier sexual behaviors, depression, PTSD, sleep disorders, insomnia, suicide, femicide (murder), and
poorer self-health perceptions (Lang, et al., 2003; Kimerling & Calhoun, 1994; McFarlane et al. 2005; Ulman & Filipas, 2001; Krakow, et al., 2002). Three studies representative of the adverse health affects of sexual assault on women’s health will be discussed in greater detail.

Kimerling & Calhoun (1994) conducted a descriptive study to analyze the relationship of sexual assault and subsequent personal health. The authors hypothesized that women who have a sexual assault history would show higher levels of psychological distress and lower reported ratings of personal health than women without a history of sexual assault. The study assessed self-rated health perceptions, health care usage, somatic symptoms, and psychological distress in the year following sexual assault.

A sample of 115 women aged 15-71 with a history of sexual assault were interviewed for the study (Kimerling & Calhoun, 1994). A comparison group of women with no history of sexual assault was used in contrast. This comparison group was screened for victimization histories such as sexual assault (attempted or actual), robbery, physical assault, childhood abuse, or sexual victimization. Potential participants were excluded if they responded positively to these histories.

Kimerling & Calhoun’s (1994) findings suggested that psychological symptoms are significantly higher in women with sexual assault histories than women without. Women with a history of sexual assault had a lower perceived personal health status at
one-month post-assault than the comparison group. Three-quarters (75%) of the women in the sample scored in the mild-to-severely depressed range immediately after sexual assault. 26% scored mild-to-severely depressed in the year following (compared to 17% for the comparison group). Almost three-quarters of the women with a sexual assault history obtained medical healthcare services (72.6%) but only a minority (19.06%) received mental health services. Physical symptoms were elevated for women with sexual assault histories at one-year post-assault [most frequently back pain (29.9%), tension headaches (26.5%), and stomachache/nausea (21.9%)]. Kimerling & Calhoun (1994) concluded that long-term psychological stressors from sexual assault may evolve into physical ailments with various somatic symptoms and complaints.

Psychological service usage for women after sexual assault has not kept pace with medical service usage (Kimerling & Calhoun, 1994). Kimerling & Calhoun (1994) reasoned that somatization of psychological stressors, a lower social stigma of receiving healthcare versus psychological care, or more readily available healthcare to the population of women studied existed. The findings are relevant to patients’ personal systems because poorer perceptions of physical health and greater psychological symptoms may commonly occur following the assault.

Lang, et al., (2003) conducted a study to examine the relationship of sexual assault history to various health behaviors. Smoking, problem drinking, obesity, risky sexual behaviors, less exercise, and less preventative health measures were behaviors hypothesized by the authors to be associated with a sexual assault history.
Questionnaires about psychological and medical symptoms, health behaviors, and health-related quality of life were completed by women aged 20-86 (average age 46.6) who have visited a primary care clinic in 1998. Demographic questions including sexual assault and other traumatic events such as a serious accident or physical assault were included (Lang, et al., 2003). Data comparisons were made between women with and without a history of sexual assault on substance use, sexual behavior, and preventative health behaviors.

A higher number of women with sexual assault histories were regular smokers (36.1% vs. 22.5%) with a trend toward higher numbers of women smoking during pregnancy (27.1% vs. 16.9%) (Lang, et al., 2003). Women with sexual assault histories were younger at first voluntary sexual intercourse (17.8 years vs. 19.6 years) and had more lifetime sexual partners (25.0 vs. 8.2 respectively). Women with sexual assault histories were also more likely to have had sex with a new partner prior to knowing the partner’s sexual history (61.8% vs. 31.9%).

In terms of preventative health behaviors, women who had been sexually assaulted had more Pap smears in the past 5 years than those women without sexual assault histories (4.5 vs. 3.8) and more of these Pap smears were abnormal (0.6 vs. 0.3) (Lang et al. 2003).

Lang, et al.’s (2003) findings show higher levels of negative health behaviors for women who have experienced sexual assault. However, the timeline of sexual assault (less than a year vs. years prior to the study) was not part of the data collection and was
identified by the researchers as a possible study limitation (Lang, et al., 2003). The higher prevalence of substance abuse and risky sexual behaviors in the study directly affected the health of women with sexual assault histories (Lang, et al., 2003).

McFarlane, Malecha, Gist, Watson, Batten, Hall, et al., (2005) conducted a study examining the effects of sexual assault to women’s substance use, risk for suicide, and risk for femicide- or murder. The researchers identified a need for separate research studying sexually assaulted-only women versus physically assaulted-only women. The participants were grouped into these two categories.

149 women participated and filled out a demographic data forms. They participated in structured interviews regarding threatened or attempted suicide and use of nicotine, alcohol, illicit drugs. Finally, a Danger Assessment Scale (a 16 item yes/no response scale) specific to risk factors associated with murder related to abuse was completed (McFarlane, et al., 2005).

The researchers found that women who reported more than one experience of sexual assault (versus one experience) were three times more likely to report beginning or increasing substance abuse (McFarlane, et al., 2005). Alcohol was the most frequently used substance, 10% of women with one sexual assault experience used versus 27% of women with more than one sexual assault experience. Not one woman with one sexual assault experience was found to use illicit drugs as compared to 9% of women who experienced more than one sexual assault. 10% of women who experienced sexual
assault versus 22% of women who experienced more than one sexual assault increased or began using tobacco.

Within 90-days of the sexual assault, 22% of women reported threatening or trying to commit suicide (McFarlane, et al., 2005). Women reporting sexual assault were 5.3 times more likely than those reporting physical assault to threaten or attempt suicide. The percentage of women reporting the person who sexually assaulted her has “threatened to kill [her]” was 76% versus 58.3% for reported physical assault.

Greater prevalence of physical and psychological symptoms along with lower-rated personal health status adversely affects the ability to heal and recuperate after sexual assault (Kimerling & Calhoun, 1994). Higher levels of substance abuse, suicide, femicide, and riskier sexual behaviors were among several findings specific to women with sexual assault histories (Lang, et al., 2003; McFarlane, et al., 2005). These factors influence several entities of King’s concept of the personal system. Damage to one’s perception, self, safety, and body image is a direct affect of sexual assault and alters a healthy personal system.

King’s Interpersonal System: Provider-Patient Interaction

The second interacting system, identified by King (1981) is the interpersonal system. Interpersonal systems include concepts such as interaction, communication, transaction, stress, and role (Alligood & Tomey, 2002). For this study, sexual assault patients interacting with primary healthcare providers was the interpersonal system of interest.
Barriers to helpful interpersonal interactions include communication problems and lack of healthcare providers’ screening initiatives (Plichta & Falik, 2001). Plichta & Falik (2001) conducted a national telephone-survey sample of 1,821 women aged 18-64 (taken as a subsample from the Commonwealth Fund 1998 Survey of Women’s Health) to uncover a more complete, current profile of violence against women. Health status, access to healthcare, and use of health services as it related to women who experienced either physical, sexual intimate (known-offender), or sexual non-intimate (unknown-offender) violence was evaluated. The study’s purpose was to uncover relevant health affects for women patients with sexual assault histories when they receive healthcare.

Plichta & Falik (2001) found that patients who experienced violence had a higher perceived barrier to obtaining healthcare although they are just as likely as non-victimized patients to receive regular healthcare or have regular healthcare providers. This barrier was identified as an inconsistency with communication difficulties at the heart of the problem (Plichta & Falik, 2001). Only 29% of the patients who experienced violence from an intimate partner discussed this with their healthcare provider (Plichta & Falik, 2001). Among those who had the discussion, 74% said they initiated the discussion (Plichta & Falik, 2001). Patients reported feeling embarrassed or uncomfortable discussing health concerns with the provider. Patients with histories of intimate sexual assault were 2.37 times more likely than patients with no history of assault to feel this way (Plichta & Falik, 2001).
Patients with sexual assault histories scored higher than patients with physical assault histories or no assault histories when asked if the doctor didn’t listen well (37.6% sexual non-intimate and 26.8% sexual intimate vs. 25.7% physical assault and 24.7% no assault) (Plichta & Falik, 2001). Patients with sexual assault histories were also more dissatisfied and had changed providers in the past 5 years (25.3% sexual non-intimate and 28.7% sexual intimate vs. 21.3% physical assault and 15.3% no assault). Patients with intimate sexual assault histories scored the highest of all groups at 2.6 times more likely to report difficulties in obtaining needed care during their healthcare encounters.

Parsons, et al., (1995) conducted research to identify barriers and analyze behaviors of practicing obstetrician-gynecologists when identifying a patient with a past history of abuse. In 1992, The American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association (AMA) put forth guidelines to help providers assist a woman when abuse is identified. These guidelines included: 1) verbalize that the abuse is wrong, 2) document the abuse history in the chart, 3) take a complete abuse history, and 4) provide sources for referrals. The ACOG added 1) provide local shelter information and emergency numbers, 2) ask about child abuse, and 3) refer to counseling (Parsons, et al., 1995). Despite these existent guidelines, Parsons, et. al., contended that abuse identification, detection, and intervention in obstetric-gynecologic providers have been difficult (1995). Parsons, et al., (1995) cited The American Medical Association’s published report in 1992 stating that providers do not identify victims of abuse and are not able to address the needs of women once this abuse
is recognized. The researchers’ aim was to identify which barriers in identification, detection, and intervention existed. Abuse was defined for this study as any past or present physical or sexual abuse, domestic violence, emotional or verbal abuse, and childhood sexual abuse.

A two-part questionnaire was mailed out between 1991-1992 to ACOG providers (Parsons, et al., 1995). The first part evaluated providers’ basic demographics (age, gender, ethnicity, and obstetrics and/or gynecology practice). The second part evaluated education in abuse, barriers to screening, actions taken for victims of abuse, and providers’ personal histories of abuse. Questions included “Is it part of your routine obstetric history to screen all patients for abuse?” “Do you screen selected obstetric patients for abuse?” “Is it part of your routine to screen patients for abuse at their annual gynecologic visit?” “Is it part of your routine history-taking on women with chronic somatic complaints, sexual problems, or chronic pelvic pain to ask about abuse?” (Parsons, et al., 1995, p.382). These questions further evaluated screening behaviors. A total of 933 questionnaires were analyzed.

Gender was associated with screening behavior. 25.9% female providers screen routinely for abuse vs. 18.9% of male providers (Parsons, et al., 1995). Female providers had a 7.4% rate of not screening at all vs. 15.9% rate for male providers. Almost half (48.9%) of providers agreed that they felt inadequacy in abuse intervention due to lack of education, 33.9% of providers did not have any education in domestic violence. This was the largest barrier to screening for abuse. Other barriers included
influence from the type of patient (46%), concern for lack of time (39.2%), frustration that they cannot do anything about the patients’ problems (34.3%). Less common sources of barriers included fear of offending the patient (15.2%), feeling that abuse is not a medical problem (13.9%), a personal history of abuse in the provider (13.1%), and concern that there is no way to verify the abuse (7.2%). When questioned if “contact is expected in a relationship” and “women bring this on themselves,” 7.9% of responders answered positively.

Providers’ education was the most common factor found that created a barrier to screening and intervening (Parsons, et al., 1995). Knowledge of the ACOG guidelines along with other abuse-specific training was the combination found in providers that would most often routinely screen women for abuse or assault histories (33.2%). Even with this level of education, it was only 1/3 of providers who would routinely screen. One approach, suggested by the researchers, was to have a nurse in the practice specially trained and familiar with the management of abuse victims and community resources. Another approach would be development of a protocol specific to overcoming these barriers to use in practice.

McNutt (2000) studied victimization and its effects on patient satisfaction after provider-patient encounters in a community-based healthcare center. A survey was administered to 102 women patients who had intimate partner sexual assault histories. These patients responded to questions regarding the quality of communication and satisfaction of their encounters. According to findings, barriers to discussing sexual
concerns or assault histories with healthcare providers were common. Lower ratings on receptive communication (66% vs. 80%) and expressive communication (49% vs. 58%) within the provider-patient interaction existed. McNutt (2000) concluded that patients with sexual assault histories were less likely than women without sexual assault histories to find it true that they felt accepted and respected during a provider-patient interaction.

McNutt (2000) suggested that shorter healthcare visits in the face of managed care along with the possibility of underlying emotional problems that exist in patients with sexual assault histories may inhibit provider-patient communication. The possibility of the increased time expenditure in counseling, screening, referring, and follow-up during routine healthcare visits may lead to healthcare providers’ reluctance in seeking assault histories from patients (McNutt, 2000). Healthcare providers may feel rushed in order to meet their own time constraints.

Higher perceived barriers to healthcare, lack of screening initiatives, and healthcare time constraints experienced by women with sexual assault histories may adversely affect the relationship between patient and provider (Plichta & Falik, 2001; McNutt, 2000; Parsons, et al., 1995). These factors influence several entities of King’s concept of the interpersonal system including dissatisfaction with provider-patient interactions, communication difficulties, and unsatisfactory healthcare transactions.

King’s Social System: Healthcare System
King's social system consists of concepts such as power, authority, role, organization, decision making, authority, and status (Alligood & Tomey, 2002). For this study, the healthcare system was the social system which was the context for provider-patient interactions.

Campbell, et al., (2001) conducted a study to describe women's experiences with healthcare, legal services, rape crisis centers, mental health services, and religious groups after sexual assault. The objective was to determine if there were any gaps in obtaining needed resources or any characteristics or demographics corresponding to obtaining needed services. Interactions between service providers and sexual assault patients were evaluated for hurtful or helpful experiences.

The study sample included 102 women with a history of sexual assault (Campbell, et al., 2001). The average age of the women in the sample was 34.29 years old. Over 2/3 were sexually assaulted by a known-offender and over half were physically injured from the assault. The women were interviewed regarding post-sexual assault psychological and physical health changes along with narratives of the assault in their own words. The study included structured questions about which services were used post-assault and how the usage affected them.

The highest community service utilization was in the form of healthcare (43%) by using sexual assault-related treatment (Campbell, et al., 2001). Other services included the legal system (39%), mental health services (39%), rape crisis centers (21%) and religious associations (18%). Women who experienced unknown-offender assaults rather
than known-offender assaults were the highest to use medical care (58% vs. 42% respectively).

Almost half of the patients who received medical attention rated it as a healing experience (47%), 21% rated it as a neither healing nor hurtful experience, almost one-third (29%) experienced it as a hurtful experience (Campbell, et al., 2001). In contrast, other services rated much higher than healthcare for helpful experiences (mental health services 70%, rape crisis centers 75%, and religious communities 85%). Women rated their contact with the healthcare system as hurtful when they did not receive post-assault HIV information or the morning-after pill (Campbell, et al., 2001). Women rated higher levels of psychological and physical health distress from the hurtful healthcare contact. These hurtful post-assault experiences with the healthcare system after may be recalled in future medical visits when women seek long term healthcare.

Campbell, et al., (2001) highlighted the phenomenon of secondary victimization when sexual assault patients communicated their history of the assault to providers within the healthcare system. The patients at greatest risk for secondary victimization and hurtful medical and psychological experiences were patients with non-stranger sexual assault as well as women from ethnic minorities. Hurtful healthcare experiences immediately after sexual assault may leave a negative impression in mind when these patients receive follow-up long-term care and further contact with healthcare providers. Campbell, et al., (2001) concluded that negative experiences with community service providers lead to poorer health outcomes.
Women's health is a specialty within the healthcare system where women undergo gynecologic examinations as part of routine health examinations. Gynecologic exams are a necessary part of women's reproductive health, cancer screening, and infection identification and treatment. Hilden, Sidenius, Langhoff-Roos, Wijma, & Schei (2003) conducted a study researching women's experiences during the gynecological examination as it related to a past history of sexual abuse. Factors associated with discomfort during the exam were analyzed.

The study sample included 798 Danish patients who visited a gynecologic outpatient clinic from October 1999 to February 2000 (Hilden, et al., 2003). A structured questionnaire was mailed one week after their visit evaluating age, education, occupation, past medical history, past mental health history, sexual satisfaction, and sexual abuse history. The mental health questions evaluated insomnia, anxiety, and depression; sexual life was categorized as satisfactory, poor, or no sexual life. The researchers defined sexual abuse as "any kind of sexual activity taking place without consent" and categorized as mild (fondling, non-genital contact), moderate (genital contact, no penetration), or severe (vaginal, oral, or anal penetration) (Hilden, et al., 2003). A Likert scale was used to measure from 0 to 10 the degree of emotional contact with the provider and discomfort experienced during the examination. Discomfort was defined as a score of 6 or more, based on a 75th percentile (Hilden, et al., 2003).

Patients who answered positively to discomfort experienced during the gynecologic exam were further analyzed for demographics. Discomfort during the exam
was related to a “young age (18-25), being a student, nulliparity, dissatisfaction with sexual life, a history of moderate to severe sexual abuse, negative emotional contact with the provider, and mental health problems such as depression, anxiety, and insomnia” (Hilden et al. 2003, p.1033). Of all respondents, 20.7% (165 of 808) reported a history of sexual abuse with 29.7% that reported discomfort during the exam. Only 7.6% (10 of 131) had told the provider about their history of sexual abuse.

The researchers discussed that the younger women (under age 26) may have experienced discomfort in higher numbers than to older women (over age 26) who have had repeated exams. The researchers discussed that the finding of exam discomfort in younger women with histories of sexual abuse may effect future experiences with providers and warrants special attention in this group (Hilden, et al., 2003).

Many studies focused on sexual assault patients’ interactions with the healthcare system immediately after the assault or within a one-year time frame (Campbell, et al., 2001; Plichta & Falik, 2001; McNutt, 2000; Kimerling & Calhoun, 1994). The studies looked at the relationship of sexual assault, physical and psychological health, and healthcare usage and satisfaction. The researchers used closed-ended interviewing techniques to arrive at conclusions which may have ultimately limited the array of possible responses. The researchers did not evaluate interactions between women with histories of sexual assault and healthcare providers beyond the one-year time frame.

Summary
This chapter provided an overview of King's (1981) nursing model, focusing on the provider-patient relationship. Emphasis was placed on key concepts of perception, communication, interaction and transaction and how they relate to the study's focus on perception of health care among women with a history of sexual assault. The review of literature revealed that much of the literature about this population was about health care in the immediate aftermath of the sexual assault or the first year. Research findings consistently indicate that women with a history of sexual assault may experience difficulties and dissatisfaction with their health care for many years. This study was designed to address this problem. The study design is described in the next chapter.
CHAPTER 3

METHODOLOGY

This chapter contains an overview of the case study research design used as the methodology for the study. Two categories of purpose served by this case study will be introduced and defined as illustrative and disconfirmation of universality. Information is also provided regarding data collection, data analysis plan, protection of human subjects, and establishment of trustworthiness of data.

Research Design- The Case Study Overview

This was a qualitative study using case study methodology in interviewing women with a history of sexual assault. Case study research methods allow an in-depth description of a studied phenomenon (Lobiondo-Wood & Haber, 2002). Case study research provides a detailed, multidimensional understanding that has traditionally been used throughout nursing to learn about patients and teach outcomes (Lobiondo-Wood & Haber, 2002). A case study presents a “holistic and lifelike description that is like those that the readers normally encounter in their experiencing of the world” (Guba & Lincoln, 1989, p. 359). Case study methodology may reveal a multi-level understanding by which the participant’s own unique experiences guide the way towards the unraveling of phenomena.

The purpose of using a case study method was two-fold. It illustrated the phenomena of provider-patient interaction and social system interaction as it was perceived by a woman with a history of sexual assault. It also served as a disconfirmation
of universality as it contrasted previous researchers’ findings in the personal health system.

The Case Study as an Illustrative Purpose

Case studies are used most frequently to illustrate a previously determined concept or problem of interest (Sechrest, Stewart, Stickle, & Sidani 1996). The illustrative focus of this case study was to describe one woman’s experience during King’s interpersonal (provider-patient interaction) and social system utilization (gynecologic exam) during the healthcare transaction. Themes that arose during these system interactions were identified. Previous researchers’ phenomena of what constitutes “typical” provider-patient interactions during the gynecologic examination were examined. Comparisons regarding the phenomena experienced during the case study’s illustrated accounts with that of previous researched phenomena were analyzed.

The Case Study as a Disconfirmation of Universality

Disconfirmation of universality is a category of purpose in case studies when newly uncovered phenomena does not universally represent previously researched phenomena (Sechrest, et al., 1996). A case study’s purpose as a disconfirmation of universality may be used to disconfirm previously accepted universal phenomena. King’s personal system with its concepts of health perception and self was contrasted with phenomena uncovered during the interview. Themes that arose during personal system were identified. Disconfirmation of universality was analyzed with previous researched phenomena regarding King’s personal system.
Research Questions

The research questions were:

1) What guides the way that women perceive their own health in the years following sexual assault (King's personal system)?

2) What are women's perceptions about communication and transactions with health care providers (King's interpersonal system) in the years following sexual assault? What guides this perception? Did the provider-patient interaction lead to goal attainment (King's transaction process model)?

3) What are women's perceptions about interactions with the health care system (King's social system) in the years following sexual assault? What guides this perception?

Sample

The population recruited for the study was women with a self-reported history of sexual assault. All possible participants were women, as women constitute the vast majority of clients seeking counseling related to sexual assault. Women from any ethnic group were eligible for participation, but had to have been English-speaking and understand written English for consent form and recruitment. Criteria for participation were

a) Female (by self-report)
b) A self-reported history of sexual assault that occurred at least two years prior to joining the study

c) The sexual assault occurred when the woman was at least 18 years of age

d) The woman has received general health care from providers for health care at least two years following the sexual assault.

Human Subjects Protection

The proposed study was initiated following approval by the University of Arizona IRB Committee and approval from the agency. (Appendix A).

Participant Recruitment

The PI met with staff at a local sexual assault center to explain the purpose of the study and the criteria for participation. After the center’s approval letter (Appendix B), flyers were placed on a table in the waiting area (Appendix D). The flyers described the study and invited potential participants to contact the PI if they were interested in participating or if they would like to have more information. When a potential participant contacted the PI, the PI explained more about the study, including the purpose of the study, the criteria for participation, what participation entailed. If the potential participant was still interested in participating, the PI then made an appointment with her at a semi-private location of her choice. At that first appointment, the PI completed the consenting process, had the participant sign the consent form (Appendix C) and asked the participant to select a pseudonym to use for purposes of the study. Next, the PI began the audiotaped interview.
Data Collection

The PI collected basic demographic data from the participant to confirm eligibility. Next, the participant was interviewed (sample questions—What type of healthcare providers did you see in the years after sexual assault? Can you describe how you perceive the communication between you and your provider? What were your healthcare experiences like?) The participant’s actual name was not used during the recorded interview, transcription, or study-related materials.

Data Analysis

The interview was audio taped and transcribed with pseudonyms. Information from the interview was then analyzed and reported in case study format. The transcribed data was analyzed for themes and linked to previous data from research in the area. King’s transaction process model was used as the key concept in data organization and analysis.

Trustworthiness

Various criteria have been established to evaluate the trustworthiness of qualitative research. One primary criterion is credibility, which refers to the “truth” of research findings (Guba & Lincoln, 1989). Trustworthiness, according to Guba & Lincoln (1989) can be addressed through peer debriefing and triangulation. Peer debriefing allowed another research committee member to approve or disapprove the evolving data by giving feedback on emerging themes and analysis. For this process, the raw transcribed data along with its potential derived meaning was given to the research
chair member to analyze, reflect, and revise. This approach allows for clarified data interpretation, clearing of the mind, and development of the emerging hypotheses (Guba & Lincoln, 1989).

The concept of triangulation is a confirmation by two or more different methods of measurement that greatly lowers theoretical interpretation error or uncertainty (Guba & Lincoln, 1989). Imperfect measures inherent in any type of research design. The more widely based the different forms of measurement are used for one proposition, the more confidence one should have that a proposition is accurate (Guba & Lincoln, 1989). The theoretical propositions of this qualitative case study were compared to other researchers’ propositions in the data analysis section. Validation of similarities and differences from the study’s findings may uphold or refute trustworthiness of the study data.

This chapter illustrated the case study research design used as the methodology for the study. An illustrative purpose and disconfirmation of universality were the two principles guiding the case study method. Information was provided regarding data collection, data analysis plan, protection of human subjects, and establishment of trustworthiness of data in the qualitative research method.
CHAPTER 4

PRESENTATION OF FINDINGS AND DATA ANALYSIS

This chapter will present the results of a case study describing one woman’s experiences in communication, perception, and interaction during her transaction with her healthcare provider in the years following sexual assault. To protect anonymity, she will be referred to as “S” and demographic information will be limited. Direct quotes will be used within this chapter to preserve the descriptive nature of the qualitative research. However, quotes with any personally identifying information will be excluded to maintain anonymity. Findings will be analyzed and then discussed with King’s transaction process model as the organizing factor. Finally, King’s personal, interpersonal, and social systems as it related to case study themes will be compared and contrasted with the themes within the reviewed literature.

Case Study Background

S is a college-educated female in her 20’s with a self-reported history of sexual assault that occurred more than two years prior to the interview. The assault occurred when she was over 18 years of age. She reported seeing providers for two reasons since the assault- either for a routine physical for employment or for her gynecologic exams (which she has every 2-3 years). S reported that her personal health was “pretty good.” She generally feels healthy, eats right, and exercises several times a week. S said she does not use tobacco, alcohol, or other substances. She did not identify problems
navigating the healthcare system and knows how to find a provider under her insurance plan. When asked about the personal, interpersonal, or social system related to her healthcare experiences, S did not report any problems interacting with regular providers. However, S identified problems when interacting with a new gynecologist once her insurance changed. Her experiences with her first gynecologist office versus her experiences with the change in provider (the second office) will be presented in the findings.

Case Study Findings

S described herself as “picky” when it comes to finding a gynecologist. She has seen male providers for past physical exams but explained that cannot see a male provider for her gynecologic examinations. Having a female gynecologist is what is “necessary for [her] comfort”. S states her first gynecology visit occurred roughly a year after the sexual assault and has had subsequent exams every 2-3 years. At her first exam, S felt compelled to tell the provider that she was “scared and nervous” because she didn’t know what to expect. “I told them what had happened to me. It was a nurse practitioner who saw me first and we had a talking session in her office”. This talking session was “a little over the top and annoying” but was “respectful [and] I knew they knew what was going on.”

In the exam room, S described the “nice pictures in the room- positioned right where my ankles were during the exam and on the ceiling too.” She stated that somebody
must have “sat right there and thought about how to exactly place the picture” as if they were a patient. It was a physician who saw S for her first exam, she never saw the nurse practitioner for her exams. “I see a different doctor almost every time there but they’re all very nice.” She went on to say, “they must have noted on my chart that I’m sensitive or something because every one of them is nice.” S explained that the doctors introduce themselves to her while she’s dressed and then come back for the exam after she’s in the gown. S explained that she was able to have her first gynecologic exam at that office without any difficulties.

S explained that eventually her insurance changed and this particular office was not covered under her new plan. She had to switch to another office and found one that was recommended to her by a friend. “My first visit [there] wasn’t that great- I thought they were careless and too laid back.” When S asked about doing breast exams “they said you don’t need to do breast exams- I forget why- I found it to be a careless comment.” She described the doctors as “not professional.” From this initial experience, S reported that it was not easy for her when she went back for her second visit. “It must make their job harder to do if I’m not relaxed for some reason.” During the exam, the physician “told me to relax.”

“The tone in her voice- I could tell she was irritated or annoyed with me. I mean, you don’t say ‘relax’ like that to someone who was assaulted, they may have been told that during the assault- there has to be a better choice of words than that. I could tell she had no clue. How could you be so
clueless like that when you work with women all the time? What was her training like?” “I was crying. I left crying. Nothing changed when I was upset, nobody noticed it. I had anxiety and panic at the end. Everybody looked at me like I was nuts. Nobody took me aside to talk to me. I was hysterical when paying my bill, it was so disturbing to me. It must have happened to someone else there before. I don’t know how they could be so clueless.”

S decided to go back to her old office stating that she is “not willing to just pay a $10 copay for that, I wouldn’t even go at all if I had to.” She pays “hundreds of dollars” every time she goes to her first office now. S stated that she would only switch gynecologists “if I needed birth control or to have a baby and would have to go more often than every 2-3 years.” S stated that if she needs to find a new office one day she’d “have to be honest and tell them.” She stated that finding a gynecologist is a “risky affair.” In regards to finding a new gynecologist one day she stated “if they don’t look at me or listen to me or become more sensitive based on [telling them my history of sexual assault] and give me the understanding and feeling that I’m well cared-for I would up and leave before the exam. I will guard against that.”

S explained that she didn’t tell the second office about her history of sexual assault. “It wasn’t on the forms [and] I didn’t tell. I told the first place because it was my first exam and I was scared the first time.” She said that she felt the first office had “acknowledgement” that the exam was “hard for me.” She stated, “people don’t always
acknowledge this on a regular basis.” Provider acknowledgement helped S because it
was “sensitive to [her] needs,” her “fear,” and “where [she’s] been.”

On the topic of gynecology visits, S stated that it “might be a good idea” to have a
question regarding sexual assault on a form in the waiting room before seeing the
provider. She stated that it would have to be worded as, “we acknowledge that this can
effect your experience [during the gynecologic exam]- have you experienced sexual
assault?” S stated that “even if women won’t check the box- and many may not- having
it in itself says something valuable to women that this is important. I would love to see
this on a form.”

Case Study Discussion: King’s Transaction Process Model

The transaction process model within the theory of goal attainment “demonstrates
that each human being is of equal worth” and perception, communication, interaction,
and transaction, are concepts at the base of any provider-patient relationship (King, 1999
p. 295). Themes present in the case study will be grouped and analyzed under the
concepts found in the Transaction Process Model.

Perception

King describes perceptions as any given meaning to one’s unique experiences that
represents one’s image of the real world (King, 1971). This image is the relationship
between the person and the environmental stimuli (King, 1971). In the case study, S
experienced two different perceptions of both positive and negative outcomes during her
gynecologic examinations based on the environmental stimuli. Her perception of the first
office was that her history of sexual assault was acknowledged and respected. She verbalized her history and felt that the providers knew that she was sensitive and that they were "all very nice." She perceived the physical environment as caring, that the pictures in the exam rooms were placed as if through the eyes of the patient. She perceived the initial "talking session" with the nurse practitioner may have been "over the top" but perceived that they at least "knew what was going on". These environmental stimuli gave S the perception that she would be cared for. Her real world experience at this office was that she tolerated the gynecologic exam without any difficulties.

At the second office, negative environmental stimuli shaped S's perceptions. The "laid-back" mannerisms of the provider along with the choice of words used during the examination gave the perception that the providers at this office were "clueless" and did not have adequate "training" when working with women. She perceived that "everyone" was looking at her like she was "nuts." From this world view experience, S perceived that choosing a gynecologist was a dangerous task and feared for the future of having to change providers or see providers more frequently.

Communication

King identified communication as information exchange from one person to another involving intra and interpersonal exchanges (McEwen & Wills, 2002). Communication can be verbal, non-verbal, or a sequence of behaviors (King, 1999). S communicated her past history of sexual assault during her first gynecology visit. The
direct effect of communicating her history brought about a two-party discussion, a visit to 
the nurse practitioner’s office, and an acknowledgment of her history. This 
communication exchange between the provider and her allowed the exam to continue 
without difficulties.

Communication at the second office was not ideal. A tone of voice and choice of 
wording “relax” used during the gynecologic exam set off anxiety and panic. S 
physically communicated her distress by crying during her exam. This distress signal 
was not reciprocated by acknowledgment, either by provider or any other office worker. 
“It was so disturbing to me [that] nobody took me aside to talk to me.” This lack of 
communication between provider and patient lead S to decide that she would not return to 
that office for another appointment.

Interaction and Transaction

King’s concept of interaction is the intermingling of perception and 
communication between person and environment and between person and person 
represented by goal-directed behaviors (McEwen & Wills, 2002). A transaction occurs 
after a process of interactions with the environment to achieve valued goals (McEwen & 
Wills, 2002).

The interplay between provider and patient, patient and the environment, and 
patient perception were positive at the first office visit. S was able to overcome her 
nervousness through her interaction with the provider and her interaction with the 
environment. Her goal of receiving the necessary gynecologic exam was achieved with as
little perceived stress as possible. The transaction allowed for a completion of S’s
gynecologic exam with future exams possible through the positive experience.

The second office visit consisted of a negative interaction between provider and
patient, patient and the environment, and patient perception. The lack of action taken by
office workers in the immediate environment after communicating distress through
crying was “disturbing.” The provider’s choice of words and tone of voice during the
exam allowed for S to experience a negative perception. These factors lead to a negative
interaction and the valued goal of having a well-tolerated gynecologic exam with possible
future exams was not possible at this office.
Table 1: Literature vs. Case Study Findings

<table>
<thead>
<tr>
<th></th>
<th>Literature</th>
<th>Case Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td>Poorer self-health perceptions, increased health care usage, somatic symptoms, (Kimerling &amp; Calhoun, 1994). Increased substance abuse, riskier sexual behavior, suicidality, femicide (or murder) (Lang, et al., 2003; McFarlane, et al., 2005). “Thick chart syndrome” (Bohn &amp; Holz, 1996).</td>
<td>Generally healthy, exercises several times a week, eats right, does not use tobacco, alcohol, or other substances.</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Embarrassment discussing health concerns, dissatisfaction with provider, higher rates of changing providers, difficulties obtaining needed care (Plitchta &amp; Falik, 2001). Lower rated receptive and expressive communication, barriers to discussing sexual assault history/concerns(McNutt, 2000).</td>
<td>Sexual assault history disclosure and acknowledgement enhanced provider-patient relationship. Negative experience with verbal and nonverbal communication during second office visit. Changed providers (from second office to first office) due to dissatisfaction.</td>
</tr>
</tbody>
</table>
King's Personal System: Case Study Themes vs. Literature

King defined health as "a dynamic life experience of a human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of one's resources to achieve maximum potential for daily living" (McEwen & Wills, 2002). Research results have linked a history of sexual assault with adverse health affects to one's personal health and perception of health (Kimerling & Calhoun, 1994; Lang, et al., 2003; McFarlane, et al., 2005) (Table 1).

No personal health affects or health themes were identified by S in the case study. S stated she did not use substances and a feeling that she was "generally healthy" was expressed. Seeing providers for issues other than every 2-3 year gynecologic exams were a rarity, with employment physicals cited as the reason.

Adverse health effects such as increased substance abuse, suicide, somatization, and increased use of health services were health behaviors exhibited secondary to a history of sexual assault (Lang, et al., 2003; McFarlane, et al., 2005; Kimerling & Calhoun, 1994). "Thick chart syndrome" was used to describe the multiple health care visits experienced from chronic medical conditions related to sexual assault (Bohn & Holz, 1996). These findings were not present from the case study interview. However, these findings have researched either within one year post-assault (Kimerling & Calhoun, 1994) or without a reported timeline at all (Lang, et al., 2003; McFarlane, et al., 2005). McFarlane et al. (2005) found a higher rate of suicidal ideation or attempted suicide after
sexual assault, but this was within a 90-day period. There was no timeline of sexual
assault as it related to adverse health affects other than suicide in the study. This lack of
data on long-term effects of personal health was identified in the discussion as a study
limitation (McFarlane, et al., 2005). This case study identified a woman with self-
reported sexual assault of at least two years prior to the study. It may be possible that
adverse health affects related to sexual assault may decline overtime. The study
participant was recruited through a sexual assault counseling center. Receiving
counseling services may have an effect on personal health perceptions. Other factors
such as age, level of education, family or social support, and the nature of sexual assault
(known vs. unknown offender, one assault versus multiple assaults) may also influence
personal health perceptions.

King’s Interpersonal System: Case Study Themes vs. Literature

King related provider-patient interactions as a relationship directed towards health
with “mutual understanding of events [and] mutually set goals to be achieved by the
patient” (King, 1999). Research has identified risk factors for poor provider-patient
interactions such as provider dissatisfaction, embarrassment discussing health concerns,
problems with receptive and expressive communication, barriers to disclosing sexual
assault history or concerns, and difficulties obtaining needed care (Table 1).
This case study found both positive and negative interpersonal interactions between provider and patient, with sexual assault history disclosure as one variable between the differences in experiences. Sexual assault disclosure at the first office may have reassured S that the providers were aware of her past experiences. It may be possible that this disclosure sensitized the providers and staff towards her individualized needs. Other variables at work during the second office visit were the choice of words, tone of voice, careless comments regarding breast exams, and S’s perceived feeling that the providers were “too laid back and unprofessional.” These variables may have led to the negative experience and the change of providers. Plichta & Falik (2001) found that women with a history of violence were 25.3% to 28.7% more likely to switch providers due to dissatisfaction of care. The case study findings supported this statistic with S’s switch from the second gynecologic office back to the first office.

King’s Social System: Case Study Themes vs. Literature

Social systems, according to King (1999) are large, organized groups that interact in one’s environment. These systems contain “multiple variables that influence perceptions, roles, responsibilities, and decision making” (King, 1999). Research has found secondary victimization experiences, low helpful experiences, and gynecologic exam discomfort when women with histories of sexual assault utilize the healthcare system (Table 1). Campbell, et al., (2000) related negative experiences with systems utilization to poorer health outcomes. Hilden, et al., (2003) related their findings
on gynecologic exam discomfort with possible future negative experiences with healthcare and that special attention should be placed on this population.

Gynecologic exam discomfort was experienced by S in this case study at the second office. The effects of her experiences shaped who she will see for her gynecologic exams, her thoughts about finding future women's healthcare providers, and how much money she spends out of pocket to ensure that she will not have another negative experience at a new office.

Acknowledgement - Case Study

The theme of acknowledgement by the provider that the gynecologic exam may be difficult was identified as important for S. S's sexual assault history was disclosed at her first gynecology appointment and S related the providers' increased sensitivity towards her needs from this disclosure. This disclosure was not screened for or questioned by the providers or intake forms; S felt the need to disclose because it was her first exam and she was "scared and nervous." The providers acknowledged the history and provided opportunity for discussion prior to her exam. Her provider met with her before disrobing for the exam. The exam was tolerated without any difficulties.

Acknowledgement of the S's history of sexual assault or the possibility of exam difficulty was not made at the second office. Like the first office, there was no screening on the intake form and no questions asked regarding history of sexual assault. S did not disclose her sexual assault history at this second office. S's gynecologic exam at this office was a negative experience to the point of leaving the office crying.
Acknowledgment of hardship was not taken when she was unable to relax during the exam and then again while she was crying both during and after the exam.

Acknowledgement- Literature

Providers’ acknowledgement of sexual assault history and giving assistance was identified by Campbell, et al., (2001) as a way to prevent secondary victimization during patient disclosure. Various studies identified barriers to recognize and acknowledge sexual assault and the subsequent poor provider-patient interactions that follow. These include but are not limited to time restrictions, provider level of comfort, lack of screening initiatives, and lack of education for abuse-specific training (Campbell, et al., 2001; Plichta & Falik, 2001; Ulman & Filipas, 2001; McNutt, 2000). Acknowledgement is the first step identified by the ACOG and AMA by verbalizing the abuse or assault was wrong when a patient discloses (Parsons, et al., 1995).

Physical Environment- Case Study

The theme of physical environment shaped S’s experiences. Environmental influences weighed S’s perceptions of her first gynecologic exam. S related that pictures were placed on the wall with attention to where they should be placed from the patient’s point of view. Pictures were on the ceiling and at her line of vision to her ankles during the exam. These environmental influences gave S the impression that the providers had the ability to identify with what it was like to be a patient from her point of view on the exam table. Perhaps the pictures served as a calming experience separate from the exam and created an outlet for distraction.
Physical Environment- Literature

Physical environment as it relates to a provider-patient interaction was not found in the literature review. It is worth analyzing if the physical environment during provider-patient encounters can effect patient satisfaction or reduce stress or anxiety levels. Physical environment may include gynecologic room set-up, artwork, furniture, room temperature, color.

Trust & Empathy- Case Study

Trust and empathy were themes shaped by S’s experiences and perceptions during the gynecologic exam. S related the provider’s comment regarding self-breast exams as “unimportant” and “careless” at the second office. The providers were “too laid back” and not “thorough.” Telling S to “relax” without acknowledging gynecologic exam hardship or past history of sexual assault may have produced feelings of powerlessness similar to feelings experienced during the sexual assault. S stated that “you don’t say relax to someone who was assaulted- they may have been told that during the assault.” However, the provider was not aware of any history of sexual assault. When S was crying after the exam without any acknowledgment, S questioned the provider’s educational training especially when considering that she was “working with women all the time.”

Empathy is defined as “identification with and understanding of another’s situation, feelings, and motives” (Compact American Dictionary, 1998). S’s questioning of the provider’s ability to empathize her experiences during the exam weighed heavily
on S’s sense that this was a provider with inadequate experience in caring for patients with her history. This interaction during the gynecologic exam may have created S’s perception of provider mistrust and inability to empathize with her experiences.

Trust & Empathy-Literature

Professionalism can be related to education and expertise in one’s field. In medicine, education and experience are cornerstones towards professional development. In order to build trust in a provider, a patient must sense that the one providing care is competent and professional. Proper diagnosis and intervention in any health care transaction is necessary for provider expertise and subsequent patient trust. ACOG researchers found that a lack of education was the most common factor among providers that created a barrier in screening and intervening with women having abuse or assault histories (Parsons, et al., 1996). Provider knowledge of the ACOG guidelines along with abuse-specific training were the two most likely educational combinations that researchers found had the highest rates of violence screening and intervening in the OB/GYN setting (Parsons, et al., 1996). This combination of training and knowledge of guidelines created a higher level of abuse and assault identification with proper intervention.

Campbell, et al., (2001) described secondary victimization and further trauma beyond the sexual assault when service providers doubt or disbelieve women during sexual assault disclosure. This lack of empathy women experienced when receiving services directly affected their interactions with system providers to the point of
describing it as "the second rape" (Campbell, et al., 2001). Health care was found as the most hurtful of all social systems used by women with a history of sexual assault (Campbell, et al., 2001). It is likely that the inability of providers to identify or empathize with a sexual assault disclosure may adversely affect health care outcomes.
CHAPTER 5

CONCLUSION

This chapter will review the case study’s implications for nursing practice. Theory implications will be discussed. Finally, study limitations, recommendations for future research, and a conclusion will be presented.

Implications for Nursing Practice

Advanced practice nurses practice as providers within women’s health specialties and perform gynecologic exams as part of routine women’s health care. Sensitivity and acknowledgement that gynecologic exam discomfort is a possibility for women with a history of sexual assault is important for optimal provider-patient relationships. The case study findings indicate that a very different experience may be possible when sexual assault history prior to the gynecologic exam is disclosed versus non-disclosure of a sexual assault history. It is not clear whether disclosure allows a greater sense of ease from the patient or if disclosure creates a heightened sensitivity of patient’s emotional needs from the provider.

The American College of Obstetrics and Gynecology (ACOG) along with the American Medical Association (AMA) recommended in 1992 that once abuse or assault is identified: 1) verbalization must be made that the abuse is wrong, 2) documentation of the history made in the chart, 3) a complete abuse history must be obtained, 4) information on referral resources must be provided. Also, 1) emergency numbers and
shelter information must be given, 2) inquiries of child abuse, and 3) counseling referrals must be made (Parsons, et al., 1995). However, with these recommended guidelines in place researchers have found “disappointing[ly]” low rates of routine screening for abuse or assault in obstetrics and gynecology practices (Parsons, et al., 1995). This barrier of assault identification and intervention is a commonality across all provider demographics (Parsons, et al., 1995).

One implication for practice is the addition of a routine question regarding sexual assault history on standard intake forms at gynecology practices. This was identified by S in the case study as a “good idea” to have a question worded as, “we acknowledge that this can effect your experience here- have you every experienced this [sexual assault]?”. S reported that even if “many women” may not “check the box” to indicate sexual assault, having a question on the form “says something valuable to women that this is important.” She explained, “I would love to see this on a form.” Perhaps with the addition of a routine question about past sexual assault history as part of a medical history intake form prior to the gynecologic exam, more women would be able to make known their history and their specialized needs during the exam. In the face of managed care, one additional question on a form would not hinder a provider’s time in a busy practice. In fact, screening for a sexual assault history may help shorten time because both parties are now aware of the history and can work together for a mutually tolerable exam. The addition of this question to intake forms may allow for enhanced provider-patient communication, toleration of the gynecologic exam, and referrals to community
resources for counseling support services. Screening and intervention should be the
mainstay for women’s health to ensure appropriate diagnosis, treatment plan, and patient
satisfaction.

Theory Development

King’s Transaction Process Model under the Goal Attainment Theory aided in the
development of categories for S’s healthcare provider experiences. This model provided
the organizing framework for the interview when assessing the health care interaction on
the personal, interpersonal, and social levels. The theory allowed for an organizing
framework during health care transactions through the Transaction Process Model.
However, specific interactions unique to the case study such as patient and the
environment or patient and the perception of provider professionalism was not included
King’s theory.

Study Limitations

There are limitations to the study. Recruitment difficulties were experienced.
Flyers were placed at one counseling center for just over 30 days with one resultant
interview. One case study analysis may have limited the ability to generalize these
findings to other women with histories of sexual assault. The case study participant was
a female in her 20s which may not be reflective of other age groups or demographics.
Parsons, et al., (1996) identified that one of the largest barriers that providers experience
when screening for histories of abuse or assault was an influence from the type
of patient (46% of providers agreed). It is not clear from the researchers if this influence is from a specific patient age group, demographic, behavior, or level of education.

Participants for the study were recruited from a sexual assault counseling center which may have had an effect on health care experiences from women who have versus who have not had counseling services. The flyers explained that the study would analyze women's experiences when receiving routine health care. It is possible that women responded to the flyers only if they have had adverse health care experiences. Because of the sensitivity of the topic of sexual assault and the use of one participant, in-depth questions regarding sexual assault and its effects on personal health along with identifying demographics was limited. The nature of the sexual assault (known vs. unknown offender, one assault versus multiple assaults) was not ascertained from the case study participant. It is possible that this varying degree of sexual assault may have influenced the participant's experiences when receiving health care.

Recommendations for Future Research

Research regarding sexual assault and its effect on women's health is an area that warrants research due to already established health effects. Research frequently identifies the relationship of sexual assault history to health either within a one-year time-frame or no identified time frame. It may be possible that the long-term effects of sexual assault on women's health may not dissipate with time and longitudinal studies may be of benefit. Also, reviewed research with women having sexual assault histories is frequently quantitative which may limit the possible responses inherent in qualitative
methods. Therefore, qualitative studies may uncover farther reaching or more complex relationships of the sexual assault on health care.

King's Transaction Process Model provided an appropriate model for the immediate interactions between the provider and patient. However, results suggest that additional concepts would be necessary for future studies: 1) environment as context for the interaction, and 2) perceptions of the role fulfillment of both providers and patients.

Future research analyzing the relationship between disclosure vs. non-disclosure of a sexual assault history during gynecologic examinations and patient satisfaction outcomes may be of benefit. Also, research incorporating outcomes of screening questions on intake forms at gynecology offices combined with the ACOG guidelines may be of benefit for women with sexual assault histories.

Summary

This chapter discussed the implications for nursing that disclosure vs. nondisclosure of a history of sexual assault may influence gynecologic exam tolerance and patient satisfaction outcomes. Routine sexual assault screening questions along with clinical applications of the ACOG guidelines were discussed as a feasible option to benefit this patient population. However, more research should be done in this area to analyze the outcomes of this combination. Discussion was made regarding King's theory and its applications to the provider-patient interaction. However, physical environment and professionalism perception experienced in the case study fell outside of King's
theory. Further research with other age groups or demographics was discussed and recommended, as data may have been limited from one case study.

The information provided by this case study illustrated the importance of provider acknowledgement that women with a history of sexual assault have been found to have higher levels of dissatisfaction with the provider-patient interaction, most specifically during the gynecologic exam. It is necessary for providers to screen for a history of sexual assault and incorporate its acknowledgment and referrals in practice. Through this case study along with other related research, provider knowledge and expertise may develop so that beneficial provider-patient interactions become the mainstay of practice.
APPENDIX A

HUMAN SUBJECTS COMMITTEE APPROVAL
Erika Soderman, BSN, RN  
Advisor: Elaine Jones, Ph.D., RN  
College of Nursing  
P.O. Box 210203

RE: BSC B06.09 HEALTH CARE EXPERIENCES AMONG WOMEN IN THE YEARS FOLLOWING SEXUAL ASSAULT

Dear Ms. Soderman:

We received your research proposal as cited above. The procedures to be followed in this study pose no more than minimal risk to participating subjects and have been reviewed by the Institutional Review Board (IRB) through an Expedited Review procedure as cited in the regulations issued by the U.S. Department of Health and Human Services [45 CFR Part 46.110(b)(1)] based on their inclusion under research categories 6 and 7. As this is not a treatment intervention study, the IRB has waived the statement of Alternative Treatments in the consent form as allowed by 45 CFR 46.116(d). Although full Committee review is not required, a brief summary of the project procedures is submitted to the Committee for their endorsement and/or comment, if any, after administrative approval is granted. This project is approved with an expiration date of 10 January 2006. Please make copies of the attached IRB stamped consent documents to consent your subjects.

The Human Subjects Committee (Institutional Review Board) of the University of Arizona has a current Federal Wide Assurance of compliance, number FWA00004218, which is on file with the Department of Health and Human Services and covers this activity.

Approval is granted with the understanding that no further changes or additions will be made either to the procedures followed or to the consent form(s) used (copies of which we have on file) without the knowledge and approval of the Human Subjects Committee and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

Theodore J Glattke, Ph.D.  
Chair, Social and Behavioral Sciences Human Subjects Committee

TJG:pm  
cc: Departmental/College Review Committee

Administrative Correction: Please note the correct expiration date for your project is 10 January 2007.

Date
APPENDIX B

SACASA APPROVAL LETTER
International Review Board (IRB)  
University of Arizona  
October 10, 2005

To Whom It May Concern:

I have met with Erika Soderman regarding her Master’s thesis project and will allow her to place flyers at the Center Against Sexual Assault for potential research participants for her upcoming research project.

Sincerely,

Anna M. Harper, L.M.S.W.  
Director of Crisis Services  
Southern Arizona Center Against Sexual Assault  
(520) 327-1171
APPENDIX C

SUBJECT CONSENT FORM
SUBJECT'S CONSENT FORM

Project Title: Health Care Experiences Among Women in the Years Following Sexual Assault

You are being asked to read the following material to ensure that you are informed of the nature of this research study and of how you will participate in it, if you consent to do so. Signing this form will indicate that you have been so informed and that you give your consent. Federal regulations require written informed consent prior to participation in this research study so that you can know the nature and risks of your participation and can decide to participate or not participate in a free and informed manner.

PURPOSE
You are being invited to participate voluntarily in the above-titled research project. The purpose of this project is to explore communication and interaction with healthcare providers and the healthcare system in the years following sexual assault.

SELECTION CRITERIA
The Principal Investigator will discuss the requirements for participation in this study with you. To be eligible to participate, you must be female (by self-report), and have had a history of sexual assault at the age of 18 or older, and that occurred at least 2 years prior to joining this study. You must also have received general healthcare from providers at least two years following sexual assault.

PROCEDURE(S)
The following information describes your participation in this study which will last about an hour. The start of the meeting will begin by prescreening questions confirming eligibility, allowing time for questions and answers regarding the study, and reviewing and signing the consent.

You will be asked to select a pseudonym (made-up name) to use throughout the recorded interview to ensure confidentiality and that there are no linkages between interview data and your actual name. The interview will then begin by asking general questions about communication while you were seeking health care, experiences you have had with the health care system, and your beliefs about your own health. You will not have to talk about the sexual assault or give any names of where or with whom you receive health care. The interview will continue for about an hour or until one person (either you or the Principal Investigator) decides the interview is over.

RISKS
There are no known physical or financial risks related to participation in this study. However,
you may experience unpleasant emotions if recalling or discussing health care experiences or experiences of communicating with your health care provider. You will be reminded that at any time, you may end the interview with no hard feelings. Participation in the study is not affiliated with the Southern Arizona Center Against Sexual Assault and will not influence the care the you are or will be receiving at the center.

BENEFITS
There is no direct benefit to you from your participation. The broader benefits of participation include enabling healthcare providers to have a better understanding of the needs of women with sexual assault histories when receiving healthcare.

CONFIDENTIALITY
There will be no linkages between study data and personal identifying information. No actual names will be used in the audiotape, its transcription, or other study-related materials. You may choose a pseudonym (made-up name) to use for identification purposes. Confidentiality will be upheld by destruction of the audiotape after the interview and transcription is finished. Since you are the sole participant in this research, no identifying characteristics (such as age or race) will be included in the research. Direct quotes will be limited. Themes or ideas from the interview will be reported as how they relate to similar themes in previous research. These added steps will be taken to uphold your anonymity and confidentiality of information.

PARTICIPATION COSTS AND SUBJECT COMPENSATION
There is no cost to you for participating except your time. You will receive a $10 Wal-Mart gift card for your participation to cover the cost of transportation or gas.

CONTACTS
You can obtain further information from the principal investigator Erika Soderman, BSN, RN at (520) 820-0069. If you have questions concerning your rights as a research subject, you may call the University of Arizona Human Subjects Protection Program office at (520) 626-6721. (If out of state use the toll-free number 1-866-278-1455.)

AUTHORIZATION
Before giving my consent by signing this form, the methods, inconveniences, risks, and benefits have been explained to me and my questions have been answered. I may ask questions at any time and I am free to withdraw from the project at any time without causing bad feelings or affecting my medical care. My participation in this project may be ended by the investigator for reasons that would be explained. New information developed during the course of this study which may affect my willingness to continue in this research project will be given to me as it becomes available. This consent form will be filed in an area designated by the Human Subjects Committee with access restricted by the principal investigator, Erika Soderman, BSN, RN at (520) 577-6131 or authorized representative of the University of Arizona Department of Nursing. I do not give up any of my legal rights by signing this form. A copy of this signed consent form will be given to me.

Version Date: 2/22/06

Subject’s Initials ___
Subject's Signature  

Date  

Witness (if necessary)  

Date  

INVESTIGATOR'S AFFIDAVIT:  
Either I have or my agent has carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who signed this consent form was informed of the nature, demands, benefits, and risks involved in his/her participation.  

Signature of Presenter  

Date  

Signature of Investigator  

Date
APPENDIX D

RECRUITMENT FLYERS
Introduction

The most common service used after sexual assault is health care.

You are being invited to take part in this study to help find out how health care providers can best interact, communicate, and create beneficial experiences for women in the years after sexual assault.

For more information or to participate, please contact Erika.

Phone: (520) 820-0069
E-mail: Esoderman@nursing.arizona.edu

Research Study

Health Care Experiences Among Women in the Years Following Sexual Assault

The University of Arizona, College of Nursing
Description of the Study

Erika Soderman, a nurse practitioner student at the University of Arizona, is doing a study called “Health Care Experiences Among Women in the Years Following Sexual Assault.” The study is based on interviewing women on their experiences when receiving routine health care in the years after sexual assault. This health care may be from a medical provider such as a doctor or nurse practitioner.

You will be asked to describe your health care experiences and communication experiences with medical providers in the years after sexual assault.

If you Decide to Join

You will meet with Erika and the study will be discussed. You may ask as many questions as you want to help you decide whether or not to join. No names will be used for this study, you will remain anonymous. If you decide to participate, you will be reassured that at any time of the interview you have the right to stop.

How long will this take?

Plan for about a one-hour session.

Do I have to talk about sexual assault? Or, do I have to talk about where or with whom I receive health care?

No.

What are the benefits for me?

Your information will help health care providers find the tools to give the best care for women with a history of sexual assault. You will also be given a small gift for participating and the knowledge that you helped guide new research.

Will I have any bad effects from the study?

Not likely. A risk of having strong emotions may exist with discussing your experiences with receiving health care. At any point you have the option to stop the interview.

How many women will be in the study?

No less than 6, no more than 12.

Who can participate?

You must be a woman. The sexual assault must have been at least 2 years ago and you must have been age 18 or older at the time. You must have received general health care for health care issues other than the immediate concerns of the sexual assault.

If you are interested in further information or in participating in this study, please contact Erika Soderman by phone or e-mail:

(520) 820-0069

or

ESoderman@messaging.arizona.edu

Thank you! Your participation is greatly appreciated.
REFERENCES


