

**ADDRESSING THE MENTAL HEALTH OF WOMEN AFTER SEXUAL ASSAULT:
THE ROLE OF FOLLOW-UP CARE**

by

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Abstract

Sexual assault is associated with debilitating mental health consequences, such as post-traumatic stress disorder (PTSD) and depression, yet a significant gap exists within the literature around the care needed to address these consequences. As a result, this project seeks to answer the question: In adult women of childbearing age who have experienced a recent sexual assault, can access to post-assault follow-up care within two weeks of the assault decrease the prevalence and severity of PTSD and depression? Eligibility criteria for this literature review included research data published in 2004 or later regarding mental health follow-up care for adult women of childbearing age who have experienced sexual assault. The majority of participants within these primary studies included adult women of childbearing age from large urbanized areas. This review utilized an ecological framework that identified individual, personal relationship, community and societal influences that impact the mental health of women after sexual assault while highlighting multi-level strategies aimed at decreasing the emotional distress experienced by women. Utilizing a trauma informed approach to care that encompasses thorough assessment and action orientated care planning, preferably within two weeks of a sexual assault, was suggested to be important for coping with emotional and psychological trauma. Limitations of this project include the retrospective nature of the studies reviewed and their reliance on participant recall or provider documentation practices. Further research is needed to develop multi-level strategies that improve the mental health of women after sexual assault.

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CHAPTER ONE

Introduction

Sexual violence is a global issue that plagues every community and threatens the health, well-being and quality of life of all who inhabit those communities. Sexual violence occurs when a person is forced or coerced into any type of sexual activity against his or her will or when the victim is unable to consent or refuse (Talbot, Neill, & Rankin, 2010). Sexual assault is a type of sexual violence defined by Perrault and Brennan (2010) as a forced or an attempt at forced sexual contact including “unwanted sexual touching, grabbing, kissing or fondling” (Perrault & Brennan, 2010, para. 7). The term sexual assault will be used throughout this project as it encompasses both attempted and completed unwanted sexual acts, regardless of force or penetration. This term will be examined separately from domestic/interpersonal violence as sexual assault may or may not be included within this type of violence.

Statistics Canada (2013) reported 21, 900 reports of sexual assault in 2012 demonstrating a decline in police-reported sexual assaults in comparison to previous years. The most recent statistics available comparing the rate of police reported sexual assaults by gender demonstrated that 92% percent of sexual assaults were experienced by females demonstrating a prevalence rate ten times greater than those reported by males (Statistics Canada, 2010). While sexual assault can affect both men and women, statistics reflect a greater prevalence among women. Thus for the purpose of this project, only women who have experienced sexual assault will be examined.

It is difficult to know the prevalence or the effects of sexual assault on women and their families, as sexual assaults are underreported with less than one in ten sexual assaults reported to police (Brennan & Taylor-Butts, 2008). Roughly one in five women will experience sexual assault within their lifetime (National Center for Injury Prevention and Control & Center for

Disease Control and Prevention, 2011). It can happen to women of every age, race, ethnicity, background, socio-economic status and family structure. Sexual assault is no longer perceived as just a social problem, but is also considered a public health problem as it affects the health of many people in a population (Talbot et al., 2010).

The physical and psychological effects suffered by some women who experience sexual assault can be far reaching and in some cases permanent or life-threatening. These women are at greater risk for acute and chronic health challenges (Wadsworth & Van Order, 2012) such as physical injuries, chronic pain conditions, sexually transmitted infections (STIs), pregnancy and gynecological complications, mental health and behavioural problems, suicidal ideation and worsening of existing chronic health conditions (Padden, 2008). These complications can be short or long-term resulting in profound effects on women, their families and society as a whole. The direct costs of sexual assault in Canada are estimated at more than 546 million dollars per year and this figure rises significantly to more than 1.9 billion if the costs associated with the ongoing pain and suffering experienced by these women are factored in (McInturff, 2013).

As a Forensic Nurse Examiner, I have conducted many medico-legal examinations of women who have reported sexual assault. The care I provided included addressing the negative psychological and physical consequences of the assault, and providing the patient with various resources to assist in their recovery process. In addition, I also provided patients with information about primary care practices that were available to provide post-assault follow-up care. The information I have received from these practices and our social work department revealed that many patients do not follow through with these post-assault appointments. This appears to be consistent with the literature suggesting less than 30% of patients attend follow-up care appointments (Ackerman, Sugar, Fine, & Eckert, 2006). As a Registered Nurse working in a

busy emergency department, I have often cared for women with previous histories of sexual assault seeking care for psychological or physiological concerns. These women often have multiple emergency visits for care of the same conditions, which in some cases, have been identified as negative consequences resulting from past sexual assault experiences. Thus in my experience, I have witnessed both the short and long term effects sexual assault can have on women. As a result, I feel it is important to investigate the role thorough follow-up care might have in decreasing the negative health consequences experienced by this vulnerable population.

As mentioned, sexual assault can have a significant negative impact on the long-term health of women, but it is less clear whether the role of follow up care can help lessen the impact or prevalence of these health challenges. Therefore the purpose of this paper is to investigate, in the research literature, the question: In adult women of childbearing age who have experienced a recent sexual assault, can access to post-assault follow-up care within two weeks of the assault decrease the prevalence and severity of post-traumatic stress disorder (PTSD) and depression?

This project introduces the topic of sexual assault follow-up care, provides further background information, and discusses the purpose of this review as well as the theoretical framework used to synthesize its findings. The literature review method and search strategy will be examined and the findings synthesized using the theoretical framework with analysis and discussion of the data collected specific to follow-up care of women after sexual assault. Recommendations will be provided for further research, practice, education, and policy.

Background

Historical Perspective

Sexual assault is pervasive and entrenched throughout history, and considered by some to be a growing epidemic. However, the term sexual assault itself was only introduced within

Canada over the last thirty years. The Criminal Code of Canada prior to 1983 only recognized the term “rape” referring only to assaults involving vaginal or anal penetration (Sex Information and Education Council of Canada [SIECCAN], 2011). The introduction of the term sexual assault allowed for a broader definition of non-consensual sexual acts ranging from unwanted kissing and touching to penetrative sex (SIECCAN, 2011). However, despite this change, less than 10% of sexual assaults are reported to police (Brennan & Taylor-Butts, 2008).

Health Consequences

Sexual assault against women is not only underreported, but more importantly, its victims are also medically underserved. “Violence takes a toll on the health of an individual, resulting in risk-taking behaviors, health problems throughout their adult lifetime and for many, resulting in death” (Ferguson & Speck, 2010, p. 153). Sexual assault remains a complex issue and while its long term impacts are not completely understood, the resulting negative health consequences can have a detrimental effect on the quality of life of women. They can also further hinder recovery and perpetuate the cycle of pain and suffering. Negative psychological health effects may include anxiety, avoidance coping, decreased self-esteem, PTSD, depression, substance use and suicidal ideation (Padden, 2008; Wadsworth & Van Order, 2012). Physical health effects may include headaches, facial and back pain, immune system suppression, gastrointestinal problems, and gynecological/reproductive health issues (Ray & McEneaney, 2014). These negative physical health effects often occur as a result of physiological stress reactions associated with the development of PTSD and depression (Padden, 2008). Therefore, it is the purpose of this paper to address the follow-up care needs of women who have experienced sexual assault in the hopes of decreasing the prevalence and severity of PTSD and depression and their associated negative health consequences.

Post-traumatic stress disorder. Post-traumatic stress disorder is a type of mental health condition that occurs after exposure to a traumatic event, such as sexual assault, causing severe psychological stress reactions resulting in negative physiological, psychological and sociological consequences (Chivers-Wilson, 2006). Diagnostically significant manifestations of PTSD include the presence of intrusion symptoms or recollections, avoidance behaviours, negative cognitive or mood alterations, and hyper-arousal manifestations related to the traumatic event experienced with symptoms lasting greater than one month (American Psychiatric Association [APA], 2013). Women who experience sexual assault are among those at greatest risk for the development of PTSD with estimations of 30% to 50% developing the disorder (Chivers-Wilson, 2006; Ray & McEneaney, 2014). While research alludes to biological disturbances that may perpetuate manifestations seen in the presence of PTSD (Bunevicius, Leserman, & Girdle, 2012), greater emphasis is placed on the psychological and sociological factors that contribute to women's risk for PTSD development. Negative self-perception, shame and self-blame have detrimental effects on a woman's psychological health (Chivers-Wilson, 2006). This negative impact is further perpetuated by societal influences such as attitudes that promote victim blaming and rape-myth acceptance (Chivers-Wilson, 2006). Examples of prevalent rape-myths include beliefs that women often lie about being sexually assaulted (Chivers-Wilson, 2006), that women who dress provocatively ask to be sexually assaulted or that women only experience sexual assault if they were assaulted by a stranger in a dark alley (Women Against Violence Against Women, 2014). These victim-blaming attitudes can have a detrimental impact on the emotional and psychological well-being of women after sexual assault.

Psychological distress associated with PTSD also can produce physiological manifestations that further impact the health of women after sexual assault. Police report that

sexual assault data demonstrates roughly 60% of females do not sustain any physical injuries at the time of assault, with 24% reporting minor injuries not requiring medical intervention (Vaillancourt, 2010). However, despite the absence of acute physical injury reported by 84% of women (Vaillancourt, 2010), long-term negative health symptomology are not uncommon with variances in severity (Ray & McEneaney, 2014). As an example, Chandler, Ciccone and Raphael (2006) posit that women with rape and abuse histories are eight times more likely to experience pelvic pain than those without a history of abuse. Other physical manifestations may include abdominal pain, digestive problems, headaches, back pain and immune suppression secondary to stress reactions (Ray & McEneaney, 2014). These potential health consequences highlight the importance of investigating whether early intervention can help decrease the prevalence and severity of PTSD and promote recovery in women after sexual assault.

Depression. It is well established within the literature that women are at risk for developing depression after sexual assault. Chandler et al. (2006) found the presence of major depressive disorder (MDD) to be significantly associated with self-reports of sexual assault. Women with depression are two times more likely to report having been abused in their life and also more likely to have experienced physical or sexual violence over the preceding year (Levine et al., 2008). While the causative factors for depression are similar to those described previously for the development of PTSD, negative disclosure responses and negative self-cognitions are believed to be significant characteristics used in the prediction of depression development (Campbell, Dworkin, & Cabral, 2009). Depression can have a detrimental impact on the health of women after sexual assault, affecting not only their mood but their quality of life. Those with depression often report significant impairments in the area of mental health, role and social functioning as well as bodily pain (Levine et al., 2008). Levine et al. found in their study that

health care utilization rates were higher in women who reported abuse with more frequent hospitalizations than those without an abuse history. Often hospitalizations are not directly related to the injuries sustained as a result of the assault, but instead are often exacerbations of chronic or somatic conditions (Levine et al., 2008). The effects of depression are far reaching, and as such highlight the importance of investigating whether identifying strategies to better care for women after sexual assault can aid in decreasing the prevalence and severity of depression.

Initial Sexual Assault Care Management

Only 27% to 40% of women who have experienced sexual assault seek medical care immediately after the assault (Tavara, 2006). Of those who do seek care, it is estimated that only 10%-31% seek follow-up care after their initial care management (Ackerman et al., 2006). Wadsworth and Van Order (2012) assert that the initial management of women who experience sexual assault is critical as recovery begins with an empathetic and supportive response whereas care provided with insensitivity and incompetence can further exacerbate a woman's feelings of guilt, shame and powerlessness. These negative experiences can affect a woman's willingness to seek follow-up care for the assault. Many primary care providers (PCPs) do not routinely provide care immediately following sexual assault in more urbanized areas as many women seek care through local emergency departments or are referred, when available, to specialized sexual assault or forensic nurse examiner programs for these examinations. However, it is essential that PCPs have an understanding of the initial care provided as they will often see these same patients for follow-up and routine longitudinal care (Ray & McEneaney, 2014). Furthermore, it is imperative that PCPs working in rural areas be aware of the initial management of women who have been sexually assaulted as specialized services that provide care in the acute aftermath of assault may not be readily available in these settings.

Follow-up Care

While the literature for acute medical forensic examinations of sexual assault appears to be robust, the availability of recommendations for primary health care follow-up is scarce. Available guidelines provide recommendations on the immediate post-assault care for women, but provide limited guidance for care to help women come to terms with the emotional aspects of being assaulted. This is an area that many primary care providers need to incorporate in their care of women who have been sexually assaulted, however current guidelines are vague about what this care entails. There are two resources available that provide recommendations specific to post-sexual assault follow-up care within a primary health care setting. They include the *Guidelines for Medico-legal Care for Victims of Sexual Violence* and *Caring for Survivors of Sexual Violence: A guide for primary care NPs*. A table comparing and contrasting recommendations for follow-up care has been compiled to demonstrate variances in the care provided to women post-sexual assault. See Appendix A: Post-Assault Care Recommendations. This table provides a quick glance at recommendations for follow-up care after sexual assault and easily identifies gaps in the mental health and emotional care recommendations for these women. Further in-depth analysis and discussion of these documents will be provided within Chapter Three.

Nurse Practitioners

The importance of comprehensive follow-up care is applicable to all health care professionals who provide care to women after sexual assault, including nurse practitioners (NPs). Nurse practitioners are health care professionals who autonomously deliver vital health services utilizing “their in-depth knowledge of advanced nursing practice and theory, health management, health promotion, disease/injury prevention, and other relevant biomedical and

psychosocial theories to provide comprehensive health services” (Canadian Nurses Association, 2010, p. 5). Within primary health care settings, NPs may provide follow-up care for a recent sexual assault or instead may provide care related to a sexual assault that occurred previously and disclosed during a routine visit (Ray & McEneaney, 2014; Sutherland, Fontenot, & Fantasia, 2014). Given the prevalence of sexual assault, NPs will likely encounter women who have experienced this violent crime. Therefore it is imperative that NPs and other PCPs alike, familiarize themselves with the care needed for this population.

Scope of practice. It is within the NP scope of practice to independently diagnose and manage the care of women post-sexual assault, including the negative emotional and psychological sequelae that may develop (College of Registered Nurses of British Columbia [CRNBC], 2015). Post-traumatic stress disorder is the only mental health condition requiring some level of physician consultation for diagnosis confirmation or management planning (CRNBC, 2015). However, further specialized theoretical and clinical experience are important components for professional development and competency in caring for women after sexual assault. Forensic nurse examiner courses provide training to nurses and other health care professionals in the provision of comprehensive and sensitive medico-legal examinations for all persons after sexual assault. More recently, the British Columbia Institute of Technology (2015) began offering this training to health care professionals as a means to standardize the care provided to persons after sexual assault. Recommended courses include the Forensic Nurse Examiner Theoretical and Practical Application courses. These courses provide comprehensive training in the medical and forensic care needs of patients after sexual assault. While the majority of these courses focus on the initial care management after sexual assault, components of the training also include the importance of understanding and responding to the long-term

psychosocial and psychological consequences associated with sexual assault. The knowledge and competency exhibited by health care professionals can have detrimental effects or conversely, can start the recovery process for women who experience sexual assault. Lane and Dubowitz (2009) stress the importance of increased experiential knowledge and the profound effect it has on provider confidence and comfort in caring for those who have experienced sexual assault. Nurse practitioners can better prepare themselves for this role by taking specialized continuing education courses and seeking out opportunities to provide care for this specialized population.

The Fraser Health Authority within British Columbia recently received funding from the Nurse Practitioners for British Columbia program (NP4BC) to develop and implement a clinic that provides follow-up care to persons who have experienced sexual violence. The Embrace Clinic is led by two NPs who provide regional mobile-outreach health services to persons after sexual violence using “a trauma-informed approach that recognizes the impact of traumatic experiences on an individual’s physical, emotional, psychosocial and spiritual well-being” (Fraser Health Authority, 2015, para. 4). Telephone contact is made within 72 hours of a referral to their clinic and care intervals are determined based on the needs of the patients. These NPs work in close partnership with various organizations to meet the physical, medical, psychological and emotional safety needs of persons within their care. Furthermore, they are actively involved in program development, collaborative partnership building as well as advocacy for education, awareness and policy changes aimed at improving the health of persons after sexual violence.

Barriers to Follow-Up Care

Provider time constraints. Time constraints are often seen as a barrier to comprehensive care of the complexities associated with sexual assault. Multiple competing demands, brief appointment blocks, and the unpredictability of the emotional needs of women presenting for

care after sexual assault present as challenges to a provider's ability to deliver comprehensive care (Sutherland et al., 2014). These constraints not only impact the care delivered to women, but can also further exacerbate women's emotional distress as they may often feel rushed, unimportant or unsupported.

Documentation. Thorough documentation of history, assessment and care planning allows for continuity of care amongst multidisciplinary team members involved in the care of women after sexual assault. It also decreases the risk of re-traumatization that can be associated with repeated disclosures to new providers. Time constraints are cited as a major barrier that limits the time PCPs have to thoroughly document their assessments and plans for care (Sutherland et al., 2014). Documentation may also have significant implications for legal proceedings. Improper or incomplete documentation may not accurately describe the characteristics of the disclosed assault or the impact it has on the women who experienced it.

Provider comfort level. Comfort with providing follow-up care to women after sexual assault reduces the risk for re-traumatization and aids women in their recovery. Lack of comfort can occur for many reasons such as lack of familiarity with the follow-up care needed by women after sexual assault, lack of experience in caring for this population, personal discomfort in providing the care and a lack of available resources (Jakubec, Carter-Snell, Ofrim, & Skanderup, 2013). Decreased exposure and decreased continuing medical education may be responsible for low levels of comfort and competency when providing follow-up care to women after sexual assault (Jakubec et al., 2013).

Geographical considerations. Statistics Canada (2011) reports that roughly 20% of the population in Canada resides within rural communities. Geographical isolation represents a health disparity that affects women who have experienced sexual assault from receiving

equitable care that is accessible to women living within urbanized areas. Lack of available resources and access to emergency or specialized care services, transportation limitations, and fear of retaliation or reprisal from the offender or the community itself represent barriers to women accessing care (Averill, Padilla, & Clements, 2007). In addition, there are often greater concerns for confidentiality found within smaller rural communities (Padden, 2008). While there are many barriers to follow-up care for all women, geographical isolation and social functioning represent an additional challenge for those living within smaller communities.

Psychological and sociological considerations. Self-blame, shame and embarrassment are strong negative emotions that can prevent women from seeking follow-up care after sexual assault (Padden, 2008). Furthermore, fear of not being believed and concerns about breach of confidentiality can also impede women from seeking care (Jakubec et al., 2013; Padden, 2008). Negative social reactions from friends and family and the societal perpetuation of rape-myths are strong social factors that can cause emotional and psychological distress to women after sexual assault. “The trauma of [sexual assault] extends far beyond the actual assault, and society’s response to this crime can also affect women’s well-being” (Campbell et al., 2009, p. 226). Fear of secondary victimization and judgment can act as a barrier to follow-up care for these women.

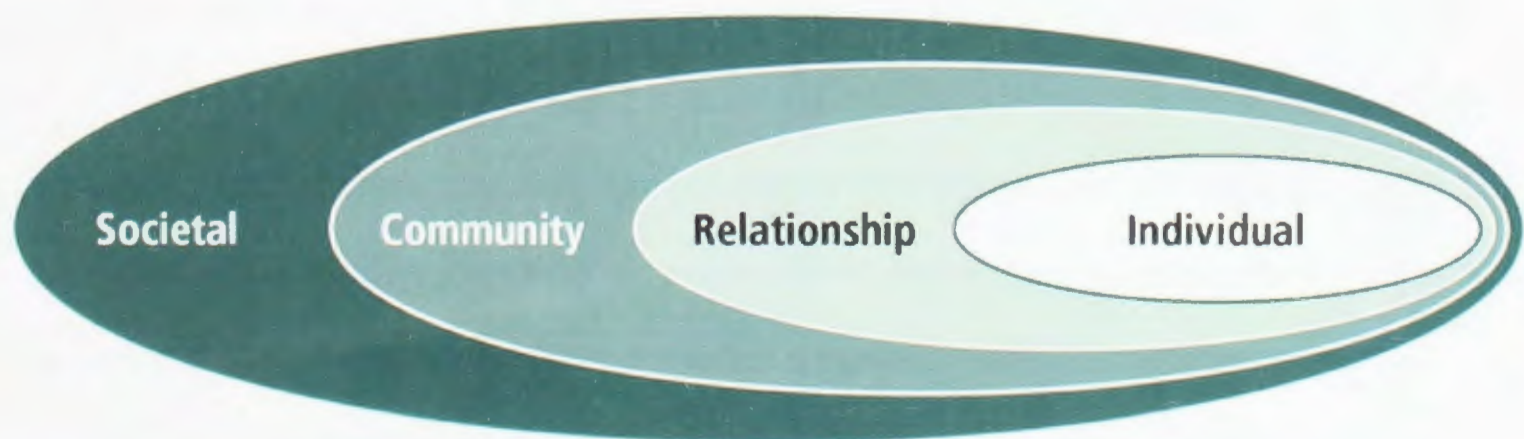
Theoretical Framework

An ecological framework was utilized to synthesize the literature findings examined within this project. It is well known that the experience of sexual assault can have detrimental effects on women’s emotional and mental health, however, the etiology and strategies to decrease the severity of these consequences are less clear (Campbell et al., 2009). An ecological framework is grounded in the belief that no one factor can explain the negative health effects experienced by women after sexual assault (Violence Prevention Alliance, 2015). The negative

sequelae of sexual assault instead needs to be considered from the perspective of varying levels of influence and the interaction that occurs between these levels (Dubosc et al., 2012; Violence Prevention Alliance, 2015). “The utility of an ecological framework is that it can suggest multiple strategies, at multiple levels of analysis, for alleviating the psychological harm caused by sexual assault” (Campbell et al., 2009, p. 226)

This project will therefore examine the ecological components that influence the mental health of women after sexual assault. It is comprised of four separate levels of influence: the individual level, personal relationship level, community level and societal level (Campbell et al., 2009; Violence Prevention Alliance, 2015). See Figure 1: Ecological Framework. Within each level, the ecological approach examines the interaction between a variety of factors such as biological, economic, cultural and the socio-political constructs (Henry & Powell, 2014). It is the interactions that occur between women and these levels of influence that impact how a woman perceives her experience and her role in its occurrence (Campbell et al., 2009).

Figure 1: Ecological Framework (Quadara & Wall, 2012).



The individual level of influence examines the biological, psychological and social characteristics of women who experience sexual assault and the impact it has on their recovery process (Campbell et al., 2009). Age, pre-existing mental health conditions and sexual assault characteristics such as the use of a weapon are examples of individual levels of influence that

may negatively impact the psychological well-being of a woman after sexual assault (Campbell et al., 2009). Examination at this level allows for a better understanding of the “choices and propensities” of women who experience sexual assault and often serves as the basis for interactions and effects seen within the higher levels of influence (Campbell et al., 2009, p. 228).

The personal relationship level of influence examines “the impact of disclosures to informal sources of support (e.g., family and friends) on victims’ postassault psychological distress” (Campbell et al., 2009, p. 228). There is a great deal of emphasis within the literature about the impact positive and negative reactions from friends and family have on the emotional and mental health of women after sexual assault. Negative reactions, such as blaming attitudes and disbelief can further traumatize women thus increasing their psychological distress (Padden, 2008), whereas positive reactions and supportive relationships can help promote recovery (Hellman, 2014). Examination at this level is imperative to understanding the personal relationship risk factors or recovery supports available to women after sexual assault.

The community level of influence examines disclosures and interactions within more formal sources of support such as community resource services, sexual assault services, as well as medical and legal systems (Campbell et al., 2009). The negative experiences at this level are not only a significant barrier to disclosure but also serve to reinforce negative self-perception, shame and self-blame thus increasing the psychological distress experienced by these women (Kelleher & McGilloway, 2009). Furthermore, geographical isolation can further impact the emotional distress experienced by women. As an example, women in remote communities may not have access to health care services, may be concerned with the confidentiality of their care or receive care by providers with no experience or training in the care of women after sexual

assault. As this can have a detrimental impact, examination at this level can help inform strategies to decrease the distress associated with these negative interactions.

The societal level of influence examines the sociocultural factors such as social and cultural norms, rape-myth acceptance and gender stereotyping that attributes responsibility for sexual assault onto the women who experience it (Campbell et al., 2009). This reinforces the negative self-perceptions, self-blame and shame experienced by some women thus increasing their psychological distress and propensity for the development of PTSD. For example, the widely held belief that if women dress provocatively, they are asking to be sexually assaulted may alter women's perception of their role in the assault leading to self-blame, negative self-cognitions and emotional distress. Examination at the societal level is important to help inform strategies aimed at changing pre-existing societal beliefs and values.

The ecological framework places equal importance on each level with the belief that a dynamic interplay among the levels exists which influences the factors of each level (Kelly, 2011; Violence Prevention Alliance, 2015). As an example, Campbell et al. (2009) discuss the concept of self-blame, arguing that it transcends any one level of influence as self-blame stems from the individual, personal relationships, community and societal interactions experienced by women after sexual assault. This highlights the importance of examining the mental health impact of sexual assault through an ecological perspective as only then can the significance of a multi-level primary care response be understood and approached.

An ecological approach to synthesis and analysis of the literature, focusing on the individual, their personal relationships, community and societal factors associated with sexual assault and its impact has been undertaken. Within the literature review, you will note that some studies will be reviewed in one context or level, but may be relevant within other levels as well.

This is because sexual assault does not occur in isolation, but instead contains factors that are dynamic and pertain to more than one level.

CHAPTER TWO

Integrative Review Method

The purpose of this integrative literature review is to determine whether access to sexual assault follow-up care within two weeks from the time of sexual assault can result in a decrease in the prevalence and severity of PTSD and depression in adult women of childbearing age. In order to answer this question, the literature search involved examining any sources pertaining to follow-up care in both urban and rural settings.

This integrative literature review was conducted utilizing the method as set forth by Whittemore and Knafl (2005). This method was appropriate for this review as it incorporates data obtained from various study types such as quantitative, qualitative and literature reviews. Whittemore and Knafl's method consists of five stages: problem identification, literature search, data evaluation, data analysis, and presentation.

Literature Search Methods

This section will discuss the literature search strategies utilized to select the sixteen studies, three clinical practice guidelines and supplementary articles used within this project.

Inclusion and Exclusion Criteria

The inclusion criteria for this project comprised research data regarding follow-up care for adult women of childbearing age who have experienced sexual assault. Exclusion criteria included any data relating to patients less than 18 years of age or men who have experienced sexual assault. In addition, articles published before 2004 were excluded.

Table 1: Inclusion/Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Articles published 2004 or later	Articles published earlier than 2004
English language	Languages other than English

Follow up care for adult women who have experienced sexual violence or assault	Sexual assault involving men, children, adolescents, veterans or those with physical or cognitive disabilities, post-exposure prophylaxis, acute care follow-up interventions
Research articles	Domestic or interpersonal violence, not specific to only sexual assault

Literature Search One

An initial literature search was conducted using the University of Northern British Columbia (UNBC) library online databases CINAHL and MEDLINE utilizing search terms and keywords as identified in Appendix B. Major Concepts included *sexual assault, examination, follow-up care, primary care and sequelae*. These concepts and similar search terms were chosen as they represent the various terms applicable to the question being researched. The Boolean phrase “or” was utilized when searching with like terms allowing for greater results with less overlap. The Boolean phrase “and” was used when searching subject headings and enabled results which yielded applicable information on sexual assault and follow-up care. A search of the CINAHL database yielded 6,134 articles for review and 1,164 article after the application of the inclusion criteria. A search of the MEDLINE database yielded 17,709 articles for review and 4591 articles after the application of inclusion criteria. Review of the first 450 articles of the CINAHL database yielded seven articles for use within this project. The review of this search was discontinued as these searches resulted in too many articles for a thorough review. The seven articles selected were kept and added to selections made from literature search two.

Literature Search Two

The secondary search was revised to include only the emotional and mental health follow-up care needs of women of childbearing age after sexual assault. The search terms were revised to reflect this focus change and to help narrow the search for applicable articles. See

Table 2 for Major Concepts and similar terms. The Boolean phrase “or” was utilized when searching with like terms allowing for greater results with less overlap.

Table 2: Major Concepts and Similar Terms

Sexual Assault	Follow up care	Sequelae
<ul style="list-style-type: none"> • Rape • Sexual abuse • Sexual violence • Rape victims 	<ul style="list-style-type: none"> • After care • Post-exposure follow-up • Follow-up • Medical follow-up • Lost to follow-up • Psychological follow-up • Health care needs • Treatment seeking behavior • Help-seeking behavior 	<ul style="list-style-type: none"> • Rape-trauma syndrome • Treatment complications • complications • Acute stress disorder • Stress-disorder, post-traumatic • Chronic complications • Treatment outcomes • Social problems • Self-medication • Stigma • Health Impact Assessment • Crime victims – Psychosocial • Victims - Psychosocial

Similar to literature search one, the Boolean phrase “and” was used when searching subject headings and similar terms and enabled results which yielded applicable information on the sexual assault and follow-up care specific to mental health sequelae. A search of the CINAHL database yielded 342 articles for review and 18 articles after the application of the inclusion and exclusion criteria. A search of the MEDLINE database yielded 868 articles for review and 21 articles after the application of inclusion and exclusion criteria. Three articles were duplicates from the CINAHL search and were thus eliminated leaving a total of 18 articles. A combined total of 36 articles from CINAHL and MEDLINE were reviewed. Closer inspection of the articles resulted in elimination of 28 articles as some focused on acute care management following sexual assault rather than the follow-up care needs of women within a primary care setting. Others were eliminated as they either did not provide any guidance or recommendations for follow-up care needs of women or they provided recommendations specific to other care disciplines not applicable to the primary care role. These exclusions yielded a total of nine

articles for inclusion. The combination of literature search one and search two yielded a total of sixteen articles for use within the literature review.

The literature search also yielded a total of three guidelines applicable to the follow-up care of women after sexual assault. The previously described CINAHL database search yielded one document for use and a hand search of the article reference lists used within this project identified a second document for inclusion. A search of the World Wide Web using the terms *sexual assault follow-up care guideline* and *primary care* yielded two documents for use and a similar search using the terms *trauma informed care guidelines* yielded one document for inclusion. As few relevant guidelines for the follow-up care of women after sexual assault exist, documents developed earlier than 2004 were included for review. One of the five documents was eliminated as it was a duplicate and another document was eliminated as it contained no recommendations for follow-up care within a primary care setting. Therefore a total of three guidelines were collected for use within this literature review.

Grey literature and supportive articles were searched using the UNBC databases, Google Scholar and the World Wide Web. In addition, a hand search of supportive literature was further conducted by reviewing available articles from previous assignments and resources utilized during my studies within the Family Nurse Practitioner Program at UNBC as well as a hand search of the references used within this project.

CHAPTER THREE

Findings

The search methodology described in Chapter Two resulted in a total of sixteen studies and three guidelines for use within this literature review to answer the research question. This Chapter will analyze the clinical practice guidelines with specific recommendations for post-sexual assault mental health follow-up care. It will also synthesize and analyze information gathered from the selected studies using individual, personal relationship, community and societal level perspectives as set forth in the ecological framework discussed in Chapter One. Furthermore, this Chapter will also highlight recommendations made within these studies specific to the emotional and psychological follow-up care needs for women after sexual assault.

Clinical Practice Guidelines

Clinical practice guidelines are systematically developed recommendations that guide health care providers' decision-making about appropriate care, screening and management for specific health challenges or circumstances (AGREE Next Steps Consortium, 2009). There are few practice guidelines available that address the follow-up care needs of women after sexual assault with fewer addressing the emotional and psychological needs of women. This section will review three documents offering recommendations for follow-up care after sexual assault.

The World Health Organization [WHO] (2003) created a document called the *Guidelines for Medico-legal Care for Victims of Sexual Violence*. The main purpose of this document is to guide the immediate forensic and medical health care of persons after sexual assault. Little guidance is offered for follow-up care within the primary care setting. This document was developed in collaboration with multiple international partners from various countries. It was also peer reviewed by an extensive list of international experts in the field of sexual violence and

the needs of persons after sexual assault. This guideline is expert-based with supportive literature citations throughout the document. As a result, no scientific process was identified or grading system for the strength and quality of the recommendations provided within this document.

The WHO (2003) document is 154 pages in length with only three pages devoted to the discussion of the medical and mental health follow-up care for persons post-assault. Of these pages, just over one page is devoted to the mental health needs of persons after sexual assault. The authors recommend follow-up care intervals at two weeks, three months and six months to address the medical and emotional status of patients, with recommendations to refer as necessary (WHO, 2003). These intervals appear to be based on the medical care needs more than the mental health care needs of patients as each visit interval represents a time period for particular medical testing or investigation. No guidance is provided about specific mental health assessments. Instead, emphasis is placed on referral to support organizations and counseling as necessary. The authors provide suggestions that help providers relay to patients the benefits of counseling and offer a list of suggested support services for practitioners to consider.

A limitation of the WHO (2003) document is its reliance on expert opinion, however, the extensive list of international contributors and peer-reviewers certainly adds strength to its recommendations. This document offers guidance for care providers in the immediate medico-legal care after sexual assault which can be beneficial for those working within rural and remote communities without access to specialized services to provide such care. However, for the purpose of this project, this document provides limited insight into the emotional and psychological care required after sexual assault. This guideline partially answered my research question as it provides recommendations for follow-up care timing intervals and provides suggestions for support services referral considerations.

Ray and McEneaney (2014) developed a more recent document called *Caring for Survivors of Sexual Violence: A Guide for Primary Care NPs*. The authors clearly state the purpose of this document is to provide recommendations that improve the care women receive after sexual assault within the primary care setting. While this document is geared to the care provided by NPs, it is applicable to all primary health care providers. This guide is based on the expert opinions of the authors with supportive literature documentation. As such, there is no identified scientific process, and no strength or quality grading of the literature used to support the expert opinions provided within this document.

Ray and McEneaney (2014) provided an overview of sexual assault and its common physical and psychological consequences with recommendations for the immediate care required post-assault. As many women do not seek health care services after sexual assault or are lost to follow-up care after the initial care management, the authors emphasized the importance of implementing screening practices within primary care offices. While screening is not pertinent to answering my current research question, its mention within this section draws attention to an area for possible future exploration of the value and impact screening has within the primary care setting. Ray and McEneaney recommended NPs provide individualized, patient-centered care in a supportive and non-judgemental manner that offers a safe environment for women. The majority of follow-up care recommendations provided within this document pertain to the ways in which NPs can decrease the anxiety and emotional distress associated with pelvic examinations thus preventing further re-traumatization.

As the Ray and McEneaney (2014) guide is based on expert opinion, the strength of its recommendations is limited. While supportive literature was used throughout the document, no literature selection process or evidence grading was provided, nor was there any indication a

peer-review process occurred. Despite these limitations, Ray and McEneaney provided an easy to read guide for the care of women after sexual assault. They offer helpful recommendations for pelvic examinations which can be one of the more emotionally distressing aspects of follow-up care for women after sexual assault. The authors recommend follow-up care intervals within one to two weeks of the assault, two to four weeks, six weeks, and three and six months as indicated by medical need with each visit representing an opportunity to assess mental health status. This document helped to partially answer my research question by offering recommendations for follow-up care provided by NPs within the primary care setting that aim to decrease the emotional distress experienced by women post-assault.

The British Columbia Center for Excellence for Women's Health [BCCEWH] (2013) published a document called the *Trauma-Informed Practice Guide*. The purpose of this guide is to support the transformation of trauma-informed principles into practice with the overall goal of bettering the care provided to those with histories of violence and trauma. The implementation recommendations within this document are expert-based with the addition of supportive literature. The Appraisal of Guidelines for Research and Evaluation II (AGREE II) tool was used to assess the strength and quality of this practice guide with scores provided over six domains. Domain one examined scope and purpose achieving an overall score of 90% while domain two scored 76% for its description of stakeholder involvement. Domain three scored 52% in terms of its developmental rigour while domain four examined clarity of presentation with an overall score of 86%. Seventy-one percent was attributed to domain five for applicability of the recommendations while domain six received a score of 57% for its editorial independence. Despite the lower score for rigour and editorial independence, the overall quality of this document was rated as 71%. See Appendix C for the complete AGREE II assessment of this

document. This guide offers recommendations for implementation of trauma-informed care at the organizational and provider level with the caveat that provider approach needs to be tailored to meet the needs of specific traumas experienced and the individual needs of each patient.

The BCCEWH (2013) provided recommendations for trauma-informed care that embodies the principles of trauma awareness, safety and trustworthiness, choice, collaboration and connection as well as strength promotion and skill building. While this document is not specific to only sexual assault, the underlying premise of care and harm-reduction is emphasized with the overall goal of establishing a positive and supportive relationship with patients that minimizes emotional and psychological distress and re-traumatization. This document offers recommendations for providers that can be tailored for the care of women after sexual assault and as such, serves to partially answer my research question.

AGREE II. The AGREE II tool for appraising guidelines was used to evaluate the BCCEWH (2013) guidelines as the entire document has implications for use within primary care. The guidelines for WHO (2003) were not evaluated using this tool as the recommendations for practice related to the mental health follow-up care of women after sexual assault consisted of just over a page of counselling and referral options for patients. Concrete recommendations were not made with regard to mental health follow-up care, but instead expert opinion of what resources may be helpful for women. The Ray and McEneaney (2014) document was not assessed using the AGREE II tool as this document was presented in article format representing an informal guide for the care of women who have experienced sexual violence.

In summary, this section examined three documents which have been developed to guide health care professionals providing care to women after sexual assault. Each of these documents offered recommendations that partially support my research question through insight into the

mental health needs of women post-assault. Two of the documents provide recommendations on how to approach and implement this care at either a provider or organizational level that minimizes the emotional distress experienced by these women.

Individual Level of Influence

Information examined at the individual level includes the personal histories, biological factors and assault characteristics that influence a woman's emotional and psychological response after sexual assault (Campbell et al., 2009). Factors within this level can have a profound effect on a woman's ability to cope with the emotional trauma associated with sexual assault. This section examines seven studies providing insight into the individual factors related to follow-up care prevalence rates, risk factors for sexual assault, sexual assault characteristics, as well as the impact of past sexual assault experiences and mental health histories of women who experienced a recent sexual assault.

The first study examined within this section is a retrospective cohort analysis completed by Ackerman, Sugar, Fine and Eckert (2006). The authors examined what demographic and sexual assault characteristics influenced access to follow-up care after sexual assault. A case-review of 812 charts of women 15 years of age and older who presented to an urban hospital with the report of sexual assault was conducted. Analysis revealed only 35.5% of women received some type of follow-up care with 18.5% receiving both medical follow-up care and counseling, 14.5% having medical follow-up care only and 2.5% receiving counseling only. Demographic information revealed follow-up rates declined as age increased. Also, lower rates of follow-up care were associated with homelessness, underlying psychiatric disorders, incarceration and police custody. Examination of assault characteristics by Ackerman et al. revealed factors more suggestive of a perceived threat of harm were associated with greater rates

of follow-up care. These factors included genital trauma, assaults occurring within their own homes, memory impairment, voluntary alcohol use, and transmission of sexually transmitted infections (STIs). Conversely, decreased follow-up rates were noted with characteristics indicating sexual assault by a partner, assaults within a public place, and illegal substance use.

Limitations of the Ackerman et al. (2006) study include the retrospective nature of the study itself. In addition, no documentation about past history of victimization nor whether any follow-up was conducted with another organization was provided. Despite the limitations, this study highlighted demographic and sexual assault characteristics that may make women more or less likely to seek follow-up care. Ackerman et al. reported that optimal timing for specific care interventions remain unclear, however, recommendations for follow-up care that is within close proximity of the assault itself may be key in identifying and treating those patients at risk for depression, PTSD and substance abuse. Recommendations also included follow-up care that includes both medical care and counselling as few return for counseling services alone. This study partially answers my research question providing some recommendation for follow-up care that includes both medical and mental health care within close proximity of the sexual assault.

The second article relevant to the individual level of influence is a retrospective study by Boykin and Mynatt (2007) which examined the impact sexual assault characteristics have on follow-up care. This study conducted a computerized chart review of 78 adult women who presented to a sexual assault nurse examine (SANE) program in a large urban center for examination where a sexual assault report was made to police. Assault characteristics revealed 83% of assaults were completed by a single offender, of which 49% were strangers. Weapons were used in 54% of assaults with firearms being the most common at 22%. Physical force was used in 71% of cases and 86% involved penile penetration. Boykin and Mynatt found

associations by Becker et al. (1984) and Bownes et al. (1991) indicating sexual assault with the use of a weapon was associated with greater levels of PTSD and depression (as cited by Boykin & Mynatt, 2007). With regard to follow-up contact, only 23% of patients were able to be reached by telephone for a three month follow-up call despite consent obtained for future follow-up given by 99% of participants during the initial examination.

The sexual assault characteristics within the Boykin and Mynatt (2007) study were not examined with regard to their impact on attendance of follow-up care appointments as seen in the study by Ackerman et al. (2006), but instead were included as they can have negative emotional and psychological consequences for women. Boykin and Mynatt highlight associations between the use of coercive force and weapons during sexual assault with increased levels of PTSD and depressive symptoms. As a result, Boykin and Mynatt stressed the importance of follow-up care that includes not only meeting the physical and mental health needs of women, but also care that includes recovery, health maintenance and future prevention.

Limitations of Boykin and Mynatt's (2007) research include its retrospective nature and its reliance on available documentation. There was no documentation about follow-up care provided at different sites, nor was there any data collected on the sexual assault characteristics of those who presented for examination without a report to police. In addition, the small sample size impacts the generalizability of these findings to larger populations. Despite these limitations, Boykin and Mynatt served to highlight the difficulty in contacting women for follow-up care and the need for improved, individualized follow-up care to meet the medical and psychological needs of these patients. The authors recommended follow-up care to address the psychological needs of patients starting as early as 24 to 48 hours after the initial examination, with medical follow-up appointments within one to two weeks of the assault and laboratory testing at six,

twelve and twenty-four week intervals. The data and recommendations provided by Boykin and Mynatt offered relevant evidence that partially answers my research question.

The third study examined is a cross-sectional study by Mark, Bitzker, Klapp and Rauchfuss (2008) which explored whether the presence of sexual violence experiences increased the prevalence of chronic gynecological symptoms in adult women aged 18 to 65 years. A survey examining the physical and sexual abuse experiences of 730 women at different time periods in their lives was conducted. Results revealed that 47.5% of women experienced physical attacks, 52.5% experienced sexual assault with 13.5% reporting sexual violence with completed rape. A significant association between sexual violence and chronic pelvic pain, vaginal infections and dysmenorrhea was found. As a result, these women often also have higher health care utilization rates, which as Mark et al. suggested, may account for why increased rates of sexual violence were noted within the medical setting examined in this study.

Mark et al. (2008) noted that 1941 women were eligible for participation in this study but only 730 completed the survey. This may be considered a weakness of the study as lower response rates are often associated with higher prevalence rates as women with no history of violence may be less inclined to respond. As seen in other studies, a limitation of the Mark et al. study is its cross-sectional design as its results rely on recall bias which may lead to over or underestimation of its findings. Regardless of the limitations, Mark et al. believe this study supports the theory that experiences of violence can have a profound impact on women, especially in the area of reproductive health. Health care providers must use caution in their examinations of these women to prevent possible re-traumatization. Mark et al. also stressed the importance of exploring the need for safety planning and referrals to mental health professionals to treat resulting emotional and psychological manifestations. This study offers partial support in

answering my research question by offering recommendations for care that may decrease the prevalence and severity of the emotional distress experienced by women after sexual assault.

A prospective longitudinal study by Ulirsch et al. (2014) examined whether women 18 years of age and older who reported acute sexual assault experienced a clinical worsening of pain and somatic symptoms at six weeks and three months independent of the area of trauma sustained as a result of the sexual assault. Women who presented for care to a SANE Program within 48 hours of the sexual assault were recruited yielding a final sample of 84 women. Financial incentive was offered resulting in a follow-up completion rate of 89% at six weeks and 82% at three months. Ulirsch et al. examined assault characteristics noting 71% were assaulted by a non-stranger, 8% of women were assaulted by multiple persons and 88% reported penile-vaginal penetration. Fifty-five percent of examinations yielded no identifiable physical findings. Despite this finding, 58% of women reported clinically significant new or worsening pain (CSNWP) in at least one body region at the six week follow-up and 60% at the three month follow-up appointment. Thirty-two percent of women reported CSNWP in three or more body regions at the six week follow-up and 28% at the three month follow-up appointment. Slightly greater than 10% of women reported CSNWP in five or more body regions at each time point. Areas of CSNWP were widely distributed with the four most common areas being the head, neck, back and abdomen. Only 23% of CSNWP were in regions where the sexual assault exam noted physical injuries at the six week follow-up with 14% of those being present at the three month follow-up appointment.

Ulirsch et al. (2014) also examined somatic symptoms using a Likert Scale from 0 to 10 to measure symptom severity and noted all women experienced an increase in number of somatic symptoms with an average increase of 4.3 at six weeks and 4.8 at the three month review. The

most common manifestations at six weeks included nausea, difficulty concentrating, taking longer to think, restlessness, persistent fatigue, racing heart, insomnia and sleep difficulties. At the three month appointment, similar symptomologies were seen with the addition of worsening noise sensitivity, more severe itching eyes and skin and more severe trembling or shaking. Ulirsch et al. reported 93% met criteria for PTSD at the six week appointment and 78% at the three month visit. PTSD severity in this study was shown to have a low to moderate correlation with number of body regions with CSNWP and a moderate correlation with the number of somatic symptoms at the six week and three month visits.

A strength of the Ulirsch et al. (2014) study was its prospective longitudinal design, however its reliance on retrospective reports of sexual assault exposures and symptom prevalence and severity may be seen as a limitation. In addition, its small sample size limits the generalizability of the findings to the general population. Despite these limitations, Ulirsch et al. provide evidence that CSNWP and somatic symptoms can be persistent consequences of sexual assault lasting a minimum of three months. These findings have important implications and as such partially answer my research question as they suggest that follow-up care shortly after the assault may decrease the prevalence and severity of PTSD and depressive symptoms experienced by women after sexual assault.

Brown, Du Mont, Macdonald and Bainbridge (2013) examined whether the presence of a pre-existing mental health condition increases a woman's risk of experiencing a sexual assault, and if assaulted, the prevalence of specific sexual assault characteristics. The authors reviewed the database of a hospital-based SANE program and identified 467 persons who had experienced a recent sexual assault with 92% of those persons being female. Roughly 34% of the sample reported the presence of at least one mental health condition with the largest categories being

anxiety and depression followed by bipolar spectrum disorder, and substance addiction.

Comparisons made between those with pre-existing mental health conditions and those without mental health histories demonstrated that those persons with underlying mental health conditions were more likely to be vaginally (62.4% versus 55.7%), orally (26.4% versus 15.6%) or anally (20.3% versus 14%) penetrated. Brown et al. makes the association that pre-existing mental health histories appear to be associated with more severe forms of sexual assault. No mention is made within the study about the emotional or psychological impact these findings have on those with pre-existing mental health histories. However, Brown et al. highlight the difficulties in contacting patients for follow-up as 89% provided a number for follow-up contact and only 64% were able to be reached with 49.9% attending one follow-up visit. Despite pre-existing mental health conditions, no differences existed for counseling referrals and it is unknown whether those with pre-existing mental health conditions sought follow-up care from previously accessed mental health services.

Limitations of the Brown et al. (2013) study are its retrospective nature and its reliance on predetermined information and self-reports contained within the charts reviewed. A weakness of this study may be the lack of sociodemographic data which may have added a better understanding of the findings, such as age and previous victimization history which have also been associated with increased rates of sexual assault (Brown et al., 2013). Despite its limitations, Brown et al. recommend follow-up care that includes screening for common mental health issues such as depression, suicide, bipolar disorder, anxiety and substance use. Additionally, the authors recommend the provision of individualized care and treatment planning to meet the emotional and psychological needs of patients such as specialized counseling referrals and multidisciplinary responses. The findings within this study partially answer my

research question by highlighting recommended approaches for follow-up care that may decrease the development and severity of the mental health consequences associated with sexual assault.

A retrospective, cross-sectional study by Dubosc et al. (2012) examined the mediating role of PTSD and depressive symptoms in the relationship between early adult sexual assault and disordered eating in female students aged 13 to 30 years of age. A questionnaire examining these factors was completed by 296 female students. Of these women, 37% reported one or more incidents of sexual assault with 41% seeking some type of professional assistance. Twenty-one percent met criteria for disturbed eating behavior and 22% scored high enough to warrant clinical evaluation for PTSD. Results also demonstrated a correlation between PTSD and depressive symptoms, as well as disordered eating with a history of early adult sexual assault. When examined together, PTSD and depressive symptoms were responsible for fully mediating the relationship between sexual assault and disordered eating. Dubosc et al. postulated the development of disordered eating after sexual assault may occur from avoidance of negative cognitions and emotions or from feeling sexually objectified.

The Dubosc et al. (2012) study is limited by its cross-sectional design and its incorporation of a convenience sample that may not be representative of the general female student population. In addition, the length of time since the sexual assault was varied making it difficult to understand the acute versus chronic emotional consequences of the assault itself. In addition, limited data was collected about assault characteristics experienced and their impact on the development of PTSD, depression and disordered eating. Dubosc et al. makes reference to recommendations made by Holzer et al. (2008) which proposes a possible need for emotional regulation as a means for coping with depression, PTSD and the prevention of eating disorder development, however, no further information is provided as to what that emotional regulation

entails. Despite these limitations, Dubosc, et al. suggested implementing screening for depression and disordered eating post-sexual assault as this may limit the development and severity of PTSD, depression and eating disorders in women after sexual assault. This study has provided some insight into the mental health follow-up care needs of women after sexual assault as such has made partial contributions to answering my research question.

The last study within this section is retrospective in nature with prospective components conducted by Wilson, Waldron and Scarpa (2014). They examined whether a history of sexual victimization was associated with an increased level of disinhibition thus increasing a woman's risk for sexual re-victimization. Disinhibition in this study referred to alcohol abuse, sexual promiscuity and gambling. The sample consisted of 211 young adult female college students from a large public university. Forty-three percent were initially identified as having experienced sexual victimization and 32.2% identified a sexual victimization having occurred during the six month prospective period. Findings revealed prior sexual victimization was associated with higher rates of disinhibition which is speculated by Wilson et al. to be a coping mechanism for the psychological distress stemming from the assault. Results also demonstrate disinhibition is considered a partial mediator between a history of sexual victimization and re-victimization identifying disinhibition as a likely causal mechanism. Wilson et al. highlight the importance of these findings citing literature by Gidycz, McNamara and Edwards (2006) and Patriquin, Wilson, Kelleher and Scarpa (2012) suggesting that disinhibition is associated with physiological blunting causing decreased physiological arousal to sexually risky situations and reduced threat detection placing its victims at further risk for re-victimization.

A limitation of the Wilson et al. (2014) study is its retrospective design, although the addition of the prospective component provides more strength to its findings. However, this

study continues to remain reliant on the recall of its participants lending it to possible recall bias. Despite its limitations, Wilson et al. recommend that health care professionals assess women for physiological blunting post-sexual assault with care planning that includes education about risk factors, threat detection for re-victimization and strategies to decrease risky behaviors. As a result of the evidence provided within this study, recommendations were suggested that served to partially answer my research question.

In summary, the individual levels of influence analyzed within this section, such as age, pre-existing mental health conditions, previous sexual assault history and sexual assault characteristics served to demonstrate the negative influential impact these factors have in the development of PTSD and depression in women after sexual assault. The evidence demonstrates they also play a role in placing women at higher risk for re-victimization, further adding to the psychopathology that can arise as a result of sexual assault. These studies provided valuable evidence supporting the need for comprehensive mental health screening and care within close proximity of the assault, with recommendations as early as 24 to 48 hours after the assault (Boykin & Mynatt, 2007).

Personal Relationship Level of Influence

Examination of personal relationships such as family, friends, intimate partners and peers are important as these relationships can profoundly impact women's response and ability to cope with the emotional and psychological trauma associated with sexual assault as well as her willingness to access treatment and follow-up care. This section will examine three studies providing insight into the personal relationship factors that can impact women after sexual assault.

The first study within this section is a retrospective study by Vidal and Petrak (2007) that examined whether feelings of shame contribute to increased levels of traumatic stress in women aged 16 years of age and older who have experienced sexual victimization. Participants were recruited from both clinical and non-clinical settings, resulting in a final sample of 25 women, 20 of which were recruited from a clinical setting. Results indicate 44% of women experienced sexual assault within 12 months of completing the questionnaire with 80% of women indicating they were assaulted by someone they knew. Sixty-eight percent reported experiencing physical consequences associated with the sexual assault such as pelvic pain, pregnancy or STIs. Fifty-six percent reported consuming alcohol voluntarily prior to the assault and 17% of women stated they were given alcohol or drugs against their will. Forty percent of women completed a medical/forensic examination after the sexual assault. Eighty percent of women considered not telling others about their sexual assault experience, however 28% of those women at some point later chose to disclose with 52% choosing not to disclose at all. Sixty-four percent of women reported they felt they were to blame for being sexually assaulted.

Vidal and Petrak (2007) used a revised Impact Evers Scale based on which 88% of participants indicated the presence of traumatic stress. The Experience of Shame Scale was administered demonstrating high levels of shame amongst participants. Women who felt they were to blame for the assault scored significantly higher levels of shame than those who did not blame themselves. Those who reported physical consequences related to the sexual assault and those who completed a medical/forensic examination scored significantly higher on levels of bodily shame than those without consequences or examination completion. No further information is provided explaining the factors associated with higher levels of shame after a completed medical/forensic examination. In addition, keeping the assault a secret was associated

with increased levels of shame, as was having been assaulted by someone they knew. In addition, women with histories of previous victimization scored higher levels of shame than those without a victimization history.

Limitations of the Vidal and Petrak (2007) study include its retrospective design and smaller sample size. In addition, most participants were recruited from a clinical setting where Vidal and Petrak speculated women may be more willing to discuss their experiences and perceptions than those who chose not to participate. Despite its limitations, Vidal and Petrak demonstrated results consistent with the literature that is suggestive of shame playing a role in exacerbating distress and traumatic stress post-sexual assault. Therapeutic intervention and empowerment were recommended for women with high levels of shame and self-blame to decrease negative self-perception and promote resiliency and recovery. The findings within this study served to partially answer my research question by providing insight into the approach to follow-up care needed to decrease the negative emotional distress experienced by women after sexual assault.

Littleton (2010) conducted a retrospective, cross-sectional study with prospective components, which examined how the role of perceived social support and negative disclosure reactions impacted the development of PTSD, depressive symptoms, and adaptive and maladaptive coping in women who have been raped. An initial survey examining negative sexual experiences, coping and psychological health was conducted with a follow-up survey at six months with similar questions. Women also completed several scales and inventories to assess for PTSD, depression, negative cognitions, coping strategies and perceived social support. Initially 1744 women were eligible to participate in this study. Of the initial 1744, 340 women reported being raped and were selected to participate, however only 262 women comprised the

final sample as these women completed both the initial and six month follow-up survey. Women who completed the six month follow-up survey received a \$20 gift certificate.

Results within the Littleton (2010) study found 33% of sexual assaults occurred within one year, 49% within the past two years and 81% of women were assaulted by someone they knew. Women were more likely to disclose the assault to someone they knew with 83.3% disclosing to a friend. Formal disclosures to health care providers occurred less often (11%). On average, women reported distress levels just below the cut-offs for PTSD and depression diagnoses at both the initial and six-month follow-up survey. Women reported higher levels of satisfaction with their social support systems, however, it was noted that negative disclosure reactions by their social supports, while distressing, were often unintentional. Littleton speculated that this occurs as a result of the social support person's difficulty in managing their own comfort level with the disclosures. Distraction and egocentric responses were the most common reactions expressed whereas stigmatization and controlling responses were the least common. Littleton noted perceived positive social support was associated with greater positive self-cognitions and use of adaptive coping. Conversely, negative disclosure responses were associated with increased negative self-cognitions and maladaptive coping. Littleton also noted both social support and negative disclosure responses, while thought to be distinct constructs, appear to moderate associations with the development of PTSD and depression during cross-sectional analysis. However, in longitudinal analysis, a moderate association was only noted between negative disclosures and PTSD.

The limitations of the Littleton's (2010) study include its retrospective design, however the use of prospective longitudinal data serves to strengthen these findings. Also, the low participation rate of the women and the study's reliance on self-reports limits the generalizability

and strength of the study findings. Despite these limitations, Littleton highlighted the potential impact social support and negative disclosures can have on women's emotional and psychological responses after sexual assault. As a result, Littleton recommended caution be exercised when encouraging women to disclose their assault experiences as this study has shown that negative disclosures can negatively impact the emotional health of women. Littleton also recommended that providers assess the strength of women's social support networks and any disclosure experiences they have had as these can affect recovery. These recommendations made by Littleton partially support my research question by guiding the provision of follow-up care that decreases the emotional suffering experienced by some women.

Hellman (2014) conducted a literature review that examined common sexual assault survivors' responses to, and long-term effects of, sexual assault, the mediating factors for recovery and the prevalence of any religious or spiritual recommendations the authors made that promote recovery. Hellman clearly identified her search methodology resulting in twenty-three peer-reviewed articles for review and analysis. Negative health consequences of sexual assault within these articles included anxiety, depression, PTSD, avoidance coping, decreased self-esteem, substance use, suicidal ideation/attempts. These responses were influenced by social support, the perceptions of others and the presence of additional traumas or substance use. The greater the negative social reactions experienced from others, and the greater avoidance coping utilized by women, the higher the levels of distress and PTSD experienced. Mediating factors for recovery identified included positive support, belief in a just world, perceived control and the number of coping strategies utilized. The literature demonstrated that the greater the positive support experienced, the greater the psychological well-being resulting in decreased levels of distress and PTSD. Belief in a just world as a mediator views the occurrence of sexual assault as

a situational occurrence as opposed to the belief that character or behavioural circumstances were to blame. Increased levels of perceived control were instrumental in positive post-sexual assault adjustments. Lastly, a greater number of coping mechanisms and strategies utilized by women after sexual assault were associated with lower levels of distress experienced. Positive spiritual coping mechanisms included the comfort and strength garnered by the belief in a higher power, the support and acceptance received from the religious community, and the use of prayer as an outlet for emotional release (Pargament, Feuille & Burdzy, 2011 as cited in Hellman, 2014).

Hellman (2014) identified gaps within the literature such as sexual assault within suburban and rural populations, changes in the belief patterns of others, and religious support. The small number of articles that met inclusion criteria supports this assertion, but is also seen as a weakness as it limits the amount of information available for review. Furthermore, the study findings are completely reliant on previously published research with varying sample sizes, participant selection processes and study methods. Despite these limitations, Hellman identified the long-term effects suffered by some women after sexual assault, as well as the mediating factors associated with positive recovery journeys. This study highlights the importance of PCPs offering positive, supportive care to women while aiding them to regain control of their bodies, lives and environment. This study partially answers my research question as the recommended approach to care may help decrease women's perceived powerlessness and as such the prevalence and severity of PTSD and depression, thus promoting recovery.

The studies reviewed within this section provided strong evidence demonstrating the impact both positive and negative personal support networks can have on women's emotional response to sexual assault. Non-disclosure and negative disclosure responses were associated

with higher levels of negative self-cognitions, maladaptive coping strategies and high levels of shame thus increasing the risk for the development of PTSD and depression. The recommendations noted within this section provide guidance for positive and supportive follow-up care that empowers and meets the mental health needs of women after sexual assault with further recommendations for assessing past disclosure experiences and the limitations and strengths of social support networks.

Community Level of Influence

Analysis of community level factors include examination of the community settings in which women who have been sexually assaulted live and the interactions between these women and the formal systems in place to support them such as the health care system. It also includes examining efficacy of protocols and practices of providers within the health care centers themselves. This section will examine four studies highlighting the community factors that may impact the emotional and psychological well-being of women after sexual assault.

The first study in this section is a retrospective study by Thurston, Patten and Legendyk (2006) which examined the prevalence of physical assault in women 16 years of age and older and sexual assault in women 18 years and older within a rural community. Thurston et al. also examined the relationship between the report of assault and self-reported health behaviours and health services use. As the ages examined for physical assault and sexual assault differed slightly, both groups were analyzed independent of the other. Of a sample of 526 women, 5% reported physical assault within the last 12 months, with 66.7% of the assailants being known to the women. Of a sample of 515 women, 24% reported experiencing sexual assault in their lifetime. While 30% of women reported using illicit drugs on at least one occasion, women who reported sexual assault were found to be more likely to report having used illicit drugs in their

lifetime than women who did not report sexual assault. With regard to health services use, women who reported physical assault were significantly more likely to access emergency and mental health services within the past 12 months, however no significant differences were noted in the use of primary care, emergency care and mental health services for women who reported experiencing sexual assault (Thurston et al., 2006).

Limitations of the Thurston et al. (2006) study include the lack of consistency in comparing physical assault versus sexual assault outcomes. Only statistically relevant data was provided within this study making data comparisons difficult to contrast. Another limitation is the original data used within this study was collected as part of a general health survey providing Canadian rural population data rather than data specific to physical or sexual assault. Given the nature of the questions posed within the original survey, it is also difficult to ascertain whether there was an increase or decrease in risky behaviours and/or health services usage post physical or sexual assault. Despite these limitations, Thurston et al. identified health risks, such as alcohol consumption and illicit drug use that may be associated with physical or sexual assault within rural communities. Thurston et al. noted that practitioners within the health sector are well positioned to work with others such as educational and legal sectors to develop collaborative service-based models to meet the health needs of women who have experienced sexual violence. Thurston et al. suggested that examination of gender and the social determinants of health within the context of the rural setting need to be considered as these factors can prevent or exacerbate the impact sexual violence has on women. This study partially answered my research question as it yielded findings that identified mental health and risk assessments for women after sexual assault with recommendations for community level collaboration to improve the accessibility of post-sexual assault services.

Sutherland, Fontenot and Fantasia (2014) conducted a qualitative, retrospective analysis which examined the documented provider responses to disclosures of interpersonal violence (IPV) or sexual assault (SA) within four urban family planning clinics in Northeastern US. The study used information collected as part of a larger retrospective review involving 2000 medical charts. A positive response to standard health history questions about violence was found in 570 charts highlighting an overall rate for lifetime violence of 28.5%. As a result, these charts were the sample used for analysis and yielded three main provider responses: no documentation, descriptive response and action-oriented response to violence. Sutherland et al. found 13% of charts with a positive screen for violence contained no documented provider response, 81.5% of providers documented descriptive responses with subcategories to further describe the type of violence experienced: past IPV (40.8%); current IPV (5.9%); and SA (24%). Slightly over 4% of providers addressed social factors of substance abuse with some notations about contextual factors associated with the violence. Nine percent of charts noted a childhood history of SA with no insight into outcome or legal involvement and no association to current episodes of violence. Sutherland et al. noted action-oriented documentation of violence in less than 6% of charts with provider responses including referrals, safety planning, lethality assessments, and recommendations for counselling and/or education. The majority of documentation discussed current episodes of violence with little to no discussion of past experiences of violence. Sutherland et al. contends that poor documentation may result in increased disclosure experiences, which in turn, may further increase the emotional distress experienced by women.

A few limitations were noted in the study by Sutherland et al. (2014). The retrospective chart review and the fact that data was gathered from one geographical location limit the strength and transferability of these findings. Despite these limitations, Sutherland et al. highlighted the

importance of a thorough assessment of the associated risks and safety concerns with complete action-oriented documentation including referrals to needed services. Sutherland et al. advocated for the use of organizational practice tools and electronic medical records (EMRs) to help address documentation barriers experienced by many providers, such as time constraints. Recommendations for individual practice settings to develop standardized procedures, algorithms or documentation tools may prove beneficial in ensuring thorough assessment and care planning. In addition, Sutherland et al. recommended each primary care office have a complete list of available resources for women that include support groups, shelters, mental health services and legal support. These results provide partial support for my research question as suggested practice level recommendations for improving sexual assault follow-up care may serve to decrease the emotional distress experienced with disorganized or time-constrained encounters.

Amstadter, McCauley, Ruggiero, Resnick and Kilpatrick (2008) conducted a cross-sectional analysis which examined whether histories of more than one sexual assault, the presence of mental health conditions or substance use are associated with any help-seeking behaviours among women after sexual assault. An initial group of 3000 women were recruited from two national population samples, of which 556 women reported a history of rape. These women comprised the final sample used within this study. A telephone interview was conducted with participants selected with a random-digit-dial methodology.

Amstadter et al. (2008) found 60% of women reported seeking help with 38% seeking help from a medical practitioner and 54% from a mental health professional. Relatively high levels of PTSD, major depression and substance use were noted within this study. PTSD was associated with increased help-seeking behaviour while substance use was moderately associated

with help-seeking. Amstadter et al. noted a history of forcible rape and major depressive episodes among women were associated with increased help-seeking from medical professionals, whereas PTSD was associated with increased help-seeking from mental health professionals. Linear regression analysis revealed that peri-traumatic fear, PTSD and major depression were significantly associated with greater number of accessed services. Amstadter et al. postulated that women with depression seek care more often from medical professionals as they often present with numerous unexplained physical manifestations requiring investigation. While findings may suggest a greater affinity for help-seeking from medical professionals for depression and mental health professionals for PTSD, Amstadter et al. highlighted findings suggesting either professional may be accessed with either condition.

A limitation of the Amstadter et al. (2008) study include its reliance on self-reported data which increases the risk for recall bias leading to possible over- or underrepresentation of the study findings. Furthermore, the brief nature of the interview could also be considered a limitation as it restricted the comprehensiveness of information collected. Despite these limitations, Amstadter et al. made important recommendations for health care professionals caring for women after sexual assault. Firstly, the authors recommended that providers assess women after sexual assault for substance use disorders as prevalence rates were high within this study. In addition, findings highlighted the need for mental health education for medical health practitioners as they will likely care for the emotional and psychological needs of women after sexual assault. This continuing education should include information about sexual assault and common reactions experienced by women. Practitioners should include the use of PTSD and depression screening tools and also ensure they are informed about the non-pharmacological and

pharmacological therapies available to treat these conditions. The results of this study yielded evidence that served to partially answer my research question.

Padden (2008) conducted a review of the research regarding sexual assault and its effects to promote awareness and provide recommendations for health care providers in caring for the mental health needs of women after sexual assault. No literature review methods, search strategies, inclusion or exclusion criteria or number of articles used were provided for this review. Instead, the author provides expert opinion with research support regarding the consequences of sexual assault, barriers to reporting and implications for the follow-up care of women who have experienced sexual assault. Padden noted multiple physiological and psychological consequences associated with sexual assault and the development of PTSD. She also makes reference to research by Frayne et al. (1999) that noted associations between higher rates of health care utilization and women with sexual assault histories. Furthermore, Padden noted barriers to disclosure of sexual assault experiences include shame, self-blame, guilt and embarrassment, fear of not being believed or supported by informal and formal systems as well as fears associated with breeches in confidentiality. Both higher rates of health care utilization and the multiple barriers that impact women's disclosure of their experiences prompts Padden to recommend general screening for sexual assault in primary care practices. While screening does not address the research question for this project, it does draw attention to the need for further research on the impact of screening for sexual assault within primary care settings.

As the Padden (2008) article provides information derived from expert opinion and research findings with no identified search method or selection strategy for its usage, it limits the strength of its outcomes. Despite these limitations, Padden provides recommendations similar to other studies within this review that support a supportive, non-judgemental and empathetic

response from health care providers when caring for women after sexual assault.

Recommendations that guide health care providers in establishing trusting rapports with women to set the foundation for supportive care are provided. Further recommendations include practitioners develop a comprehensive list of available referral services for providers use and resources available for use by women accessing care. This article provides partial support in answering my research question by providing guidance for PCPs, such as NPs, in the provision of safe and therapeutic follow-up care after sexual assault.

In summary, review of community factors of influence revealed that geographical isolation, provider time constraints and lack of provider knowledge about sexual assault and its management act as barriers to the provision of follow-up care that meets the emotional and psychological needs of women after sexual assault. The authors within this section partially answered my research question offering recommendations for care aimed at improving the services provided within rural and remote areas, the development of organizational tools to improve practitioner efficiency and care provision, as well as increasing access to education that enhances provider knowledge and comfort in caring for women after sexual assault.

Societal Level of Influence

This section will examine two studies highlighting the societal factors that may impact the emotional and psychological well-being of women after sexual assault. Examination of studies at the societal level allow for insight into the mental health impact societal beliefs, norms and the acceptance of rape-myths have on women who have experienced sexual assault.

The first study within this section is a qualitative, comparative descriptive study conducted by Kelleher and McGilloway (2009) examining the key issues and challenges reported by service workers employed in sexual violence support organizations. The sample consisted of

18 female service workers recruited from various organizations. A semi-structured interview was administered in person, recorded and transcribed for thematic analysis. Key themes within this study included examination of barriers and current gaps in service provision. Kelleher and McGilloway identified shame and guilt, naming or acknowledgement of the assault and societal myths around rape as significant barriers to accessing care after sexual assault.

Shame and guilt were thought to result from women's perceived responsibility for the sexual assault, the amount they resisted and the concern over the responses and reactions by their informal support systems. Kelleher and McGilloway (2009) noted that reluctance in naming or acknowledging their sexual assault experience often prevented women from disclosing their experiences resulting in women trying to cope with negative emotions without support from service providers or informal supports. Furthermore, Kelleher and McGilloway noted the prevalence and acceptance of rape-myths often perpetuates negative self-cognitions, self-blame and shame in women after sexual assault as their experience of sexual assault does not match the stereotypical belief of who a victim or offender is or the circumstances surrounding the sexual assault itself. The concern that women will not be believed or supported was a significant barrier for access to initial and follow-up care. Kelleher and McGilloway identified the largest gap in service provision to be the limited education and awareness women have about available services, and for communities and society, about sexual assault itself.

Limitations of the Kelleher and McGilloway (2009) study include its small sample size and the qualitative nature of the study examining the service providers' beliefs of what impacts the care of women. These both limit the transferability of findings to the general population. While this study focused on service providers in crisis centers, findings can inform strategies targeting societal beliefs and views employed by health care providers. Kelleher and

McGilloway suggested using appropriate language when communicating to the public to ensure all women can identify their experiences as sexual assault. Education and awareness targeting the varying societal levels about sexual assault, its varying presentations, its impact and how to access health services can help decrease stereotypical beliefs, thus limiting the negative emotional consequences experienced by women. This study provides evidence that partially supports my research question with recommendations geared at societal level system changes.

Adding to the discussion of societal influence, Munro (2014) conducted a literature search which examined the barriers that decrease access to comprehensive care for women of childbearing age after sexual assault. Munro utilized Whitemore and Knafl's (2005) integrative review method for this study which yielded twelve studies and four national surveys for review. Munro themed her findings according to personal and environmental factors that act as barriers to accessing care. Personal factors identified within the literature included emotional states such as shame, embarrassment, humiliation, guilt and self-blame. Fear of unhelpful interactions with formal systems such as not being believed, negative reactions, and lack of confidentiality were also personal factors identified that may deter women from accessing care. Also, fear of reprisal from the offender or the public as well as a lack of knowledge of available services to care for women after assault further impacted accessibility. Munro also identified environmental factors within the literature in the form of structural or organizational barriers such as limited services or access to services as well as care by health care professionals who are inexperienced in providing care to women after sexual assault. Furthermore, Munro noted that societal myths are a significant environmental barrier to care as they affect both informal and formal systems. These myths can make it difficult for women to name or acknowledge their experience as sexual assault causing them to feel their experience was not serious enough to warrant care. In addition, many

service providers including health care professionals may respond inappropriately when caring for women as a result of rape-myth acceptance.

Limitations of the Munro (2014) review include its complete reliance on previously published research, many of which were retrospective with a cross-sectional design reliant on self-reported data or secondary data sources. A strength of Munro's study is its use of the Whittemore and Knafl (2005) integrative review method and its clearly demonstrated literature search results and sample selection criteria. In addition, Munro made many recommendations for NP practice to better care for women of childbearing age after sexual assault. Recommendations specific to emotional and psychological well-being included provider awareness of the possible mental health and somatic symptoms that may manifest as a result of emotional distress suffered after sexual assault. Munro also stated that NPs have a responsibility to conduct thorough health histories and assessment of current health care needs. NPs were encouraged to become familiar with the structural and organizational barriers specific to their practice environments and problem-solve methods to decrease these barriers. Furthermore, Munro advocated that NPs provide education and raise awareness about sexual assault to women, communities and society as a whole. In addition, compilation of a resource list for formal supports available was provided that may be helpful for providers in aiding women's access to other services.

To summarize, societal influences perpetuating feelings of shame, self-blame and guilt among women after sexual assault may result in feelings of fear and concern that informal, formal and public systems may not believe or may attribute further blame on these women for the occurrence of the assault itself. Furthermore, women often have difficulty locating or accessing available health and social services to help cope with the trauma they have experienced. These two studies encourage providers to engage in societal level strategies aimed

at increasing education and awareness of sexual assault, its consequences and services available to help women after sexual assault. As a result, these research articles provided partial support for my research question.

Summary of Findings

In summary, review of existing guidelines that inform the care needed for women post-sexual assault was limited. The application of a trauma-informed approach to care, while not specific to sexual assault, represents an approach to care that aims to minimize the emotional distress experienced by women. An ecological framework was utilized to synthesize the remaining literature allowing for multi-level analysis of factors that impact women's emotional and psychological response to sexual assault. Individual level findings reveal that demographic, assault characteristics, pre-existing mental health conditions, and personal coping responses can negatively impact women's emotional response after sexual assault. Examination of personal relationships were pivotal in identifying the role social support can have in promoting recovery or conversely, increasing the negative self-cognitions and emotional distress experienced by women. Community and societal level interactions were closely related in that negative responses by formal systems and society itself can further perpetuate the shame, embarrassment and the negative emotional responses exhibited by some women. Furthermore, lack of education and awareness of sexual assault, its impact, the care needed and the resources available further negatively impedes women's accessibility to available care and services.

A significant gap exists within the literature regarding follow-up care that meets the emotional and psychological care of women after sexual assault. Few articles made recommendations for optimal timing for follow-up care within primary care settings after sexual assault. Despite identified gaps, the various authors provided recommendations and strategies

based on their study findings that either specifically related to or are transferable to the care provided by primary care practitioners, including NPs. The following chapter will discuss these research findings and further explore the strategies suggested to decrease the prevalence and severity of PTSD and depression in adult women of childbearing age after sexual assault.

CHAPTER FOUR

Discussion

Much of the literature available discusses the importance of follow-up care in decreasing the negative effects associated with a particular medical or psychological health consequence related to sexual assault, but there are few documents that provide any specific recommendations for care that meets the mental health needs of women. In speaking with care providers involved in the follow-up care for women after sexual assault, their focus of care has been to assess general mental health status, any injuries sustained at the time of the assault, review and reorder necessary diagnostic tests, provide treatment specific to client concerns and initiate referrals as needed. There is little time and little guidance on the necessary elements needed to address the emotional impact sexual assault has on women.

Review of the research described in Chapter Three has yielded some important contributions to understanding the mental health follow-up care needs of women after sexual assault. This Chapter will discuss these findings within an ecological framework to highlight existing gaps in the mental health follow-up care of women after sexual assault. Specific areas examined within this section will include optimal timing intervals for follow-up care, and the role individual level characteristics, personal relationships, community and societal factors have in influencing the emotional and psychological well-being of women after sexual assault. Discussion of the impact these ecological levels of influence have on women will serve to inform strategies that improve the care provided after sexual assault. Specific recommendations for follow-up care will be discussed in more detail in Chapter Five.

Optimal Intervals for Follow-up Care

There are no standard recommendations indicating optimal intervals for follow-up care that target the psychological trauma that results after sexual assault. The WHO (2003) recommends two week, three and six month follow-up visits after a sexual assault. Ray and McEneaney (2014) suggest follow-up care intervals between one and four weeks, six weeks and at six months. However most of these recommendations are related to the medical care needs of women after sexual assault such as further STI and pregnancy testing. Research has documented the consequences of PTSD, depression and for some women, drug and alcohol use as a coping mechanism for intrusive thoughts associated with sexual assault, yet follow-up recommendations or intervals for care do not adequately reflect these care needs. This represents a significant gap in the emotional and psychological care of women who have been sexually assaulted.

Ackerman et al. (2006) noted that care should take place within close proximity of the assault itself and should include care that address both the medical and mental health needs of women. Interestingly, Boykin and Mynatt (2007) felt that mental health follow-up care should begin much sooner starting within 24-48 hours of the sexual assault with following appointments provided at two week and three month intervals or as needed based on individual need. These studies have shown women are easily lost to follow-up, therefore starting follow-up care that addresses the emotional and psychological well-being of women within one to two weeks of the assault may represent an acceptable approach to improving mental health care after sexual assault.

Individual Levels of Influence

Factors impacting follow-up care. Individual level examination of factors that can impact follow-up care and re-victimization are important in not only understanding the barriers in accessing care for women who have experienced sexual assault, but also serve to highlight

important variables practitioners should consider when caring for these women in the aftermath of assault. Factors that can impact follow-up care include demographics such as age and level of education, previous history of sexual assault and past mental health histories.

Demographic characteristics. The findings suggest that demographic characteristics impact women's accessibility and receptiveness to follow-up care. Ackerman et al. (2006) found older women, homeless women and those incarcerated were associated with decreased rates for follow-up care. In comparison to older women, younger age at the time of sexual assault showed greater associations with the development of high risk sexual behaviours (Campbell, Sefl, & Ahrens, 2004). It is theorized that this may be related to the differences in normative developmental processes and health seeking behaviours associated with each age category (Ackerman et al., 2006; Campbell et al., 2004). It was also suggested that women who abstain from sexual encounters after sexual assault display low-risk sexual behaviours, yet one must speculate that perhaps these women abstained from sexual relations due to traumatization (Campbell et al., 2004). This raises the question whether low-risk sexual behaviors exhibited by these women represent a positive health outcome, or conversely, a negative response to a traumatic event.

These findings highlighted the complexities that must be considered when examining demographic characteristics and health outcomes after sexual assault. This project provided a small glimpse into the research available discussing the impact demographic characteristics have on women's mental health and accessibility of services. As a result, its clinical relevance is not entirely clear. What is clear from these findings is the emotional and psychological follow-up care after sexual assault should target all women with individualized care planning tailored to the specific demographic, developmental and educational stages of each woman.

Past history of sexual assault. The development of health risk behaviours (Wilson et al., 2014), PTSD, depression, disordered eating (Dubosc et al., 2012) and chronic pain disorders (Mark et al., 2008; Ulirsch et al., 2014) have been associated with past histories of sexual assault. There is no contesting the impact sexual assault histories can have on the development of negative mental and physical health. However, caution must be exercised when asking about past sexual assault histories as this can have a negative impact on the mental health of women. While knowledge of past histories of sexual assault can aid providers in better understanding the impact these traumas have on the emotional health of women, non-disclosure should not change the care that providers offer women. The premise of trauma-informed care is that disclosure of past or present sexual assault is not necessary for its provision (BCCEWH, 2013). Individual consideration and ongoing assessment is needed to decide whether disclosure of past histories will improve the care we provide to women and if so, when in the continuum of care is that disclosure appropriate. Strategies that inform conversations about past trauma histories may be crucial in decreasing the emotional distress experienced by women, but a providers' ability to assess a woman's readiness to disclose and discretion around when to ask about trauma may also be of paramount importance.

Pre-existing mental health disorders. Review of the literature suggests that pre-existing mental health issues may be a predisposing risk factor for more serious forms of sexual assault involving oral, vaginal and anal penetration (Brown et al., 2013). One could speculate that pre-existing mental health conditions and higher rates of penetration may have implications for higher rates of emergency and follow-up care services (Mark et al., 2013). However, unrelated to the direct effects of sexual assault, higher utilization patterns were instead associated with exacerbations of chronic illnesses (Mark et al., 2013). These findings demonstrate the dynamic

interplay of variables that impact sexual assault characteristics as well as the associated physiological complexities that may occur in the aftermath. What these studies do not discuss is the mental health impact sexual assault may have on women with pre-existing mental health conditions. In normal daily life, mood and emotions naturally fluctuate in response to daily physiological and psychological stressors. Even in the most stable mental health conditions, periods of mood fluctuations and instability may occur (Patel et al., 2015). One can only imagine the impact sexual assault might have on a woman with a stable pre-existing mental health condition, let alone a condition that is poorly managed.

Awareness that pre-existing mental health conditions can increase women's risk of experiencing more severe forms of sexual assault is integral to understanding the indirect impact mental health disorders have on the health and wellness of women. Furthermore, the importance of managing pre-existing mental health problems is key to decreasing the prevalence and severity of negative emotional and psychological consequences associated with sexual assault.

Assault characteristics. Sexual assault characteristics serve to describe the nature and severity of an assault. These characteristics, in some cases, have been shown to have a profound effect on women's emotional health (Ackerman et al., 2006; Campbell et al., 2009). The development of PTSD often results from negative based emotional responses related to specific sexual assault characteristics, such as assaults by known or multiple offenders, use of a weapon, the presence of genital trauma and alcohol usage (Ackerman et al., 2006; Boykin & Mynatt, 2007; Jozkowski & Saunders, 2012). Therefore, assessment of sexual assault characteristics and the emotional impact they can have on women is imperative to individualizing care that meets the psychological needs of women after sexual assault. However, similar to disclosures of past sexual assault histories, a trauma-informed approach to care where providers assess a woman's

readiness to discuss the characteristics surrounding the assault is fundamental to providing safe and supportive care.

Individual level analysis of the factors that affect follow-up care and the impact of sexual assault characteristics has highlighted the influence these factors have on developing or exacerbating the negative emotional responses experienced by some women. However, caution must be exercised when assessing women who have been assaulted as each experience can impact women differently. Thus an individualized approach to assessment and care with attention to factors that may further impact the health and wellness of these women is paramount.

Personal Relationships Level of Influence

Social relations can be a positive mediating factor in the recovery of women who have been sexually assaulted (Hellman, 2014), however it must also stand to reason that negative social relationships or responses can have the opposite effect. Women assaulted by non-strangers and those who kept the assault a secret were noted to have higher levels of shame (Vidal & Petrak, 2007). Previous sexual assault histories have been associated with increased characterological and body shame and higher levels of concern about how they are perceived by their peers and close relations. Research has demonstrated strong correlations between lack of social support and negative disclosure responses with the development of PTSD and depression (Littleton, 2010). The severity of these long-term psychological health effects are dependent on the level of social support available and other's perceptions (Hellman, 2014). Research reviewed suggested a need to examine the role of shame in exacerbating stress levels post-sexual assault (Vidal & Petrak, 2007) and as such represents important points to discuss when caring for women after sexual assault.

Community and Societal Levels of Influence

Community and societal influences can have a huge impact on the mental health and well-being of women. This section will discuss the impact community level influences such as community setting, provider comfort level, and provider documentation practices can have on the care provided to women after sexual assault. It will also examine the impact societal level influences such as cultural and societal norms and the use of language can have on the development of negative emotional consequences experienced by women.

Community setting. Much of the literature reviewed was written with reference to large urban centers with easy access to multidisciplinary care and referral services. However, there are many women who live in remote areas that do not have access to such specialized services. Often PCPs in these areas deliver most, if not all of the follow-up care provided to these women. Furthermore, although prevalence rates of sexual assault were similar between urban and rural settings (Thurston et al., 2006), higher health care utilization patterns were noted among sexually assaulted women in the urbanized areas (Levine et al., 2008; Mark et al., 2008). This prompts the question as to whether women may be less inclined to seek health care within smaller communities. Within rural settings, the fear of judgment and breach of confidentiality are common barriers that account for women's reluctance to disclose their sexual assault experiences or access health care services. Other identified barriers to care for women living in rural settings include geographical isolation, lack of services and social system complications relating to a small town, which are often further complicated when the offender is known and living within the same community (Thurston et al., 2006). The impact of sexual assault in rural communities and its associated barriers to care requires further study to determine how best to care for this population.

Provider comfort level. Many health care professionals do not routinely provide follow-up care to women after sexual assault. As a result, care providers are often uncomfortable discussing the events of a sexual assault or the emotional distress it has caused for the women who experience it (Amstadter et al., 2008). This may be perceived as a secondary victimization further exacerbating shame-based beliefs, thus possibly contributing to the development of PTSD and depressive symptoms (Vidal & Petrak, 2007). Increasing a provider's comfort in having these sensitive conversations with women and increasing their knowledge of the mental health follow-up care needed after sexual assault is vital to promoting recovery (Amstadter et al., 2008).

Provider documentation practices. There are few studies available specifically analyzing documentation practices found within formal systems related to sexual assault disclosures or follow-up care provision. Incomplete charting can negatively impact providers' abilities to provide comprehensive care for women post-assault as little information may be available about care planning to guide longitudinal care (Sutherland et al., 2014). Furthermore, follow-up care can be complex requiring multiple care visits and often a multidisciplinary response to help facilitate recovery and prevention of further re-victimization. With access to incomplete documentation, repeated assault disclosures to new providers or multidisciplinary team members may occur which may further exacerbate the negative emotional reactions experienced by women (Littleton, 2010). Moreover, there is no statute of limitation on the reporting of sexual assault (Limitation Act, 1996), thus the importance of thorough documentation practices cannot be overstated. Medical records provide legal documentation of disclosure and the health impacts associated with sexual assault (Sutherland et al., 2014). Incomplete or poor documentation can cause women further emotional distress while compromising their legal pursuits.

Two of the most common barriers to thorough documentation include multiple competing demands on PCPs and lack of documentation time (Sutherland et al., 2014). Although not mentioned within the literature, lack of skills in medicolegal documentation could also be seen as another common documentation barrier. Sutherland et al. suggested the use of organizational practice tools and computerized EMRs to help address these barriers. While these suggestions are valid options, it only partially addresses the issue of documentation. Documentation inadequacies may also stem from lack of awareness or training of what constitutes important information to include when documenting care encounters with women after sexual assault. Informal education sessions highlighting important details to be included during documentation and utilization of the SOAP format for charting that includes subjective, objective, assessment and planning information should also be considered.

Social and cultural norms. An increase in negative shame-based beliefs and self-cognitions experienced by women may result when characteristics of a sexual assault do not match the constructs of prevalent rape-myths (Munro, 2014; Vidal & Petrak, 2007; Weiss, 2010). These negative emotions and cognitions can have strong implications for the development of PTSD and depression. However, community and societal level strategies to change the acceptance of rape-myths are challenging as efforts are required that involve all ecological levels of influence. Education and awareness of sexual assault, its consequences and the resources available to help women are needed that target individuals, their personal relationships, community organizations and providers as well as society as a whole. This is not an undertaking of one person, but instead of many. The identification of stakeholders and collaborative partnerships are key in promoting changes to society's response to sexual assault disclosures and availability of social support.

Language. Societal influence can be seen in the terminology that we use to describe sexual assault and the women who experience it. There are various terms used to discuss sexual assault within the literature, often used interchangeably, however their underlying meaning can be interpreted quite differently. See Appendix D for Definition of Terms. Terminology is important as how one defines what they experienced can certainly impact their willingness to disclose and access health care services (Thurston et al., 2006). Furthermore, how a woman is identified after a sexual assault can also have negative emotional ramifications. Women have been commonly referred to as victims, and more recently, survivors (Hellman, 2014). Some women have difficulty identifying what happened to them as rape and may also have difficulties accepting the label of victim or survivor. These terms can increase feelings of shame, guilt and other negative cognitions thus increasing the risk for the development of PTSD and depression. The use of neutral terminology and/or having discussions with women about the terms that they find empowering may help them in their recovery process (Kelleher & McGilloway, 2009).

The Role of Nurse Practitioners in Follow-up Care

Nurse practitioners care for a number of vulnerable patient populations and often provide routine care to both women and children (Dahrouge et al., 2014). Often, NPs have slightly longer appointment times allowing them to spend a greater amount of time providing education, support and counseling (Dahrouge et al., 2014). As there is a great deal of psychosocial trauma and support needed for women who have experienced sexual assault, the NP model of care provides the necessary time needed for longitudinal care of these women. Women who have been sexually assaulted often have poorer health status than women with no history of assault and greater health care utilization patterns (Levine et al., 2008; Pikarinen, Saisto, Schei, Swahnberg, & Halmesmaki, 2007). It can then be inferred that with poorer health status and increased

encounters with the health care system, these women will face increased medical costs and missed time from work. “Care provided by NPs has been associated with less time lost from work, lower overall drug costs... and fewer hospitalizations” (Nurse Practitioners’ Association of Ontario, 2011, p. 3). Certainly the healthcare model from which NPs provide care makes them an attractive option for the provision of post-assault sexual assault care. Sexual assault can negatively impact a woman’s health, wellness and quality of life. As a result, a comprehensive approach to follow-up care that is not rushed is imperative to the mental health care of women after sexual assault (Linden, 2011).

CHAPTER FIVE

Recommendations for Nurse Practitioner Practice

The purpose of this project is to examine the research to determine whether follow-up care within two weeks of a sexual assault would decrease the prevalence and severity of PTSD and depression in women of childbearing age. While no research studies were found that examine the impact of follow-up care on health outcomes, the research analyzed within this project offers insight into the mental health strategies that could be incorporated into follow-up care to decrease the negative emotional responses and cognitions of women after sexual assault and thus the incidence and potential severity of PTSD and depression. These recommendations will be organized using an ecological perspective examining strategies for follow-up care targeting the providers' response to individual, personal relationships, community and societal levels of influence. Furthermore, while recommendations in this Chapter discuss using strategies targeting specific levels, recommendations are dynamic with the overall outcome aimed at decreasing the negative mental health consequences experienced by women after sexual assault. See Appendix E for a quick reference of recommendations made within this project.

Recommendations for Optimal Follow-up Care

The authors report that optimal timing for specific care interventions remains unclear, however, recommendations for follow-up care within close proximity of the assault itself may be key in identifying and treating those patients at risk for depression, PTSD and substance abuse (Ackerman et al., 2006; Ulirsch et al., 2014). Follow-up care specifically addressing the psychological needs of women may need to start as early as 24 to 48 hours after sexual assault or the initial forensic examination (Boykin & Mynatt, 2007). Early follow-up care offers an opportunity to provide support, education, anticipatory guidance, and initiate referrals needed to

facilitate recovery (Boykin & Mynatt, 2007). Therefore, initiating follow-up care within a maximum of two weeks of the sexual assault represents a reasonable time frame that may facilitate the initiation of appropriate interventions and access to care needed to support recovery. Intervals for future appointment will depend on the level of emotional distress experienced by women. However, general follow-up care appointments should also be considered at two and six weeks as well as four and six months. These intervals represent opportunities for medical assessment and care, but also serve as a time where providers can assess the mental health and wellness of women who have not been identified as needing closer follow-up.

Recommendations Targeting Individual Levels of Influence

This section will discuss recommendations for providers with specific strategies aimed at the provision of care to women at an individual level. These include approaches to care, mental health follow-up care components and ongoing care planning.

Approach to care. A trauma-informed approach to care offers a solid foundation from which to base the mental health follow-up care for women after sexual assault. This approach is well supported within the literature (Jina & Thomas, 2013; Wadsworth & Van Order, 2012) and embodies the use of non-judgmental, empathetic and supportive approaches to care that creates safe, trustworthy and confidential environments for women to share their experiences (BCCEWH, 2013). Providers are encouraged to use neutral, non-verbal communication as seen with open posture, culturally appropriate eye contact with positioning at eye level while also remaining attuned to the non-verbal behaviours exhibited by women during care (Padden, 2008). Establishing rapport with women, acknowledging their feelings and concerns and taking the time to listen to their stories can help decrease their negative self-beliefs (Ray & McEneaney, 2014). Supportive comments such as “I’m sorry this happened to you. It takes a lot of courage to talk

about something like this” (Padden, 2008, p. 112) convey empathy but also empower women by acknowledging the strength of character needed to disclose and seek care after sexual assault.

An approach to supportive and non-intrusive care also requires that women be involved in the care decision-making process. Allowing women to share their follow-up care needs and providing women with information about various care options empowers women, allowing them to regain some of the control over their bodies, their health, their lives and their environment (BCCEWH, 2013; Hellman, 2014; Vidal & Petrak, 2007). This collaborative approach to care may help decrease their perceived powerlessness and negative self-perceptions while promoting resiliency and recovery (BCCEWH, 2013; Hellman, 2014).

Primary care providers must also exercise caution in their examination approach to prevent re-traumatization (Mark et al., 2008). How providers approach the medical care, such as gynecological examinations, can impact the emotional health and well-being of women. Ray and McEneaney (2014) recommend that NPs “take the time and effort needed to perform gynecological exams in ways that decrease anxiety on the part of the patient and promotes future engagement with health care practitioners” (p. 48). Explaining examination components and reiterating to women that they control the aspects involved in the care provided is imperative. Options for gynecological examinations can include providing women with a mirror so they can inspect their genitalia while providers describe normal, healthy anatomy offering reassurance of health (Ray & McEneaney, 2014). Allowing women to insert the speculums themselves or avoiding the use of foot rests and instead using a modified lithotomy position are alternative options that have been shown to decrease women’s emotional distress (Ray & McEneaney, 2014). There are varying approaches to care that can be employed, however, all of them require open, non-judgemental, and supportive approaches that incorporate patient choice.

Mental health follow-up care components. Mental health follow-up care involves assessing women's past mental health and sexual assault histories as well as the sexual assault characteristics of their most recent assault. These components can impact the emotional and mental health of women after sexual assault (Ackerman et al., 2006; Brown et al., 2013). Furthermore, exploration of current medical and mental health concerns serve to ensure women's health care needs are met while also increasing their willingness to access care in the future. However, caution must be exercised by providers when assessing for past sexual assault histories and assault characteristics as these disclosures can increase the emotional distress experienced by women. Assessment of women's readiness to disclose becomes imperative to not only developing a trusting and therapeutic rapport, but also in minimizing further negative mental health consequences.

Further recommendations for mental health follow-care include screening for common mental health issues that often present after sexual assault such as PTSD, depression, anxiety, substance abuse and disordered eating (Amstadter et al., 2008; Brown et al., 2013; Dubosc et al., 2012; Jina & Thomas, 2013). Various tools are available to assist providers in assessing for these conditions such as the Primary Care - Post-traumatic Stress Disorder (PC-PTSD) screen, the Patient Health Questionnaire (PHQ- 9) for depression, the Generalized Anxiety Disorder (GAD-7) questionnaire, the CAGE-AID questionnaire for substance use and the SCOFF questionnaire for disordered eating. See Appendix F for more information on these mental health screening tools. Assessment of physiological blunting should also be encouraged as this may predispose women to engage in health risk behaviors thus increasing their risk for re-victimization (Wilson et al., 2014).

Equally important within the realm of follow-up care is the provision of education so women better understand what sexual assault is and the varying effects it can have on their health. Furthermore, it is important that women are made aware they are not to blame for the sexual assault. This education can help women better identify and acknowledge their experience and may also serve to decrease the guilt and shame associated with sexual assault.

Much of the literature focuses on identification of negative health consequences associated with sexual assault, and while extremely important, only one resource discussed identifying individual strengths of women and how to further develop a woman's capacity for coping and resiliency (BCCEWH, 2013). Such strategies include trigger recognition, relaxation and grounding techniques and positive self-talk (BCCEWH, 2013). After all, it is through improved coping strategies and strength building that women are better able to manage the various ecological levels of influence that negatively impact their emotional wellness. This strategy, while discussed at the individual level, is applicable to all levels of influence. As an example, positive self-talk can also be used when confronted with negative disclosure responses from friends and family, the health care and legal systems and the general public as a whole.

Ongoing care planning. The provision of individualized care and treatment planning is a key component in the longitudinal care of women after sexual assault. Ongoing care planning components such as individual coping and safety planning vary over the care continuum, thus ongoing assessment, reinforcement and modifications to care plans are important in meeting the longitudinal mental health needs of women after sexual assault. This care planning should include ongoing education about risk factors, threat detection for re-victimization and strategies to decrease health risk behaviours (Wilson et al., 2014).

Multidisciplinary and specialist referrals, such as mental health teams, support services, counseling and specialized behavioural therapies, should also be included in the care planning process to help with the management of emotional and psychological manifestations (Brown et al., 2013; Mark et al., 2008; Dubosc et al., 2008). Ongoing mental health follow-up care and symptom monitoring is recommended to ensure that mental health conditions such as PTSD and depression can be identified early and managed appropriately (Jina & Thomas, 2013).

While not discussed within the literature, one might consider the use of a tool that evaluates the impact of mental health symptoms on daily functioning. The APA (2013) advocates for the use of the World Health Organization Disability Assessment Schedule (WHODAS) as a tool to assess disability across six domains: understanding and communication, ability to get around, self-care, interactions with others, activities of daily living, and interaction and participation with society. Simple scoring method of use with this tool represents an easy and practical approach for busy clinicians (APA, 2013). While no studies have measured the efficacy of such a tool in caring for women after sexual assault, it certainly would provide a generalized overview of the mental health impact of sexual assault on women and perhaps offer insight into areas of daily functioning requiring closer assessment.

Recommendations Targeting Personal Relationships Level of Influence

The research strongly associates negative disclosure experiences with the development of emotional distress and negative self-cognitions, the development of PTSD, and depression (Kelleher & McGilloway, 2009; Littleton, 2010). Strategies targeting the influence personal relationships have on women after sexual assault begins with assessing women's disclosure experiences. Recommendations for providers include assessing the strength of women's social support networks and any disclosure experiences they have had (Littleton, 2010). Padden (2008)

recommends using open-ended questions such as “who else have you shared this information with” (p. 112). Social support and positive disclosure experiences can be a positive mediator for recovery, however negative disclosure experiences or a lack of social support can have the opposite effect further causing emotional harm (Hellman, 2014).

Following assessment of social support and disclosure experiences, recommendations are made for providing women with various resources to help support their recovery process. This is beneficial for all women, but especially for those with limited or negative social support systems. It is also recommended that informal support systems, such as personal relationships and informal support providers, are provided with education and resources to help them better support women after sexual assault. Campbell et al. (2009) advocates for referrals to or implementation of sexual assault awareness programs to educate informal support providers about sexual assault and the varied effects it has on women. “These programs should also emphasize... that positive reactions such as emotional support and tangible aid are helpful for recovery, and negative reactions, such as egocentrism and blame, may overshadow any positive efforts” (Campbell et al., 2009, p. 239). While these recommendations are discussed within a personal relationship level, change at this level does not occur with these suggestions in isolation. Strategies developed and implemented at the societal level of influence will also help improve the responses and support offered by personal support networks.

Recommendations Targeting Community Levels of Influence

Recommendations for providers targeting community levels of influence are important in decreasing the negative emotional responses associated with lack of provider knowledge and comfort in the discussion and provision of sexual assault care. Strategies will be reviewed that

address the organizational barriers that impact provider's abilities to deliver comprehensive mental health follow-up care to women after sexual assault.

Strategies for providers. All health care professionals should ensure they are comfortable recognizing and managing various mental health disorders associated with sexual assault such as PTSD and depression (Ray & McEneaney, 2014). Continuing education should include the use of mental health screening tools and the various strategies used to manage these conditions (Amstadter et al., 2008). Providers should be educated and sensitized about sexual assault and its effects with additional training on how to respond to disclosures and guide discussions with women about sexual assault and their experiences (Jina & Thomas, 2013).

In addition to education, every primary care provider involved in the care of women after sexual assault should have a complete list of online and local resources for women such as support groups, mental health services and legal support (Ray & McEneaney, 2014; Sutherland et al., 2014). When providing written resources, it is important to ensure they are culturally appropriate with attention to the language and literacy level of the women receiving these resources (Jakubec et al., 2013). A list of local specialists and resources to support providers should also be compiled for quick reference (Munro, 2014; Padden, 2008). See Appendix G for Online Resources for Patients and Appendix H for Resources for Care Providers.

The BCCEWH (2013) is the only document that also advocates for the education and awareness of care providers about vicarious trauma. Vicarious trauma is the emotional impact or indirect emotional trauma providers can experience when caring for women who disclose the experiences of trauma they have endured (American Counselling Association, 2011). It is important for providers to be aware of vicarious trauma and to implement safeguards to protect their own emotional health. This condition can not only impact providers on a personal level, but

this distress can also have a negative impact on the care they provide to women after sexual assault.

Strategies for organizations. Nurse practitioners need to become familiar with the structural and organizational barriers specific to their current practice setting and actively problem-solve ways to overcome these barriers (Munro, 2014). The most common barriers include multiple competing demands for providers' time and lack of time for thorough documentation. Strategies suggested include the development of standardized procedures and the use of EMRs with easily accessible practice tools such as algorithms, safety and lethality assessments, mental health screening tools and documentation templates (Sutherland et al., 2014). Tool and template selection or development requires an assessment of the EMR capacity for types of templates and the ease of their accessibility and use within such a system. It also requires an assessment of the users within the practice to assess for computer literacy and willingness to utilize these tools. Therefore, a collaborative approach to development would be best to ensure tools developed are successfully integrated into practice. The tools may help increase provider efficiency and care provision, despite the multiple competing demands for providers' time. Furthermore, organizations are encouraged to implement routine integrated processes for updating educational, referral resources and algorithms utilized to ensure up-to-date care is provided to women after sexual assault (Jakubec et al., 2013).

Recommendations Targeting Societal Levels of Influence

Intervening at a societal level is often considered the most difficult as comprehensive intervention models are required that target multi-system levels which should include "a wide variety of strategies, such as policy change, organizational change, systems advocacy, media campaigns, and rape awareness/prevention education to create a broad-based systemic change"

(Campbell et al., 2009, p. 240). While this project will not describe how to develop models for intervention, it will discuss the importance of appropriate language usage, educational strategies to increase awareness and the NP role as an advocate for change targeting societal levels of influence.

Language. Language is discussed at the societal level as it requires a shift in not only individual and provider thinking, but also a shift in the thinking and beliefs of society itself. Educational efforts and interactions with women, families and communities should use language that is neutral in nature. Not all women may identify their experiences with the varying terms used such as sexual assault or rape as it does not meet the stereotyped myths widely prevalent within society. Perception of terminology definitions can impact women's willingness to access follow-up care and resources (Jozkowski & Saunders, 2012). Using appropriate language such as forced or coerced sexual experiences when communicating with women and the public may help women better identify their experiences as sexual assault and increase their access to formal follow-up care services (Jozkowski & Saunders, 2012; Kelleher & McGilloway, 2009).

Education and Awareness. Education and awareness about sexual assault, its varying presentations and how to access services aimed at a societal level will help facilitate changes on a greater scale than targeting only those at the individual level (Kelleher & McGilloway, 2009; Munro, 2014). Dissemination of information to the public requires long-term strategic planning as it may take many years before there is any evidence of change.

Developing Partnerships for Change. Nurse practitioners and other care providers are well-positioned within the health care system to work with various public sectors to develop collaborative service-based models that meet the health needs of women after sexual assault (Thurston et al., 2006). Examination of gender and the social determinants of health within the

context of each individual community setting needs to be considered as these factors can prevent or exacerbate the impact sexual violence has on women (Thurston et al., 2009). The overall goal of such interventions is to increase public knowledge of sexual assault and its negative emotional consequences experienced by women in an effort to change the existing stereotypes thus improving the community's response to sexual assault (Campbell et al., 2009).

The actions of NPs are not confined to the clinic setting and instead they can act as advocates for change within the community and society itself. Nurse practitioners can have a huge impact on community development of services and resources that better the care for women after sexual assault. This can be achieved by becoming involved on the boards of rape crisis centers, sexual assault counseling services and other specialized support services. Nurse practitioners can impact health care legislation by lobbying for changes and funding that improves the health care response to sexual assault. Furthermore, lobbying to improve accessibility and availability of supportive services for women is key to ensuring women receive needed supports. Raising societal awareness also includes mass media messages about sexual assault and its effects, but can also be accomplished in the form of charitable events, that both raise awareness and money to support the improvement of services and care for these women. Furthermore, NPs can continue to improve the care of women after sexual assault by furthering the research available to guide practice.

Conclusion

Review of the literature in conjunction with my professional experiences as a registered nurse caring for women in the aftermath of sexual assault prompted a need to address the mental health follow-up care services provided after sexual assault. As a result, the purpose of this project was to answer the question: In adult women of childbearing age who have experienced a recent sexual assault, can access to post-assault follow-up care within two weeks of the assault decrease the prevalence and severity of post-traumatic stress disorder (PTSD) and depression? This paper conducted a comprehensive literature review which resulted in the use of three guidelines and sixteen research articles for review. The review process identified significant gaps in the literature around mental health follow-up care and the elements necessary to better meet the psychological and emotional needs of women after sexual assault.

An ecological framework was utilized within this project to synthesize and analyze the research articles collected. This framework allowed for greater exploration of the ecological factors that contribute to the complexity of mental health and the emotional responses exhibited by women after sexual assault. It also served to help organize strategies and recommendations for change that target specific levels of influence, all the while understanding that these same strategies are dynamic and can be effective throughout the levels.

The research examined in this paper has posited associations for follow-up care interventions and approaches that have potential positive outcomes on the mental health of women, but these findings are not proofs. Suggested recommendations include the use of a trauma-informed approach to care that emphasizes supportive and non-judgemental care in a safe and trustworthy environment may be key to developing rapport with women while engaging them to access future health care services. Thorough assessment and individualized action-

oriented care planning within close proximity of the assault, preferably within a maximum of two weeks after the sexual assault, may be important in helping women cope with the physical, emotional and psychological traumas associated with sexual assault. Recommendations aimed at individual, personal relationship, community and societal levels of influence are provided that may assist in improving the emotional and psychological aspects of follow-up care.

Nurse practitioners are well-positioned within primary care settings to care for women after sexual assault. The NP model of care allows for the time needed to better meet the mental health needs of these women. Strategies employed by NPs are required on all levels of influence including those efforts that go beyond work within the clinic setting. Further research is needed in the form of randomized control trials to better understand the health impact current follow-up care strategies have on improving the psychological wellness of women after sexual assault.

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Appendix A
Post-Assault Care Recommendations

Guidelines	Medical Care Follow-up	Advocacy Group Follow-up	Referral to Consider	Follow-up Care Intervals
Guidelines for Medico-legal Care for Victims of Sexual Violence	<ul style="list-style-type: none"> ✓ Treatment of physical injuries ✓ Address ongoing medical concerns ✓ STI, HIV, pregnancy, immunizations ✓ Care plan for 2 weeks, 3 & 6 months 	<ul style="list-style-type: none"> ✓ Counseling ✓ Social support ✓ Crisis-intervention ✓ Accessing services ✓ Legal support 	<ul style="list-style-type: none"> ✓ Rape crisis centres ✓ Shelters ✓ HIV/AIDS counselling ✓ Legal counsel ✓ Victim services ✓ Support groups ✓ Therapists ✓ Financial Assistance ✓ Social services 	<ul style="list-style-type: none"> ✓ 2 weeks ✓ 3 months ✓ 6 months
Caring for survivors of Sexual Violence: A guide for primary care NPs	<ul style="list-style-type: none"> ✓ STI, HIV, pregnancy, immunization ✓ Acknowledges treatment for physical/mental health sequelae ✓ Education ✓ Self-care ✓ Health risk behaviors ✓ Support 		<ul style="list-style-type: none"> ✓ Mental health ✓ HIV specialist ✓ Counselling ✓ Social work 	<ul style="list-style-type: none"> ✓ Should last at least 6 months ✓ STI testing in 1-2 weeks (no prophylaxis) ✓ 2-4 weeks (if given prophylaxis) ✓ 6 weeks for syphilis and HIV testing

Appendix B

Literature Search One Major Concepts and Similar Terms

Sexual Assault	Examination	Follow up care	Primary Care	Sequelae
<ul style="list-style-type: none"> • Rape • Sexual abuse • Sexual violence • Rape victims 	<ul style="list-style-type: none"> • Gynecological examination • Sexual assault examination • Forensic examination • Physical examination • Psychological examination • Health assessment • Patient assessment • Risk assessment 	<ul style="list-style-type: none"> • After care • Post-exposure f/u • Follow-up • Medical f/u • Lost to f/u • Post-exposure prophylaxis • Gynecology • Psychology • Health care needs • Treatment seeking behavior • Gynecological f/u 	<ul style="list-style-type: none"> • Rural health centers • Rural health personnel • Hospitals, rural • Rural population • Rural health services • Rural health nursing • Rural areas • Rural health • Australian rural nurses and midwives • Nurse practitioners (Acute Care, Adult, Emerg, Ob-gyn) • Primary care providers • Health care providers • Sexual assault nurse examiners • Primary health care • Secondary health care • Family physicians 	<ul style="list-style-type: none"> • Rape-trauma syndrome • Treatment complications, delayed • Treatment complications • complications • Sexual assault complications • Acute stress disorder • Stress-disorder, post-traumatic • Risk for injury • Acute complications • Chronic complications • Impact of events scale • Pain • Pelvic pain • Acute pain • Chronic pain • Abdominal pain • Treatment outcomes • Rape psychosocial • Social problems • Self-medication • Sexually transmitted infections • Stigma • Health Impact Assessment

Appendix C

AGREE II Assessment of Clinical Practice Guidelines

AGREE II Domain and Overall Assessment of <i>Trauma Informed Practice Guide</i>	Score: Likert scale rating 1-7 with 1 representing strongly disagree and 7 representing strongly agree
<u>Domain 1: Scope and Purpose</u> <ol style="list-style-type: none"> 1. The guide is intended to support the translation of trauma-informed principles into practice to better the care for those with histories of violence and trauma. 2. No specific question posed, instead provides recommendations that trauma-informed care be provided for all interactions with persons with a history of violence and trauma, especially those working within the mental health and substance abuse areas of care. 3. Generalized recommendations for providers are applicable to any person with a history of trauma or violence. 	<p>7</p> <p>6</p> <p>6</p> <p>Overall Domain Score: 90%</p>
<u>Domain 2: Stakeholder Involvement</u> <ol style="list-style-type: none"> 4. The guide development group includes professionals from relevant organizations and disciplines. However, exact content expertise and role in guide development process was not included. 5. The benefit and need for the trauma-informed recommendations was based on research findings presented within the document. The views of providers caring for the target population were sought, but the views and preferences of target population themselves was not mentioned. 6. The target users of the guideline are clearly identified as health system planners and health care providers caring for persons with a history of trauma or violence, especially those within the practicing within the mental health or substance abuse areas. 	<p>5</p> <p>4</p> <p>7</p> <p>Overall Domain Score: 76%</p>
<u>Domain 3: Rigour of Development</u>	

7. The guide provides a summary of the sources used a basis for its recommendations but does not provide a description of the systematic method used to search for evidence.	3
8. The criteria for selecting the evidence is not clearly described.	3
9. The guide describes limitations in the available research related to implementation of trauma-informed practices but refers to multiple practice-based resources that strengthen the recommendations provided. No further descriptions provided.	3
10. The methods for formulating the recommendations are not clearly described.	2
11. Supportive data is provided that identifies the mental health benefits of using a trauma-informed approach to care and the risks associated with non-using this approach.	6
12. No explanation of the process for linking evidence to recommendations, however, recommendations are cited with supportive literature where practitioners can further investigate the supporting literature.	5
13. The guideline was reviewed and provided with feedback by experts and leaders in these care areas prior to its publication.	6
14. No mention of a procedure for guide updates was noted.	1
	Overall Domain Score: 52%
<u>Domain 4: Clarity of Presentation</u>	
15. Recommendations are clearly identified by generalized headings with more specific details provided within each section. No individual statements of recommendations provided.	6
16. The different options for implementation to the populations are clearly presented under each generalized headings.	6
17. Key guidelines, messages and overall goals for care are easily identifiable near the end of the document.	6
	Overall Domain Score: 86%

<p><u>Domain 5: Applicability</u></p> <p>18. The discussed provider level barriers to providing trauma-informed care such as vicarious trauma, however the guidelines do not clearly describe facilitators and barriers to implementation of these practices.</p> <p>19. The guideline provides key practice approaches to implementation as well as an organizational checklist to support discussion and action on implementation of trauma-informed practice.</p> <p>20. The guide indirectly discussed the training needs to ensure providers are educated on the principles and application of trauma-informed practices as part of the organizational checklist for implementation.</p> <p>21. The guideline indirectly discussed monitoring and evaluation monitoring and evaluation criteria as part of the organizational checklist for implementation.</p>	<p>3</p> <p>7</p> <p>5</p> <p>5</p> <p>Overall Domain Score: 71%</p>
<p><u>Domain 6: Editorial Independence</u></p> <p>22. The views of the funding body have not influenced the content of the guideline as indicated in the acknowledgements.</p> <p>23. No mention of competing interests of guide development group members was noted within the document.</p>	<p>7</p> <p>1</p> <p>Overall domain score: 57%</p>
<p><u>Overall Assessment</u></p> <p>1. Overall quality of the guideline</p> <p>2. I would recommend this guideline as it offers guidance on approach implementation to trauma-informed care with the caveat that provider approach needs to be tailored to the needs of the specific traumas associated with each patient population.</p>	<p>5</p>

Appendix D

Definition of Terms

Term	Definition
Domestic/ Interpersonal Violence	“...any use of physical or sexual force, actual or threatened, in an intimate relationship. It may include a single act of violence, or a number of acts forming a pattern of abuse through the use of assaultive and controlling behaviour. The pattern of abuse may include: physical abuse; emotional abuse; psychological abuse; sexual abuse; criminal harassment (stalking); threats to harm children, other family members, pets, and property” (Alberta Justice and Solicitor General & Alberta Crown Prosecution Services, 2014, p. 11).
Sex Trafficking	“...occurs when an individual recruits, transports, transfers, harbours or receives people by means of deception, fraud, coercion, abuse of power, payment to others in control of the victim, threats of force, use of force or abduction for the purposes of sexual exploitation” (United Nations, 2000 as cited in Perrin, 2010).
Sexual Abuse	“...unwanted sexual activity, with perpetrators using force, making threats or taking advantage of victims not able to give consent (American Psychological Association, 2015, para 1).
Sexual Assault (SA)	<p>“Forced sexual activity, an attempt at forced sexual activity, or unwanted sexual touching, grabbing, kissing, or fondling” (Perrault & Brennan, 2010, para 7).</p> <p>The Criminal Code of Canada (1985) further subdivides SA into 3 levels of severity:</p> <ul style="list-style-type: none"> • Level 1: “An assault committed in circumstances of a sexual nature such that the sexual integrity of the victim is violated... involves minor physical injuries or no injuries to the victim” (Brennan & Taylor-Butts, 2008, para 9). • Level 2: SA using a “weapon, threats, or causing bodily harm” (Brennan & Taylor-Butts, 2008, para 9). <p>Level 3 Aggravated SA: SA resulting in “wounding, maiming, disfiguring or endangering the life of the victim” (Brennan & Taylor-Butts, 2008, para 9).</p>
Sexual Violence	“A term covering a wide range of activities, including rape/forced sex, indecent assault and sexually obsessive behaviour” (WHO, 2003, p. 5).
Rape	“...rape includes physical force or psychological coercion by sexual intercourse and, within this definition, forced sexual intercourse is vaginal, anal, or oral penetration by the offender or a foreign object” (Boykin & Mynatt, 2007, p. 875).

Appendix E

Summary of Recommendations for Mental Health Follow-up Care

Level of Influence	Recommendations
Optimal Follow-up Care Intervals	<ul style="list-style-type: none"> ➤ Follow-up appointments within a maximum of two weeks ➤ May be beneficial as early as 24 -48 hours after the assault ➤ Further follow-up care intervals at 2 and 6 weeks, 4 and 6 months.
Individual Level	<ul style="list-style-type: none"> ➤ Approach to care <ul style="list-style-type: none"> • Use of empathetic, supportive and non-judgemental approach • Establish safe, trustworthy and confidential environment • Use of neutral body language • Use of active listening • Use of supportive and acknowledging statements • Shared decision-making, choice and collaboration • Provide explanation for medical procedures and their process, such as gynecological examinations. • Offer alternative methods for the pelvic exam that decreases emotional distress, such as women inserting speculum themselves or using lithotomy position without foot rests ➤ Mental health follow-up care components <ul style="list-style-type: none"> • Assess women's past mental health histories, past histories of sexual assault and sexual assault characteristics (assess readiness to disclose) • Current medical and mental health concerns • Screen for depression, anxiety, PTSD, substance abuse, disordered eating, physiological blunting and health risk behaviours • Provide education about sexual assault and its effects • Strength identification and skill building • Ongoing education of risk factors, threat-detection for re-victimization, and ways to decrease health risk behaviours ➤ Ongoing care planning <ul style="list-style-type: none"> • Coping strategies and safety planning • Ongoing assessment, reinforcement and modifications to care plans as determined by a woman's needs • Multidisciplinary and specialist referrals as needed • Ongoing assessment of symptoms severity, such as PHQ-9, GAD-7, and WHODAS.
Personal Relationships	<ul style="list-style-type: none"> ➤ Assess disclosure experiences ➤ Assess strength of social support networks ➤ Offer resources to support recovery journey

	<ul style="list-style-type: none"> ➤ Offer education and resources for personal relationships and informal support networks on how to support women after sexual assault
Community Level	<ul style="list-style-type: none"> ➤ Strategies for providers <ul style="list-style-type: none"> • Understanding of sexual assault and its effects • Education to increase provider comfort in recognizing and managing various mental health conditions associated with sexual assault • Training to improve provider ability to receive and respond to disclosure of sexual assault and its characteristics • Education about vicarious trauma and importance of self-care for providers • Create an easily accessible list of online and local resources for patients • Create an easily accessible list of resources and specialized referrals for providers ➤ Strategies for organizations <ul style="list-style-type: none"> • Become familiar with structural and organizational barriers to care of women after sexual assault (multiple competing demands, time constraints, etc...) • Consider collaborative development of standardized procedures, assessment and management algorithms and templates for documentation • Consider implementing routine strategies for updating educational materials and practice tools
Societal Level	<ul style="list-style-type: none"> ➤ Educational strategies to promote awareness of sexual assault that uses neutral language ➤ Collaboration with community partners to develop collaborative service-based models for care ➤ Become involved on the boards of support services for women after sexual assault ➤ Lobby for health care reform and legislative changes that reflect the needs of women after sexual assault ➤ Engage in mass media education and awareness, as well as the organization of charitable events that raise awareness and funding for services

Appendix F

Mental Health Screening Tools

Screening Tool	Description of Tool
Primary Care PTSD screen (Prins, Ouimette, & Kimerling, 2003 as cited in U.S. Department of Veterans Affairs, 2015)	Primary Care – Post Traumatic Stress Disorder screen – Four questions used to screen for PTSD in Veterans at the VA. The screen should be considered positive if a woman answers yes to any of the four questions.
PHQ-9 questionnaire (University of British Columbia, n.d., adapted from PRIME-MD, n.d.)	Patient Health Questionnaire – Nine questions used to determine assess the severity of depressive symptoms. A score greater than four indicates some level of depression. Severity is determined based on the scores obtained.
GAD-7 questionnaire (Family Practice Notebook, 2015a, adapted from Spitzer, 2006)	Generalized Anxiety Disorder Questionnaire – Seven questions used to determine the presence and severity of anxiety symptoms. A score greater than eight indicates a positive screen for anxiety or panic disorder
CAGE-AID questionnaire (John Hopkins Medicine, n.d., adapted from Ewing, 1984)	Four question tool used to screen for alcohol and drug use. Used within primary care limits the scoring threshold to one positive answer out of four.
SCOFF Questionnaire (Family Practice Notebook, 2015b, adapted from Morgan, 1999)	Five question tool used to screen for disordered eating that is easy to use within primary care settings. Two or more positive responses is suggestive of an eating disorder.

Appendix G

Online Resources for Patients

National Sexual Violence Resource Center. <http://www.nsvrc.org>

- Offers access for the public about sexual violence, offers resources and e-learning opportunities.

Men Can Stop Rape. <http://www.mencanstoprape.org/>

- Offers resources and educating targeting youth and adults by raising awareness of sexual violence and ways that males can help combat violence against women

Rape, Abuse, & Incest National Network Hotline. <http://www.rainn.org>

- Offers resources, education and support to persons who have experiences sexual assault.

National Online Resource Center on Violence against Women. <http://www.vawnet.org>

- Provides resources, support, and education to persons who have experienced sexual violence. Also discusses international and global issues of sexual violence.

Appendix H

Resources for Care Providers

Canadian Guidelines on Sexually Transmitted Infections. Sexual Assault in Postpubertal Adolescents and Adults. <http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-6-6-eng.php>

- Offers guidance on care and treatment of adolescents and adults who have experienced sexual assault.

Center for Disease Prevention. Sexual Violence. Retrieved from <http://www.cdc.gov/violenceprevention/sexualviolence/index.html>

- Offers guidance on combating sexual violence, includes fact sheets and links to resources for providers.

International Association of Forensic Nurses. <http://www.iafn.org>

- Offers contact information and guidance for the forensic care of persons who have experienced crime, trauma or violence. Membership grants access to various resources, weblists and IAFN Journal articles.

Forensic Nurses' Society of Canada. <http://forensicnurse.ca/>

- Discusses education opportunities, upcoming events and resources for providers. Also has membership opportunities for further networking and updates on forensic practice.

British Columbia Institute of Technology: Forensic Health Science Certificate. <http://www.bcit.ca/study/programs/525hascert>

- Offers educational opportunities in the care of persons who have been a victim of crime, trauma and violence.

The Embrace Clinic within the Fraser Health Authority. <http://www.fraserhealth.ca/your-care/abuse-assault-and-neglect/Sexual-Assault-and-Violence/about-the-forensic-nursing-service/embrace-clinic/>

- NPs providing mobile follow-up care services to persons after interpersonal violence.

Surrey Women's Center – SMART Team. <http://surreywomenscentre.ca/services/24-hour-response>

- Offers 24-hour crisis response that provides services in partnership with Surrey Memorial Hospital over the phone and in-person service for women and girls who have experienced physical or sexual violence.