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Physician's perceived roles, as well as barriers, towards caring for women sex assault survivors

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Abstract

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

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

Results—Physicians described two main categories of roles: clinical tasks (e.g. testing and treating for sexually transmitted infections, managing associated mental health sequelae) and interpersonal roles (e.g. providing support, acting as patient advocate). Physician barriers fell into

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three main categories: (1) internal barriers (e.g. discomfort with the topic of SA); (2) physician-patient communication; and (3) system obstacles (e.g. competing priorities for time).

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

INTRODUCTION

Sexual assault (SA) is a prevalent problem that affects over 40% of women in the United States population (Breiding et al., 2014). Sexual assault is defined by the Department of Justice as “any type of sexual contact or behavior that occurs without the explicit consent of the recipient.” Rape falls under the umbrella of sexual assault and is defined by the Department of Justice as “penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim”. In the United States, 19.3% of women experience rape during their lifetime, with an 11.5% prevalence of completed rape (Breiding et al., 2014). In addition, 43.9% of women have experienced sexual violence in a form other than rape during their lives (Breiding et al., 2014). In 2014, the White House Council on Women and Girls issued a national call to improve prevention and intervention for rape and SA, highlighting this issue as a national priority (*Rape and Sexual Assault: A Renewed Call to Action*, https://www.whitehouse.gov/sites/default/files/docs/sexual_assault_report_1-21-14.pdf).

There are numerous mental and physical health sequelae from SA. Women who have experienced SA have a higher risk of asthma, diabetes, irritable bowel syndrome, headache, chronic pain, dyspareunia, poor sleep, and overall poor physical and mental health (DeLahunta & Baram, 1997); (Breiding et al., 2014). Post-traumatic stress disorder (PTSD) is 2.4 to 3.5 more likely in women who have experienced one SA and 4.3 to 8.2 for women who have experienced more than one SA (Walsh et al., 2012). Additionally, survivors of SA use more medical and mental health care services (Basile & Smith, 2011) associated with higher health care costs. The latest study estimating national costs for sexual assault was published in 1996 and estimated that rape in the United States accounted for \$127 billion dollars per year, in 1993 dollars. Most of this cost is attributed to health care costs (Miller, Cohen, & Wiersema, 1996). More recent regional reports estimated that sexual assault cost the state of Minnesota \$8 billion in 2005 (or \$1540 per resident) (*Costs of Sexual Violence in Minnesota 2007*, <http://www.health.state.mn.us/svp/>) and the state of Utah \$4.9 billion in 2011 (\$1700 per resident) (Utah Violence and Injury Protection Program Costs of Sexual Violence in Utah 2015, <http://www.ucasa.org/wp-content/uploads/2016/01/Costs-of-Sexual-Violence-in-Utah-Final.pdf>).

Given this high prevalence, associated medical conditions, and higher health care utilization, health care providers certainly encounter women with a history of SA. Appropriate identification of SA and provision of support, treatment, counseling, and referrals could potentially mitigate the sequelae. Studies indicate that women, including those who have experienced SA, felt comfortable with their health providers screening for SA and believe that discussing SA with their physicians and learning about the sequelae and available

community resources and hotlines can help them recover (Berry & Rutledge, 2016; Friedman, Samet, Roberts, Hudlin, & Hans, 1992; Littleton, Berenson, & Radecki Breitkopf, 2007). However, while women feel physicians can help them deal with SA, physicians often do not bring up SA with their female patients (Friedman et al., 1992; Littleton et al., 2007). Few studies have explored what prevents health providers from addressing SA with their women patients. In particular, there is little literature exploring physicians' perceptions of caring for SA survivors.

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

MATERIAL AND METHODS

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

We recruited physicians from the five specialties that would most likely address and manage issues related to adult SA: internal medicine, family medicine, psychiatry, obstetrics & gynecology (ob/gyn), and emergency medicine. We focused on faculty physicians as we were interested in the perspectives of those who have a responsibility to teach and train residents and medical students. All faculty of our medical school are based in the same health system in a city. This health system includes multiple hospitals and clinics all located in various neighborhoods in the same mid-sized metropolitan area and provides both inpatient and outpatient clinical services. Our sampling process focused primarily on ensuring representation from each of the five clinical specialties listed above.

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

respect their willingness to contribute and to ensure inclusion of their perspectives. Interviews were conducted in a private room the physicians selected.

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

All interviews were transcribed and transcriptions reviewed by the interviewer (PA) for accuracy. We performed the qualitative analysis of the transcripts using an iterative constant comparison approach to develop the codes with both investigators coding separately and then meeting to compare codes and interpretations (M.Q. Patton, 2014). Codes were created using an editing approach without application of a predetermined coding scheme (Crabtree & Miller, 1992). We chose this approach to performing this content analyses as we did not have any pre-existing hypothesis of how physicians would respond to our open-ended questions (Hsieh & Shannon, 2005). Once the final coding scheme was developed, the two investigators compared their coding on six out of the sixteen transcripts (37.5%). No major differences in interpretation occurred, so no third arbitrator was needed. Codes were examined to identify relationships, patterns, and themes. We used a method in qualitative research known as “triangulation” to ensure that the results of this study were valid. Two forms of triangulation were employed: investigator triangulation, which involved more than one investigator coding the data, and corroboration, which involved sharing our findings with a group comparable to our study group to make sure the themes we found were consistent with their experiences (Giacomini & Cook, 2000; M.Q. Patton, 2014). Those to whom we presented the findings all found the presented themes to be plausible, recognizable, and accurate.

RESULTS

Participant characteristics (Table 1)

Seven women and nine men participated in the study. The average age of the participating faculty was 42 years ($SD = 7.7$ years), with females averaging 40 years old and males 44 years old. The average number of years since residency began was 14 (range = 4.5-26). A majority of the sample identified as white. Interviews lasted between 30 to 60 minutes with most around 35-40 minutes.

Themes

Physicians' perceived roles and responsibilities regarding care for women survivors of SA fell into two themes (Table 2): (1) clinical tasks and (2) interpersonal roles. In terms of fulfilling the aforementioned roles, physicians identified multiple barriers which hinder them. These obstacles can be broken into three main themes (Table 3): (1) internal barriers; (2) challenges in the physician-patient communication; and (3) system-imposed obstacles. In the following sections, we provide more details of each of these themes and some illustrative quotations.

Roles

Providers identified five clinical tasks which are physician responsibilities: (1) screening patients for SA; (2) completing and documenting a history and physician exam; (3) conducting a forensic exam by completing a "rape kit", which is a pre-assembled box of instructions and containers designed to ensure evidence collection (e.g. patients' clothing, specimens for DNA testing, photographs of injuries) occurs in a standardized, ordered, and thorough manner; (4) providing appropriate treatment for injuries and sexually transmitted infections as well as emergency contraception; and (5) providing referrals to SA experts, SA crisis lines, women's shelters, and/or mental health professionals. Providers agreed on three key interpersonal roles. First, they educate and provide anticipatory guidance to a SA victim to the emotions and sequelae she may face. Second, physicians provide support to SA survivors once a disclosure is made. Last, physicians felt advocating for patients, both at work to change the culture to be more supportive of SA survivors, and in the community by increasing SA awareness, is an important, though underperformed, role.

Barriers to caring for SA survivors

Providers described facing multiple challenges to caring for SA survivors. These included internal barriers or their personal discomfort and biases related to the topic of rape and sexual assault; challenges in the patient-provider relationship such as communication difficulties or concerns regarding lack of patient honesty/openness; and system obstacles such as limited time and competing priorities.

Internal barriers

Physicians described three distinct internal barriers: (1) the fear of getting a SA disclosure; (2) the emotional burden of managing SA; and (3) the personal opinions providers have about SA and SA survivors.

Participants described that one barrier to performing the responsibility of SA screening was physicians' fear of getting a positive SA disclosure. They described that many physicians feel unprepared or uncomfortable dealing with the topic. As one participant explained:

"...First of all, there's the fear of asking the question and getting a yes and not knowing what to do with it. Second is the fear of offending the patient that people have. The third is I think the fear of that whole piece about alcohol, drugs, assault the fear of um making a patient feel worse you know? Not only offending but making it worse. So I think it's not knowing how to ask the questions in a

comfortable way not knowing what to do if you get a yes and the fear of actually making it worse for the patient are the three biggest barriers.”

Participants explained their concern that such a disclosure will lead to additional time and energy needed to take care of the patient. As stated by this participant, “I think physicians are afraid to open that door because you know it's like don't open Pandora's Box because all of it will come flooding out and you only have 15 minutes to see the patient.” Yet another described how this discomfort with obtaining and feeling obligated to respond to SA disclosures may explain the lack of SA screening, “It's sort of a ‘don't ask don't tell.’ If you don't ask people won't tell and you never have to open that can of worms.”

Another internal barrier described by participants was additional emotional burden when dealing with SA. They described both the emotional weight on the provider as well as the concern about triggering distressing patient emotions by broaching the topic. As an example, one provider described how she copes with the traumatic and disturbing situations shared with her by emotionally distancing herself and becoming “desensitized” to the issue. However, she admits that one drawback with this method of protecting herself is the risk of having or expressing less empathy:

“...How do I make sure I'm not desensitized so when a patient tells me I can validate their experience and not just say “oh you know just one sexual assault? that's not bad”...which I never do, you know what I mean. You hear such horrible things sometimes that there's a part of you that tries to protect yourself and how do you find that balance.”

Another emotional burden described by our participants was feeling powerless and frustrated when patients did not follow up on their referrals or management plans or when patients remain in sexually abusive relationships.

Study participants also described that medical providers may struggle with their own preconceived opinions and beliefs about SA and SA survivors that in turn inhibit their comfort and willingness to address it. Providers expressed that when a woman is reporting a SA occurring while she was intoxicated on alcohol and/or other drugs, they sometimes questioned whether a SA actually occurred. Participants also admitted that there may be times when they have difficulty believing the victim's report of SA and suspect an ulterior motive for the disclosure. They describe that their suspicion of false reports occurs particularly when there was no physical evidence or when the patient declined to file a police report. As one provider explained, “...there's no proof for it; there's no first-hand evidence.”

Challenges in the physician-patient communication

Our participants reported that subpar physician-patient communication also hamper their ability to perform their roles. These communication barriers can take the form of language barriers, difficulty helping patients feel comfortable disclosing or discussing SA, and challenges posed when patients do not disclose their histories of SA. With patients who require communication in another language, participants described feeling uncomfortable discussing such a sensitive topic through translators, particularly if the translator is not

physically present or a member of the medical team who then can pick up on some of the subtle or non-verbal cues. As one participant expressed:

“If they don't speak English it's brutal because going through a translator is very difficult. It's better if you can have a translator in the room but that seems to be less and less the case now in my practice and more and more it has to go through a AT&T telephone operator and I'm positive that I'm missing things that way.”

Communication barriers also included trouble understanding patients with disabilities. A provider detailed one particularly challenging situation:

“I had somebody who was deaf and blind who came in complaining-and oh Chinese—and describing an assault....We had to get translators and people that knew them [the patient] and it was very difficult to determine what actually happened.”

Participants also described how difficult it is to create the right environment or setting to make patients comfortable talking about SA. Some discussed that there were things out of their control that they felt inhibited communication such as the clinical setting or even the providers' own gender or appearance. One provider described how he felt his appearance hindered communication: “...my height or my skin color or my gender...[makes it]...challenging then to get more information from patients”.

Another communication challenge described by the participants is when health providers had a high suspicion for a history of SA but patients were not willing to disclose. Our participants described elements in the patient encounter that lead physicians to have a high index of suspicion include migraine headaches, chronic pelvic pain, bruises found on exam, and emotional distress with the pelvic exam. However, they feel stymied in their ability to help a patient address what are likely sequelae of SA and trauma when patients do not disclose. One provider summarized this:

“...the biggest barrier I have is there are women who have these histories who have them all packaged in a little drawer in the back of their brains and don't want to take them out, and yet, at the same time, I know it's causing their chronic pelvic pain or their migraines or their irritable bowel, and, so for me, the biggest barrier I have is the sense that I have a patient who has struggled with this, and I can't get to it.”

System Obstacles

All of the participants identified system obstacles which hindered them from caring for SA survivors. The two major forms of obstacles are time limitations and competing demands. All of the providers admitted that the reality of how the health system's prioritization to see more patients in less time do impact whether and how they address SA with their patients. One participant admitted that having limited time impacted his practice: “...in my perfect world, I would ask every patient. It would be a question that would come out of my mouth every time, but it's not. And probably, it's because of time...constraints...”

Participants described that having limited time and multiple patients in turn produced competing demands and required them to prioritize what they address. Participants reported feeling like they are being pulled in many directions due to their competing demands which, in turn, may impact the quality of the care they provide to a SA victim. In the following illustrative quotation, one participant described this dilemma:

“It is very difficult to conduct a rape kit ... with all the emotional follow-up medical, and the time involved in doing it.... I am not going to lie...When you have a guy having a heart attack, and then a woman who's had a stroke and can't breathe, and you know all this other stuff going on, it is very difficult ...to get the details of the [SA] case. It's very difficult to hold hands....You want to, but you're torn in ...many directions...”

DISCUSSION

We found that physicians perceived two major roles for themselves in caring for SA survivors: (1) performing procedural tasks, such as screening for SA and doing a “rape kit”; and (2) providing interpersonal support and education, such as providing anticipatory guidance. Our study also showed that while physicians report roles in caring for SA survivors, which are the same as those set forth by national medical societies, they struggle to fulfill them due to several internal, communication, and systems barriers.

Overall, physicians identified many key roles which echo those put forth by national medical societies. For example, the American College of Obstetrics and Gynecology recommends universal screening for all women (Varner et al., 2014). The American College of Emergency Physicians’ policy statement states hospital should “address the medical, psychological, safety, and legal needs of the sexually assaulted patient. The plan should provide for counseling and should specifically address pregnancy and testing for and treatment of sexually transmissible diseases, including HIV” (“Management of the Patient with the Complaint of Sexual Assault,” 2014).

Despite recognizing and describing these roles and responsibilities, our participants acknowledged that many physicians do not address or manage SA. This correlates with findings from Campbell's validation study surveying recollections of service provision, types, and quality from the perspectives of emergency department nurses and physicians, rape survivors who had sought care in the emergency department, and law enforcement officers. In this study, nurses and physicians acknowledged that they often did not provide comprehensive medical treatment, address counseling needs, or offer relevant referrals. Campbell's study also noted a discordance between patients and physicians regarding completion of interpersonal roles such as counseling, support and advocacy; while physicians perceived they were performing these interpersonal roles, patients did not recognize receiving these services (Campbell, 2005).

The emotional burden and challenges described by our physicians have been expressed by nurses, particularly sexual assault nurse examiners (SANE), in Maier's qualitative interview study of 39 SANE nurses. These SANE nurses described the same concern regarding triggering emotional distress or re-traumatizing SA survivors when addressing the SA as

expressed by our participants (Maier, 2012). Additionally, they described their own experiences of emotional challenges when dealing with SA such as vicarious trauma and burnout (Maier, 2011).

While few other studies have examined barriers to addressing SA specific to physicians, many of the challenges described by our participants in caring for SA survivors echo barriers described by physicians with regarding addressing intimate partner violence (IPV) (Chang et al., 2009; Cohen, De Vos, & Newberger, 1997; Elliott, Nerney, Jones, & Friedmann, 2002; Sugg & Inui, 1992). Physicians have described the fear of obtaining an IPV disclosure both because of personal discomfort as well as lack of training on the issue (Chang et al., 2009; Cohen et al., 1997; Elliott et al., 2002; Sugg & Inui, 1992).

System barriers such as lack of time and competing priorities require system changes and more facilitators. For example, asking about SA through confidential questionnaires filled out in waiting rooms, which already include items such as alcohol use and mood, may help facilitate disclosure and access to care while providing a safe environment and saving time. Studies have found that this method of screening for IPV yielded more disclosures than those made in person (Fincher et al., 2015; Rhodes, Lauderdale, He, Howes, & Levinson, 2002). In addition, having coordinated care teams would allow providers to collaborate with social work and mental health to provide support to SA survivors. While physicians will continue to be pulled away due to competing demands, especially in the emergency setting, hospital systems could use SA Response Teams (SART) or SANE programs staffed with nurses who have special training in completing a rape kit and providing support (Campbell, Patterson, & Lichty, 2005). Studies have shown that use of SARTs and SANEs helps survivors' experiences in seeking care after SA (Greeson & Campbell, 2013, 2015).

Given the majority of women want physicians to address SA and the sequelae of SA have significant health care costs, physicians could decrease costs and improve survivors' quality of life if they were to address SA (Berry & Rutledge, 2016; Friedman et al., 1992; Hurley et al., 2005; Littleton et al., 2007; Miller et al., 1996). Provider fear of opening "Pandora's box" could be overcome by increasing knowledge of care roles, such as providing referrals. Residents in one study who were aware of referrals for intimate partner violence (IPV) were 3.54 times more likely to ask about IPV (Baig, Shadigian, & Heisler, 2006). This correlation between IPV referral knowledge and screening practices may hold true for SA.

Regarding the barrier of personal opinions, physicians are often susceptible to the same misconceptions regarding SA as the general public. In a study of medical students, students showed more positive attitudes towards a woman who reported being robbed than one who had obvious physical findings of trauma who reported being raped. Students had less favorable attitudes when a woman disclosed a rape without overt signs of trauma (Best, Dansky, & Kilpatrick, 1992). Stigmatizing attitudes towards SA survivors pervade through medicine as they do on a societal level, and these attitudes and acceptance of rape myths are tied to more hesitancy in addressing SA. Even therapists who work specifically with SA survivors may hold negative perceptions of SA survivors (Ullman, 2014). Importantly, these attitudes are modifiable with education about SA myths and facts (Milone, Burg, Duerson, Hagen, & Pauly, 2010). Societal barriers are challenging to address. National campaigns

such as Men Can Stop Rape as well as No More are public efforts to challenge cultural norms around SA and violence against women.

There are several study limitations. Qualitative study findings cannot offer any generalizability. We conducted this study with physicians working at one hospital system. This may partially account for why redundancy was reached relatively soon at the 10th interview. It is possible that physicians working in other health systems or other regions would have identified different barriers. There remains a need to assess perspectives from different institutions, including those with SART and SANE programs. Additionally, our study was focused on getting a cross section of physicians' experiences rather than all the roles and barriers of one field versus another. Thus, we were not able to make any comparisons across medical specialties. We were also unable to make comparisons about subgroups of providers, such as males versus females. We had only one family medicine physician participate in the study. Another limitation is that pediatricians were not included in the study. While this would have been a useful specialty to include given that 78.7% of all rapes occur in women ages 25 and younger, with 40.4% occurring before age 18 (Breiding et al., 2014), we had wanted to focus on adult women for this study.

Additionally, our study findings skewed toward barriers to caring for women who had experienced SA rather than facilitators. This is likely partially explained by the way we framed and ordered our interview questions. We began interviews asking participants to discuss what they viewed as physicians' roles and responsibilities in caring for women with histories of SA and then transition to their perceptions of what makes carrying out those responsibilities difficult. We did not specifically ask them to reflect on what makes those tasks easier. We did ask participants about SA training experiences and to brainstorm what strategies and training would be helpful. We are completing this analysis for future dissemination. Another explanation for this is that the region and particular health care system where this study took place does not have a SANE program or SARTs, nor does it use questionnaires to assess for SA in the waiting rooms. Likely perceptions of physicians' experiences addressing SA would be different had these resources existed in our study location.

There are many possible future directions for this research. It would be useful in the future to learn if pediatricians face any additional barriers to caring for SA survivors, especially as they encounter family dynamics and minors. Similarly, because we focused on women SA survivors, our findings do not reflect providers' perceived roles and challenges in addressing and managing SA experiences among men. We are interested in how gender differences may influence physician perception on SA. Also, we did not specifically ask about nor did our participants mention specific aspects of caring for women SA survivors who are gender and sexual minorities, such as transgender, lesbian, or bisexual women. A government survey found that 46.1% of bisexual women report being raped, as compared to 17.4% of heterosexual women (Walters, Chen, & Breiding, 2013). Forms of SA other than raped have been reported by 46.4% of lesbian and 74.9% of bisexual women versus 43.3% of heterosexual women (Walters et al., 2013). Future studies are needed to explore health provider's attitudes and experiences caring for SA survivors who are not heterosexual women.

This study helps to address a gap in knowledge about the beliefs, barriers, and experiences of physicians who care of survivors of SA. To the authors' knowledge, there is no interview-based qualitative research study on physicians caring for SA survivors. While literature exists on barriers to caring for survivors among rape victim advocates (Clemans, 2004; Ullman & Townsend, 2007), future research and work is needed to develop strategies to overcome the identified barriers to addressing and dealing with SA. Such work could include development of targeted curriculum and training to improve physicians' care of women SA survivors. This could also include ensuring health care systems have access to SANEs and SARTs so as to address the more difficult to address system barriers which we identified.

IMPLICATIONS for PRACTICE and/or POLICY

Our study findings provide some direction regarding clinical guidelines and services that should be provided to women who have experienced SA. The identified barriers to providing SA care presented in this study helps to inform where training, resource, and support needs exist in current health systems and medical education. As studies have shown increased willingness and comfort among physicians to address IPV with greater training in the topic (Glowa, Frasier, & Newton, 2002; Haist et al., 2003; Jonassen, Burwick, & Pugnaire, 1996; Jonassen et al., 1999), additional training in addressing SA may similarly improve physician comfort and competence regarding this topic. Our study findings suggest that including a focus on communication skills, dealing with emotion, and understanding trauma may be helpful. Ullman and Peter-Hagene emphasize how important focusing on these communication and relational skills may be. Their work noted that how individuals react to SA disclosures can have an impact on the long term health of the victim—while positive reactions to SA disclosure can help with adaptive coping, negative reactions are related to greater PTSD symptoms (Ullman & Peter-Hagene, 2014). Studies show health care providers can be trained to improve communication; create a safe, nonjudgmental environment; and build a good patient rapport (Fallowfield et al., 2002; Fallowfield, Lipkin, & Hall, 1998; Gordon & Tolle, 1991; Roter et al., 1995; Tulskey et al., 2011). The interventions that help physicians provide care for other sensitive topics could be adapted to help break down internal and physician-patient communication barriers as well as correct misinformation and misperceptions about SA. Our collective culture stigmatizes SA survivors, and cultural change is slow. We can begin working on this with physicians by addressing this at an earlier stage, as medical trainees, and continued to challenge myths through both formal and on-the-job training. Increasing access to and collaboration with SANEs, SARTs, and SA advocacy centers could also help address these challenges.

CONCLUSIONS

Physicians from several different specialties where women SA survivors are likely to seek care all identify key roles and responsibilities in addressing SA and providing SA survivors with specific services and assistance. These roles mirror those advocated by each of the targeted specialties' organizations. Despite this, physicians identify multiple barriers to providing care to SA survivors and appropriately addressing their needs related to their SA experiences. Physician training interventions that address myths and misconceptions of SA

survivors as well as communication strategies may help reduce barriers such as physician discomfort and communication challenges, which would ultimately improve clinical care for SA survivors.

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Table 1

Composition of Participants

Physicians (n=16)	n	%
Obstetrics and Gynecology	4	25
Psychiatry	4	25
Internal Medicine	4	25
Family Medicine	1	6.25
Emergency Medicine	3	18.75
	n	%
Men	9	56.25
Women	7	43.75
		Range
Average age	42	(31-56)
Average years since residency began	14	(4.5-26)
	n	%
White	15	93.75
Hispanic/Latina	1	6.25

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Table 2

Physicians' Perceived Roles in Caring for SA Survivors

CLINICAL TASKS
Screening
Completing and documenting a history and physical exam
Conducting a forensic exam
Providing treatment
Providing referrals
INTERPERSONAL ROLES
Educating and providing anticipatory guidance
Providing support after a disclosure
Advocating for patients

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Table 3

Physician Barriers to Caring for SA Survivors

INTERNAL
Fear of disclosure
Emotional burden
<u>Personal opinions</u>
PHYSICIAN-PATIENT COMMUNICATION
Language/communication barriers
<u>Lack of patient disclosure of SA</u>
SYSTEM
Time limitations
Competing demands

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