

A NARRATIVE ANALYSIS OF WOMEN'S ADAPTATION FOLLOWING
A SEXUAL ASSAULT

by

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Abstract

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Sexual assault against women violates every area of their lives: safety, security, physical health, and social status. Available evidence is inadequate to guide interventions to promote effective adaptation following assault. No studies have been found specifically on sexual assault of women from the perspective of the affected woman. The purpose of this study was to describe the narratives and coping strategies of women who have been sexually assaulted. The study questions and analysis were framed using Roy's Adaptation model.

Narrative analysis was the research design used to examine stories of the women's experiences after sexual assault and how the women's lives have been affected. Women (n=12) were recruited from flyers distributed to apartments, residence halls, women's shelters, and university classroom buildings. Following the semi-structured interview, each woman completed a short demographic survey. The participants ranged in age from 21 to 59 years and half were from minority groups. Interviews were transcribed and the data were analyzed for themes in the women's stories.

Themes emerging from the stories reflected four chapters: the prologue, the event, the aftermath, and the present. The prologue was how the women described themselves before the assault. The prologue involved the two main themes: violated trust and unsuspecting. The aftermath incorporated what the women did immediately after the assault: seeking safety and security, seeking support, stress in their body, survivor mode, and adaptive mode. In the present, the women's lives today were either stuck in the past or taking back control. The themes and chapters were further analyzed in the context of Roy's Adaptation Model. The women who were

taking back control reflected integrated adaptation, while the stories of the women who were stuck in the past were consistent with compromised adaptation.

The women lived in one geographical area, three counties in a metropolitan area. Although half of the women were ethnic minorities, none of them were African American or Hawaiian/Pacific Islanders. Recruitment extended beyond the university, but seven women were college students, further limiting the diversity of the sample.

Women's stories included several possible services and interventions that may help other women who have experienced an assault. They recommended dissemination of pamphlets educating the public on sexual assault and services for women and on the use of therapy dogs for recovering sexual assault victims; additional training for healthcare workers and hospital staff in how to deal with sexually assaulted women; and the preparation of websites on which it would be easier to locate counseling services and healthcare agencies specializing in sexual assault. The women recommended along with the additional training of healthcare professionals, the development of screening tools to identify physical violence and sexual and methods to provide follow-up care of the women treated for sexual assault. Several of the women also felt creative expression such as art and journaling had helped them process the event and move forward with their lives. Future proposed studies would include the study of women abused as a child into adulthood, secondary victims and their needs, and the differences between men and women's coping and adaptation following a sexual assault. Additional studies evaluating the effectiveness of creative expression strategies, comparing the effectiveness of trauma-focused psychotherapy with eye movement desensitization and reprocessing are recommended.

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Chapter 1

Introduction

Sexual assault against women violates every area of their lives, their safety and security, and their physical and social status. Victims' shame and fear of negative consequences and retribution often cause under-reporting. Women who are sexually assaulted may feel isolated, unsupported, vulnerable, and unable to cope with the consequences of the event. The research that has been published related to sexual assault is limited and inadequate to guide interventions by the healthcare team and to promote effective adaptation following assault. No studies were found which specifically focused on sexually assaulted women from the perspective of the affected woman. The prevalence and consequences of sexual assault will be described in this chapter to establish the significance of the problem.

Roy's Adaptation Theory (RAT) provided the framework for the study, because Roy describes the resources, systems, and processes involved in adapting to stressors (Roy, 2009), such as sexual assault. The theory and its concepts will be presented to provide context to the narratives of women who have experienced a sexual assault. The research problem, the study purpose, and research questions will be stated, followed by the study assumptions.

Background and Significance

The background and significance of sexual assault will be discussed in this section.

Sexual assault is defined as:

Any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Falling under the definition of sexual assault are sexual activities such as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape (Office of Violence Against Women, 2014).

Approximately one out of every five women have been sexually assaulted (Basile, Smith, Breiding, Black, & Mahendra, 2014; Black et al., 2011). The statistics of sexually assaulted women are concerning because the researchers have estimated that only one out of every three assaults was reported (Boykins et al., 2010; Langton, Berzofsky, Krebs, & Smiley-McDonald, 2012). Less than one-third of all women who are assaulted receive follow-up care after the initial

examination (Ackerman, Sugar, Fine, & Eckert, 2006). Black et al. (2011) found only 36% of women sought medical assistance. Statistics probably understate the problem due to under-reporting by victims. Under-reporting and under-prosecution are understandable because of the negative societal views associated with sexual assault (Ullman, Townsend, Filipas, & Starzynski, 2007).

Reasons for Underreporting

Several reasons exist why most sexual assaults are not reported to the police, making it difficult to know the accuracy of the numbers of sexual assaults (Boykins et al., 2010; Cook, Dinnen, & O'Donnell, 2011; Lewis-O'Connor, 2009; Moore, 2009; Murphy, Potter, Pierce-Weeks, Stapleton, & Wiesen-Martin, 2011). One of the reasons women may not report the assault is fear of retaliation. In a large survey of 701,000 persons from 2006 to 2010, 28% of sexual assaults were not reported because of fear of retaliation; over half of the women knew their perpetrator (Langton et al., 2012). In another study (n=148), McFarlane and Malecha (2005) found only 6% of women reported the assault to the authorities while an additional 8% filed for protective assistance.

In addition to fear of retaliation, women may not report a sexual assault because of their feelings of shame, sense of responsibility for the assault because of their behaviors, and fear of what others will think. Feelings of shame, self-blame, and doubt from others that the victims actually have been sexually assaulted have been reported by women in several studies (Lewis-O'Connor, 2009; Logan, Cole, & Capillo, 2007; Moore, 2009; Murphy et al., 2011; Sadler, Booth, Cook, & Doebbeling, 2003; Ullman et al., 2007).

The women were viewed by some as having been promiscuous by dressing or acting in a manner that encouraged the assault. The women felt guilt and shame that they were violated (Lewis-O'Connor, 2009; Logan et al., 2007; Moore, 2009; Murphy et al., 2011). Miller et al. (2011) found in their study of undergraduate women (n=144) that sexual assault produced shame and disgrace, in addition to only one woman reporting the sexual assault to police. The role of stigma threat (shame and disgrace) has not been investigated (Miller et al., 2011). Because of the social

stigma or perceived stigma, women were at a higher risk for another sexual assault (Miller et al., 2011). If the women did not discuss and reveal their assault, then their behavior continued and created more vulnerability to experiencing another sexual assault (Miller et al., 2011). Fear of contracting a sexually transmitted disease (STD) and/or getting pregnant increased the assault victim's feelings of guilt. More research is needed in examining the reactions of others to women after sexual assault and its effect on their recovery (Ullman et al., 2007).

Barriers to Prosecution

Reasons for under-prosecuting sexual assault are that some police may not complete a report of the assault and may not complete the process of filing the report for further examination (Campbell, 2006). Law enforcement agencies may "re-victimize" the women by asking questions about how the women were attired and how women were acting at the time prior to the assault (Campbell, 2006).

Socio-Demographic Differences

Differences in geographic locations may be a factor in the victims' reporting sexual assault and receiving healthcare services. A lower rate of reporting sexual assault occurred in rural areas and was thought to be related to small rural community dynamics, lack of services, and a negative connotation attributed to the woman's reputation (Moore, 2009). Because of the unique tribal setting of Native American Indians, sexual assault was high among women, but reporting was low due to mistrust of authorities (Bryant-Davis, Chung, & Tillman, 2009).

Some racial and ethnic minority disparities were found to exist (Bryant-Davis et al., 2009). Differences were found in assault characteristics between White and African American women (n=173) in a two year cross-sectional study at an urban hospital (Boykins et al., 2010). Additionally, Boykins et al. (2010) found the lack of recordkeeping of the surveys, statistics, and demographics of the victims made it difficult to accurately describe the racial and ethnic identities of women affected by sexual assault. Another large survey (N= 700,000) from the Census Bureau reported Hispanic women under-reported sexual assault (Langton et al., 2012). A reason for Hispanic women under-reporting sexual assault was related to fear of deportation (Bryant-Davis

et al., 2009). Bryant-Davis et al. (2009) reported American Indian and African American women were at higher risk for sexual assault. Littleton, Grills-Taquechel, Buck, Rosman, and Dodd (2013) studied ethnically diverse college women (n=1620) at three southeastern universities, examining use of alcohol and/or illegal substances. They found there were differences between the ethnic groups; African American women reported a higher number of physical violence during the sexual assault. Cultural values and norms were another factor in women's ability to cope after sexual assault (Littleton et al., 2013).

Research is limited in sexual assault and ethnic minority women (Littleton et al., 2013). Miller et al. (2011) recommended a need for studying ethnic differences in post-traumatic growth after a sexual assault while Littleton et al. (2013) stressed a need for research to focus on sexual assault experiences of ethnic minority women. Furthermore, information was lacking on how ethnic minority women arrive at the emergency room and what follow-up care, if any, they received (Boykins et al., 2010).

Women in the military have high rates of sexual assault. In one study by Murdoch, Polusny, Hodges, and O'Brien (2004), 71% of active military (n=1683) women reported being sexually assaulted. Another study found military women (n=160) with less education were at higher risk for sexual assault (Iverson, Mercado, Carpenter, & Street, 2013). Many military women did not report the sexual assaults because the women lacked the information to report the incident or feared reporting the sexual assault as the perpetrator was the next chain of command or was a friend of the next chain of command (Bell, Turchik, & Karpenko, 2014). Reasons for not disclosing the sexual assault while serving in the military were fear of work environment reprisal and disruption of the woman's military career (Bell et al., 2014). Military women may be conditioned to not report the crime because nothing would be done about it. Another study found cultural and religious beliefs affected the military women's ability to report or reveal the sexual assault (Mason & Lodrick, 2013). In one study of military veterans (n=125,729), military women who were sexually assaulted had a high probability of being diagnosed with anxiety, depression, substance abuse, and Post Traumatic Stress Disorder (PTSD) (Kimerling et al., 2010).

Consequences of Sexual Assault

In addition to social consequences, sexual assault has physical, psychological, and financial consequences. The physiological consequences of sexual assault may affect women in many ways. Some common physical ailments that have been reported were headaches, chronic pain, insomnia, asthma, irritable bowel disorder, and diabetes (Black et al., 2011). Smith and Breiding (2011) found an increase in heart attack and heart disease among women after sexual assault. Additional physical injuries were reported by women (n=672) if the perpetrators had taken drugs or alcohol before and during the sexual assault (Busch-Armendariz, DiNitto, Bell, & Bohman, 2010). Abbey, BeShears, Clinton-Sherrod, and McAusian (2004) found physical force by the perpetrator during the sexual assault produced more negative outcomes in the victim and more disruption in the women's lives (n=139).

The psychological consequences of sexual assault on the lives of women are numerous, from PTSD to inability to engage in personal relationships. However, researchers have documented not all women will experience PTSD after a sexual assault (Ullman et al., 2007). PTSD occurred after the life-threatening crisis or trauma had taken place (Boykins et al., 2010; Heke, Forster, & d'Ardenne, 2009; Lavin, 2011). Australian women who were sexually assaulted (n=1218) were found to be at risk for developing psychiatric issues, inability to function, and disabilities (Rees et al., 2011). Littleton et al. (2013) found increased depression and anxiety among college women that had been sexually assaulted. Bryant-Davis et al. (2009) reported more cases of psychiatric disorders among ethnic minority women following sexual assault.

Anxiety disorders may occur after the sexual assault with women exhibiting fear and anxiety with potential muscle strain, fear of leaving their homes or interacting with others, fear of impending doom, even imminent death resulting in panic and phobias (American Psychiatric Association [APA], 2013). Inability to have relationships was a possibility when therapy and other interventions were unsuccessful or none had been employed after sexual assault (Heke et al., 2009; Lavin, 2011). Depression was also prevalent among assault victims, as found by Beydoun,

Beydoun, Kaufman, Lo, and Zonderman (2012) in their systematic review of 37 studies of a positive association between intimate partner violence and depression.

Contemplating suicide was reported frequently among sexually assaulted women (Boykins et al., 2010; Heke et al., 2009; McLinden & Harms, 2011). Boykins and colleagues (2010) reported in their study that the women (n=173) felt something had been taken away, findings that were consistent with previous findings by Ullman et al. (2007). The women later said that they had held what had happened to them deep inside, unable to verbalize the terror they experienced (Boykins et al., 2010). In one study, most women (n=374) were afraid to share that they had been assaulted due to fear of how the listener would respond (Orchowski, Untied, & Gidycz, 2013). Alcohol abuse occurred frequently among sexual assault victims (Boykins et al., 2010; Heke et al., 2009; Kalmakis, 2010). Also, drug abuse was greater in assault victims than in those who had not been sexually assaulted (Boykins et al., 2010).

The cost of sexual assault is great, whether to the victim herself, or to the society treating her. One study of sexual assault offenders (n=654) found each sexual abuse was estimated to cost the victim approximately \$29,000, accounting for counseling, medical expenses, loss of work and/or job (DeLisi et al., 2010). Rape crisis centers have been funded partially by the Violence Against Women Act of 1994, but more are needed (Clark, Biddle, & Martin, 2002). Funding is needed to provide adequate staffing and reduce the burden of meeting the needs of the women (Dolezal, McCollum, & Callahan, 2009).

Post-Assault Healthcare Services

Some women may not seek health care for a sexual assault. One barrier was the lack of access. Medical and mental health services were not available or the woman lacked transportation to the healthcare services (Lewis-O'Connor, 2009; Logan et al., 2007; Moore, 2009; Murphy et al., 2011).

The personnel and programs to address the needs of sexual assault victims are limited. Specially trained nurses and health care workers (Sexual Assault Nurse Examiners [SANE], Sexual Assault Forensic Examiners [SAFE], and Sexual Assault Response Team [SART]) are

prepared to provide the sensitivity and necessary skills when dealing with assault victims (Boykins et al., 2010; Lewis-O'Connor, 2009; Maier, 2011). These skilled nurses and health care teams, however, are not available in every city or hospital emergency room (Boykins et al., 2010). SANE, SAFE, and SART programs are limited and are generally located in larger metropolitan areas that serve high level trauma centers (Boykins et al., 2010).

In summary, despite the frequency and consequences of sexual assault, few studies have been conducted to examine the adaptation of women after sexual assault. The research problem for this study was no studies were identified in which researchers described how sexually assaulted women adapted from the woman's perspective. The purpose of the research study was to describe sexually assaulted women's perspectives during the first year and beyond after recovery. Roy's Adaptation Theory was utilized as a framework for guiding this research study and will be discussed in the following section.

Roy's Adaptation Theory

Roy's Adaptation Theory may be useful in elucidating how sexual assault affects the lives of victims by explaining how one adapts to changes and occurrences in life (Roy, 2009). Roy's Adaptation Theory views the person as a human system, constantly interacting with the environment (Roy, 2009). A human being is an "adaptive system" and throughout the life processes of the human being, adaptation will occur (Roy, 2009, p. 32). The adaptation may be observed as a negative behavior or as a positive behavior. Women who experience sexual assault may adapt or mal-adapt, depending on the services available, the extent of the emotional and psychological trauma that has occurred, and the strength and resilience of the women's adaptive modes and subsystems (Roy, 2009).

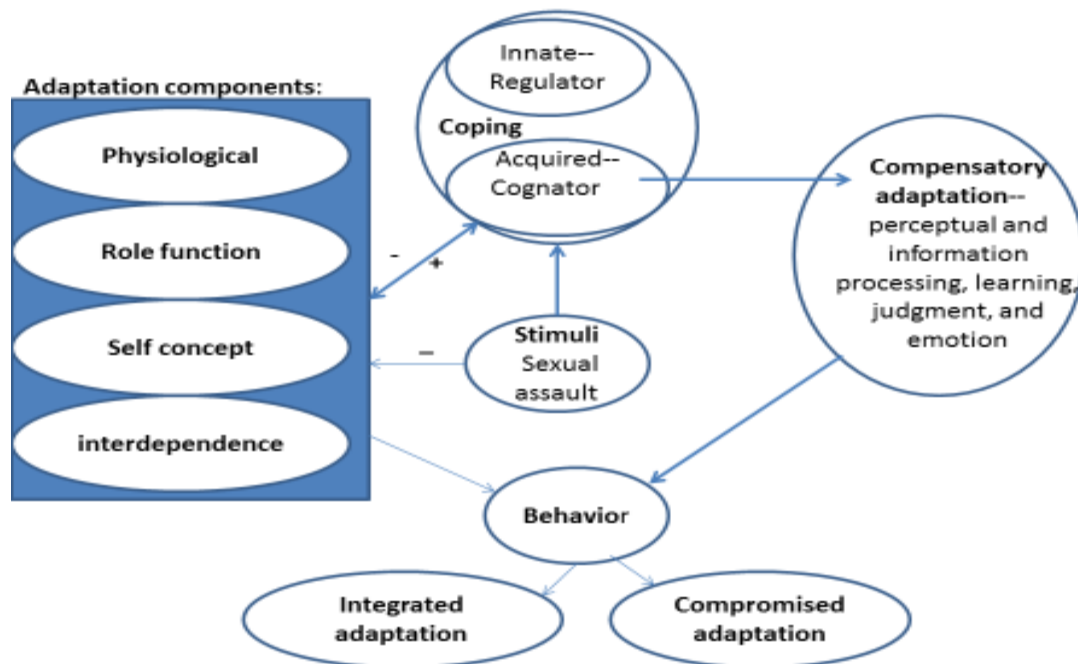
Concepts of Roy's Adaptation Theory for this study included stimuli, behavior, adaptation level, coping, and adaptive modes (see Figure 1). Each concept will be briefly described and examples of the concepts will be provided detailing how sexually assaulted women may respond.

Stimuli

Stimuli consist of focal, contextual, and residual types (Roy 2009). The focal stimulus, which may be internal or external, immediately challenges the human body (Roy, 2009), as the sexual assault does for the assaulted woman. A woman after assault may channel her energy into healing physically and emotionally from the sexual assault, the focal stimulus. Contextual stimuli surround the human adaptive system but are on the periphery and affect how the human system manages or copes with the focal stimulus (Roy, 2009). An example of a contextual stimulus may be a woman after a sexual assault learning of being at risk for a sexually transmitted disease. Residual stimuli are remnants of the environment affecting the human adaptive system (Roy, 2009). The residual stimuli, events from the past, will not be known until the woman verbalizes a problem. The residual stimuli, once verbalized, may then become focal or contextual stimuli.

Behavior

Behavior is defined as “internal or external actions and reactions under specified circumstances” (Roy, 2009, p. 39). A woman after sexual assault may have an increased heart rate (internal response) and may try to flee from the perpetrator (external response). Another example of behavior after a sexual assault may be the woman sleeping with a light on. The stressor imposed upon her affects her neurobiology, increasing cortisol release from the hypothalamic-pituitary-adrenal axis, reducing at times the neurotransmitters such as dopamine and serotonin, causing depression. Anxiety symptoms are further provoked by increased glutamate and norepinephrine activity that causes a fight or flight mechanism (Stahl, 2013). These mechanisms may contribute to the development of various mental health diagnoses, such as PTSD, depression, and anxiety (Stahl, 2013).



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Figure 1-1. Model of Roy's Adaptation Theory (Roy, 2009)

Adaptation Level

Adaptation consists of three potential processes: integrated, compensatory, and compromised (Roy, 2009). The integrated adaptation level involves all the processes of the human adaptive system (Roy, 2009). The compensatory level proceeds after the integrated process and may be recognized when women exhibit signs of distress, anxiety, or are calm and independent. Women may adapt physically by seeking the medical help needed to manage/prevent sexually transmitted diseases and assistance with dealing with concerns about pregnancy or becoming pregnant. The compromised adaptation level occurs when the integrated and the compensatory levels fail. Women may adapt negatively by turning to drugs, alcohol, or suicide.

Coping Processes

Coping is the ability to respond to something in the environment. Two general forms of coping exist: innate and acquired (Roy, 2009) and involve two subsystems. The regulator subsystem is “comprised of neural, chemical, and endocrine systems” (Roy, 2009, p. 27). Innate coping takes place automatically without any knowledge of it happening through the regulator sub-system. A woman’s innate coping during and following sexual assault may be exhibited when the woman responds immediately to protect herself and/or flee from the perpetrator. A woman coping after sexual assault may have increased heart rate and/or the “fight or flight” response to flee from the perpetrator. This subsystem affects her behaviors and includes the neurochemical and structural changes discussed above.

The cognator subsystem is comprised of “emotion, learning, judgment, and perceptual and information processing” (Roy, 2009, p. 26) and leads to acquired coping. Acquired coping occurs when one remembers a previous similar situation or learns a new way to deal with the assault. The exhibited behavior is “deliberate, conscious, and acquired” (Roy, 2009, p. 41). Acquired coping may be the target of interventions to promote adaptation following a sexual assault. Without assistance or a plan to acquire coping, the woman after the sexual assault may turn to drugs, alcohol, and/or may be afraid to be alone. An example of cognator ineffectiveness would be a woman after sexual assault exhibiting poor judgment and inappropriate affect altered by her poor management and decision making following her assault (Roy, 2009).

Adaptive Modes

Four modes reflect the person’s ability to adapt: physiological, self-concept, role-function, and interdependence modes (Roy, 2009). Each mode will be discussed and will include effective and ineffective examples of each.

Physiological

The physiological mode is comprised of “oxygenation, nutrition, elimination, activity and rest, protection, senses, neurologic function, endocrine function, and fluid, electrolyte, and acid-base balance” (Roy, 2009, p. 43). Whenever physiological changes occur, the person responds

by adapting to the situation. A negative physiological adaptation may occur when the woman is not able to sleep and get the proper amount of rest after the sexual assault. An example of a positive adaptation is the healing of physical injuries.

Self-Concept

A person's self-concept is how the person views him- or herself (Roy, 2009). A person's beliefs, thoughts, and feelings may affect the person's behavior (Roy, 2009). The person's behavior is an outward expression of positive and negative ways of coping (Roy, 2009). The self-concept of women following sexual assault may have been altered negatively. This violation, thus, may influence women, causing them to think of themselves unworthy and contemplate suicide as an ineffective behavior. An effective behavior may be demonstrated by women seeking counseling and getting the medical treatment needed and by recognizing their feelings of sadness, unworthiness, or blame are normal responses to the assault.

Role Function

Role function in a person's life is the "roles the individual occupies in society" (Roy, 2009, p. 44). A woman may be a wife, a mother, a student, and an employee. If a woman has been sexually assaulted, her role function may be altered as a consequence of the trauma of the experience. Role function as an adaptive mode may promote coping by allowing women to perform the other roles in their lives following the assault.

Interdependence

Interdependence is comprised of "interactions related to giving and receiving of love, respect, and value" (Roy, 2009, p. 45). Significant others and support systems are important relationships for women. Social contexts and support shape individual responses and whether the woman recovers (Ullman et al., 2007). Negative social reactions may interfere with recovery (Ullman et al., 2007). A woman having been sexually assaulted may have difficulty in maintaining relationships with the significant other, family, and peers at work. These relationships, however, may be a valuable resource for coping

Roy's Adaptation Theory (Roy, 2009) guided the study by framing the interview questions. The Roy model provided a comprehensive way to view the women's experiences, responses, and adaptation. This theory helps healthcare providers understand the "interaction of people in their world and with others in it" (Roy, 2009, p. 34).

Statement of Purpose

The purpose of this study was to describe the narratives of women who have been sexually assaulted. The primary research question was:

How do the stories that women tell about personal sexual assault reveal their adaptation after the sexual assault?

In order to better understand the coping strategies used by women, the secondary questions were:

1. How do women respond after a sexual assault?
2. How do women's responses to sexual assault affect their ability to adapt?

Narrative analysis was used to analyze the women's stories from beginning to end, providing a better understanding of the influence of certain events (Hesse-Biber, 2010; Sandelowski & Jones, 1996). The reason why the qualitative approach was appropriate in addressing this problem was that narrative analysis can allow the researcher to extract meaning from the women's experience. The collection of stories of women was the source of the data. The language used reflected the identities of the women and revealed meanings of the women's lives (Hesse-Biber, 2010; Munhall, 2012). Narrative analysis will be discussed in detail in Chapter Three.

Statement of Assumptions

The assumptions for this study were:

1. Women were willing to describe what they remember after the sexual assault.
2. Women who had been assaulted were able to describe the specifics of care they received and life after the assault.

3. Women who had been sexually assaulted were in some ways different/changed following the sexual assault.
4. Women who had been sexually assaulted were able to describe the differences in how they were before and after the assault.

Summary

The background and significance of sexual assault against women have been described. Roy's Adaptation Theory provided the framework for the study as an explanation of either positive or negative adaptation to a difficult situation, such as sexual assault. The purpose for this study was presented along with the study questions and assumptions for this study. The study was proposed to describe adaptation of sexually assaulted women.

Chapter 2

Review of Literature

This chapter will review the literature on sexual assault. The literature review was organized to begin with prevalence followed by a description of geographical variations, physiological and psychological effects, and concludes with resources and disparities.

Prevalence

Approximately 20% of all women will experience a sexual assault during their lifetime (Basile et al., 2014; Black et al., 2011). The 40% of women who were sexually assaulted as children were twice as likely to be assaulted as an adult (Breiding et al., 2014). Twenty-eight percent of undergraduate women were sexually assaulted a second time during a 10 week college term (Miller et al., 2011). Of the women sexually assaulted, 33% were also physically assaulted (Black et al., 2011). When comparing genders, women were twice as likely as men to incur physical injuries during the sexual assault (Littleton et al., 2013; Rees et al., 2011; Tjaden & Thoennes, 2000).

Women who were sexually assaulted before the age of 18 were more likely to report the crime (Tjaden & Thoennes, 2000). The researchers also found that 99% of the sexual assaults to females under 18 years of age were assaults by males (Tjaden & Thoennes, 2000).

Racial and ethnic differences regarding sexually assaulted women existed, as shown in Table 1 (Black et al., 2011). Some discrepancies have been observed between two executive summaries by Black et al. (2011) and Tjaden and Thoennes (2000). Black et al. (2011) interviewed 9086 women and projected their findings to fit the current proportions of ethnicities, excluding Asian Pacific women. Tjaden and Thoennes (2000) interviewed approximately 7,850 women and calculated the percentage of actual reported sexual assaults by race and ethnicities. The prevalence of sexual assault was lower, but may have been due to the few Asian Pacific women interviewed (Tjaden & Thoennes, 2000); however, Littleton et al. (2013) found Asian American women reported less sexual assaults than other ethnicities because they were not sexually assaulted as frequently. One challenge with reported prevalence rate among Asian

Pacific women was that the label includes “25 groups and 40 distinct cultural subgroups” (Bryant-Davis et al., 2009, p. 336). Mixed race women have the highest number of sexual assaults while Native American Indian and Native Alaskan’s have the second highest rate of sexual assault (Black et al., 2011). Bryant-Davis et al. (2009) posit Hispanics may report sexual assault less often for fear of deportation. Minority women were disproportionately affected by sexual assault.

Table 2-1. Comparison of Percentage Reported Sexual Assaults by Race/Ethnicities (Black et al., 2011, p. 20) to Population Distribution (Humes, Jones, & Ramirez, 2011, p. 4)

	White	African American	Hispanic	American Indian	Mixed Race
N	15,225,000	3,186,000	2,202,000	234,000	452,000
%	18.8	22	14.6	16.9	35.5
% in General Population	72.4	12.6	16.3	.9	2.9

According to Truman, Langton, and Planty (2013), 28% of the sexual assaults in 2012 were reported to police. Other researchers have found that most sexual assaults were not reported, making it difficult to know the accuracy of prevalence (Boykins et al., 2010; Campbell, 2006). Several reasons exist for why statistics may not accurately reflect the actual prevalence. Officers may fail to complete a report of the assault or may not complete the filing process to trigger further examination (Campbell, 2006; Langton et al., 2012). Law enforcement agencies may have re-victimized the women by asking questions that indicate the women brought on the sexual assaults (Campbell, 2006). Ethnic minority women were less likely to report to authorities due to mistrust (Bryant-Davis et al., 2009). Over 50% of women (n=701,000) in the National Victimization Survey from 2006 to 2010 knew their perpetrator, a factor that may have prevented the women from reporting the crime to police because of fear of retaliation (Langton et al., 2012).

Differences by Geography

Differences between how women in rural and metropolitan areas deal with sexual assault have been identified. The differences found in the literature will be presented in the following sections.

Rural Areas

Women living in rural areas have a higher incidence of sexual assault with only a small number of assaults being reported (Moore, 2009). Small towns have less confidentiality and anonymity (Moore, 2009). Services are not always available to rural women and the women may be uninformed about the type of care they need after sexual assault (Moore, 2009). The connotation of a sexual assault on the woman's reputation was different in a small local community, with some believing the woman was dressed provocatively and thus to blame for the assault. Some Native American Indian women had higher rates of sexual assault if they had stronger tribal identity than those women who lived near the border or away from their tribal land (Bryant-Davis et al., 2009).

Metropolitan Areas

Highly populated areas are more likely to have enhanced emergency care for sexually assaulted women. SANE programs are throughout the United States, located in hospitals with 24 hour emergency rooms. Some programs have rooms specifically designed to help the women feel less threatened and more comfortable during the examination process (Boykins et al., 2010). SART provided emotional and psychological support when treating the women, in addition to collecting forensic evidence and follow up care with the women (Lewis-O'Connor, 2009). Lewis-O'Connor (2009) investigated 420 female sexual assault cases in three geographical areas and found the SANE/SART staff collected better evidence to support prosecution and helped guide the women through the care and services needed after the assault than hospitals without SANE/SART programs. The study supported the concern that specialized SANE and SART teams were limited in locations and were generally found in metropolitan areas (Lewis-O'Connor, 2009).

Even in metropolitan areas, women may receive less than optimal care due to the skills of the health professionals they encounter. McLindon and Harms (2011) explored the needs and feelings of 15 mental health staff caring for sexually assaulted women in a qualitative study. Most staff did not feel they had enough instruction to help them in caring for the women. The mental

health staff in the study did not seek advice from sexual assault experts or encourage the women to seek more specialized services (McLindon & Harms, 2011). Clinics and non-profit agencies have limited funding and resources to reach and assist women in metropolitan areas (Lewis-O'Connor, 2009). The specially trained advocates provided beneficial services and resources to the sexually assaulted women. Campbell (2006) interviewed 81 women from two metropolitan hospitals, examining the services available to the women and treatment by the staff. Women who had an advocate during the initial hospital visit described better outcomes (Campbell, 2006).

Impact on the Woman

Sexual assault affects each woman differently. The literature identified the following as having an impact on the woman after sexual assault: loss of job, inability to have relationships, and mental health issues. Each potential impact will be presented in this section.

Loss of Job

Sexual assault negatively affects the woman's ability to work and provide for herself financially as noted in two studies (Busch-Armendez et al., 2010; Bryant-Davis et al., 2009). Busch-Armendez et al. (2010) found sexually assaulted women experienced more days off of work and were unable to fulfill their daily responsibilities. Bryant-Davis et al. (2009) reported financial constraints among ethnically diverse women after sexual assault. No other recent studies addressed the employment and financial effects after a sexual assault.

Military women that were sexually assaulted experienced additional problems. When some military women filed a sexual assault complaint, their commanding officer ignored the allegations and did nothing about the complaint (Bell et al., 2014). Among the military women who pursued the sexual assault allegations, 12% resigned earlier than their term of enlistment while 22% transferred to another area (Sadler et al., 2003).

Inability to Have Relationships

Some women who were sexually assaulted have demonstrated an inability to have intimate relationships and friendships after telling someone about this occurrence (Orchowski et al., 2013; Ullman et al., 2007). Orchardski et al. (2013) conducted a quantitative study (n=374)

examining college women's social and dating behaviors, but their sample included a limited number of ethnic minority women. They found that even when sexual victimization was acknowledged, women did not specify when the victimization occurred: as a child, teenager, or as an adult (Orchowski et al., 2013). More research investigating the nurse-patient interactions after the assault and the women' experience with the nurses, physicians, and hospital staff is needed.

Mental Health Issues

Mental health issues may occur after sexual assault. Substance abuse and suicidal ideations may be issues following an assault. Drug addiction (Boykin et al., 2010) and alcoholism (Boykins et al., 2010; Kalmakis, 2010) were more likely to occur with women who had been sexually assaulted. Depression may also result after a sexual assault. Kalmakis (2010) reported sexually assaulted women exhibited heavy drinking and alcohol problems in a descriptive study examining models and theories of sexual assault and alcohol use. Twenty-two percent of women contemplated suicide after being sexually assaulted in McFarlane and Malecha's (2005) study of 148 women. Mason and Lodrick (2013) reported some women may be disorientated and dissociate from reality following the assault.

Anxiety and fear may be observed in women after a sexual assault. PTSD is "an anxiety disorder that develops after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened" (Lavin, 2011, p. 41). More commonly these individuals exhibit lack of pleasure and enjoyment in life combined with a dysphoric mood and extreme anger, aggression, and dissociative symptoms (APA, 2013). Signs and symptoms of PTSD may be recurring dreams, distressing memories, flashbacks, psychological or physiological distress, hypervigilance, numbing of emotions, and avoidance of people, places and things reminiscent of the trauma (APA, 2013). PTSD has been reported to occur in 50% of women who have been sexually assaulted (Boykins et al., 2010; Heke et al., 2009). In another study, Zinzow et al. (2010) surveyed 2000 collegiate females by telephone, exploring the effects of sexual assault, such as PTSD and depression. Bodily harm and depression increased the likelihood of but was not found

to be related to PTSD (Zinzow et al., 2010). Sadler et al. (2003) found military women (n=558) had emotional problems and only 20% sought professional counseling.

Resources

Resources may be available to sexually assaulted women and utilized after a sexual assault. Resources include having an advocate at the woman's side to support her during and after the initial physical examination, having a SANE or SART nurse perform the physical examination and collect forensic evidence, and receiving other healthcare services. Barriers may exist for sexually assaulted women and may prevent them from getting the resources and healthcare they really need.

What is Recommended for Care

Advocates are recommended to assist women to navigate the healthcare system immediately after the assault (Campbell, 2006). Women that utilized advocates usually reported the assault to police and had less negative experiences (Campbell, 2006). SANE/SART staffs have the necessary training to collect the specimens and give the women the necessary care for their specific situations and needs (Lewis-O'Connor, 2009).

Tjaden and Thoennes (2000) reported approximately 36% of women sought medical services after a sexual assault. Of those that received medical services, 81% had gone to a hospital while others saw a doctor privately (Tjaden & Thoennes, 2000). After the initial examination and care received from the health professional, follow-up was needed. In one study, some women (n=81) were never seen by a medical professional or waited several days until they could go to the hospital or doctor's office (Campbell, 2006). After women walked out of the hospital, no formal follow-up existed to see if their needs were met (Campbell, 2006). Boykins et al. (2010) concurred in their study that health care professionals did not track or follow up with post sexually assaulted women. Researchers with the Virginia Department of Health (2009) reported health care providers were not following through with the appropriate screening tools for intimate partner violence. More research investigating the nurse-patient interactions after the assault and the women's experience with the nurses, physicians, and hospital staff is needed.

Barriers

Barriers for seeking assistance after a sexual assault have been reported to be embarrassment, self-guilt, healthcare staff ineptitude, inability to accept self and others, lack of transportation and access to healthcare, and financial costs from loss of work and healthcare costs for treatment and preventative care (Lewis-O'Connor, 2009; Logan et al., 2007; Moore, 2009; Murphy et al., 2011). Additional barriers reported by women included cost, inadequate resources, lack of knowledge, and lack of training for advocates and health professionals (Lewis-O'Connor, 2009; Logan et al., 2007; Moore, 2009; Murphy et al., 2011).

Cost

Women may not be able to afford health care or have the access to resources. Affordability was a barrier for sexually assaulted women to seek care as reported in four studies (Lewis-O'Connor, 2009; Logan et al., 2007; Moore, 2009; Murphy et al., 2011). Costs to the women were reported as \$29,000 (DeLisi et al., 2010).

Inadequate Number/Quality of Resources

Resources such as advocates and rape crisis centers were not readily available, and the lack thereof were a barrier to women receiving the care they needed post-assault (Lewis-O'Connor, 2009; Logan et al., 2007; Moore, 2009; Murphy et al., 2011). Rape crisis centers were available in some urban areas, but were not available in rural areas (Clark et al., 2002). In one survey, 22% of sexual assault victims received assistance from agencies related to physical needs, legal issues, and support in restoration (Truman et al., 2013).

Accessibility to healthcare and emergency rooms was also a barrier to women because of lack of knowledge of services, lack of transportation, and few specialty services being available (Lewis-O'Connor, 2009; Logan et al., 2007; Moore, 2009; Murphy et al., 2011).

Lack of Knowledge

Knowledge of services for sexual assault victims was found lacking. Kalmakis and Banning (2012) surveyed sexually assaulted women (n=37) to see if they knew how to retrieve information using the internet. Most women had computers and access to the internet, and were

open to searching for healthcare information using the internet (Kalmakis & Banning, 2012). Most women preferred maintaining anonymity and accessing information on the internet. The internet may be a helpful way for the women to obtain information on the healing process physically and emotionally.

Sadler et al. (2003) found 33% of military women lacked knowledge of how to report a sexual assault while on active duty. Despite increased awareness of sexual assault among military women since 2003, orientation to procedures of how to report and where to receive assistance for military women continue to be needed.

Lack of Training and Support for Staff

Lack of adequate staff training for those working with sexual assault victims has been documented in several studies. Heke et al. (2009) evaluated a risk management tool with 79 self-reported sexual assault cases. The findings after using the risk management tool were that healthcare workers needed to be trained in evaluating the potential of self-harm or suicide in a woman who had been sexually assaulted (Heke et al., 2009). Health care workers with a mental health background were able to use the risk management tool immediately (Heke et al., 2009), but many did not have comprehensive mental health training backgrounds. SANE nurses have reported experiencing burnout and may need more debriefing after each situation, or may need staff development to alleviate the reported stress (Maier, 2011).

Failure to record important information from the assault victim was noted in one study, along with a lack of standardization of care among sexually assaulted women (Boykins et al., 2010). In a qualitative study, mental health workers (n=15) reported inadequate sexual assault training and lack of preparation on how to respond to the women. Most of the 15 mental health staff did not feel they had enough instruction to help them in caring for the women. The mental health workers, therefore, never referred the women to specialized sexual assault referral centers (McLindon & Harms, 2011).

Disparities

Disparities may exist among the quality of healthcare received by women after sexual assault. However, the lack of documented follow-up after a woman is seen by a health care provider contributes to the inability to adequately compare the care received by women of different races and ethnicities. Quality of healthcare and lack of data collection will be presented in this section.

Quality of Healthcare

Differences in location and services received were found to exist between African American and White women (Boykins et al., 2010). African American women were more likely to arrive at a hospital by ambulance than White women were (Boykins et al., 2010). A lack of evidence was found in the documentation of resources received by the women (Boykins et al., 2010). The conclusion was that support systems have not been addressed or studied in racial or ethnic minorities (Boykins et al., 2010).

Lack of Data Collection

Race and ethnicity were often not recorded in the medical record, and, therefore it was difficult to know the numbers of women that were affected. In one study, Saltzman et al. (2007) found the data collected from assaults did not include race or ethnicity, making it difficult to know the ethnic populations that were at risk or in need of initial care and follow-up care services. Cook et al. (2011) conducted a systematic quantitative literature review of over 65 research studies of older women and sexual assault and found a lack of information collected regarding ethnicity and culture. Older women did not disclose their histories of trauma to their healthcare workers because the older women did not feel it was significant to report (Cook et al., 2011).

Boykins et al. (2010) studied 173 women using a retrospective, cross-sectional study in an urban hospital emergency department for over two years. Differences in sexual assault characteristics were found between African American and White women, inferring more comprehensive care was needed for minority women in urban areas (Boykins et al., 2010).

Gaps in Knowledge

Gaps in knowledge have been identified in the review of literature. Inaccuracy of statistics created difficulty in knowing how many have been sexually assaulted and the specific effect of the assault on the victims (Clark et al., 2002). Limited availability of assault victim's advocacy services were due to limited funding (Campbell, 2006). Little is known about the barriers of rural women in reporting and receiving treatment and support (Moore, 2009). Researchers have conducted few empirical studies evaluating the effectiveness of assault crisis center interventions (Campbell, 2006). Lack of follow-up care for sexually assaulted women was prevalent in most health care agencies (Boykins et al., 2010; Campbell, 2006). A study examining the nurse-patient interactions after sexual assault and patient perceptions of healthcare received is needed in order to provide better services (Kalmakis, 2010). By understanding the experiences of women after sexual assault, health care providers will be better prepared to plan effective, appropriate care and follow-up for their patients. No literature was found that described how women adapted after the sexual assault and how the women decided what services were needed to assist with their adaptation.

This study addressed the research problem of a lack of knowledge about the aftermath of sexual assault from the perspective of the women who were assaulted. The research question for this study was: How do the stories that women tell about personal sexual assault reveal their adaptation following the sexual assault? The rationale for the research question was to better understand the adaptation and coping strategies utilized by women in order to provide the better healthcare services to the assault victims.

Summary

This chapter has included the prevalence of sexual assault in different settings, the impact on the women, and the resources and barriers to care. Women in the studies encountered a loss of job after a sexual assault, PTSD, inability to have relationships, and mental health issues. Barriers to a woman after sexual assault were cost, inadequate resources, lack of knowledge, and lack of healthcare provider training and support.

Chapter 3

Method

The process of narrative analysis of the stories of women who have been sexually assaulted will be described in this chapter. The method, rationale, sample, setting, data collection method, procedure, rigor, ethical considerations, and data analysis will be discussed. Narrative analysis examines the stories of women after sexual assault and how that event affected their lives.

Narrative analysis was the design for this qualitative study. Describing the stories of the participants' experiences after sexual assault is the purpose of the narrative analysis (Crossley, 2003; Jordans, Little, Paul, & Sayers, 2001; Kacen, 2002; Leonard & Ellen, 2008; Munhall, 2012). Narrative analysis has been used effectively to study decision-making of women to terminate pregnancies and in sharing the lives of battered women. Sandelowski and Jones (1995) utilized narrative analysis with women and their partners (N=40), exploring the stories of having fetal anomalies and their decisions to terminate or continue the pregnancy. Kacen (2002) interviewed seven battered women and had them title their life stories in order to give meaning to their lives. The titles summarized the women's meanings of their life. The usefulness of narrative analysis to study emotionally-intense experiences made the method appropriate for studying sexual assault.

Narrative inquiry focuses on the plot and the events in the story (Riessman, 2008). In the classic article by Poirier and Ayres (1997), "stories are created to fit an author's purpose" (p. 552) and "bring meaning to the teller of the tale, to the listener and to the researcher" (Ayres & Poirier, 1996, p. 163). Each story has a beginning, middle, and an end (Ayres & Poirier, 1996; Riessman, 2008). The researcher analyzed the stories for meaning. The analysis of narrative data began with words and the words created a storyline using the descriptive themes: "point of view, narrative voice, and figurative language" (Ayres & Poirier, 1996, p. 164). The reviewer then interprets the story's meaning (Munhall, 2012; Riessman, 2008).

In order for the researcher to remain neutral, memos, audit trails, and research expertise were used to reduce any bias (Munhall, 2012). By being neutral, the researcher limited the effect

of any predetermined beliefs, judgments, or biases and remained open to whatever the participant wanted to share during the interview. Analytical memos were used by the researcher during the interview and after data collection (observations, main themes, patterns) (Munhall, 2012). An audit trail was created as means of maintaining truthfulness and a timeline of the study (Riessman, 2008). Rereading the narratives revealed gaps in the story and raised questions regarding interpretation, recurrences, stillness, and discrepancies in order to render an accurate rich interpretation (Poirier & Ayres, 1997). The researcher listened to the transcript several times and selectively re-transcribed passages for more detailed analyses (Riessman, 1993).

Sample

The sample consisted of women 18 years of age and older who indicated they had been sexually assaulted as an adult (at least 18 years old at the time of the assault). The women recruited for the study were English speaking women of all races and ethnicities. The length of time since the assault was not a factor in selection because researchers found that time did not alter memory of traumatic events (Josselson, 2009). However, in one study (n=71), memory was found to vary due to different types of traumatic events related to the woman's reaction to the event, but time since the traumatic event did not predict the extent of detail that was included in the interviews (Welton-Mitchell, McIntosh, & DePrince, 2013). Based on available evidence, women who were assaulted earlier in their adult lives as well as those assaulted more recently were included. Non-English speaking women were not included since the researcher was part of the method for communication, and she only spoke English (Munhall, 2012). Exclusion criteria included women with cognitive or degenerative health issues that may have affected their ability to remember details. The method depended on the woman's ability to remember the assault and its aftermath. If a woman was cognitively or emotionally unable to remember, she was eliminated from the study. Any women still in crisis from the aftermaths of sexual assault were excluded from this study since they may not be ready to talk about and answer questions pertaining to the assault. The time suggested to recover from the actual single traumatic event crisis was between

four to six weeks (Caplan, 1964; Roberts, 2005). As a result, women who were less than six weeks post-assault were excluded.

Setting

The interviews were conducted in a non-threatening place which provided privacy and comfort, such as a coffee shop, private office, or wherever the participant felt safe (Leonard & Ellis, 2008). The setting was mutually agreeable to the researcher and the participant. The interviews took place in a variety of locations: a study room, a coffee shop, a conference room, and a private office.

Data Collection

The research recruited the participants by leaving approximately 20 flyers about the study at counseling centers, emergency rooms, ladies Bible study groups, and crisis centers (see Appendix A). Cards were also placed in women's bathrooms at restaurants and bars (see Appendix B). Snowball sampling from these other women was also used. The researcher obtained a temporary phone and email address for potential subjects to use to contact the researcher. The phone number and email address were provided on the flyer or card. These temporary means of communication were used to protect the personal information of the researcher. Women who were interested phoned or emailed the researcher to arrange an interview.

Life after sexual assault stories was explored using semi-structured interviews with participants. The researcher explained the study and obtained verbal consent from participants, and verbal permission to record the interviews. The researcher asked the participants to describe their life after the sexual assault and how they have adapted. After the interview, the participants were requested to complete a short demographic survey (17 questions) (see Appendix C). The demographic survey was developed from the literature review and mental health and women's health experts. Participants were debriefed after completing the survey and were given a handout with community resources and phone numbers. Providing resource information had been

identified as being important by other researchers (Abbey et al., 2004; Edwards, Kearns, Calhoun, & Gidycz, 2009).

An interview guide was used with approximately seven questions that guided the women's interviews (see Appendix D). Interviews lasted from 45 to 120 minutes and were digitally audio recorded using two separate devices. Field notes were used by the researcher during the interview process to document facial and body appearance, posturing, and pauses during the interview.

The demographic surveys were maintained in a locked file cabinet and office at the University of Texas at Arlington with all computer data being password protected. Each demographic survey was given a number with a code linking it to the recording and the transcript for that woman. No personal identifying information was recorded.

Ethical Considerations

Institutional Review Board (IRB) approval from the University of Texas at Arlington was obtained (see Appendix E). Once approval was received, the researcher began recruiting participants.

Benefits of the study were described to participants as being the potential to help health care providers caring for sexually assaulted women. The women were given the opportunity to receive a copy of the study findings if they provided an email address.

Risks of this research study included the stress to subjects of talking about the event. One study reported women (n=1056) found the interview distressing, but felt the benefits outweigh the costs (Edwards et al., 2009). Despite concerns that women might become upset reliving their experiences, only two women cried or became visibly upset. During the interview the researcher had a plan if an adverse event or psychological stress occurred: the researcher would stop the interview, summon professional help or counseling and wait with the subject until help arrived. The participant was also allowed to stop the interview at any time. The plan did not have to be activated and counseling services were not needed. Upon conclusion of the interview, consistent with the methods of other studies (Abbey et al., 2004), an additional question was

asked to assess the extent to which the interview had upset the woman. The participants were debriefed at the conclusion of the interview and given a handout of community resources with phone numbers (Abbey et al., 2004; Welton-Mitchell et al., 2013).

Anonymity and confidentiality were maintained without any personal identifying information on notes or transcripts. The participants provided the researcher a name they would like to be called during the interview. A waiver for signing the consent form was approved by the IRB, allowing the participants to give verbal consent. They were given a copy of the Informed Consent Document (see Appendix F). Digital tape recordings from interviews will be maintained for three years on University of Texas at Arlington encrypted computers.

Data Analysis

Demographic data were collected and entered into SPSS software program and Microsoft Excel and were analyzed to produce frequencies, means, and standard deviations. The transcripts were typed using Dragon Home Edition, a voice recognition transcription computer software program. The researcher listened to the audio recording to correct any inaccuracies in the transcript. Methodological notes and analytical memos were used when reviewing the transcripts as a first step in data analysis.

The researcher reviewed the transcripts by reading and rereading each woman's story for meaning. Important themes were noted on each transcript. A list of the themes emerging from the transcripts were then compiled. The quotes from each theme were collected and reviewed for similar meaning. Additionally, the transcripts were reviewed for concepts in Roy's Adaptation Model (2009). Each event in the narratives were grouped according to the timing of when it occurred within the story. The women's stories were re-told using quotes and discussion of the common themes and findings from the analysis. Finally, the narratives were reviewed for the possibility of telling one story representing all the women.

Rigor was maintained by the researcher re-phrasing and validating statements by the participant to ensure trustworthiness and accuracy of her thoughts. An expert reviewed the first two transcripts to guide the researcher's interview analysis (Kacen, 2002). The researcher then

met with the expert to review the analysis and compare findings. This process of reviewing the transcripts continued until all transcripts were reviewed and analyzed by the researcher and expert. An audit trail was utilized by the researcher using Microsoft Excel (2013) (see Appendix G).

Summary

The method, rationale, sample, setting, data collection process, and ethical considerations have been presented. Semi-structured interviews were conducted in a safe environment as determined by the participant and researcher. The women's stories were transcribed and reviewed for themes and story components. The narratives were retold in a story format using quotes from the participant after the detailed content analysis was completed.

Chapter 4

Findings

Analysis of the themes was organized by telling a story from how the women were before the sexual assault and then following the assault how the women adapted. The demographic characteristics of the women interviewed are presented first, followed by answering the research questions from the story of the women with emerging themes.

Sample Demographics

Eighteen women contacted the researcher of which 16 women met the inclusion criteria. The two women who did not meet the inclusion criteria had only been assaulted as a child. Of the remaining 16 women, one woman changed her mind and did not show up for the interview, one

Table 4-1. Age, Ethnicity, Employment (n=12)

Characteristic	Mean (SD)
Age	34(13.73)
Monthly household income	\$4675 (4355.75)
Ethnicity	F (%)
American Indian or Alaska Native	1 (8.33%)
Asian	1 (8.33%)
Hispanic or Latino	3 (25%)
White	7 (58.33%)
Type of Employment	F (%)
Full Time	5 (41.67%)
Part Time	6 (50%)

woman did not schedule an interview, and two women did not respond back after initial contact. The sample consisted of 12 women. The ages of the women participating in the study ranged from 21 years to 59 years of age (see Table 4-1).

Table 4-2. Family Characteristics (n=12)

Marital Status (n=12)	Frequency (%)
Single	7 (58.33%)
Living with significant other	1 (8.33%)
Married	4 (33.33%)
Living with	
Parents	3 (25%)
Roommate	1 (8.3%)
Partner	1 (8.3%)
Spouse	4 (33.33%)
Grandparents	2 (16.66%)
Self	1 (8.3%)
Children	
Yes	7 (58.33%)
No	5 (41.66%)

Table 4-3. Assault Characteristics

Characteristics	F(%)
Assaulted more than once (n=12)	4 (33.33%)
Made an outcry (n=12)	4 (33.33%)
Report was believed (n=10)	5 (50%)

Almost half (42%) of the women were from minority groups; however, no African Americans or Native Hawaiian/other Pacific Islanders were recruited. Seven women were college students. All of the women except for one were employed. Types of employment identified by the women were reporter, secretary, childcare worker, retail employee, trainer/educator, author/activist, coffee shop barista, founder of a non-profit, and tutor at a high school. The women were open to discussing their adaptation and coping strategies following a sexual assault.

Most of the women lived with someone else (family or friend) rather than living alone (see Table 4- 2). The majority of the women reported being single, however, that did not mean they lived alone. Over half of the women had children or stepchildren for whom they were responsible. The number of children each woman had ranged from one child to six children (including step-children). The ages of the children ranged from 10 months to 29 years of age.

Table 4-4. Mental Health Characteristics

		Onset	
		Before assault F (%)	After assault F (%)
Mental health disorder began (n=8)		4 (50%)	4 (50%)
Diagnosis (n=8)	F (%)		
Depression	7 (87.5%)		
General anxiety disorder	4 (50%)		
Post-traumatic stress disorder	2 (25%)		
Panic attacks	2 (25%)		
Suicide Ideation (n=12)			
Yes	8 (66.67%)		
Attempted suicide (n=12)		2 (16.7%)	7 (58%)
Ever cut or do self-injury (n=12)	5 (36.36%)		

The women's age at time of assault ranged from 18 to 49 years of age. The average length of time since the assault was 9.5 years (SD= 10.22 years). Several of the women had

reported being assaulted more than one time during their adult life. A few women also reported being assaulted as a child and then again as an adult. Some of the women felt they were believed when they reported having been assaulted (see Table 4-3).

Half of the women (n=4, 50%) reported having mental health problems following the assault (see Table 4). One woman reported not “cutting” but had a bulimic/anorexic disorder throughout life. Three women reported suicide thinking with two woman considering suicide before and after the assault. Not all women had been diagnosed with a mental health disorder following the assault.

None of the women indicated drinking alcohol until passing out. The alcohol reported by the women was consumed on special occasions or on a monthly basis (see Table 5). Most of the women that drank alcohol had begun drinking before the assault. Only one woman reported drinking to get drunk after the assault.

Table 4-5. Alcohol Characteristics

Frequency of drinking (n=8)	F (%)
Monthly	7 (87.5%)
Weekly	1 (12.5%)
Type of drink (n=7)	
Beer	2 (28.57%)
Wine	4 (57.14%)
Liquor	4 (57.14%)
Drink to pass out (n=7)	
No	7 (100%)
Began drinking (n=8)	
Before assault	6 (75%)
After assault	2 (25%)

Eleven of the women had healthcare insurance. Eleven women had seen a health care provider at least one time during a two year period (see Table 4-6). One woman did not remember how many times she had been to a health care provider. The prescribed medications taken by the women were birth control pills, hormone replacement medications, thyroid replacement medications, anti-anxiety drugs, anti-depressants, vitamin injections, and anti-hyperlipidemic medications. Not all women reported taking prescription drugs (n=3).

Table 4-6. Health Care Characteristics

Characteristic	Range
Number of visits to health care provider over two years (n=11)	1-40
Prescribed medications (n=9)	F (%)
Psychotherapeutic meds	5 (55.56%)
Women's health meds	4 (44.44%)
Other medications	4 (44.44%)

The research question was: How do the stories women tell about personal sexual assault reveal their adaptation after sexual assault? The story had four main chapters: the prologue, the event, the aftermath, and the present. The prologue was how the women described themselves before the assault. The event involved the two main themes: violated trust and unsuspecting. The aftermath incorporated what the women did immediately after the assault: seeking safety and security, seeking support, stress in their body, survivor mode, and adaptive mode. The present part of the stories was the women's lives today: stuck in the past, stronger in a lot of ways, time heals, and taking back control. Each main part of the story will be described in the next sections.

Themes

There are two stories emerging from this study: women with integrated adaptation and women that experienced compromised adaptation. Themes were applied to Roy's Adaptation Model (Roy, 2009) (see Table 4-7). A table was created to summarize the chapters, themes, and subthemes of the women's narratives (see Table 4-8).

In one version of the story, the woman was confident and trusting before the assault, never thinking she would become a statistic of sexual assault. After the assault the woman went home to a safe environment. Time spent recovering from the event varied. The woman went to a clinic or hospital sometime after the assault, focusing on her safety and coping strategies. Counseling, use of creative strategies, and pets as companions helped the woman process the event helping her to be stronger and take control of her life. Over time she healed but the woman may still experience a variety of triggers, and she never fully forgets.

The other version of the story is a woman who thought abuse was normal since she had grown up as a child being assaulted. The woman did not seek help and repressed or denied the sexual assault had occurred. She may have detached or dissociated herself from the event and similar situations occurring throughout her life. The woman may have attempted suicide or had bulimia/anorexia as a negative coping strategy. This woman experienced difficulty in moving on with her life and continuing in therapy.

Table 4-7. Themes Applying Roy's Adaptation Model (Roy, 2009)

Concepts	Integrated Adaptation (Roy, 2009)	Compromised Adaptation (Roy, 2009)
Self-Concept (Roy, 2009)	Confident and trusting	Abuse is normal
Role function (Roy, 2009)	Violated trust	Unsuspecting
Physiological (Roy, 2009)	Seeking safety and security Seeking support Adapting mode	Stress in my body Survivor mode
Interdependence (Roy, 2009)	Taking back control	Stuck in the past

The Prologue

The women described themselves before the assault as the prologue to their story. The two themes emerging from their descriptions were confident and trusting, and abuse is normal.

Confident and Trusting

The women described themselves as “confident” having “high self-esteem” before the sexual assault. Miriam volunteered, “I have always been confident and have a high self-esteem...”. Claudia said, “I think I was more confident. Actually I was feeling very confident. That day I was very confident...”. With the confidence and trust, came fearlessness. One woman stated “I just trusted everybody. I would trust you” (Claudia). Most of the women thought they would never become a statistic to an assault, that they were safe. Another woman,

Table 4-8. Summary of Chapters, Themes, and Sub-themes

Chapters	Themes	Sub-themes
The Prologue	Confident and trusting Abuse is normal	
The Event	Violated trust Unsuspecting	
The Aftermath	Seeking safety and security	Home Healthcare
	Seeking Support	People- family, friends, professional Reactions
	Stress in my body	Physical problems Mental and emotional problems
	Survivor mode	
	Adapting mode	Counseling Creative expression Protective boundary Social Sexual
The Present	Stuck in the Past	Triggers Stress management
	Taking back control	Confident/compassion/empathy Time heals Helping others What resources are needed

Sophie, offered, “I view myself as someone who’s slightly naïve and trusts people a little too much and doesn’t understand the boundaries properly”.

Abuse is Normal

Some women had grown up in a home with domestic abuse/violence or sexual abuse. Since this was all they knew, they thought this was normal. Daisy shared, “My parents’ marriage was pretty bad. My dad hit me when I was 16, and I just thought that was normal”. Bonnie expressed, “So you can imagine all these years I had been in these relationships and didn’t know that was not OK”.

The Event

From the women’s descriptions of the event, two themes emerged: violated trust and unsuspecting. The women that knew their perpetrator experienced violated trust. Unsuspecting women were doing their normal daily activities when they were assaulted.

Violated trust

Violated trust was defined by the women as a previously trusted male friend or boyfriend who sexually assaulted them. Sophie shared she knew the friend for five years and had just gone to his apartment to watch a political debate. “It was actually one of my closet friends. We’ve known each other for five years but sometimes I wonder if he drugged me”. Daisy was in a dating relationship and stated, “The person that assaulted me was a boyfriend at that time and I was stupid to think it was normal”.

Unsuspecting

Some women were doing their normal activities and were unsuspecting that anything bad was about to happen. Bridget described what happened in this way: “I had my TV on and my back was to the door and I remember turning around and hearing a noise and looked and didn’t see anything and then the next thing I know he was already behind me with a knife at my neck”. Lucille was leaving work and going home. In the parking lot, she was kidnapped. Patricia was meeting a blind date for a weekend out of town. Claudia was leaving the bars after celebrating

with friends when she was assaulted. Bonnie accepted a ride to her apartment because she did not have a car at the time.

I worked at a hotel and I didn't have a car and so this young man who was ah, offered me a ride home and he said, "Can you come up to my apartment?...and I said OK, and he said he was just going to get something and then he was going to take me home and that's not what he had in mind" (Bonnie).

The Aftermath

The aftermath involved what the women did immediately after the assault. This period of time was approximately up to eight to 12 weeks post assault. The themes in this chapter of the story included seeking safety and security, seeking support, "stress in my body", survivor mode, and adaptive mode. Some women went home after the assault to process what had just happened to them. They sought out safety and security, and made the changes in their schedule and their social activities in order to protect themselves. Others, after going home, went to the hospital. The women disclosed the sexual assault to a trusted person: a family member, a friend, or a professional. Even though the trusted persons received the disclosure, not all of the persons reacted in a desired way.

Daisy volunteered, "It takes these women time to figure out what happened to them".

I went home that day and basically became a hermit for a couple of days. Ah probably a week while I tried to process what was going on and, and figure out what I wanted to do I wasn't sure I wanted to press charges; I wasn't sure I wanted to think about it at all. Um but of course it is prevalent and I did have to think about it and I did have to process it and that took probably about a week before I felt like facing the world again (Patricia). Sophie went to her boyfriend's home to process what had just happened. "I drove to my

boyfriend's house and was there immediately and I stayed there for a week". Bridget was at home when the attempted assault occurred and called her friend first before calling police.

Honestly I was totally in denial for a long time. I didn't really, I didn't want to report it. I didn't take it to anyone, I didn't, I just kind of froze I guess is really what it was (Allie).

Seeking Safety and Security

After the assault, the women sought safety by enhanced protection. A GPS tracker application was utilized by one woman and her boyfriend so they would have peace of mind in knowing the other's location at all times. "Cautious to the point of being paranoid. My boyfriend

and I now have this GPS thing on each other's phone so we know exactly where the other is always" (Sophie). As a protective shield and to prevent recurrence, two women changed their physical appearance from feminine "girlish" and "long hair" to looking "mannish" and "cutting hair" in order to not "stand out".

The women have become more proactive in paying attention to body language and understanding consent culture. Consent culture was defined by one woman as a "yes" means "yes" and a "no" means "no."

Home

Most women went directly home after the sexual assault. The women made changes to the way they had been living to protect themselves. Daisy "moved, got a new car, and a new bank account". "The car alarm gave me reassurance" (Daisy). Patricia installed a home security system and double checked all windows and doors to be certain they were all locked for her personal security. "Much more conscious and much follow through on making sure I had my personal security: the doors are always locked; the windows are always locked. Live on the second floor to make that more difficult" (Patricia). Bridget moved to another apartment complex "that had a security gate" and selected an apartment on the second floor. Patricia reported doing background checks on future prospective dates to ensure her safety. "I do things like run background checks on the people I now date. I Google them. I don't trust what they're telling me about themselves is really what is there" (Patricia).

Healthcare

Some of the women did go to a clinic or a hospital to make sure they were physically healthy following the assault. One woman complained she had an elevated temperature so she went to the hospital. "I started having some symptoms two or three days later, running a fever and things like that and I ended up going to the emergency room four days later" (Patricia). Another woman was taken to the hospital after she was found, "...after I was found, we were at one hospital, then I had to go to another hospital to get 'the kit' " (Lucille). Another woman went to a clinic after going to her church to get help. The women went to the hospital one day to several

days after the assault. Another woman did not do anything due to what she had heard about how assaulted women were treated at the hospital.

Seeking Support

When at home, some of the women disclosed the sexual assault to a friend or family member, but the disclosure varied in length of time of notification from immediately after the assault to several years later. The women identified in their support groups someone they could “trust and unpack” (Chalice). “Trust and unpack” was defined as being able to let one’s guard down and discuss everything of pertinence from the event. According to Miriam, the support groups exhibited “empathy” and “reached out” to her. Some friends “did not know how to say it” (Miriam) when dialoging with the assaulted woman. Patricia did not reveal the assault to her mother until “at least 1-2 years later”.

Many did not report the assault to the police. Reasons given for not reporting the sexual assault were fear of retaliation and the long legal process bringing the crime to justice. The legal process and investigation would take “too long” to convict and in two years the women would not know where they would be in life.

People – Family, Friends, Professional

Women after the assault reached out to family, friends, and professionals. The women were fearful of how the person would respond or react to the news they had been assaulted. Some women did not reveal the assault to their mother because they were afraid of their mother’s reaction. The reactions of the significant person/people varied. “I told my sister immediately. I called her from the hotel room. ...she had the same response I did which was ‘come home, come home now’” (Patricia). Her family members were “cohesive with the crisis” (Patricia). Jene’ told her mother but her mother was not very helpful. Some women did not go home but went to a friend’s home. “I just stayed with my boyfriend... he actually lives with his parents and sister... they were all very supportive and his sister gave me something like a journal... they just let me hole up in his room” (Sophie). Because of the close proximity, some women could not hide what had happened to them. “I told my sister....so that made it a little bit harder with her being in my

room.... She was actually able to help me more than probably anybody else could because she could relate” (Claudia).

Cats and dogs provided the women additional support during the recovery and healing phases. The dogs and cats provided companionship and heard noises to alert them of potential dangers. Cats were “my best friends, companions, and intuitive” (Daisy). Miriam explains she

got a dog to be trained as a service dog and he helped a lot. Just letting me feel in control. He became very attached to me and he really just helped me to get through life and day-to-day and he gave me a lot of joy and love. He went everywhere with me, even to watch the kiddos that I was nannying for. Well I think having the dog helped ‘cause he heard. He was very unique; he hears (sighs) people and car doors, anything unusual to nature I guess ... He hears and responds to. . . would bark and let me know and would get real close to me so I was just more peaceful (Miriam).

A family member of Bridget “got me a puppy dog . . it’s like a companion almost. You can trust that dog is going to bark or do something if somebody enters or whatever”.

Reactions

Not all friends and family that received the news of the sexual assault were supportive. A group of friends asked Patricia “to leave the Bunko group . . . I was asked to leave the group because I talked about what happened to me”.

Some friends were supportive during the immediate crisis period, but then later they didn’t communicate as frequently as before. As the time after the assault increased, “people forget and move on”, forgetting about the assaulted woman (Miriam).

The women experienced health care issues. Miriam felt her religious beliefs of not wanting to take “the day after abortion pill” were violated. Hospital workers were rude and labeled the assaulted woman, in addition to not believing her or taking her seriously. “I didn’t feel like they [the hospital staff] were very trustworthy or genuine. They made me feel guilty. They made me feel like I put it on myself... their attitude was all wrong and they could have been more sensitive with things” (Miriam). The women were treated as bringing on the assault.

And I guess there was a lot of, I don’t know I had a lot of, I don’t know if it was fear of judgment. I heard all those horror stories about people going into the hospital and like it was a really of bad experience for them. And I think it was some of that but I was kind of in shock as well and so I just didn’t do anything . . . You know when you’re talking to

people at healthcare centers who may be kind of rude to you or talk to you like you're crazy. I've had that experience before. ...I've had one or two people who kind of question me and I felt they were kind of questioning me, 'Oh no did this really happen?' and so that has been a difficult experience and it's just something that's been hard to overcome. (Allie)

After the sexual assault, the women experienced some economic changes. Some of the women worked full time and continued working immediately after the assault. The work "helped me to keep my mind off..." (Bridget). Some worked part-time and went to work the day immediately following the assault but had to go home because of the stress from work in addition to the assault (Miriam & Claudia). "I quit my job as shift manager" (Miriam) because of the inflexibility of the new store manager. Lucille took a leave of absence for approximately three and a half months from her work before she felt she could return to work.

Stress in My Body

Stress in my body was identified as physical problems and mental/emotional problems. Most women experienced a combination of health issues.

Physical Problems

Physically the women were "tired" and "had no energy" (Sophie, Claudia). Several women gained weight or weight fluctuated after the assault, with one woman admitting she was "an emotional eater" (Claudia). Women expressed difficulty sleeping at night. One woman kept "the lights on at all times", and was so tired she finally "fell asleep from physical exhaustion" (Bridget). One woman complained of having "back pain and spasms" (Miriam), while another woman had "a herniated disk" in her back (Allie).

I carry stress in my lower back and when I bent down to tie my shoes, I guess I had spasms and it was just torture; couldn't walk; couldn't move. Just with everything that happened that it really was just horrible and I never experienced anything like that before. (Miriam)

"Like I've had a lot of physical aches and pains. Like I actually injured my back last year when I was moving and I had a herniated disc. And I think that was aggravated; like I can feel the stress of my body" (Allie).

Sophie verbalized her "posture and balance changed." Patricia expressed "severe blood loss from a deep gash in her uterus/vagina." Allie feared getting pregnant should she be sexually

assaulted again, so she started taking the pill and going to a HIV/AIDS/STD clinic after the assault. Bonnie experienced a mysterious illness that doctors were not able to diagnose. "...I had gotten sick. It was a mysterious illness. They did not know what was wrong; horrible headaches...As I've grown older I realized it was stress from the abuse" (Bonnie).

Mental and Emotional Problems

The women were affected mentally in a variety of ways after the sexual assault. Some women complained of anxiety disorders that were triggered by something that occurred during the assault.

I'd be afraid to go into an elevator. I'd feel closed in and I was never afraid of that...And like flying on an airplane, he [my husband] would have to get me an aisle seat or he would get on but I would be the last one to get on because I don't like that closed in feeling of like I couldn't breathe... I started having anxiety attacks and stuff and I never had those before (Bridget).

Women experienced anxiety attacks, nightmares and flashbacks, in addition to depression, separately or in combination. "I had was... I think the actual nightmares, waking up in a sweat or just nightmares" (Miriam). "Legitimate fears" were verbalized by some. Legitimate fears were defined as fears based on actual experiences. PTSD and suicidal thoughts were described by some women. The suicidal ideation occurred especially in the women that had been assaulted as a child. Women had detachment/dissociation coping mechanisms during the event and in later sexual encounters; some lost custody of children, and later attempted suicide as a result of losing custody. When Allie attempted to learn more about PTSD at a health center, she was asked if she had served in the military, making her feel as if only those that served in the military could have PTSD.

The women's self-concept and self-confidence changed after the assault. The women felt guilt, shame, more self-conscious, ruined and worthless. "I couldn't get anything done and it would perpetuate this deep, deep cycle of worthlessness" (Bonnie). The women's images were changed after the assault. "Just more awkward, more self-conscious, way less social, and more unsure of myself" (Sophie).

Survivor Mode

The women wanted to be survivors. Chalice stated she was a “very lucky survivor.” They used the survivor mode as a coping mechanism in order to live each day after the assault. In order to cope, they had to repress or deny that the sexual assault had actually taken place. They grieved the loss of something being taken from them. Miriam defined the loss as “grieving what was lost like that of losing a baby”.

And talk through what I was dealing with at the time and how I was doing in life and just being OK that it was OK to grieve what was lost and just, I don't know, was really helpful. ...but I was reading a blog a few weeks ago and it was talking about losing a baby and sort of what is appropriate to say or not say. That's grieving and I related, I could relate to this in my situation (Miriam).

And living life I think at first I adapted just to survive, just to get through every day. Because it's hard; it's something that's painful. It was something that's was done to you. You don't have control over it and so it's hard when something like that happens. (Miriam)

Coping was defined by being “much more critical” towards everything in life and towards people. For example the women are more scrutinizing and discriminating towards people they date and spend time with, in addition to the life choices the women made. One main goal was to “get over it”. For example, the women attempted to put the assault behind them and move on with their lives.

Some woman expressed denial or repression that they had been sexually assaulted. “Honestly I was in denial for a long time” (Allie). Woman repressed the assault for several years until some other mental health issues appeared requiring resolution. Some women and their families act as though it never happened. “We [family] usually don't talk about it. We treat it as if it didn't happen even though it did” (Lucille).

Adapting Mode

The adapting mode occurred when the women actively made a decision to seek ways to bring healing to them physically and emotionally. For each woman, the time varied when the decision was made to adapt and return to a somewhat normal life. Counseling, creative expression, and protective boundaries were identified by the women as helping them to heal.

Counseling

Women sought counseling because they had been encouraged by friends and family and/or the hospital to do so. "I had been through counseling as a child and already knew what to do" (Patricia). The length of time of counseling varied from two months to several years. "Before I did that, I thought I'm going to need counseling" (Ella).

One woman's counselor called her "resilient" because she was able to cope and adapt in two to three months after the assault. Non-resilient women received counseling services for two or more years after the assault.

Like I told you I went to counseling for probably like that week after so it was really, really bad. Went to one of those crisis centers. They helped me talk about it but so it happens there was one actually close to where I live... (Claudia).

Sophie expressed interest in her parents receiving counseling as secondary victims. "I referred my parents to secondary victims like some kind of thing for them to go to and it helped them a lot."

Creative Expression

Some women processed the assault in various creative ways from journaling, writing poetry, or short stories to praying and reading the Bible to gain some perspective. Creative expression helped them to process what had happened to them and bring forth healing. Another option was a blog that helped in processing things in her life.

The only thing I kept up with was I write and I've always written and I will continue to do that 'cause that helps a lot. .. I have a blog actually. I guess it could be called the modern journal, (laughs) you would say. But I write poetry, short stories, and essays about it.. . . (Allie).

I think reading the Bible has really helped in healing. . . I think prayer has helped me cope; just praying through what's happened; just really, I don't know just really getting a peace from that what was done was wrong (Miriam).

Another book, *Rid of My Disgrace*, was helpful in meeting one woman's need of resolution from the assault.

Protective Boundary

Protective boundary was identified as another way of adapting to heal from the sexual assault. Two areas, social and sexual, were predominantly changed during the woman's adaptation process.

Social. After the sexual assault the women reported changing their social behaviors. After the assault the women reported "not dating," "not going out much," and "being less social." The women stated they "do not drink any more" as a result of the sexual assault. "So yeah, I haven't gone to the bar since or any really nightlife" (Claudia).

Some women had "strained relationships" and changed with whom they would talk. "And I know some of my relationships with my friends will be strained because of my irritability ..." (Allie). Patricia changed how transparent she was with men. "...more open to other women but less open in how I approach men and how I deal with men."

Sexual. The women experienced changes in their sexuality after the assault. Most women stopped "being close with guy friends". Some women expressed having estranged relationships with male relatives because the women associated the assault to every male being a potential perpetrator. Sophie "felt awkward around her dad and had a sickened feeling". Most women had experienced intimacy issues and were trying to work through the problems. "I am married now to a very nice and kind man and intimacy is hard for me" (Bonnie). Intimacy was difficult for the women because of the extent of the sexual abuse and assault that had taken place. Some women complained of having "issues with certain aspects of sex". The women closed up if a man touched them, and therefore, would avoid men and any physical contact as a method of coping. Conversely, Chalice explained she "dove in to more sex" but still has some sexual problems.

The Present

The women have moved on with their lives. The present time represents from eight to 12 weeks up to 30 years after the assault. The themes in the present story include stuck in the past, and taking back control. Some of the women had male friends they were dating. Some women

were on a career path and close to graduation. Many of the women were students having career goals of becoming a lawyer, a sports trainer, a psychologist, a sociologist, and a public policy activist for women.

Chalice stated she is “a different person now” explaining she has a purpose in life. Bridget offered, “I pay more attention to everything, even when working at [the coffee shop]; the customer’s I’m waiting on, their demeanor, and somebody walking around in there and whatever, pay attention now to the body language of everybody.”

Stuck in the Past

Most of the women continue to experience PTSD-type responses. They often experience triggers that remind them of the assault. The women define stuck in the past as always seeing or experiencing reminders from the sexual assault, no matter how long ago the sexual assault took place. The women look for ways to manage their stress to help them cope.

Triggers

After a sexual assault, the women attempted to forget and move on, however, triggers, perhaps indications of PTSD that are unresolved, occurred that cause a renewed reaction. For example, a trigger is something that makes them remember the assault: being alone in the dark alley or street, walking to a car after work, seeing a male that resembled the perpetrator, or watching something on television that relates to the assault. “But there were still triggers throughout the years, you know like the airplane and things like that or feeling closed in somewhere” (Bridget).

...there’s a taste of toxicity. Something about us that when something happens we could work through the trauma but there’s a part of us inside like a chemical piece of it, in which I don’t understand that stays there (Bonnie).

Some of the women are resolved to the fact that they may still continue to have problems the rest of their lives. “I think I’ll have some issues for the rest of my life but they are manageable” (Allie).

Some women still experience waking up at night having “a rapid heartbeat”. Some women hope one day they will be able to go out again with friends. The women become fearful and shut down when they see a man of the same ethnic background that assaulted them. Some

women become frightened when someone comes from behind and touches them on their shoulders. "I'm fine unless they try to touch me, I start getting awkward and get very closed up" (Daisy).

Stress Management

Stress management occurred in various ways from exercise to talking to themselves in order to manage their anxiety level. "I talked to myself and calm myself down" (Jene'). Running was an effective way to reduce stress. "And you know working out helps me with a lot of stress and but sometimes ...I think running helps a lot with stress and I think getting through the tough times" (Miriam). An object may be grabbed to displace the distress they are feeling. "I grab something like a raisin or a rock or something and now hold it and I'll try to come back to myself" (Bonnie).

Taking Back Control

The women were able to readjust to their normal state of life and take back control of their lives. Taking back control was defined by the women as being in charge of every aspect of their lives. Taking back control gave the women a sense of empowerment. "I found a purpose in life. I found the direction and I found something I am very good at" (Chalice). Some women expressed they are stronger in many aspects. Patricia learned to set boundaries and be able to make decisions in her life. "Self-concept has gotten stronger in that I have to make those boundaries. I have to protect myself" (Patricia). Another woman explained she has a purpose in life and that is to protect her cousins and siblings from this ever happening to them. "I am much stronger" (Lucille). Many of activities that had been put on hold during the recovery process were now resumed.

I adapted to just going out more or going out with friends to the movies, to trying to get more control of my life and I think having the dog really helped me do that. I was like, 'Wow, I can do this' (Miriam).

Confident/Compassion/Empathy

The effects of sexual assault changed the women. Some of the changes included becoming more empathetic and compassionate towards other women because they have a better

understanding of what women in their past had experienced and now felt a connection to them. “So what has happened to me, it’s made me more compassionate and see that there really is a fear” (Bridget). “As far as my role as an employee, it’s man, it’s really opened up empathy. I’m feeling much more empathetic, much more compassionate” (Patricia).

Time Heals

The women healed over time even though they struggled some days or had recurring problems. “I’ve learned to move on and I think time heals but there are some days that are hard” (Miriam).

Helping Others

The women were now reaching out to other women who had recently experienced sexual assault and being available to help them through the process. “And especially advocating for sexual assault victims as well, women’s rights, that kind of thing. It has been very powerful and helpful for me as a person” (Allie). “As an older sister, I don’t want it to happen to my younger cousins or even my older sister. And I just feel like protecting them in a way. So that’s my purpose in life: to protect” (Lucille).

What Resources are Needed

There are needed resources to help women following a sexual assault. If the women had not been college students or worked full time with benefits, they would not have been able to afford counseling services. The women did have health care insurance but found the insurance provider made it difficult for utilization of benefits. Improvement of websites for health care and counseling services was noted so the women could easily find exactly what phone number to call for help. “It is a little difficult figuring out where to call. I will say that on the website the numbers can be confusing, but that’s the only criticism I have (laughs)” (Allie). Some women suggested that the public needs to know all the resources available up front, before a sexual assault. “I wish everybody knew upfront all the resources that they had available before [with emphasis] it happens” (Sophie). Sensitivity training for health care workers and hospital billing employees

was recommended since one woman had experienced a stressful phone call from the hospital billing department which made her “remember everything” from the assault.

Summary

This chapter has presented the findings from the demographic surveys and interviews of women following a sexual assault. The stories of the women consisted of four main chapters: the prologue, the event, the aftermath, and the present.

Chapter 5

Discussion

This chapter discusses interpretation of the findings, summation of the findings, and limitations of the study. Implications for theory, nursing, and specific recommendations for practice will follow.

The women were open in sharing their adaptation stories following a sexual assault except for one woman. A few women during the interview stated they had never thought of nor shared previously with anyone some of the details from their assault.

The Prologue

The confidence and trust of the women prior to the sexual assault allowed the women to “let their guard down.” The women believed they were infallible and were always safe in everything they did. The women never expected to become a statistic of sexual assault. No literature was found on confident and trusting traits prior to sexual assault.

Women, growing up in families where sexual or physical violence was present, may believe abuse is normal. Women who lived with spouses or boyfriends and experienced intimate partner violence and believed that the sexual and physical abuse was normal, did not know to report the assault, supporting Tenkorang, Owusu, Yeboah, and Bannerman’s (2013) research findings. Women growing up in a home with physical or sexual abuse were more likely to experience sexual and physical assault later in their life (Tenkorang et al., 2013). Valdez, Lim, and Lilly (2013) found a relationship existed between childhood sexual assault and “desensitization and normalization of violence” (p. 131). Wong and Mellor (2014) reported factors that increased intimate partner violence were related to their culture, sexual abuse as a child, and remaining in an unstable relationship.

The Event

Violated trust occurred when the friend or boyfriend took advantage of the situation. Langton et al. (2012) found that over half of the women knew their perpetrator.

The unsuspecting women were in different locations at the time of the assault: apartment doing work; walking to car; walking home; or at an art festival. The women were taken by surprise with no warning. Langton et al. (2012) also found that not all women knew their perpetrator.

The Aftermath

Seeking safety and security meant that the women sought a safe haven, either at their home or at a friend or relative's home to process the event. Each woman went to where she felt the safest. After the event most women increased their awareness of surroundings and either took a safety defense course or purchased pepper spray, a hand gun, or a Taser to carry with them when out doing errands or other activities.

Some women went to the hospital for care following the assault though variations in the timeframe for seeking help occurred. Conversely, Murphy et al. (2011) reported that most women sought immediate healthcare within the first 24 hours after the assault. Perhaps the prolonged length of time for seeking help in this study was related to the women's effort to mentally process the sexual assault. Women may seek services for sexual assault while others may seek screening clinics for STD's, HIV, and AIDS. Hospitals with SANE and SART may not be available in every city (Boykins et al., 2010). In this study, one woman was taken from one hospital after her kidnapping/sexual assault to another hospital that was equipped with sexual assault services. Access to medical and mental health services, as noted by Lewis-O'Connor (2009), Logan et al. (2007), Moore (2009), and Murphy et al. (2011), was a problem as some women in this study complained of not being able to find affordable counseling or appropriate health care. Even though some of the women did not go to their physician or hospital, the value of free clinics was evident especially for those with no personal financial resources. For instance, health care workers may not have training on how to reassure and address specific needs of sexually assaulted women in emergency room or hospital visits following sexual assault (Heke et al., 2009) and training may be needed to ensure this occurs. Certainly, health care providers should screen for suicide and PTSD initially and on future scheduled appointments, although this may not occur.

The women in this study stated they did not report their assault to the police. This is supported in the literature. They may not have felt safe and secure (Langton et al., 2012; Truman et al., 2013); they may have fear of retribution from the perpetrator or they may not want to relive the event as may occur when the length of time to prosecute and convict may be prolonged (Campbell, 2006; Langton et al., 2012). Reactions from friends and/or family dictated whether or not the woman reported the assault to law enforcement (Miller et al., 2011).

Reactions from family, friends and professionals either enabled the women through the healing process or disabled the women. The effect of the response or reaction from the family or friend affected the recovery of the woman leading to the inability to have friendships after the assault (Orchowski et al., 2013; Ullman et al., 2007). If the women did not receive a favorable reaction, then the women complained of experiencing shame, guilt, and self-blame. Ullman and Peter-Haggen (2014) found a relationship between PTSD and negative social reactions. If the women did not receive any emotional or caring support, they may encounter difficulty moving past the traumatic experience.

The finding that women assaulted as children may be revictimized later in life supports the findings by Tjaden and Thoennes (2000; 2006). Thoresen, Myhre, Wentzel-Larsen, Aavaeg, and Hjemdal (2015) found that child sexual assaults were more likely to include adult revictimization. Simmel, Postmus, and Lee (2012) found when women did not report the assault as a child, the women were more apt to report the assault as an adult. Additionally, being assaulted as a child leaves lasting effects as an adult (Simmel et al., 2012).

Pets (cats and dogs) as companions and protectors may help women during the recovery process. No literature was found discussing the use of therapy dogs with women following a sexual assault. Dietz, Davis, and Pennings (2012) found that therapy dogs were useful in decreasing traumatic events in a study of sexually abused children. Lavin (2011) suggested the use of service dogs trained to help those experiencing PTSD, such as veterans.

Physical problems discussed by women in this study ranged from back spasms, migraine headaches, pelvic pain, fibromyalgia, to Crohn's disease and is supported in reviewed research

as Black et al. (2011) reported similar physical ailments in their study. Golding (1999) suggested an association between sexual assault and poorer health. Postma, Bicanic, van der Vaart, and Laan (2013) acknowledged sexual problems and pelvic floor muscle issues when the woman was sexually assaulted as a teenager. It may be prudent of the health care workers to assess women presenting with a history of childhood or adolescent sexual assault, in addition to observing for physical complaints following an adult occurrence of sexual assault.

The women in this study identified mental and emotional problems after a sexual assault. Researchers support that women who had not disclosed the assault, or sought help and lived in denial or repressed the assault, reported having more mental health issues (Rees et al., 2011). Abbey et al. (2004) found a relationship between physical violence and negative health outcomes which may explain why depression and mental health issues occurred. The women assaulted as a child reported anxiety and depression supporting Thoresen et al.'s, (2015) study. Ullman, Noydowski, and Filipas' (2009) study noted detachment and dissociation as predictors for further victimization later in life. Women, who were abused as a child and revictimized as an adult, attempted suicide (Imren, Ayaz, Yusufoglu, & Aman, 2013). Women with a history of child assault reported detachment or dissociation as coping mechanisms (Kaysen, Morris, Rizvi, & Resick, 2005). Mason and Lodrick (2013) reported that these coping mechanisms helped the women to endure the sexual trauma of repeated incidents and to persevere. The report of increased anxiety and depression among these college age women is also supported in the literature (Rees et al., 2011). Some women may experience a combination of anxiety disorders as was noted by APA (2013). Suicide was more common in these women (Boykins et al., 2010). The report of PTSD following a life threatening event found in this study was confirmed by Boykins et al. (2010), Heke et al. (2009), and Lavin (2011). Beydoun et al. (2012) confirmed a relationship between intimate partner violence and depression that this study's subjects described.

Women assaulted as children may turn to drugs, alcohol, suicide, or anorexia/bulimia. Alcoholism was not a problem in this sample compared to the findings of Boykins et al. (2010) and Kalmakis (2010), that alcoholism was common among sexually assaulted women.

Santaularia et al. (2014) linked alcohol, drug use, and eating disorders to chronic diseases.

Sozen et al. (2013) investigated and found that sexually assaulted women that had a negative self-image experienced psychopathologic issues.

In the survivor mode, the women will do what they have to do in order to stay alive and attempt to perform their responsibilities. Some had the “drive” while others blended in so they would not receive any unwanted attention. Repression/denial may be experienced by women that are not willing to discuss the assault (Boykins et al., 2010). Grieving after a sexual assault was not found in any literature, however women did describe as something had been taken away from them (Boykins et al., 2010; Ullman et al., 2010).

Sexually assaulted women found counseling to be therapeutic. Counseling services were not available to everyone. Support services and counseling were found to be a needed and a useful component for health care workers when treating sexually assaulted women (Fernandez, 2011).

Family or friends close to the women may experience the trauma as a secondary victim. No study was found investigating the secondary victims affected after a sexual assault. Morrall, Hazelton, and Shackelton (2011) reported the importance of assessing the secondary victims for health and mental health issues in a study of people witnessing a homicide. When a woman receives health care services, the nurses and health care workers may want to assess if any family members are having physical or mental health problems following the assault. Support groups for parents, family members, or significant others may provide further assistance during the healing process of the women and those close to them.

Most of the women supported themselves and continued working after the assault. For some women their work helped them to stay busy and forget the assault ever happened. Changes of jobs or occupations may occur after a sexual assault supports the findings of Delisi et al. (2010). Busch-Armendez et al. (2010) and Bryant-Davis et al. (2009) had similar findings. The changes may be related to stress, additional work responsibilities, scheduling issues, or other

unpleasant circumstances. Women may have difficulty being able to perform their work expectations.

Creative expression may have a positive effect on the women. Journaling was reported helpful by the women in processing what happened to them. Meslon, Lorenz, and Stephenson (2013) studied the effects of journaling of women with a history of childhood sexual abuse, the results noted improvement on the women's depression and PTSD, and improvement in their sexual dysfunction. Art therapy may be helpful to women in expressing themselves after the sexual assault. Saltzman, Matic, and Marsden (2013) reported a positive effect on women's healing using Adlerian art therapy with sexual assault victims. The art therapy provided a comprehensive approach to all aspects of the women's lives (Saltzman et al., 2013). Reading the Bible and prayer may have a positive influence in the healing of the women following a sexual assault, but no studies were found to support that.

Protective boundaries may develop after a sexual assault. Women may protect themselves by limiting their friendships or by the inability to have friendships (Orchowski et al., 2013; Ullman et al., 2007). Woman may also experience the inability to have sexual relationships as was also noted by Orchowski et al. (2013) and Ullman et al. (2007).

The Present

Triggers may continue throughout the women's lives as found by Lavin (2011). Stress management may help women decrease their level of anxiety when a trigger or event occurs. Only one study examined the effect of self-defense training and traditional martial arts effectiveness in reducing fear and enhancing the women's independence (Ball & Martin, 2012).

The women may feel more confident, compassionate, and empathetic towards others following a sexual assault. Most women were available and wanted to help other women heal after a sexual assault. No studies were found reporting the positive outcomes of women after healing took place.

Resources may still be needed post assault. The women did not discuss follow-up visits but did report seeing their physicians at least several times during the past two years. More

affordable counseling services and easier to locate information may be necessary for needed services (Dolezal et al., 2009). A few women complained that healthcare and office staff workers were offensive and aggressive towards them. Sensitivity training of all hospital employees may help future encounters with sexually assaulted women as was discussed by Kwence (2012). Encouraging and emphasizing follow up with this target population may help the women to have a more favorable positive experience.

Summation of the Findings

Two stories emerged from the study. The women are either confident and trusting or living in a situation where abuse is normal. Support, security, and safety were sought by the women or the women lived in denial and became detached after the assault. The women became stronger and took back control of their lives, or they lived as though they were stuck in the past, just trying to get by.

Limitations

One limitation of this research study includes a sample from only three counties in a metropolitan area. The population represented college students as a majority of the sample. The ethnic /racial variation did not include African American, mixed race individuals, or Hawaiian/Pacific Islanders participants.

Implications for Theory

Roy's Adaptation Model (Roy, 2009) was useful for this study. Women may either experience integrated adaptation in their lives or compromised adaptation. Overall, the women may experience a combination of the two types depending on additional stressors in their lives. A life changing event may cause variations in their ability to adapt creating a continuum between integrated adaptation and compromised adaptation. Each woman is unique and will experience a combination of the continuum.

Implications for Future Nursing Research

Sexual assault women continue to not report and seek medical care immediately following the assault. The study's findings indicate a need for healthcare workers to undergo

sensitivity training when dealing with sexually assaulted women. A study investigating the effects of the sensitivity trained healthcare worker versus the untrained healthcare worker on the sexually assaulted woman's healthcare experiences is recommended. The women in this study also continued to experience triggers throughout their lives after the assault and even after having counseling. A future study investigating trauma-focused psychotherapy that would include exposure therapy and cognitive restructuring and comparing it to eye movement desensitization and reprocessing would be useful in identifying effects of psychotherapy on the women's triggers.

Future considerations would include utilization of multi-site recruitment and sampling of ethnic minorities to increase diversity of participants. Future research would include: further study of women abused as a child in order to study the effect into adulthood; further investigation on the secondary victims and their needs; and investigating what are the differences between the coping/adaptation of women and men following a sexual assault. An experimental study needs to be conducted to evaluate the effect of creative expression on the post sexual assault victim's adaptation.

Recommendations for Practice

Health care providers and nurses may benefit from this study when working with and helping sexually assaulted women. Ideas for therapeutic approaches were provided by the women in this study. Using creative expression may be beneficial as these women felt this approach had a positive effect by allowing them to process and write about how that made them feel. Journaling was utilized by half of the women and expressed as therapeutic. Sensitive, active listening may be important to the women since their stories shared were of negative experiences in dealing with nurses and healthcare personnel. Providers need to remember to treat the client and not pass any judgment on whether the woman encouraged the sexual assault.

Even though strides have been made in health care, recognition of some of the barriers and problems to obtaining optimal care for the assaulted woman will be important. Women continue to underutilize women's centers and specialized hospitals for post sexual assault examinations. The majority of women who did seek health care options waited until after the first

24 hours. Some assessments may have been missed and none of the women reported being followed up by the nurses and/or hospital staff. Counselors may have missed cues of women that had been sexually assaulted and experienced physical violence. Most of the women sought counseling but did not start the counseling immediately after the assault. More education directed at health care workers and the communities is needed on sexual assault services availability. Counseling services and websites that are easy to maneuver and navigate are needed.

Several recommendations to help sexually assaulted women find the help they need would include: pamphlets educating the public on sexual assault and services for women; easier websites for locating counseling services and healthcare agencies specializing in sexual assault; screening tool to ask women questions to identify physical violence and sexual assault; sensitivity training for healthcare workers and hospital staff in how to deal with sexually assaulted women; encouraging women to draw and/ or journal to help in processing the traumatic event; pamphlets on the use of therapy dogs for recovering sexual assault victims; and emphasis on follow-up care of the women treated for sexual assault should be provided.

Summary

The interpretations of the findings have been presented. No research studies were found in the literature on personality traits of women before the sexual assault, the effects of sexual assault on the secondary victims of sexual assault, and the use of therapy dogs in the recovery of women post sexual assault. Future proposed research studies would include study of women abused as a child into adulthood, secondary victims and their needs, and the differences between men and women following a sexual assault.

Appendix A

Flyer

A Narrative Analysis of Women's Adaptation Following a Sexual Assault



Sexual assault happens to one out of five women in the United States today. I am conducting a study about women's adaptation/coping strategies following a sexual assault. I am interested in interviewing women about their recovery. If you have been sexually assaulted as an adult (over 18 years old) would you please help me in my study by sharing your story in a confidential, anonymous interview?

Ages: 18 years old or older

For your time and effort you will be given a \$10 gift card (to Starbuck's or Target)

Study approved by UT Arlington IRB and College of Nursing

Contact: Debra (a nurse researcher)

debra.researcher@[gmail.com](mailto:debra.researcher@gmail.com)

Or by phone: 972-948-3407

Appendix B
Business Card

I am conducting a study about women's adaptation/coping strategies following a sexual assault. I am interested in interviewing women about their recovery. If you have been sexually assaulted as an adult (over 18 years old) would you please help me in my study by sharing your story in a confidential, anonymous interview?

If interested call Debra at: 972-948-3407
Or by email: debra.researcher@gmail.com

Appendix C
Demographic Survey

1. Age: _____
2. Ethnicity
American Indian or Alaska Native _____
Asian _____
Black or African American _____
Hispanic or Latino _____
Native Hawaiian or Other Pacific Islander _____
White _____
Other _____
3. Marital Status:
Single _____
Living with significant other _____
Married _____
Divorced _____
Widowed _____
4. With whom do you live? _____
5. Children Yes _____ No _____
How many? _____
Ages: _____
6. Type of employment? _____
Full Time _____
Part Time _____
7. How long ago was your assault? _____
8. Have you been assaulted more than one time? Yes _____ No _____
9. Did you make an outcry at the time? Yes _____ No _____
10. Did you feel you were believed? Yes _____ No _____
11. How old were you when you were assaulted? _____

12. Do you have any mental health problems? Yes _____ No _____
- Have you received a mental health diagnosis from a health care provider?
- Yes____ No____
- Check the box with any mental health diagnosis you have been given:
- Depression____ Bipolar disorder____ Schizophrenia____ General anxiety disorder____
- Post-traumatic stress disorder____ Dissociative identity disorder____ Panic attacks____
- List any others: _____
- Check one: My mental health disorder began before____ after ____ the sexual assault.
13. How often do you drink alcohol?
- Monthly _____ Weekly _____ Daily _____ Not at all _____
- How much alcohol do you drink? _____
- What do you drink? Beer _____ Wine _____ Liquor _____
- Do you drink to pass out? _____
- Check one: Alcohol use began after____ or before____ my assault.
14. Have you ever considered suicide? Yes____ No____
- Check one: Have you ever attempted suicide before____ or after____ the assault?
- Have you ever cut or done other self-injurious behavior though not intended to commit suicide? Yes____ No____
15. In general, what is your monthly household income? _____
16. What are your current prescribed medications?
- _____
17. Do you have health care insurance? Yes _____ No _____
- Number of visits to the health care provider during the past two year's _____

Appendix D
Interview Questions

I'm interested in what happened after you went home from the emergency room/hospital and during the following year. In other words, I want to understand the recovery period and how you coped. Tell me about what you did after the sexual assault.

Concept	Questions
Physiologic Integrity	How has your health been? How has this changed since the assault? Why do you think this is so?
Self-Concept	How do you view yourself? How has this changed?
Role Function	How has your role as a partner/friend/employee been affected by the assault?
Interdependence	Describe your support system. How has this changed since the assault?
Behavior	How have you been coping?
Adaptation	How have you adapted (changed) since the assault?

Appendix E
Institutional Review Board Approval



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OFFICE OF RESEARCH ADMINISTRATION
REGULATORY SERVICES

June 13, 2014

Debra Hurd
Dr. Jennifer Gray
The University of Texas at Arlington
College of Nursing
Box 19407

EXPEDITED APPROVAL OF HUMAN SUBJECT RESEARCH

IRB No.: 2014-0686
TITLE: *A Narrative Analysis of Women's Adaptation Following a Sexual Assault*
Effective Date: June 12, 2014
Expiration Date: June 12, 2015

Approved Number of Participants: 30 (Do not exceed without prior IRB approval).

The University of Texas Arlington Institutional Review Board (UTA IRB) has made the determination that this research protocol involving human subjects is eligible for expedited review in accordance with Title 45 CFR 46.110(a)-(b)(1), 63 FR 60364 and 63 FR 60353, categories (6)(7). The IRB Chairperson (or designee) approved this protocol effective June 12, 2014. IRB approval for the research shall continue until June 12, 2015.

APPROVED NUMBER OF PARTICIPANTS:

This protocol has been approved for enrollment of a maximum of 30 participants and is not to exceed this number. If additional data are needed, the researcher must submit a modification request to increase the number of approved participants **before** the additional data are collected. Exceeding the number of approved participants is considered an issue of non-compliance and will result in the destruction of the data collected beyond the approval number and will be subject to deliberation set forth by the IRB.

INFORMED CONSENT DOCUMENT:

The IRB approved and stamped informed consent document (ICD) showing the approval and expiration date must be used when prospectively enrolling volunteer participants into the study. The use of a copy of any consent form on which the IRB-stamped approval and expiration dates are not visible, or are replaced by typescript or handwriting, is prohibited. The signed consent forms must be securely maintained on the UT Arlington campus for the duration of the study plus a minimum of three years after the completion of all study procedures (including data analysis). The complete study record is subject to inspection and/or audit during this time period by entities including but not limited to the UT Arlington IRB, Regulatory Services staff, OHRP, and by study sponsors (if the study is funded).

REGULATORY SERVICES

The University of Texas at Arlington, Center for Innovation
202 E. Border Street, Ste. 201, Arlington, Texas 76010, Box#19188
(T) 817-272-3723 (F) 817-272-5808 (E) regulatoryservices@uta.edu (W) www.uta.edu/rs



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MODIFICATION TO AN APPROVED PROTOCOL:

Pursuant to Title 45 CFR 46.103(b)(4)(iii), investigators are required to, “promptly report to the IRB any proposed changes in the research activity, and to ensure that such changes in approved research, during the period for which IRB approval has already been given, are **not initiated without prior IRB review and approval** except when necessary to eliminate apparent immediate hazards to the subject.”

Modifications include but are not limited to: Changes in protocol personnel, number of approved participants, and/or updates to the protocol procedures or instruments and must be submitted via the electronic submission system. Failure to obtain approval for modifications is considered an issue of non-compliance and will be subject to review and deliberation by the IRB which could result in the suspension/termination of the protocol.

ANNUAL CONTINUING REVIEW:

In order for the research to continue beyond the first year, a Continuing Review must be completed via the online submission system within 30 days preceding the date of expiration indicated above. A reminder notice will be forwarded to the attention of the Principal Investigator (PI) 30 days prior to the expiration date. Continuing review of the protocol serves as a progress report and provides the researcher with an opportunity to make updates to the originally approved protocol. Failure to obtain approval for a continuing review will result in automatic *expiration of the protocol* all activities involving human subjects must cease immediately. The research will not be allowed to commence by any protocol personnel until a new protocol has been submitted, reviewed, and approved by the IRB. Per federal regulations and UTA's Federalwide Assurance (FWA), there are no exceptions and no extensions of approval granted by the IRB. The continuation of study procedures after the expiration of a protocol is considered to be an issue of non-compliance and a violation of federal regulations. Such violations could result in termination of external and University funding and/or disciplinary action.

ADVERSE EVENTS:

Please be advised that as the principal investigator, you are required to report local adverse (unanticipated) events to The UT Arlington Office of Research Administration; Regulatory Services within 24 hours of the occurrence or upon acknowledgement of the occurrence.

HUMAN SUBJECTS TRAINING AND CONFLICTS OF INTEREST DISCLOSURE:

All investigators and key personnel identified in the protocol must have documented Human Subjects Protection (HSP) training on file AND must have filed an annual Conflict of Interest Disclosure (COI) with The UT Arlington Office of Research Administration; Regulatory Services. HSP completion certificates are valid for 2 years from completion date.

COLLABORATION:

If applicable, approval by the appropriate authority at a collaborating facility is required prior to subject enrollment. If the collaborating facility is *engaged in the research*, an OHRP approved Federalwide Assurance (FWA) may be required for the facility (prior to their participation in research-related activities). To determine whether the collaborating facility is engaged in research, go to: <http://www.hhs.gov/ohrp/humansubjects/assurance/engage.htm>

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CONTACT FOR QUESTIONS:

The UT Arlington Office of Research Administration; Regulatory Services appreciates your continuing commitment to the protection of human research subjects. Should you have questions or require further assistance, please contact Robin Dickey by calling 817-272-9329.

Sincerely,

A handwritten signature in black ink that reads "Maria Martinez-Cosio".

Maria Martinez-Cosio, Ph.D.
Associate Professor
UT Arlington IRB Chair

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OFFICE OF RESEARCH ADMINISTRATION
REGULATORY SERVICES

September 8, 2014

Debra Hurd
Dr. Jennifer Gray
Nursing
The University of Texas at Arlington
Box 19407

IRB No.: 2014-0686

Title: *A Narrative Analysis of Women's Adaptation Following a Sexual Assault*

EXPEDITED PROTOCOL MODIFICATION APPROVAL

The UT Arlington Institutional Review Board (UTA IRB) Chair (or designee) reviewed and approved the modification(s) to this protocol on **September 4, 2014** in accordance with Title 45 CFR 46.110(b)(2). Therefore, you are authorized to conduct your research. The modification approval will additionally be presented to the convened board on September 9, 2014 for full IRB acknowledgment [45 CFR 46.110(c)]. The modification(s), indicated below, was/were deemed minor and appropriate for expedited review.

- Update the recruitment flyer
- Update the format of the consent form to accurately reflect approved procedures

MODIFICATION TO AN APPROVED PROTOCOL:

Pursuant to Title 45 CFR 46.103(b)(4)(iii), investigators are required to, "promptly report to the IRB any proposed changes in the research activity, and to ensure that such changes in approved research, during the period for which IRB approval has already been given, are **not initiated without prior IRB review and approval** except when necessary to eliminate apparent immediate hazards to the subject."

Modifications include but are not limited to: Changes in protocol personnel, number of approved participants, and/or updates to the protocol procedures or instruments and must be submitted via the electronic submission system. Failure to obtain approval for modifications is considered an issue of non-compliance and will be subject to review and deliberation by the IRB which could result in the suspension/termination of the protocol.

INFORMED CONSENT DOCUMENT:

The IRB approved informed consent document (ICD), showing the stamped approval and expiration date of the article must be used when prospectively enrolling volunteer participants into the study. The use of a copy of any consent form on which the IRB-stamped approval and expiration dates are not visible, or are replaced by typescript or handwriting, is prohibited. The signed consent forms must be securely maintained on the UTA campus for the duration of the study plus three years. The complete study record is subject to inspection and/or audit during this time period by entities including but not limited to the UT Arlington IRB, Regulatory Services staff, OHRP/FDA and by study sponsors (if the study is funded).

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ADVERSE EVENTS:

Please be advised that as the principal investigator, you are required to report local adverse (unanticipated) events to The UT Arlington Office of Research Administration; Regulatory Services within 24 hours of the occurrence or upon acknowledgement of the occurrence.

TRAINING

All investigators and key personnel identified in the protocol must have filed an annual Conflict of Interest Disclosure (COI) and have documented *Human Subjects Protection (HSP)* training on file with this office prior to protocol approval. HSP training certificates are valid for 2 years from completion date.

COLLABORATION:

If applicable, approval by the appropriate authority at a collaborating facility is required prior to subject enrollment. If the collaborating facility is *engaged in the research*, an OHRP approved Federalwide Assurance (FWA) may be required for the facility (prior to their participation in research-related activities). To determine whether the collaborating facility is engaged in research, go to: <http://www.hhs.gov/ohrp/humansubjects/assurance/engage.htm>

CONTACT FOR QUESTIONS:

The UT Arlington Office of Research Administration; Regulatory Services appreciates your continuing commitment to the protection of human research subjects. Should you have questions or require further assistance, please contact Robin Dickey at robind@uta.edu or Regulatory Services at regulatoryservices@uta.edu or 817-272-2105.

Sincerely,

Judy R.
Wilson, Ph.D.

Digitally signed by Judy R. Wilson,
Ph.D.
DN: cn=Judy R. Wilson, Ph.D.,
o=University of Texas at Arlington,
ou=Vice-Chair IRB,
email=jwilson@uta.edu, c=US
Date: 2014.09.15 11:06:55 -0500

Judy R. Wilson, Ph.D.
Associate Professor
UT Arlington IRB Vice-Chair

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Appendix F
Informed Consent Document

**UT Arlington
Informed Consent Document**

PRINCIPAL INVESTIGATOR

Debra Ann Hurd, PhD Candidate, MS, RN, CNE,
College of Nursing,
Cell 972-948-3407
Email: debra.researcher@gmail.com

FACULTY ADVISOR

Jennifer Gray PhD, RN
College of Nursing
Email: jgray@uta.edu
Phone: 817-272-5295

SEP 0 4 2014

APPROVED

JUN 1 2 2015

Institutional Review Board

TITLE OF PROJECT

A Narrative Analysis of Women's Adaptation Following a Sexual Assault

INTRODUCTION

You are being asked to participate in a research study about women's adaptation after sexual assault. Your participation is voluntary. Refusal to participate or discontinuing your participation at any time will involve no penalty or loss of benefits to which you are otherwise entitled. Please ask questions if there is anything you do not understand.

PURPOSE

The specific purpose of this research study is to explore the recovery process of women who have experienced a sexual assault from the women's perspectives.

DURATION

You are being asked to participate in one interview that lasts approximately 60 to 90 minutes.

NUMBER OF PARTICIPANTS

The number of anticipated participants in this research study is up to 30 women. Fewer women may be interviewed, but the maximum number is 30.

PROCEDURES

The procedures which will involve you as a research participant include:

1. Completing a demographic survey of 17 questions
2. Answering open ended questions about your adaptation/coping skills related to your recovery after an assault.

You will be asked to select a pseudonym (fake name) that the researcher will use the interview. The interview will be audio recorded. After the interview, the tape will be transcribed, which means it will be typed exactly word-for word by the researcher. The recording and the transcript will be labeled with your pseudonym and will not include your real name or any identifying information. The digital recordings and transcriptions

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will not be used for any future research purposes not described here. The digital recordings and transcripts from interviews will be maintained for three years after the study has been completed on University of Texas at Arlington encrypted computers.

POSSIBLE BENEFITS

Possible benefits of the study are that understanding women's perspectives may help health care providers provide more sensitive, compassionate support and treatment to women who have been sexually assaulted. At the conclusion of the interview, you will be provided a handout of community resources. Also, if you choose to provide an email address, you will be sent a summary of the findings when the study is over.

POSSIBLE RISKS/DISCOMFORTS

Talking about your sexual assault may be stressful although the interview is focused on your coping/adaptation strategies rather than the actual events. During the interview, if you become upset, you may stop the interview at any time and not continue. The researcher is a nurse who will assess how the interview is affecting you. If you become extremely upset, the researcher may stop the interview, summon professional help or counseling, and wait with you until help arrives. You have the right to quit the study at any time at no consequence just by telling the researcher you want to stop. A handout of community resources will be provided at the end of the interview.

COMPENSATION

For your time and effort you will be given a \$10 gift card to Starbuck's or Target.

ALTERNATIVE PROCEDURES

There are no alternative procedures offered for this study. However, you can elect not to participate in the study or quit at any time at no consequence.

VOLUNTARY PARTICIPATION

Participation in this research study is voluntary. You have the right to decline participation in any or all study procedures or quit at any time at no consequence. Should you choose not to complete all study procedures, you will still receive a \$10 gift card to Starbuck's or Target.

CONFIDENTIALITY

Every attempt will be made to see that your study results are kept confidential. A copy of all data collected including transcriptions/tapes from this study will be stored in the College of Nursing at UTA for at least three (3) years after the end of this research. The results of this study may be published and/or presented at meetings using the pseudonym you provide. Additional research studies could evolve from the information you have provided, but your information will not be linked to you in anyway; it will be anonymous. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the UTA Institutional Review Board (IRB), and personnel particular to this research have access to the study records. Your records

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UT Arlington Informed Consent Document

will be kept completely confidential according to current legal requirements. They will not be revealed unless required by law, or as noted above. The IRB at UTA has reviewed and approved this study and the information within this consent form. If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, the University of Texas at Arlington will protect the confidentiality of those records to the extent permitted by law.

CONTACT FOR QUESTIONS

Questions about this research study may be directed to Debra Hurd PhD candidate, MS, RN, CNE by phone 972-948-3407 or email debra.researcher@gmail.com or Jennifer Gray, PhD, RN, Faculty Advisor by phone: 817-272-5295 or email jgray@uta.edu. Any questions you may have about your rights as a research participant or a research-related injury may be directed to the Office of Research Administration; Regulatory Services at 817-272-2105 or regulatoryservices@uta.edu.

As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

Signature and printed name of principal investigator or person obtaining consent

Date

CONSENT

You confirm that you are 18 years of age or older and have read or had this document read to you. You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you continue, and you have been told that you can ask other questions at any time.

You voluntarily agree to participate in this study. By continuing with the interview, you are not waiving any of your legal rights. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits, to which you are otherwise entitled.

SEP 04 2014
APPROVED

JUN 12 2015

Institutional Review Board

Appendix G

Audit Trail

Audit Trail

Order	Interview	Subject	Date	Verbal consent	Interview Date	Reason Not Done	Notes
1	None	NA	6/25/2014				
2	1	Patricia	7/2/2014	Yes	7/10/2014	No Show	email
3	2	Sophie	7/20/2014	Yes	7/30/2014		email
4	3	Daisy	9/26/2014	Yes	9/29/2014		email
5	4	Claudia	10/9/2014	Yes	10/14/2014		email
6	None	NA	10/20/2014			Assaulted as a child; did not meet criteria	email
7	5	Allie	10/23/2014	Yes	11/3/2014		email
8	6	Chalice	10/29/2014	Yes	11/3/2014		email
9	7	Miriam	11/7/2014	Yes	11/15/2014		email
10	8	Bridget	11/12/2014	Yes	11/20/2014		email
11	None	NA	1/9/2015			no response after initial contact	email
12	9	Bonnie	1/12/2015	Yes	1/21/2015		email
13	None	NA	1/12/2015			assaulted as a child; did not meet criteria	email
14	11	Ella	1/12/2015	Yes	1/22/2015		email
15	10	Lucille	1/15/2015	Yes	1/22/2015		email
16	None	NA	1/20/2015			no response after initial contact	email
17	None	NA	1/22/2015			unable to schedule appointment	text
18	12	Jene'	1/22/2015	Yes	1/26/2015		phone

References

- Abbey, A., BeShears, R., Clinton-Sherrod, A. M., & McAusian, P. (2004). Similarities and differences in women's sexual assault experiences based on tactics used by the perpetrator. *Psychology of Women Quarterly*, 28, 323-332. doi: 10.1111/j.1471-6402.2004.00149.x
- Ackerman, D. R., Sugar, N. F., Fine, D. N., & Eckert, L. O. (2006). Sexual assault victims: Factors associated with follow-up care. *American Journal of Obstetrics and Gynecology*, 194, 1653-1659. doi: 10.1016/j.ajog.2006.03.014
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA.: American Psychiatric Association.
- Ayres, L., & Poirier, S. (1996). Virtual text and the growth of meaning in qualitative analysis. *Research in Nursing & Health*, 19, 163-169. doi: 10.1002/(SICI)1098-240X(199604)19:2<163::AID-NUR8>3.0.CO;2-K
- Ball, K., & Martin, J. (2012). Self-defense training and traditional martial arts: Influences on self-efficacy and fear related to sexual victimization. *Sport, Exercise, and Performance Psychology*, 1, 135-144.
- Basile, K. C., Smith, S. G., Breiding, M. J., Black, M. C., & Mahendra, R. R. (2014). *Sexual violence surveillance: Uniform definitions and recommended data elements, Version 2.0*. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Bell, M. E., Turchik, J. A., & Karpenko, J. A. (2014). Impact of gender reactions to military sexual assault and harassment. *Health & Social Work*, 39, 25-33. doi: 10.1093/hsw/hlu004
- Beydoun, H. A., Beydoun, M. A., Kaufman, J. S., Lo, B., & Zonderman, A. B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: A systemic review and meta-analysis. *Social Science & Medicine*, 75, 959-975. doi: 10.1016/j.socscimed.2012.04.025

- Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens, R. R. (2011). The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf
- Boykins, A.D., Alvanzo, A. H., Carson, S., Forte, J., Leisey, M., & Plichta, S. B. (2010). Minority women victims of recent sexual violence: Disparities in incident history. *Journal of Women's Health, 19*(3), 453-461. doi:10.1089/jwh.2009.1484
- Breiding, M. J., Smith, S. G., Basile, K. C., Walters, M. L., Chen, J., & Merrick, M. T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization — National Intimate Partner and Sexual Violence Survey, United States, 2011. *Surveillance summaries*. Atlanta: Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
- Bryant-Davis, T., Chung, H., & Tillman, S. (2009). From the margins to the center: Ethnic minority women and the mental health effects of sexual assault. *Trauma, Violence, & Abuse, 10*, 330-357. doi: 10.1177/1524838009339755
- Busch-Armendariz, N. B., DiNitto, D. M., Bell, H., & Bohman, T. (2010). Sexual assault perpetrators' alcohol and drug use: The likelihood of concurrent violence and post-sexual assault outcomes for women victims. *Journal of Psychoactive Drugs, 42*, 393-399. doi: 10.1080/02791072.2010.10400702
- Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference? *Violence Against Women, 12*, 30-45. doi: 10.1177/1077801205277539
- Caplan, G. (1964). *Principles of preventive psychiatry*. New York: Basic Books.
- Clark, K. A., Biddle, A. K., & Martin, S. L. (2002). A cost-benefit analysis of the Violence Against Women Act of 1994. *Violence Against Women, 8*, 417-428. doi: 10.1177/10778010222183143

- Cook, J. M., Dinnen, S., & O'Donnell, C. (2011). Older women survivors of physical and sexual violence: A systematic review of quantitative literature. *Journal of Women's Health, 20*, 1075-1081. doi: 10.1089/wh.2010.2279
- Crossley, M. L. (2003). "Let me explain": Narrative emplotment and one patient's experience of oral cancer. *Social Science & Medicine, 56*, 439-448.
- DeLisi, M., Kosloski, A., Sween, M., Hachmeister, E., Moore, M., & Drury, A. (2010). Murder by numbers: Monetary costs imposed by a sample of homicide offenders. *Journal of Forensic Psychiatry & Psychology, 21*, 501-513. doi: 10.1080/14789940903564388
- Dietz, T. J., Davis, D., & Pennings, J. (2012). Evaluating animal-assisted therapy in group treatment for child sexual abuse. *Journal of Child Sexual Abuse, 21*(6), 665-683. doi:10.1080/10538712.2012.726700
- Dolezal, T., McCollum, D., & Callahan, M. (2009). Hidden costs in healthcare: The economic impact of violence and abuse. Retrieved from <http://avahealth.org/vertical/Sites/%7B75FA0828-D713-4580-A29D-257F315BB94%7Duploads/%7B316BEE7E-F788-418E-A246-AF9BB8175CF8%7D.PDF>
- Dragon Naturally Speaking Home Edition (Version 12) [Computer software]. (2012). Burlington, MA: Nuance Communications, Inc.
- Edwards, K. M., Kearns, M. C., Calhoun, K. S., & Gidycz, C. A. (2009). College women's reactions to sexual assault research participation: Is it distressing? *Psychology of Women Quarterly, 33*, 225-234. doi: 10.1111/j.1471-6402.2009.01492.x
- Fernandez, P. A. (2011). Sexual assault: An overview and implications for counseling support. *Australasian Medical Journal, 4*(11), 596-602. doi:10.4066/AMJ.2011.858
- Golding, J. M. (1999). Sexual-assault history and long-term physical health problems: Evidence from clinical and population epidemiology. *Current Directions in Psychological Science, 8*(6), 191.

- Heke, S., Forster, G., & d'Ardenne, P. (2009). Risk identification and management of adults following acute sexual assault. *Sexual and Relationship Therapy, 24*, 4-15. doi: 10.1080/14681990802641307
- Hesse-Biber, S. N. (2010). *Mixed methods research: Merging theory into practice*. New York: Guilford Press.
- Humes, K. R., Jones, N. A., & Ramirez, R. R. (2011). Overview of race and Hispanic origin: 2010. Retrieved from <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>
- İmren, S., Ayaz, A. B., Yusufoğlu, C., & Arman, A. (2013). Clinical features and risk factors related with suicide attempts in sexually abused children and adolescents [Abstract]. *Marmara Medical Journal, 26*(1), 11. doi:10.5472/MMJ.2012.02518.1
- Iverson, K. M., Mercado, R., Carpenter, S. L., & Street, A. E. (2013). Intimate partner violence among women veterans: Previous interpersonal violence as a risk factor. *Journal of Traumatic Stress, 26*, 767-771.
- Jordans, C. F. C., Little, M., Paul, K., & Sayers, E-J. (2001). Life disruption and generic complexity: A social linguistic analysis of narratives of cancer illness. *Social Science & Medicine, 53*, 1227-1236.
- Josselson, R. (2009). The present of the past: Dialogues with memory over time. *Journal of Personality, 77*(3), 647-668. doi: 10.1111/j.1467-6494.2009.00560.x
- Kacen, L. (2002). Supercodes reflected in titles battered women accord to their life stories. *International Journal of Qualitative Methods, 1*(1), Article X. Retrieved from <http://www.ualbertaca/~ijqm/XXXX>
- Kalmakis, K. A. (2010). Cycle of sexual assault and women's alcohol misuse. *Journal of American Academy of Nurse Practitioners, 22*, 661-667. doi: 10.1111/j.1745-7599.2010.00557.x
- Kalmakis, K. A., & Banning, L. J. (2012). Web-based follow-up information for and research on victims of sexual assault. *Online Journal of Nursing Informatics, 16*(1). Retrieved from: <http://ojni.org/issues/?p=1272>

- Kimerling, R., Street, A. E., Pavao, J., Smith, M. W., Cronkite, R. C., Holmes, T. H., & Frayne, S. M. (2010). Military-related sexual trauma among Veterans Health Administration patients returning from Afghanistan and Iraq. *American Journal of Public Health, 100*, 1409-1412.
- Kwence, S. (2012). Encountering the victim of sexual assault. *Clinician Reviews, 22*(12), 16-20.
- Langton, L., Berzofsky, M., Krebs, C., & Smiley-McDonald, H. (2012). Victimization not reported to the police, 2006-2010. National Crime Victimization Survey. Retrieved from the Bureau of Justice Statistics website: www.bjs.gov/content/pub/pdf/vnnp0610.pdf
- Lavin, J. (2011). Surviving posttraumatic stress disorder. *Nursing 2011, 41*(9), 41-44. doi: 10.1097/01.NURSE.0000403726.45691.b8
- Leonard, L., & Ellen, J. M. (2008). "The story of my life": AIDS and 'autobiographical occasions'. *Qualitative Sociology, 31*, 37-56. doi: 10.1007/s11133-007-9086-5
- Lewis-O'Connor, A. (2009). The evolution of SANE/SART- Are there differences? *Journal of Forensic Nursing, 5*, 220-227. doi: 10.1111/j.1939-3938.2009.01057.x
- Littleton, H. L., Grills-Taquechel, A. E., Buck, K. S., Rosman, L., & Dodd, J. C. (2013). Health risk behavior and sexual assault among ethnically diverse women. *Psychology of Women Quarterly, 37*, 7-21. doi: 10.1177/0361684312451842
- Lieser, C. (2014). Model of Roy's Adaptation Theory. Unpublished model.
- Logan, T. K., Cole, J., & Capillo, A. (2007). Sexual assault nurse examiner program characteristics, barriers, and lessons learned. *Journal of Forensic Nursing, 3*, 24-34.
- Maier, S. L. (2011). The emotional challenges faced by sexual assault nurse examiners: "ER nursing is stressful on a good day without rape victims." *Journal of Forensic Nursing, 7*, 161-172. doi: 10.1111/j.1939-3938.2011.01118.x
- Mason, F., & Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practice & Research Clinical and Gynecology, 27*, 27-37.
- McFarlane, J., & Malecha, A. (2005). Sexual assault among intimates: Frequency, consequences & treatments. Final report submitted to the National Institute of Justice. Retrieved online <https://www.ncjrs.gov/pdffiles1/nij/grants/211678.pdf>

- McLindon, E., & Harms, L. (2011). Listening to mental health workers' experiences: Factors influencing their work with women who disclose sexual assault. *International Journal of Journal of Forensic Nursing*, 7, 137-144. doi: 10.1111/j.1447-0349.2010.00697.x
- Meston, C. M., Lorenz, T. A., & Stephenson, K. R. (2013). Effects of expressive writing on sexual dysfunction, depression, and PTSD in women with a history of childhood sexual abuse: Results from a randomized clinical trial. *Journal of Sexual Medicine*, 10(9), 2177-2189. doi:10.1111/jsm.12247
- Microsoft Excel [Computer software]. (2013). Redmond, WA: Microsoft Corporation.
- Miller, A. K., Canales, E. J., Amacker, A. M., Backstrom, T. L., & Gidycz, C. A. (2011). Stigma-threat motivated non-disclosure of sexual assault and sexual revictimization: A prospective analysis. *Psychology of Women Quarterly*, 35, 119-128. doi: 10.1177/0361684310384104
- Moore, L. (2009). Barriers to reporting sexual assault in rural areas. *On The Edge*, 15(4). Retrieved from: <http://iafn.org/displaycommon.cfm?an=1&subarticlenbr=396>
- Morrall, P., Hazelton, M., & Shackleton, W. (2011). Homicide and its effect on secondary victims. *Mental Health Practice*, 15(3), 14-19.
- Munhall, P. (2012). *Nursing research: A qualitative perspective* (5th ed.). Sudbury, MA.: Jones & Bartlett Learning.
- Murdoch, M., Polusny, M. A., Hodges, J., & O'Brien, N. (2004). Prevalence of in-service and post-service sexual assault among combat and noncombat veterans applying for Department of Veterans Affairs posttraumatic stress disorder disability benefits. *Military Medicine*, 169, 392-395.
- Murphy, S.B., Potter, S. J., Pierce-Weeks, J., Stapleton, J. G., & Wiesen-Martin, D. (2011). An examination of SANE data: Clinical considerations based on victim-assailant relationship. *Journal of Forensic Nursing*, 7, 137-144. Doi: 10.1111/j.1939-3938.2011.01110.x
- Office of Violence Against Women. (2014). Sexual assault. Retrieved from www.justice.gov/ovw/sexual-assault

- Orchowski, L. M., Untied, A. S., & Gidycz, C. A. (2013). Social reactions to disclosure of sexual victimization and adjustment among survivors of sexual assault. *Journal of Interpersonal Violence, 28*(10), 2005-2023. doi: 10.1177/0886260512471085
- Poirier, S., & Ayres, L. (1997). Endings, secrets, and silences: Overreading in narrative inquiry. *Research in Nursing & Health, 20*, 551-557. doi: 10.1002/ (SICI)1098-240X(199712)20:6<551::AID-NUR9>3.0.CO;2-L
- Postma, R., Bicanic, I., Vaart, H., & Laan, E. (2013). Pelvic floor muscle problems mediate sexual problems in young adult rape victims. *Journal of Sexual Medicine, 10*(8), 1978-1987. doi:10.1111/jsm.12196
- Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., . . . Forbes, D. (2011). Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *Journal of American Medical Association, 306*, 513-521. doi: 10.1001/jama.2011.1098.
- Riessman, C. K. (1993). *Narrative analysis* (Vol. 30). Newbury Park, CA: Sage Publications.
- Riessman, C. K. (2008). *Narrative Methods for the human sciences*. Thousand Oaks, CA: Sage Publications.
- Roberts, A. R. (2005). *Crisis intervention handbook: Assessment, treatment, and research* (3 ed.). Oxford, England: Oxford University Press.
- Roy, C. (2009). *The Roy Adaptation Model* (3rd ed.). Upper Saddle River, N.J.: Pearson Education.
- Sadler, A. G., Booth, B. M., Cook, B. L., & Doebbeling, B. N. (2003). Factors associated with women's risk of rape in the military environment. *American Journal of Industrial Medicine, 43*, 262-273.
- Saltzman, L. E., Basile, K. C., Mahendra, R. R., Steenkamp, M., Ingram, E., & Ikeda, R. (2007). National estimates of sexual violence treated in emergency departments. *Annals of Emergency Medicine, 49*, 210-217. doi:10.1016/j.annemergmed.2006.10.015\

- Saltzman, M., Matic, M., & Marsden, E. (2013). Adlerian art therapy with sexual abuse and assault survivors. *Journal of Individual Psychology, 69*(3), 223-244.
- Sandelowski, M., & Jones, L. C. (1995). 'Healing fictions': Stories of choosing in the aftermath of the detection of fetal anomalies. *Social Science Medicine, 42*, 353-361. doi:
[http://dx.doi.org/10.1016/0277-9536\(95\)00102-6](http://dx.doi.org/10.1016/0277-9536(95)00102-6)
- Santaularia, J., Johnson, M., Hart, L., Haskett, L., Welsh, E., & Faseru, B. (2014). Relationships between sexual violence and chronic disease: A cross-sectional study. *BMC Public Health, 14*(1), 868-882. doi:10.1186/1471-2458-14-1286
- Simmel, C., Postmus, J. L., & Lee, I. (2012). Sexual revictimization in adult women: Examining factors associated with their childhood and adulthood experiences. *Journal of Child Sexual Abuse, 21*(5), 593-611. doi:10.1080/10538712.2012.690836
- Smith, S. G., & Breiding, M. J. (2011). Chronic disease and health behaviors linked to experiences of non-consensual sex among women and men. *Public Health, 125*, 653-659.
- Sözen, A., Özgür, T. B., Elçi, Ç., Bakır, P., Efil, H., Özver, İ., . . . Emül, M. (2013). The relationship between internalized stigma and psychopathology in sexually abused individuals [Abstract]. *Journal of Mood Disorders, 3*(2), 64.
doi:10.5455/jmood.20130301045826
- SPSS (Version 22) [Computer software]. (2013). Armonk, NY: IBM Corporation.
- Stahl, S. (2013). *Essential psychopharmacology* (4th ed.). Cambridge: Cambridge University Press.
- Tenkorang, E., Owusu, A., Yeboah, E., & Bannerman, R. (2013). Factors influencing domestic and marital violence against women in Ghana. *Journal of Family Violence, 28*(8), 771-781. doi:10.1007/s10896-013-9543-8
- Thoresen, S., Myhre, M., Wentzel-Larsen, T., Flood Aakvaag, H., & Hjemdal, O. K. (2015). Violence against children, later victimization, and mental health: A cross-sectional study

- of the general Norwegian population. *European Journal of Psychotraumatology*, 61-12.
doi:10.3402/ejpt.v6.26259
- Tjaden, P., & Thoennes, N. (2000). Full report of the prevalence, incidence, and consequences of violence against women. Retrieved from <http://www.ojp.usdoj.gov/nij>
- Tjaden, P., & Thoennes, N. (2006). Extent, nature, and consequences of rape victimization. National Violence Against Women Survey. Washington D. C.: U. S. Department of Justice.
- Truman, J., Langton, L., & Planty, M. (2013). Criminal victimization, 2012. Retrieved from <http://www.bjs.gov/content/pub/pdf/cv12.pdf>
- Ullman, S., Najdowski, C., & Filipas, H. (2009). Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors. *Journal of Child Sexual Abuse*, 18(4), 367-385.
- Ullman, S. E., Townsend, S. M., Filipas, G. H., & Starzynski, L. L. (2007). Structural models of the relationships of assault severity, social support, avoidance coping, self-blame, and PTSD among sexual assault survivors. *Psychology of Women Quarterly*, 31, 23-37. doi: 10.1111/j.1471-6402.2007.00328.x
- Valdez, C. E., Lim, B. H., & Lilly, M. M. (2013). "It's going to make the whole tower crooked": Victimization trajectories in IPV. *Journal of Family Violence*, 28(2), 131-140.
doi:10.1007/s10896-012-9476-7
- Virginia Health Department. (2009). Intimate partner violence health care provider survey Virginia. Retrieved from http://www.vdh.virginia.gov/ofhs/prevention/dsvp/projectradarva/documents/2012/pdf/IPV_providersurvey2009final.pdf
- Welton-Mitchell, C., McIntosh, D., & DePrince, A. P. (2013). Associations between thematic content and memory detail in trauma narratives. *Applied Cognitive Psychology*, 27, 462-473. doi: 10.1002/acp.2923

Wong, J., & Mellor, D. (2014). Intimate partner violence and women's health and wellbeing: Impacts, risk factors and responses. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 46(2), 170-179. doi:10.5172/conu.2014.46.2.170

Zinzow, H., Resnick, H., Amstadter, A., McCauley, J., Ruggiero, K., & Kilpatrick, D. (2010). Drug- or alcohol-facilitated, incapacitated, and forcible rape in relationship to mental health among a national sample of women. *Journal of Interpersonal Violence*, 25, 2217-2236.

Biographical Information

Debra Hurd is a clinical faculty for the University of Texas at Arlington. She received her Bachelor of Science degree in 1975 from the Pennsylvania State University, a Master of Science degree in Community Health Nursing with a minor in Nursing Administration from the Texas Woman's University August 1980. Debra has been teaching nursing since 1999. Her background consists of advanced medical surgical nursing and working as a home health nurse. Research interests include nursing education and women's health following a sexual assault. Debra participated in the NLN/Laerdal/American Heart Association multisite research study investigating the effectiveness of teaching CPR using electronic manikins 2008-2009. Plans for future research studies include investigating the effects of trauma-psychotherapy with eye movement desensitization reprocessing.