ARRIVING AT READINESS: HOW WOMEN DEAL WITH SEXUAL ASSAULT

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ABSTRACT

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Few sexual assault survivors seek the resources developed to help them with recovery from emotional consequences of sexual assault. A lack of knowledge of help-seeking endeavors hampers nurses' efforts to develop strategies for delivering care to survivors. The purpose of this study was to discover the evolving behaviors and processes as women survivors seek help. Using the methods of grounded theory, the process model Arriving at Readiness was developed from data collected during semistructured interviews with eleven women survivors of sexual assault and three other expert informants.

Arriving at Readiness illustrates a differing, often lengthy, and potentially beneficial process women survivors of sexual assault follow to heal. Many survivors keep silent to avoid the risk of further hurt unless a Triggering Experience occurs. Responses to calls for help are harming or helping. Harming responses may begin a cycle of increasingly more dangerous behaviors.

Nurses should develop and test protocols that support survivors through the process of arriving at readiness. Education programs are needed to disseminate information about behaviors that may indicate sexual assault and about sources of help for survivors.

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INTRODUCTION

Sexual assault occurs when sexual acts are committed by one person against another nonconsenting person (Gidycz & Koss, 1991; Koss & Gidycz, 1985; Norris, 1992; Sales, Baum, & Shore, 1984). The incidence of sexual assault is underestimated because the majority of women who are raped do not report the crime (Kilpatrick, Best et al., 1985). Most survivors of childhood sexual assault did not tell a parent about the assault (Gallop, McKeever, Toner, Lancee, & Lueck, 1995). Many women never seek help, either in the immediate aftermath of the assault or in the longer term (Walker, Torkelson, Katon, & Koss, 1993). Women may not acknowledge, even to themselves, that they have been sexually assaulted (Layman, Gidycz, & Lynn, 1996).

A review of the literature (Medline, 1986-1996) showed a reported incidence of sexual assault from 7% to 59% (Beebe, Gulledge, Lee, & Replogle, 1994; Hutchings & Dutton, 1993; Norris, 1992). Both the populations studied and the definition of assault used in a given study influence the reported frequency. Women attending a psychiatric care center reported the highest lifetime incidence of sexual assault (59%) (Hutchings & Dutton, 1993). From 28% to 57% of women receiving care in medical clinics had a history of sexual assault (Beebe et al., 1994; Walch & Broadhead, 1992; Walker et al., 1993). Only 7.3% of women interviewed in their homes by a stranger reported sexual

assault (Norris, 1992). Of women in the USA, it is estimated that 12% to 14%, have been raped at least one time in their lives (Bureau of Justice Statistics, 1992; Kilpatrick, Edmonds, & Seymour, 1992).

Women survivors of sexual assault (WSSA) enter treatment at three time periods following sexual assault. They may receive crisis intervention immediately after the assault by going to an emergency room, contacting the police, or calling a rape crisis hot line. Crisis counseling may begin soon after the assault through referrals to women's centers or private therapists by the crisis management team, friends, police, or rape crisis hot line volunteers. Delayed counseling occurs months or years after the assault.

Many authors recommend that WSSA receive crisis intervention and supportive counseling during the sexual assault exam. Crisis intervention will lessen the probability that survivors will suffer long term psychological consequences (Ledray, 1992; Moynihan & Duncan, 1981; Ruch & Chandler, 1983). All nurses who care for survivors of sexual assault during the acute phase may provide, and facilitate others to provide, psychological support for WSSA. Early nursing crisis management for WSSA helps reduce the intensity and duration of symptoms resulting from the trauma (Arndt, 1988; Ledray & Arndt, 1994; Minden, 1989). WSSA will be less likely to experience severe emotional problems in the long term if they receive crisis intervention soon after the assault (Ledray, 1992; Moynihan & Duncan, 1981; Ruch & Chandler, 1983); however, only about 30% of survivors seek crisis intervention (Kilpatrick, Best et al., 1985).

Many women who seek initial crisis intervention do not pursue follow-up crisis counseling (Herbert, Grams, & Berkowitz, 1992). Although WSSA benefit from counseling even long after the assault (Herman, 1992; Roth, 1993), few seek later counseling (Walker et al., 1993).

A literature search did not reveal any studies of the factors that lead to WSSA seeking or avoiding crisis intervention, crisis counseling, or later counseling. Such information will enable nurses to implement protocols that encourage women to obtain the help they need.

Problem of Study

The purpose of this study was to discover behaviors and processes that lead WSSA to seek help with emotional recovery. To investigate the life events of these women several questions were asked: What happened to them following sexual assault? How did others respond to them following sexual assault(s)? How did survivors perceive the responses of others? What did WSSA think nurses and others (friends, family, police, counselors, and other heath care workers) should have done to help?

Rationale for Study

WSSA are at increased risk for psychiatric and physical illnesses. Emotional problems may be short term, long term, or both (Burgess & Holmstrom, 1974; Zeitlin, McNally, & Cassiday, 1993). Compared to women who have never been sexually

assaulted, WSSA are nine times more likely to attempt suicide (Kilpatrick, Best et al., 1985), three times more likely to experience sexual dysfunction (Becker, Skinner, Abel, & Cichon, 1986), and are subsequently sexually assaulted at a higher rate (Layman et al., 1995). WSSA are at risk for sexually transmitted diseases, including human immunodeficiency virus (Irwin et al., 1995).

Short-term reactions to sexual assault include fear, anger, shock, disbelief, anxiety, self-blame, physical soreness, bruising, and sleep disturbances. Soon after an assault, many WSSA experience startle reactions to minor incidents, gastrointestinal distress, and gynecological problems. Many WSSA move or take trips to get away (Burgess & Holmstrom, 1974).

Longer term psychological consequences include alexithymia (constriction of emotional experience) (Zeitlin et al., 1993), anger (Kilpatrick, Resick, & Veronen, 1981), many somatic symptoms (Lees, 1981), and substance abuse (Rich & Burgess, 1986). Another long-term consequence of sexual assault is posttraumatic stress disorder (PTSD). WSSA may become perpetual victims of PTSD. They may suffer flashbacks, numbing or constriction of feelings, increased arousal, chronic anxiety, depression, phobias, impaired sexual and social adjustments, and impaired ability to enjoy life (Davis & Breslau, 1994).

Norris (1992) found that 13.6% of all self-identified sexual assault survivors suffer PTSD. The incidence of PTSD suffered by WSSA would double to 27%, if the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association,

1994) required only two, rather than the current three, specifiers to meet the avoidance and numbing criterion for PTSD. Norris concluded that for survivors "PTSD represents only the tip of the iceberg in terms of experienced distress" (p. 416). The diagnosis PTSD, first introduced in 1980, has gradually replaced rape trauma syndrome (Burgess & Holmstrom, 1974) as the term used to describe the severe psychological trauma many women experience following sexual assault.

Women who are survivors of childhood sexual assault are also at risk for other types of long-term psychological trauma. They may experience lowered self-esteem (Curtois & Sprei, 1988). They may also suffer perceptual disturbances, including dissociation and recurring hallucinations (Chu & Dill, 1990; Ellenson, 1986). Recurring childhood sexual assault is associated with an adult diagnosis of borderline personality disorder (Silk, Lee, Hill, & Lohr, 1995). Survivors of childhood sexual assault are more likely to have major depressive episodes and anxiety disorders than those who did not experience assault (Burnam, et al. 1988).

Most WSSA do not receive early nursing care. The clinical literature describes the role of sexual assault nurse examiners (SANE) in providing crisis intervention to the WSSA soon after an assault (Andrews, 1992; Ledray & Arndt, 1994; Thomas & Zachritz, 1993). SANE are specially trained to carry out the sexual assault exam. The exam includes an interview and physical exam designed to collect forensic evidence following sexual assault and to give emotional support.

Missing from the literature are studies of what occurrences lead WSSA to seek sexual assault exams and crisis counseling programs that SANE usually recommend. Knowing the behaviors and events that influence WSSA to seek follow-up crisis counseling will enable nurses to develop more effective protocols for referring WSSA to crisis counseling programs. Increased utilization of crisis counseling should result in decreased incidence of physical and psychological problems in these women.

Many WSSA will never receive help directly related to the sexual assault because they do not overtly seek help with the process of recovering from sexual assault. Walker et al. (1993) found that only 44% of survivors in their sample had told anyone about their assault, and just 8% had told a physician. WSSA are more likely than women who have not been sexually assaulted to seek mental health and medical care. Often they present with somatic or psychological symptoms and do not mention the history of sexual assault (Golding, Stein, Siegel, Burnam, & Sorenson, 1988; Hendricks-Matthews, 1993). Nurses are likely to see these women in a variety of settings for complaints that bear no obvious relation to sexual assault but may be consequences of it. Nondisclosing WSSA are unlikely to receive needed nursing care because they are difficult to identify and little is known about this group. Understanding experiences of women who receive help may enable nurses to develop systems to improve delivery of care to those who are not receiving needed help.

Grounded Theory

Grounded theory served as the conceptual framework for this study. Grounded theory method is rooted in symbolic interactionism. The goal of symbolic interactionism is to discover social reality, by understanding the symbolic meaning artifacts, clothing, gestures, and words have for interacting people (Stern, 1994). Symbolic meaning is understood to be developed socially, negotiated, and changed over time (Morse, 1994). Data necessary for an understanding of symbolic meaning are individual perceptions, which result from interacting with others (Heiss, 1981). Conceptual models or theories based in symbolic interactionism emphasize social acts and relationships, perception, communication, role, and self-concept (Fawcett, 1989). Assumptions of symbolic theory are congruent with using the paradigm model in grounded theory method. The paradigm model is a linking of subcategories to categories in relationships which specify causal conditions, phenomena, context, intervening conditions, action/interaction strategies, and consequences (Strauss & Corbin, 1990).

Grounded theory method evolved when Glaser and Strauss (1967) modified existing sociological methods in pursuing an understanding of the symbolic meaning of dying. In grounded theory, as in symbolic interactionism, data are the respondents' individual perceptions. The researcher elicits respondents' stories about the phenomenon of interest using voice-recorded semistructured interviews (Morse, 1994).

Grounded theory is purposefully developed by analysis of systematically obtained data

to predict and explain behavior in everyday life. Using methods of grounded theory, "an inductively derived grounded theory about a phenomenon" is developed (Strauss & Corbin, 1990, p. 24). Grounded theory gives clinicians a basis for understanding behavior, and provides researchers with categories and hypotheses that can be verified in quantitative studies when appropriate (Glaser & Strauss, 1967). The methods of grounded theory are useful in discovering details of people's experiences regarding phenomena about which little is known (Strauss & Corbin, 1990). Lack of knowledge about experiences involved in women's lives as they deal with issues of sexual assault indicated a need for qualitative research to generate a grounded theory (Morse, 1994); therefore the grounded theory method was used for this study.

This study focused only on WSSA who attended programs in one center; therefore, the grounded theory developed from this study is a substantive theory rather than a formal theory. A formal theory can not be developed until the phenomenon of interest has been studied in a number of settings (Strauss & Corbin, 1990).

The ultimate goal of this study, and of grounded theory, was the development of a theory based on data that was grounded in information collected from respondents in naturalistic settings (Strauss & Corbin, 1990). Data collection and analysis led to identification of behaviors and processes experienced by informants that helped or hindered their seeking help. Using grounded theory methods, concepts and conceptual linkages were identified and developed into a grounded theory based on the research

findings (Strauss & Corbin, 1990).

Strauss and Corbin (1990) specified three main sources of a qualitative research problem: suggestions or assignments by someone other than the researcher, discrepancies or gaps in technical literature, and personal and professional experience. The research question for this study evolved from gaps in the technical literature and from the author's professional experience.

Summary

Perhaps one in four women sustain sexual assault. Many WSSA will suffer severe short and long-term emotional sequaelae. Short term reactions to sexual assault include shock and self-blame. Among long term reactions are somatic symptoms, substance abuse, and PTSD. An extensive, loosely organized system of short and long-term care resources has developed with the goal of ameliorating the aftermath of sexual assault; however, relatively few sexual assault survivors avail themselves of these sources of help.

Crisis intervention, crisis counseling, and later counseling are available to decrease the severity of short term reactions, lessen the probability of developing severe psychological problems such as PTSD, or aid the WSSA with recovery from severe psychological problems. Many WSSA do not take advantage of the help available to them. Little is known about behaviors and processes that lead WSSA to seek help. Ignorance of the behavior patterns associated with help-seeking endeavors inhibits nurses from developing effective strategies for delivering care to this population.

This study was designed to explore processes that help or hinder WSSA in seeking help with emotional recovery. The premise was that such knowledge will enable nurses to support survivors as they attempt to recover from the trauma. Nursing interventions that result in more WSSA seeking help will lead to a decrease in complications, such as PTSD, that women suffer as a consequence of sexual assault.

CHAPTER 2

REVIEW OF LITERATURE

The purpose of this study was to discover behaviors and processes that evolve as women survivors of sexual assault (WSSA) seek help. The review of literature included discussions of clinical findings and research studies about: (a) prevalence of sexual assault; (b) consequences of sexual assault; (c) care available following sexual assault, and (d) WSSA who receive help.

Prevalence of Sexual Assault

Estimates of the number of women who have been sexually assaulted vary widely. Researchers have found lifetime sexual assault rates from 7.3% (Norris, 1992) to 59% (Hutchings & Dutton, 1993). If the lowest reported rate of sexual assault were accurate, more than 1 of every 15 women would be a victim. Even if only one woman was assaulted, the incidence of assault should be considered "high" given the cost to that woman. In this discussion, high and low refers only to the number of assaults reported in a given study compared to findings in the other studies.

The lowest sexual assault rate (7.3%) was based on data obtained in a setting that did not ensure confidentiality and used nonspecific questions; therefore, the rate probably greatly underestimates frequency of sexual assault. Discrepancies in reported rates of

sexual assault are related to the setting in which information was obtained, the wording of interviews or questionnaires about sexual assault experiences, and the population used for collection of prevalence data. Findings from studies of the prevalence of sexual assault are summarized in Table 1 and are discussed in more detail in the following sections.

Setting

Prevalence of sexual assault has been evaluated in settings such as interviewees' homes, medical clinics, welfare offices, and mental health clinics. Study setting may have influenced findings regarding incidence of assault. Women in a nonclinical sample of African-Americans and Caucasians, interviewed in their homes, reported the lowest lifetime sexual assault rate of 7.3% (Norris, 1992). A community sample of Hispanic and non-Hispanic whites also reported a relatively low lifetime sexual assault rate (16.7%) (Sorenson, Stein, Siegel, Golding, & Burnam, 1987). Half of the interviews in the latter study could be overheard by others. Researchers found no statistical differences when reported rates by those whose interviews could be overheard were compared with interviews that could not be overheard; nevertheless, disclosure of sensitive material may be curtailed when interviews by strangers take place in an environment (family home) that is not associated with anonymity and confidentiality.

Table 1 Studies of Prevalence of Sexual Assault (Female Subjects Only)

Study	Setting/Method	Population (women)	(L)Lifetime % (C)Childhood % (A)Adult % (G)Group differences
Beebe, Gulledge, Lee, & Replogle, 1994	Two family practice residency training clinics/ Self-report - Specific	188 66% black* 34% white	(L)28.7 (G)Not signif.
Hutchings & Dutton, 1993	Mental health center/Self-report - Specific	81	(L)59
Walker, Torkelson, Katon, & Koss, 1993	Primary care clinic/Self-report - Specific	162	(C)37 (A)29
Norris, 1992	4 SE city neighborhoods/ Interview - General	About 500 Half Black Half White	(L)7.3 (G)Not signif.
Walch & Broadhead, 1992	Combined family practice (FP) & student health center (SH)/ Self-report - Specific	405 total 147 FP. 258 SH	FP(L)47.6 (C)36.7 (A)40.1 SH(L)57.0 (C)34.5 (A)50.0 (G)Not signif.
Goodman, 1991	Homeless: private room in welfare office or shelter Housed: homes or welfare office/ Interview - Specific	50 homeless 50 housed	(C)46 (A)37 (G)Not signif.

(table continues)

Study	Setting/Method	Population (women)	(L)Lifetime % (C)Childhood % (A)Adult % (G)Group differences
Greenwood, Tangalos, & Maruta, 1990	Medical clinic serving an urban and rural area of Minnesota/ Interview - Semistructured	59	(C)16.9
Koss, Gidycz, & Wisniewski, 1987	32 higher education settings across the USA/ Self-report - Specific	3187	(L)53.7 (G)Rape only: 40% Native 16% White 12% Hispanic 7% Asian $\underline{X}^2$ (16, $\underline{n}$ = 3, 075) = 37.05, $\underline{p}$ < .002)
Sorenson, Stein, Siegel, Golding, & Burnam, 1987	Los Angeles homes & institutions/ Interviews - Specific	1,645 total 766 Hispanic 678 non-Hispanic White 201 other	(L)16.7 (A)13.5 (G) life-time, $\underline{p}$ < .001 Hisp: Non-Hisp: (18-39 yrs) 10.3% 26.3% (40+ years) 5.9% 15.5%
Siegel, Sorenson, Golding, Burnam, & Stein, 1987	Los Angeles homes & institutions/ Interviews - Specific	1,645 total 766 Hispanic 678 non-Hispanic White 201 other	(C)6.8 (G) childhood $\underline{p}$ < .001) Hisp: Non-Hisp: (18-39 yrs) 4.6% 15.2% (40+ years) 2.8% 8.0%

*ethnicity stated as reported

Detailed Versus General Interviews or Questionnaires

Higher lifetime rates of sexual assault were found in studies where information was gathered in clinics, offices, and colleges, using self-report questionnaires with detailed descriptions of sexual assault behaviors. Lower rates were found in most community-based studies that defined assault using general terms such as abuse or assault. Reported rates ranged from 28.7% to 59% (Beebe, Gulledge, Lee, & Replogle, 1994; Hutchings & Dutton, 1993; Koss, Gidycz, & Wisniewski, 1987; Walch & Broadhead, 1992).

Lower reported rates of assault may be an artifact of the research methods. Researchers who found relatively low rates of childhood sexual abuse stated that their use of face-to-face interviews increased the likelihood that their findings were reliable (Greenwood, Tangelos, & Maruta, 1990). This finding was not supported by this researcher's review of the literature which indicated that in all but one study (Goodman, 1991), face-to-face interviews, regardless of the setting, resulted in relatively low prevalence rates (Norris, 1992; Siegel et al., 1987; Sorenson et al., 1987).

Differences in findings may depend more on the nature of questions than on the use of interview or questionnaire. Norris (1992) used a nonspecific and intrinsically contradictory definition of sexual assault in a brief question about sexual assault: "Did anyone ever make you have sex by using force or threatening to harm you? This includes any type of unwanted sexual activity" (p. 411). In the Los Angeles study, the definition of sexual assault was limited to contact only: "In your lifetime, has anyone ever tried to

pressure or force you to have sexual contact? By sexual contact I mean their touching your sexual parts, your touching their sexual parts, or sexual intercourse?" (Siegel et al., 1987, p. 1146). In contrast, Goodman's (1991) interviews used two questionnaires, developed to "obtain detailed information on the prevalence, type, and severity of abuse experienced" (p. 491).

The importance of using detailed descriptions of events rather than broad terms such as 'rape' was highlighted by the finding that 72.9% of rape victims did not conceptualize their experience as rape (Layman, Gidycz, & Lynn, 1996). In this study women were first asked detailed questions about their sexual experiences, then asked to choose a description of their experience. Of 85 women whose experiences met the definition of rape, only 23 viewed themselves as rape victims. Researchers, who used vague questions to determine sexual assault frequencies, probably greatly underestimated the number of women who experience assault.

Population

Differing ethnic, economic, clinical, and age groups have varying reported victimization rates (see Table 1). No significant lifetime assault frequency differences were found between white and black women (Beebe et al., 1994; Norris, 1992); however, Native American college women reported rape rates (40%) more than double that of white college women (16%). Hispanic college women were reportedly raped less frequently (12%) than both previous groups, but more frequently than Asian college women (7%)

(Koss et al., 1987). Non-Hispanic Whites, aged 18 to 39 years, reported much higher rates (26.3%) of lifetime assault than Hispanic women in the same age group (10.3%). Women over the age of 40 reported lower lifetime rates (15.5% non-Hispanic whites; 5.9% Hispanics) (Sorenson, Stein et al., 1987). Mental health clients (59%, Hutchings & Dutton, 1993), college students (57%, Walch & Broadhead, 1992; 53.7%, Koss et al., 1987), and family practice clients (47.6%, Walch & Broadhead, 1992) have high reported rates of sexual assault. Poor mothers have high reported rates of childhood (46%) and adult (37%) sexual assault (Goodman, 1991). These findings are from relatively few studies limited to specific populations; therefore, the results should not be generalized from the study populations to other groups or areas of the country.

Consequences of Sexual Assault

A summary of research findings about the outcome of sexual assault is presented in Table 2. Specific results of statistical tests are included in the table.

WSSA may not perceive themselves as survivors of assaults even after reporting that they had had experiences similar to sexual assaults described by researchers. Layman and her collaborators (1996) found that WSSA who acknowledged that what happened to them was an assault, had higher scores on the posttraumatic stress disorder (PTSD) diagnostic interview than those who did not describe the experience as an assault. The significance of this finding is questionable because only one member of each group (acknowledged and unacknowledged) met the criteria for diagnosis of PTSD.

Table 2 Studies of Consequences of Sexual Assault

Study	Findings (Unless stated comparisons are to never sexually assaulted)
Davidson, Hughes, George, & Blazer, 1996	Survivors had higher rates of 1) suicide attempts (14.9% vs 1.4%, X^2 (1, n = 2918) = 4.0, p < .05). 2) PTSD (45.2% vs 14.3%, X^2 (1, N = 2918) = 9.9, p < .01).
Laws & Golding, 1996	Survivors had more eating disorder symptoms (df = 1, N = 3413) 1) thought self too fat (X^2 (1, 3413) = 16.40, p < .001). 2) lost ≥ 15 lbs (X^2 = 36.04, p < .001). 3) weight loss to 85% of normal (X^2 (1, 3413) = 6.74, p < .05). 4) 1 or more anorexia symptoms (X^2 (1, 3413) = 17.68, p < .001). 5) sudden weight change (X^2 (1, 3413) = 10.76, p < .001).
Layman, Gidycz, & Lynn, 1996	Acknowledged survivors (n = 40) had higher PTSD scores than unacknowledged survivors (n = 20) (F(2, 79) =13.77, p < .0001).
Gallop, McKeever, Toner, Lancee, & Lueck, 1995	Compared to nonabused (n = 189) survivors (n = 42) had 1) significantly greater past (t = 7.88, p < .001) and present (t = 5.62, p < .001) distress. 2) significantly lower self-esteem scores (t = 18.19, p < .001).
Gidycz, Hanson, & Layman, 1995	Surviving sexual assault significantly predicted subsequent assault (N = 796) 1) child and adolescent victimization correlated with adult assault in a 3 month period (X^2 (1, N = 168) = 8.05, p < .05). 3) sexual assault during one 3 month period correlated with assault during the next 3 months (X^2 (1, N = 168) = 12.49, p < .01).
Romans, Martin, Anderson, Herbison, & Mullen, 1995	More survivors of childhood sexual assault (n = 252) than nonabused (n = 225) reported deliberate self-harm (8.7% vs 0.4%, X^2 (df = 1, N = 477) = 16.0, p = .0005). Of those who reported suicidal ideation but no suicide attempts (N = 35) 74.3% were survivors of childhood assault (X^2 (df = 1) = 7.4, p = .007).

(table continues)

Study	Findings (Unless stated comparisons are to never sexually assaulted)
Silk, Lee, Hill, & Lohr, 1995	Significant predictors of scores on the Diagnostic Interview for Borderline Patients include 1) duration of sexual abuse (X^2 (1, N = 36) = 4.58, p < .05). 2) ongoing sexual abuse (X^2 (1, N = 36) = 3.90, p = < .05).
Walling, O'Hara, Reiter, Milburn, Lilly, & Vincent, 1994	Adult sexual abuse predicted anxiety (r = 0.368, df (2, 129), standardized β = 0.186, p ≤ .05).
Gidycz, Coble, Latham, & Layman, 1993	Child rape (69.9%) & attempted rape survivors (78.7%) were more likely to be assaulted as adolescents (X^2 (16, N = 833) = 77.38, p < .001). Survivors of adolescent assaults were more likely to be adult victims (X^2 (16, N = 830) = 28.84, p < .05).
Zeitlin, McNally, & Cassiday, 1993	Survivors of multiple assaults (n = 7) more alexithymic than survivors of single assault (n = 17) (t = 3.62, df = 22, p < 0.003).
Wyatt, Guthrie, & Notgrass, 1992	Childhood abuse survivors suffer 2.4 X more adult assaults (X^2 (1, N = 248) = 9.06, p = .0026).
Winfield, George, Swartz, & Blazer, 1990	Survivors were significantly more likely to experience (df = 1, N = 1,157): 1) Major depression (X^2 = 5.58, p = .02). 2) Panic disorder (X^2 = 4.38, p = .04). 3) PTSD (X^2 = 4.71, p = .03).

(table continues)

Study	Findings (Unless stated comparisons are to never sexually assaulted)
Burnam, Stein, Golding, Siegel, Sorenson, Forsythe & Telles, 1988	Survivors had higher rates of (standard errors of prevalence rates using SESUDAAN, N = 3,125) 1) major depressive disorder (17.93% survivors, 4.68% non-assaulted, p < .001). 2) phobia (22.18% survivors, 9.71% non-assaulted, p < .001). 3) panic disorder (4.55% survivors, 0.82% non-survivors, p <. 001).
Golding, Stein, Siegel, Burnam, & Sorenson, 1988	Survivors were significantly more likely to (N =1113) (calculated using confidence intervals): 1) use mental health services (17.8 vs 9%, p < .01). 2) use medical services (66.5 vs 50.7%, p <. 01).
Becker, Skinner, Abel, & Cichon, 1986	Survivors (n = 372) significantly more likely to experience 1) fear of sex (X^2 (1, N = 471) = 13.38, p < .001). 2) arousal dysfunction 58.6% vs 17.2% (X^2 (1) = 4.51, p < .05).
Kilpatrick, Best, Veronen, Amick, Villeponteaux, & Ruff, 1985	Survivors were more likely to have attempted suicide 1) completed rape (X^2 (1, N = 1,663) = 58.96, p < .001). 2) attempted rape (X^2 (1, N = 1,641) = 11.66, p < .001. 3) attempted molestation (1%) (X^2 (1, N = 1600) = 4.84, p < .05).
Santiago, McCall-Perez, Gorcey, & Biegel, 1985	Compared to nonassaulted (n = 110) survivors (n = 35) significantly more: depressed (t = 4.80, df = 135, p ≤ .01). fearful (t = 2.50, df = 108, p < .01). trait anxiety (t = 3.72, df = 140, p < .01). Compared to one time assaulted, survivors of previous assaults had significantly higher: depression (t = 3.58, df = 19, 12, p < .01). trait anxiety (t = 2.96, df = 20, 12, p < .01).

Also, unacknowledged survivors may have lower PTSD scores simply because many of the criteria for PTSD are related to perceiving an event as traumatic (APA, 1994). Other psychological measures, including anxiety, depression, and self-blame, did not differentiate between the acknowledged and unacknowledged WSSA in the Layman study.

WSSA reported statistically significant higher rates or levels of suicide attempts (Davidson, Hughes, George, & Blazer, 1996); (Kilpatrick et al., 1985), PTSD (Davidson et al., 1996; Winfield, George, Swartz, & Blazer, 1990), use of mental and medical health services (Golding, Stein, Siegel, Burnam, & Sorenson., 1988), eating disorder symptoms (Laws & Golding, 1996), anxiety (Walling et al., 1994), depression and fear (Burnam et al., 1988; Santiago, McCall-Perez, Gorcey, & Biegel, 1985; Winfield et al., 1990), and sexual dysfunction (Becker, Skinner, Abel, & Cichon, 1986; Mackey et al., 1991) than nonvictims. Repeated sexual assaults were associated with more severe symptoms of alexithymia (Zeitlin, McNally, & Cassiday, 1993), depression, and anxiety (Santiago et al., 1985). Women with past experiences of sexual assault were more likely to suffer sexual assault again (Gidycz, Hanson, & Layman, 1995).

Nurse survivors of childhood assault had significantly greater distress and lower self-esteem than nonvictims (Gallop, McKeever, Toner, Lancee, & Lueck, 1995). Survivors of childhood assault were more likely to report deliberate self-harm (Romans, Martin, Anderson, Herbison, & Mullen, 1995) and to be sexually assaulted as adults (Gidycz, Coble, Latham, & Layman, 1993; Wyatt, Guthrie, & Notgrass, 1992). Longer

duration of childhood assault was associated with higher scores on the diagnostic interview for borderline personality disorder (Silk, Lee, Hill, & Lohr, 1995). (A disorder characterized by unstable self-concept, interpersonal relationships, and mood. APA, 1994)

Researchers have established that many WSSA suffer physical and psychological problems secondary to sexual assault. It is not surprising that researchers evaluating help-seeking women found that these women experienced significant difficulties. In studies of nonclinical populations in Epidemiologic Catchment Areas (ECA), other community surveys, and colleges, researchers also found that survivors experienced significant emotional sequaelae to sexual assault. WSSA are at risk for severe psychological distress whether they seek treatment or not.

Care and Outcomes

Clinical literature emphasizes the importance of care following sexual assault. Nurses have written extensively about the need for immediate, comprehensive nursing care that provides medical treatment, collection of forensic evidence, support, and referrals for ongoing help (Andrews, 1992; Ledray, 1992; Ledray & Arndt, 1994; Minden, 1989; Raiha, 1983). Unfortunately, such care remains relatively rare. Social work researchers using data collected from 31 Florida post-rape examination sites found that, while physicians dislike doing postassault exams and hospitals fear legal entanglements, prosecutors and judges often object to nonphysician exams. Only one of the 31 sites had a successful sexual assault nurse examiner program (SANE) (Martin & DiNitto, 1987).

More recent clinical nursing literature includes descriptions of a few SANE programs that are designed specifically to provide comprehensive care to sexual assault survivors. SANE programs are located in Minneapolis, Minnesota (Ledray, 1990) and Tulsa, Oklahoma (Thomas & Zachritz, 1993).

Herman (1992) described the care given to survivors at the Boston Area Rape Crisis Center, emphasizing the need for individual and family counseling in the weeks or months following trauma, before the survivor begins the first of three stages of group therapy. The stages of group therapies relate to specific therapeutic tasks: first to establish safety, then remembrance and mourning, and finally reconnection.

Researchers statistically evaluated the outcomes of group treatment for WSSA in four studies. A summary of the studies is presented in Table 3. In contrast to the control groups (survivors on a waiting list for groups), sexual assault symptoms were significantly reduced in treatment groups (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick, Jordan, Girelli, Hutter, & Marhoeffer-Dvorak, 1988; Resick & Schnicke, 1992). Differences in outcome by treatment groups (differing group therapy methods) were not found, perhaps because of the small sample sizes. Late and immediate treatment seekers differed on stress symptoms before but not following treatment, suggesting that treatment is equally effective at any stage following assault (Frank et al., 1988).

Table 3 Studies of Outcomes of Care Following Sexual Assault

Study	Population & Setting	Conclusions
Resick & Schnicke, 1992	39 survivors of rape, more than 3 months ago, no incest, no severe psycho-pathology, PTSD	19 participated in 12 session cognitive processing therapy (CPT), 20 in waiting list control group. Many subjects had chronic rape-related symptoms. CPT participants had significant improvement in PTSD (1.56 to 0.93) and depressive symptoms (2.15 to 1.39) over 6 months, compared to waiting list group (PTSD 1.37 to 1.35; depression 1.78 to 1.71). PTSD $F(1, 37) = 8.41$, $p = .01$. depression $F(1, 37) = 4.79$, $p = .05$.
Foa, Rothbaum, Riggs, & Murdock, 1991	45 rape survivors with PTSD.	Randomly assigned to 1 of 4 groups: stress inoculation training (SIT), prolonged exposure (PE), supportive counseling (SC), or wait-list (WL). All treatment groups produced significant improvement. SIT, $F(2, 48) = 24.14$, $p < .001$; PE, $F(2, 48) = 23.87$, $p < .001$; SC $F(2, 48) = 8.59$, $p < .002$.
Frank et al., 1988	104 late & immediate treatment seekers.	Rape victims who received cognitive behavior therapy and systematic desensitization experienced a significant reduction in stress from pre to posttreatment. $t(64) = 13.34$, $p < .000$.
Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988	50 survivors 3 mos to 34 yrs postassault.	37 in one of 3 group therapies (stress inoculation, assertion training, supportive psychotherapy), 13 wait-list. No differences were found between treatment groups, significant improvement (> 1/2 to > 1 standard deviation for global severity index, phobic anxiety, & depression) was related to attending the sessions. No sig. change for waiting-list.

Friends and family may also influence survivors' adjustment following sexual assault. Davis, Brickman, and Baker (1991) found supportive behaviors by a significant other or by the usual support person were not associated with adjustment following assault ($n = 105$, beta = .18, p = not specified), but unsupportive behaviors were associated with poorer adjustment (beta = .40, $p < .001$). Popiel and Susskind (1985) also found that supportive behaviors by support networks were not significantly correlated with adjustment; however the support rating of physicians, a group survivors perceived as nonsupportive, was associated with a significant increase in trauma symptoms on the Impact of Events scale (measure of traumatic event survivors' psychological symptoms) ($N = 25$, $r = .47$, $p < .05$) and on the SCL-90-R Symptom Checklist (measure of psychiatric patients' symptom patterns) ($r = .43$, $p < .05$, $df = 23$).

Few WSSA Receive Help

Many survivors of sexual assault will receive no care at all because they do not seek help. Walker, Torkelson, Katon, and Koss (1993) found that only 44% ($N = 162$) of the survivors in their sample had told anyone at all. Just 8% of the survivors had told a physician. Only 11 of 67 nurses who had survived childhood sexual assault had told a parent (Gallop et al., 1995). As noted above some women did not acknowledge to themselves that they were survivors of sexual assault (Layman et al., 1996). Of those who do seek help, many will only receive mental health care if it is given at the time of the

sexual assault exam. Herbert, Grams, and Berkowitz (1992) found that 46% of survivors ($\underline{N}$ = 294) were lost to follow up 48 hours after postassault health care at an emergency room.

Survivors are also unlikely to report the crime to police. In a study of 167 women, 34 had a history of sexual assault. Survivors reported to the police only 18% of adult rapes and 11% of childhood assaults. Various reasons are cited for not reporting childhood assaults: parents did not want them to (37.5%), fear of assailant (37.5%), embarrassed (25%), did not think they needed attention (25%), and guilt (12.5%). Survivors of adult assault gave various reasons for not reporting: guilt (39%), embarrassed (35%), fear that police would think they provoked the attack (23%), fear of assailant (19%), and feeling that it would not be useful (16%) (Binder, 1981).

Even WSSA who acknowledge the assault experience may delay seeking treatment. Women at rape crisis centers who sought immediate (within 1 month) or delayed (2 months to more than 3 years) treatment did not differ significantly on demographic factors or past psychiatric history. Women who delayed treatment were more likely to know their assailant (73% vs. 50%, $\underline{X}^2$ = 11.8 (3), $\underline{p} < .008$) and were less likely to have acted defensively (58% vs. 27%, $\underline{X}^2$ = 6.9 (1), $\underline{p} < .01$) (Stewart et al., 1987).

Based on this literature review, it was found that WSSA may receive emergency care but not follow up with crisis counseling, may delay obtaining help, and that many will never receive any of the help available to them. A literature search did not disclose any

studies designed to determine what behaviors and processes lead WSSA to seek or continue to get help.

Summary

Although the reported incidence of sexual assault varies widely, researchers have established that many women experience sexual assault. Among the studies reviewed, Norris (1992) reported the lowest assault rate. The Norris (1992) findings likely underestimated incidence of assault because data were obtained in a setting that did not ensure confidentiality and nonspecific questions were used to elicit history of assault. Several researchers reported lifetime rates of sexual assault around 50%. A conservative extrapolation from literature citations is that 1 in 4 women experience sexual assault.

Researchers consistently found that many women suffer severe, untoward effects secondary to assault. WSSA are at higher risk for PTSD, depression, dissociative reactions, alexithymia, eating disorders, and anxiety than nonvictims. Surviving multiple assaults increases the severity of alexithymia. Adult survivors of childhood assaults experience ongoing psychological problems.

Outcome studies support clinical findings that treatment is beneficial in ameliorating suffering. Unfortunately, many WSSA never receive help. Studies that provide information about women's experiences seeking and obtaining help are lacking. Having such knowledge will enable nurses to plan care to reduce barriers to treatment and increase the likelihood that women will receive help. Until the behavior patterns

associated with help-seeking endeavors are understood, nurses' efforts to develop effective strategies for delivering care to this population are hampered.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The purpose of this study was to discover the everyday life events that lead women survivors of sexual assault (WSSA) to seek help with emotional recovery. It is well established that self-reported WSSA have a high incidence of severe emotional problems and that they face multiple barriers in seeking help. There is a lack of information about events in their lives that lead WSSA to seek help with emotional recovery.

Qualitative Research

Qualitative research has as its goals the description, understanding, explanation, or development of a theory about a phenomenon (Morse, 1994). Qualitative research is used to discover people's experiences with a phenomenon (such as emotional recovery from sexual assault). Qualitative research is useful in discovering information about a little known phenomenon or in gaining a different perspective to better understand a phenomenon. Qualitative research facilitates the discovery and description of details about a phenomenon that would be difficult to discover and describe using quantitative techniques (Strauss & Corbin, 1990). Qualitative studies may provide testable theory for quantitative studies, develop accurate and detailed descriptions, or supplement quantitative studies (Knafl & Howard, 1984). The approach (phenomenology, ethnology,

or grounded theory) taken is related to the goal of the study (Lowenberg, 1993).

The grounded theory approach is designed to build theory which can explain reality and provide a basis for action (Strauss & Corbin, 1990), the goal of this study. A grounded theory provides clinicians with the means to predict and explain behavior (Glaser & Strauss, 1967). Using methods of grounded theory enhances the likelihood of discovering details of people's experiences with some phenomenon about which little is known (Strauss & Corbin, 1990). There is a lack of knowledge about events that lead some women to seek crisis intervention, crisis counseling, or delayed counseling. To understand what behaviors and processes lead WSSA to receive help, WSSA with a variety of experiences in obtaining help will be asked to tell their stories. Qualitative research is especially useful in building a knowledge base and an understanding of complex subjects (Morse, 1994), such as events that lead WSSA to seek help with emotional recovery; therefore, grounded theory methodologies were used for this study.

The understanding of a phenomenon (theory) that results from qualitative research provides the foundation for future research. An extensive or complete theory about a phenomenon is the basis for meaningful future research (Morse, 1994). The knowledge base that has developed about the phenomenon of obtaining help following sexual assault is limited and fragmented. A theory about the process of obtaining help following sexual assault did not exist.

Grounded theory is based in the experiences of participants in the phenomenon of interest. Concepts and conceptual linkages are discovered through analysis of data. Theory is developed which is grounded in data and connected to a greater body of knowledge (Morse, 1994). For this study, each participant had expert knowledge of events that lead WSSA to seek help with emotional recovery.

Grounded theory is inductively derived and involves a process of systematic collection and analysis of data about a phenomenon. Findings result from the creative process of identifying and naming categories and identifying relationships among the categories. Findings are verified as the researcher alternates between collecting and analyzing data. Analysis of data takes place through the processes of coding. Sampling (theoretical) is modified to ensure that data which allow for evaluation of the emerging hypotheses are obtained (Strauss & Corbin, 1990).

Setting

The setting for this study was a Women's Center located in a large southern metropolitan area (hereafter referred to as the center). The metropolitan area has a population of over 3 million people. The center provides a wide variety of services for women who are survivors of violence. There is a rape crisis program, a family violence program, and a community education program. Many of the center's programs, including the rape crisis program, are conducted in a newly renovated building that is located on a bus line in the center of the metropolitan area. To gain access to the building, volunteers

and clients must identify themselves to a staff member who provides entry through a constantly monitored, locked door; this procedure promotes the safety of women in the center. Support groups meet in comfortably furnished rooms that readily accommodate 12 people. Several smaller rooms are available for interviews.

The rape crisis program includes a crisis hot line, individual counseling, and support groups for WSSA. The rape crisis program also provides services for children and men who have been sexually assaulted. The crisis hot line is answered by volunteers 24 hours per day, 7 days a week. Individual counseling is available, but clients are encouraged to begin participation in support groups as soon as possible. There are six support groups that meet each week for female survivors: one for adolescents, one a time-limited closed group, one for survivors with special needs, one for survivors of incest, and two ongoing open groups for adult survivors of sexual assault. In addition, there are two support groups for families and friends of survivors. Support groups are facilitated by volunteers who are often survivors of sexual assault. Child care is provided during some support group meetings.

The number of survivors attending support groups vary. Generally, attendance at support groups ranges from 6 to 12 women. Women participating in open groups (any women survivors of sexual assault may attend as often or as seldom as they wish) choose which groups they will attend. Clients who attend the time-limited, closed group (only selected participants may attend) are screened by a counselor to ensure they are prepared

to participate in this intense group. Participants in both groups agree to maintain confidentiality.

Population and Sample

The population from which study participants (sample) were drawn included women 18 years of age or older who were self-identified survivors of sexual assault. They were participants in rape crisis programs at the center. All women who met these criteria, regardless of the nature, time, or frequency of sexual assault were considered to have expert knowledge of events that lead WSSA to seek help with emotional recovery.

Staff and volunteers in the rape crisis program also have expert knowledge because they have heard stories from WSSA about how they obtained help. The manager of the rape crisis program identified expert staff and volunteers. The researcher or the manager then asked them to participate in this study. The staff and volunteers also acted as allies, facilitating the process of meeting potential informants (Lofland & Lofland, 1984).

Theoretical sampling was used for this study. Theoretical sampling is an evolving process that begins when initial data are obtained for the study of a specified phenomenon. These data are analyzed. Hypotheses are developed about the concepts and their relationships from the data analysis. Sampling decisions are based on results of the analysis. Sampling is focused on events or incidents. The first goal of sampling is to discover as many categories as possible; therefore, a wide range of data are gathered. Later, the goal is to develop dense, saturated categories; therefore more specific data are

gathered. Theoretical sampling is cumulative; increases in depth of focus; gathers data for each category systematically; notes variation, process, and density; and is flexible in responding to indications of new or unexpected areas. Sampling is guided by purposes of the three basic coding procedures: open, axial, and selective (Strauss & Corbin, 1990).

Sampling continued until theoretical saturation of the categories that emerged from data collection and analysis was accomplished. Three main criteria indicated that theoretical saturation had occurred: no new data were emerging, the categories accounted for paradigm elements, variation, and process. The relationships between categories were then established and validated (Strauss & Corbin, 1990). At that point, data collection stopped. A total of 14 women participated in the study.

Protection of Human Subjects

Approval to conduct this study was obtained from Texas Woman's University Human Subjects Review Committee (Appendix A) and the center (Appendix B). All guidelines for protection of human subjects were followed. Participation in the study was voluntary. The purpose of the study was explained to potential participants before written consents to participate (Appendix C) and to be audiotaped (Appendix D) were obtained. Adequate time was given for questions and discussion of any concerns of potential participants. Participants were informed that the research was not expected to benefit them directly but was expected to add to the understanding of events that lead WSSA to seek help with emotional recovery.

Participants were informed that possible risks included that their name might become known or that their voice might be identified by others (loss of confidentiality). They were informed that measures to guard against loss of confidentiality would include keeping audio tapes locked in a secure location or in the researcher's possession and that only the investigator would have access to the tapes. Code numbers were used on data forms and audio tapes.

Participants were informed that they might experience some anxiety during the interview, and, if that occurred, they were free to interrupt the interview at any time. They might ask questions, discuss any concerns, rest, or stop the interview. Additionally they were informed that the interviewer would remain with them following the interview to answer any questions or to discuss any other concerns if they wished. They were also informed that they were free to participate or not participate and might withdraw from the study at any time without penalty. Participants were given a copy of the written consent with the researcher's name and phone number, should they wish further contact.

Interviews

Participants were recruited from support groups in two ways. Initially the group facilitator asked group members for permission for the researcher to come into the group and briefly describe the project. The facilitator invited the researcher into the group only if every group member agreed. To decrease pressure on group members to agree the facilitators pointed out that if anyone did not agree members who were interested could

meet with the researcher following the group. The final five participants were recruited using handouts distributed by group facilitators. The handout described the purpose of the project and giving the researcher's phone number. Those interested in participating in the study were invited to call the researcher.

The researcher met with volunteers in a private room at the center. The consent form was reviewed with the volunteers. All volunteers who came to this meeting remained and completed the interview, after signing and receiving a copy of the consent form.

Demographic information, including current age, ethnic identity, length of time since assault, years of education, and length of time attending the women's center, was obtained before proceeding with the interview. Demographic information was used to describe participants. Semistructured interviews were used for data collection. A set of probing questions (Appendix E) was developed and used to facilitate data collection. Additional questions that encouraged the participant to elaborate on emerging phenomena were also posed. As conceptual categories emerged, the interviews became more focused. Interviews were audiotaped.

Treatment of Data

The constant comparative method of grounded theory was used for data collection and analysis. Interviews, designed to elicit participants' descriptions of events that lead WSSA to seek help with emotional recovery, alternated with analysis of content of the interviews. Analysis used open, axial, and selective coding. To discover relevant

concepts, the process of open coding was used. Data were examined and divided according to different themes, then evaluated and compared, and grouped into categories with conceptual labels. Open coding alternated with axial coding in which connections were made between categories and their subcategories. Open and axial coding were followed by selective coding in which the core category was identified and related to the other categories, integrating the categories into a conceptual, reasonable, and grounded theory. During data collection and analysis, relationships between categories, properties of categories, and dimensions of categories were constantly proposed (deductive reasoning) and then verified by data (inductive reasoning) (Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1990).

Open Coding

To accomplish the goals of open coding, the raw data (the content of the interview) were divided into discrete parts that represented phenomena as they emerged. Similar phenomena were then grouped together and given one name or conceptual label. The resulting concepts were then grouped into categories with more abstract conceptual labels. This process of identifying and naming categories based on their dimensions and properties was the beginning of thinking analytically about the categories (Strauss & Corbin, 1990).

Open sampling was used during open coding, with the goal of discovering as many relevant categories, their properties and dimensions, as possible. Open sampling involved

interviewing all participants who met the inclusion criteria and had consented to participate in the study. During open sampling the interviewer was sensitive to cues from the participants and varied the interview questions accordingly, thus maintaining openness to the possibility that unexpected but relevant concepts might be identified (Strauss & Corbin, 1990).

Axial Coding

To accomplish the goals of axial coding, data that resulted from open coding (categories and subcategories) were combined in new ways to form several main categories. There are four analytic steps in axial coding. First, subcategories were linked to categories in statements specifying the causal conditions, context, intervening conditions, action/interaction strategies, and consequences of the relationships. Second, hypotheses were verified through review of the data. Third, the search continued for the properties of categories and subcategories and the relative location of data that indicated the categories and subcategories. Fourth, comparisons (to begin to discover variation in phenomena) were made between each category, its subcategories, and the relative location of data (Strauss & Corbin, 1990). This process of analysis resulted in a paradigm model linking subcategories to a category in complex ways, giving the grounded theory analysis density and precision.

Relational and variational sampling (a form of theoretical sampling) was performed during axial coding. Sampling was still based on the emerging concepts. The goal of

sampling shifted to discovering and validating relationships between categories and to following the categories with the goal of discovering as many variations in each category as possible (Strauss & Corbin, 1990).

Selective Coding

To accomplish the goals of selective coding, the data that resulted from open coding (categories with properties, dimensions, and paradigmatic relationships) was developed into a story line. Subsidiary categories were related around a core variable by the paradigm (conceptual pattern). Categories were related at a dimensional level, relationships were validated against the data, and categories that needed refinement or development were completed. The data were integrated, and an analytic story resulted. Throughout data analysis, the researcher was alert for process; reasons why events changed, stayed the same, progressed, or regressed; and consequences of the events (Strauss & Corbin, 1990).

Discriminate sampling was performed during the process of selective coding. The goals of the direct and deliberate approach of discriminate sampling were to integrate the categories into a theory, validate the statements of relationship between categories, and complete the development of any inadequately developed categories. Sites, persons, or documents that were likely to enhance the possibility of meeting this goal were chosen. Findings were again verified through review of the data. Theoretical saturation was reached when no additional relevant categories emerged from the data, category

development was dense (e.g., accounted for paradigm elements, included variation and process), and relationships were well established and validated (Strauss & Corbin, 1990).

Methodological Concerns

Participants for this study were recruited from clients who attended a rape crisis program at one center. Findings are not reflective of the entire WSSA population because participants in this study are among those WSSA who have sought help. The participants had chosen support groups and/or individual counseling at the center. They are a unique group of women who reside in southwest Texas.

There was potential for research bias in this study because the researcher is a nurse who has cared for WSSA. Professional experience may enhance theoretical sensitivity, or conversely, may preclude the researcher from seeing the obvious (Strauss & Corbin, 1990). Basing qualitative research in one's experiences will enhance the probability that the personal and emotional will link with the intellectual operations, resulting in meaningful work; however, it may also lead to methodological and ethical problems (Lofland & Lofland, 1984). Neutrality is the absence of research bias. To increase the likelihood of neutrality, the researcher generated a decision trail, describing, explaining, and justifying procedures at each stage of the research. Using the procedures of grounded theory also guarded against research bias. The researcher compared the results of initial conceptual coding with data from subsequent informants, incorporating new or

differing information into the evolving findings, using the constant comparative method (Strauss & Corbin, 1990).

Qualitative research may be subject to error if informants are not truthful or give less than accurate accounts. To lessen the likelihood of error due to inaccurate accounts the researcher obtained first hand accounts from women who were survivors of sexual assault. These women had first hand experience obtaining help with the process of emotional recovery from sexual assault. Accounts based on direct perception are more likely to be accurate than those based on second, third, or fourth-hand reports. The accounts were evaluated for internal consistency (plausible and without contradictions) and for external consistency (agreement among accounts) (Lofland & Lofland, 1984).

The researcher may have also been a source of truth error. If the researcher's interpretations of the data were distorted, then the people to whom the emerging theory applies and those who work with them will not recognize the emerging theory as applying to their experiences. This form of truth error was evaluated by using the constant comparative method of data analysis and by discussing the findings with expert informants who are staff members at the women's center. Because they found the emerging theory accurate, its credibility was supported (Sandelowski, 1986).

Generalizability, applicability, and fittingness all refer to the meaningfulness or fit of the findings in situations other than that of the research study. Generalizability is supported when practitioners in other locations perceive that the theory is appropriate

based on their experiences (Guba & Lincoln, 1981; Sandelowski, 1986). Generalizability was evaluated in this study by a nurse psychodramatist with extensive experience working with sexual assault survivors in inpatient and outpatient settings. The nurse was asked to review the study findings based on her experiences working with WSSA. She concluded that the findings were "true", supporting the generalizability of the findings. Generalizability will continue to be evaluated after the findings are disseminated and readers recognize, or do not, that the findings are applicable in the situations they know.

Summary

The purpose of this study was to gain understanding of the behaviors and processes that lead WSSA to seek help with emotional recovery. Qualitative research is particularly suited to building a knowledge base and an understanding of complex subjects. The goals of the grounded theory approach to qualitative research (knowledge and a basis for action) are congruent with the goals of this study. If these goals have been met, the reality experienced by WSSA is explained and nurses have a basis for implementing protocols to care for WSSA.

All participants in the study had expert knowledge of the process of recovery from sexual assault because of their experience as WSSA or because they had heard WSSA describe their experiences. Participants were interviewed after informed consent was obtained. Collection of data from the participants followed the process of theoretical sampling. Theoretical sampling was used to identify as many categories as possible and

then to ensure they were well developed, with dense and saturated categories. Sampling continued until the categories accounted for paradigm elements, variation and process, and the relationships between categories were established and validated.

Analysis of data used open, axial, and selective coding. Open coding alternated with axial coding to discover relevant concepts and to make connections between a category and its subcategories. Selective coding followed to identify the core category and relate the other categories to it, thereby integrating the categories into a conceptual, reasonable, and grounded theory. The outcome of data collection and analysis is a substantive grounded theory that provides some additional knowledge and basis for action about behaviors and processes that lead WSSA to seek help with emotional recovery.

CHAPTER 4

ANALYSIS OF DATA

Women survivors of sexual assault (WSSA) are at high risk for untoward emotional consequences (Burgess & Holmstrom, 1974; Zeitlin, McNally, & Cassiday, 1993); however, relatively few women utilize the variety of resources developed to aid in ameliorating these effects of sexual assault (Walker, Torkelson, Katon, & Koss, 1993). This study was designed to add to the understanding of behaviors and processes that lead WSSA to seek help with emotional recovery. This knowledge may aid nurses in developing protocols to enhance the likelihood that WSSA receive help, decreasing the suffering of WSSA and their families.

Semistructured interviews were used to collect data about the events and behaviors that lead to WSSA obtaining help. The data were analyzed using grounded theory method. Categories and relationships among categories were identified and named through the process of conceptual coding and constant comparison. Using theoretical sampling, findings were verified as they emerged from the data (Strauss & Corbin, 1990). The findings were evaluated for truth error (distorted interpretations of the data) by discussing the findings with expert informants who were staff members at the women's center (Sandelowski, 1986). Finally, generalizability was assessed by a nurse psychodramatist with extensive experience working with sexual assault survivors (Guba & Lincoln, 1981; Sandelowski, 1986).

Participants

Participants were recruited from sexual assault support groups, staff, and volunteers at the women's center. The exact response rate is unknown because many potential participants were in more than one of the groups approached. In one of the early groups approached, more than half of the members eventually participated. In many of the groups approached, no one volunteered to participate. In other groups only one or two people volunteered. Many volunteers were survivors who perceived themselves as experts because of their long history of dealing with assault-related issues or who perceived their experiences as different from those of many other survivors. Participants reported benefiting from reading or hearing about other survivors' experiences. Many had read The Courage to Heal by Ellen Bass and Laura Davis (1994). Others had watched Oprah Winfrey's programs on sexual assault or had attended educational talks about sexual assault at churches or other locations.

Semistructured, audiotaped interviews with 14 respondents, were conducted in privacy. Three of the respondents were staff or volunteers who did not identify themselves as WSSA. Eleven of the respondents were WSSA. All were experts in the process of recovery from sexual assault. Respondents ranged in age from 19 to 60: five (36%) were in their 20's, two (14%) in their 30's, five (36%) in their 40's, one (7%) in her fifties, and one (7%) sixty. The majority of the respondents (nine, 64%) gave their ethnic identity as caucasian, three (21%) as Hispanic, one (7%) as African-American, and one (7%) as Asian. All respondents had graduated from high school. Five (36%) had one

or two years of post-secondary education. Two (14%) had baccalaureate degrees. Two (14%) had completed some post-graduate work and two (14%) had masters degrees.

The majority (seven, 64%) of the eleven WSSA had been assaulted as children. Assailants included biologic and step-fathers, grandfathers, older brothers and cousins, family acquaintances, and strangers. Five (45%) women had been assaulted by more than one male during their childhood. Three (27%) women reported that the perpetrator of the childhood assaults continued to assault them into their adolescence. Three (27%) who were assaulted by more than one person during childhood were again assaulted in adolescence or adulthood. Five (45%) women reported that they had experienced assault during their adolescence and four had during adulthood. Eight (73%) of the women were survivors of repeated assaults. Three (27%) women had been assaulted by total strangers. One woman survived a gang rape.

Findings

Arriving at Readiness

The process model depicted in Figure 1 and its categories (Figure 2) evolved from analysis of the interviews, using the constant comparative method of grounded theory. The model reflects the process of arriving at readiness in dealing with issues related to sexual assault. Women may remain in one mode, such as protecting, for indefinite periods of time. Survivors may be caught in a cycle of triggering event, telling, receiving a harmful response, then acting out their increasingly desperate need for acknowledgment, help, and protection silently, then again telling in response to a triggering event. Survivors

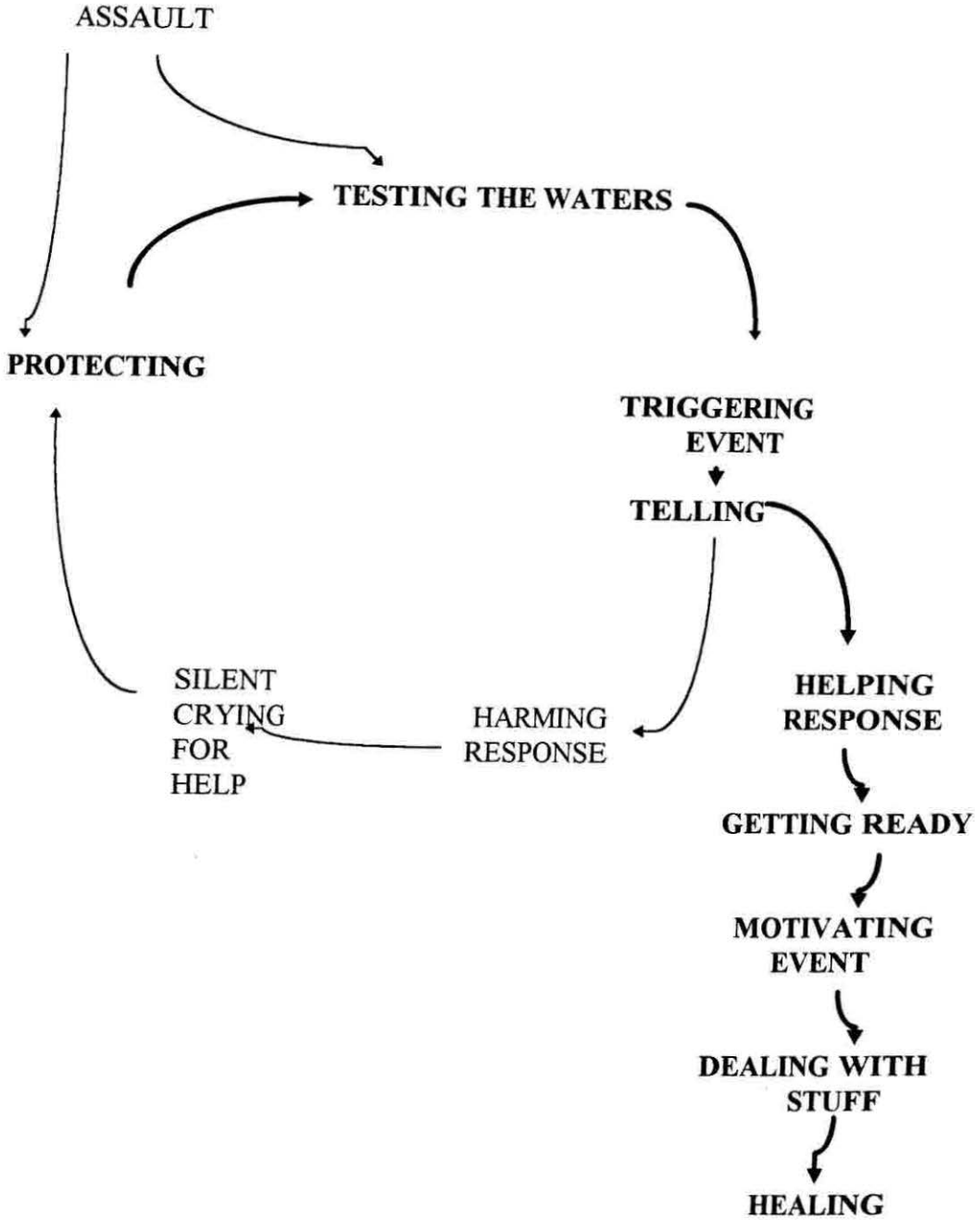

Figure 1. Arriving at readiness: A process model of the behaviors and events women experience as they deal with issues related to sexual assault.

Bold typeface indicates path to readiness and healing.

Protecting
Keeping silent/ Avoiding perpetrator.
Withdrawing socially.

Triggering event
Assault or increase in severity of assaults.
Meeting perpetrator at a social event.
Consequences of rape (fleeing to safety, requiring medical help).
Models/ learning what sexual assault is.
Fear of "losing mind"/ a need to confirm.

Helping responses
Listening, believing, protecting, educating.
Attending family and friends support group.
Ensuring multiple sources of help.
Treating as individual not statistic/diagnosis.
Caring, non-exploitive men.
Encouraging to attend support groups.
Encouraging to report crime.
Calling child protective services.

Silent crying for help
Self-destructive acts.
Alcohol/ drug abuse.
Promiscuity.
Parenting problems.
Destructive acts.
Victimize others.

Motivating event
Major life change (new partner or divorce).
Concern for own children.
Getting tired of problems (anger, intimates).

Testing the waters
Hinting (insinuating).
Not wanting to be with perpetrator.

Telling
Impulsive (blurting).
Urgent (need protection/help).
Prepared.

Harming responses
Not believing, judging, minimizing.
Not providing safety.
Encouraging secrecy.
Pushing to talk before ready.
Siding with perpetrator.
Leaving alone, no counselor, in ER.
Feeling self-blame.

Getting ready
Feel caring, warmth, belief in self from others.
Feel connection with other survivors.
Feel some trust, hope.
Have psychological calluses.
Have some control of reactions.
Personal religious experience.

Dealing with stuff
Putting feelings into words.
Accepting results of own actions.

Healing
Feel trust, hope, can problem solve.
Stop victimizing self and others.
Realize: "not my fault"; "I have strength."; "What happened matters."

Figure 2. Categories of the model arriving at readiness

may receive helpful responses either immediately from emergency personnel, family, and friends or in agencies that they seek or to which they are brought because of the symptoms of their distress. These survivors may remain in the relatively stable stage of getting ready or, in response to motivating factors, may go on to the intense work of dealing with stuff, and then to healing.

The model evolved through many forms. The categories emerged early in the research process. The core variable arriving at readiness became clear after the first eight interviews. The relationship between the categories was not finalized until the nurse psychodramatist pointed out that the model needed to illustrate that recovery is progressive, that survivors may remain at various stages indefinitely, but that survivors do not move backwards once they reach the stage of getting ready.

The process of arriving at readiness was lengthy for many participants. Throughout the process the women engaged in many productive activities and relationships as students, workers, friends, partners or spouses, and parents.

The following text contains descriptions of respondents, of behaviors and events they described, and includes quotations. Some descriptions and quotations are pastiches drawn from several sources. All identifying information was altered to ensure confidentiality while remaining true to the spirit of the information.

Protecting

Protecting strategies arose from survivors needs to avoid more pain following assault. Strategies included keeping silent, avoiding the perpetrator, and withdrawing socially. Bea, a survivor of numerous childhood assaults by a father figure and other males, kept silent at first because

> I didn't have the strength to tell my mom. I don't think I could get the words out. I just couldn't. I was scared of him. Very scared of him.... He told me he'd kill me, he'd kill my mom. And I decided he had the power to do it. He could just reach out and do something.... It hurts really badly to come out and say 'hey this happened to me.' A knife inside - in heart and soul.

April, assaulted by an acquaintance in high school, explained her silence

> I just assumed everybody would be like 'well you put yourself in the situation. It's your fault. You shouldn't have been there at that time. You shouldn't have done this.' I expected my whole family to, not disown me, but not want to have anything to do with me.

Bea and April were initially silent to protect themselves. Bea's attempts to tell after years of abuses, that were escalating in severity, were unsuccessful and reinforced her protective silence. After months of silence, circumstances forced April to tell and she received much needed support. Bea was six years old when the assaults began. April was 18 years old when the assault occurred.

WSSA are individuals who keep silent for unique reasons. In addition to using keeping silent as a protective strategy, WSSA reported keeping silent because they did not know how to say what had happened or did not understand what had happened. Jennifer survived an assault, by an authority figure, as an adolescent. It was not until many years later, at an educational presentation, that she understood what had happened: "15 years after - first time I realized I had been sexually assaulted. Oh! That is why I felt so badly." June, a survivor of childhood incest, did not have a reason for keeping silent. She reported "I didn't think much about why I never said it. I just never did."

Unlike most survivors, Tess, a survivor of adult stranger rape, knew she should tell her friends soon after the event. She kept silence to protect herself from others at times when she wasn't ready to answer their questions. Tess felt able to make some choices about whom she told and how she told them.

Several informants reported withdrawing socially. Jennifer stated "I isolated. I felt like a pariah, not worthy of relationships with anyone." Others reported that while their outward behavior did not change, there were inner changes. Rosemary, a survivor of assaults by older males when she was very young was successful in school and had friends but: "My reaction to it was that I just gave my life away and shut myself up inside...so I wouldn't be hurt again." Although Tess did not isolate herself socially, she still felt alone.

Protecting strategies were effective for varying periods of time for some of the survivors, allowing them to avoid additional sources of hurt. When Jennifer finally told

her father, twenty years after an assault by an authority figure in her high school, "Initially he was comforting then very, very shaming. I knew at the time I would be accountable."

The protective strategy of keeping silent added to many of the survivors hurt by delaying their getting help and by shutting out potential support from others. April, assaulted by an acquaintance in high school, kept silent several months. When her doctor diagnosed a sexually transmitted disease (STD) acquired during the assault, her mother had to be informed. To April's relief, her parents were very supportive. She now wishes she had said something immediately (before evidence was destroyed), so that the perpetrator could have been prosecuted, and so that she could have had the support of family and friends several months sooner. She reported "Because I waited so long to say anything there was no physical evidence anymore. He didn't get caught." By keeping silent, avoiding friends, and her usual activities she added to the hurt rather than protecting herself.

It may be impossible for survivors to know if telling will be harmful or helpful. For example, April's doctor's response to her explanation of how she had become infected with STD was devastating because "His reaction was basically how I expected everybody to react. You know I asked for it. I deserved to have it happen to me. That I was responsible or whatever." However, in contrast to her expectation, "That was the only negative reaction I got the whole time." Fortunately April's mother, family members, friends, and other professionals' responses were helpful.

Testing the waters

To evaluate whether telling will be harming or helpful survivors may test the waters. The strategies of this category allow WSSA to make a somewhat more informed choice about the wisdom of revealing what happened to them. Strategies for testing the waters included verbally hinting at what had happened and using other behaviors that an observer might realize indicated a problem. Hinting was a means of understanding what had happened and evaluating how people would react if they were told. Jennifer used hinting in the weeks and years following the assault, reporting "I insinuated to several people as if I wanted them to know. A friend said it wasn't assault. A couple of years later I tried to tell another girl. Very ashamed. It was a long time after that." When the response to hinting was negative, WSSA returned to the strategy of keeping silent to maintain a sense of protection.

Some behavioral strategies are similar for testing the waters and for protecting: avoiding the perpetrator and withdrawing socially. The differing goals for these strategies may result in confusion for those who attempt to respond to the behavioral cues. Friends who express concern may be rebuffed and left with hurt feelings if the survivor continues to act in a protecting manner.

Triggering event

Testing the water strategies may also elicit help. When others identify and respond to these strategies the survivor may begin telling about the event. However, telling is often preceded by a triggering event.

Triggering events result in a change in the survivor's strategies for dealing with assault issues. These events may prompt the survivor to speak out, to seek help, or to seek a different kind of help. For some survivors these events are a direct result of the assault. Escaping from the assailant to request help from someone else, seeking medical care following the assault, and reporting the assault to police all require the survivor to tell others what happened. An increase in the severity of the assaults, perhaps from fondling to penetration, may lead to speaking out because the protecting strategies were not effective.

A triggering event may also be more internal. Women may be motivated to seek help in response to suicidal impulses or other severe psychological problems. For example, Tess said, "I would lose my mind if I didn't do something." Being in treatment groups and support groups, including alcoholics anonymous, inpatient groups, and women's center groups, where others are able to speak safely about their traumatic experiences may lead to changes such as telling.

Telling

Telling what happened is usually driven by a hope that the listener's response will alleviate or lessen the hurt the survivor is experiencing. Telling always includes the risk that the hurt will intensify. To lessen that possibility survivors may test the waters first. Not all survivors can take time to do that. Survivors may tell because they have an urgent need for help or may impulsively blurt out what happened, even many years after the assault. At other times, they may prepare carefully before telling. Many of the participants described telling urgently, impulsively, and with preparation at different times.

Urgent telling may occur in the aftermath of a rape, when the survivor escapes and requires help. This form of telling may also occur when a survivor of childhood assault tells someone else, perhaps the mother, to prevent further assault episodes. Urgent telling usually has protection as the goal. Impulsive telling, blurting it out, may have as its goal that the perpetrator and those adults responsible for the survivor during the time of the assaults acknowledge and become accountable for what happened.

Telling preceded by preparing usually occurs when the survivor has begun seeking help for problems that may be related to the assault(s). Listening to others talk about their experiences may be a triggering event that leads to prepared telling. Rosemary was hospitalized to protect her from suicidal impulses. The inpatient treatment groups were important in preparing her for telling her own experiences:

> It was so powerful. It was the first time in my life I've ever felt I wasn't alone because I met other people in the hospital - especially in group therapy. They were

> thinking, feeling, experiencing life in a similar way to what I was. Made me feel not alone, connected into something. Like an experience that actually does exist, that's not just in my mind, very validating. It gave me a whole new perspective. It was very liberating to know I wasn't alone, wasn't bizarre, crazy. It wasn't until I felt that trust, that connection with the other people there that I was able to really go into what was really going on.

By observing others talking about their traumatic experiences and their reactions to them, Rosemary prepared to begin telling her experiences.

Preparing experiences may occur long before telling. June, a survivor of incest, had a neighbor who suspected the assault. He told her that he would help if she needed help: "I felt loved when he said to tell him if my daddy touched me there. But I couldn't tell him." While she was hospitalized, following a suicide attempt, other early preparing experiences occurred: "I didn't share but one girl shared (told) with me. Made me feel love. I got hugs and kisses." These and similar events helped prepare June but she did not begin telling until after she had heard others speak in support groups several years later. Telling may elicit helpful or harmful responses from the listener.

Helping responses

Helping responses move the survivor toward getting ready to deal with assault-related issues. Someone listens, believes, and protects the survivor. Protection occurs when a mother ensures that the child has no further contact with the perpetrator, a

neighbor calls Child Protection Services, a best friend (children) tells an adult who can act to protect the survivor, the nurse suggests the survivor report the crime, and the police confront the perpetrator.

Family members and friends who encourage the survivors to attend rape crisis groups and who attend the rape crisis support groups for family and friends are an important source of help to survivors. Along with professionals and trained volunteers, they may remind the survivor that help can come from many sources.

Caring, non-exploitive men are very important to survivors. These men include step-fathers, other support group members, husbands, boyfriends, fathers, sister's boyfriend etceteras. These are men who show by their words and their actions that they are genuinely concerned about the survivor and that "not every man rapes, not every man harasses." An adult male Alcoholics Annonymous group member who consistently asked Bea, then an adolescent survivor, about her grades in school, about her plans for the future, and declined her sexual offers, enhanced her sense that she was worthwhile. When the survivor experiences helping responses, she moves towards getting ready. Unfortunately, many survivors experience harming responses to telling.

Harming responses

Harming responses delay the survivor's readiness to deal with assault-related issues. Ignoring what the survivor says, not providing protection, blaming or judging the survivor, minimizing the impact of the assault, siding with the perpetrator by sitting near

him, and providing financial help to him during a trial, may all further harm the survivor. It may be harming to encourage the survivor to keep the assault secret, even from a few people, such as one set of grandparents. Survivors who are advised not to report the crime, even with the stated purpose of protecting the survivor from further distress, may experience years of regret and a delay in psychological resolution. For example, Susan was assaulted by her mother's boyfriend when she was seven. Many years later she and her mother regret that they did not report that sexual assault. They live with the knowledge that that perpetrator may have victimized others because they did not report him.

Nurses in emergency rooms who do not suggest that a rape crisis counselor be called lessen the possibility that the survivor will benefit from the rape crisis program. The survivor is also likely to be left alone in the emergency room (ER) for some time, while waiting for the friend's arrival, adding to the trauma. The nurse who admitted Pearl to the ER immediately after she was raped by a stranger didn't request a rape crisis counselor. She told Pearl it wasn't necessary because she was waiting for a friend. Pearl was then left in an examination room with the door open. Strangers wandered in and asked her why she was there until an aide closed the door. Then she was alone in the room for forty minutes before her friend arrived. Neither she nor her friend received information about the recovery process and sources of help.

Harming responses may also be internal. Survivors may tell, and may participate in support groups, then withdraw into silence. This occurs when survivors feel resentment at

needing to take time and energy to work on issues related to the assault, blame themselves for what happened, or feel that what happened to them is less important than what happened to other survivors. Whether internal or external, harming responses may delay readiness and may also lead to crying silently for help.

Silent crying for help

Silent crying for help is associated with behavioral strategies that are more intense and often more dangerous to the survivor, and occasionally to others, than those of protecting and testing the waters. Some respondents described suicidal acts, cutting themselves, abuse of alcohol and drugs, promiscuity, destruction of property, and victimizing others. These behaviors spiraled from less to more severe as the number of harming responses increased. The goals of crying silently for help strategies are to make others aware of the assault(s) that have happened or are continuing to happen, to have others acknowledge the assault(s), and to gain protection from the assailant(s), or to gain help with emotional recovery. After years of abuse and attempts to get help, when "nothing, nothing was done. Like I wasn't there." Eleven year-old Bea cut up a stuffed animal: "I cut her up because that is how I felt. I wish I could have taken her to church because then somebody would have known." Because no one knew, it was several years before Bea reached readiness to deal with assault related issues.

Getting Ready

Getting ready to deal with issues related to sexual assault generally requires some degree of stability in the survivor's life, including a relatively safe home environment and some trust in others. If others attempt to push the survivor into dealing with assault issues, rather than the immediate problems of stability, safety, and trust, then readiness is delayed. Bea described being required to attend therapy and being pushed, in the therapy session to deal with assault-related issues, when she was not sure she had a home.

> Therapy failed me. I wasn't ready to deal with it. It was too new, too raw. Everything was on the surface at first, too open to vulnerability. I was too vulnerable and I knew that. I didn't want to be vulnerable. The therapy didn't work because I shut down. Which is what I did when he assaulted me. I shut the feelings down. Too fresh, too new. Now I'm ready. I have calluses, scab stuff.

Because Bea needed a stable home and emotional supports before attempting to deal with very disturbing assault events, the therapy was harming rather than helpful. She would have been helped by a therapist who supported her to achieve the getting ready stage, rather than pushing her prematurely into the dealing with stuff stage.

Readiness is preceded by being ready in varying senses. The survivor may be ready to tell a best friend, to report the crime, to call the rape crisis line, or to attend a support group. Survivors are helped to readiness by experiences that result in them feeling that others care about them, have warm feelings toward them, will support their need for control, and believe they are worthwhile and able. Getting ready results when

survivors have a sense of connection with other survivors and begin to feel some hope and trust. Some survivors reported that feelings of hope and trust were enhanced by personal religious experiences, such as sensing the presence of God or of a guardian angel. Many of the respondents reported that support group experiences were important to achieving readiness.

June saw various therapists over a period of many years but often kept the interaction relatively superficial, she reported

> I was just going so I could tell myself I was trying to help myself. It was comfortable. Not doing any good but not any harm. I wanted desperately to seek help but so hard to do alone and then have to keep concentration at work. It is too much work to try to do by yourself. I believe if someone had been there it would have been different.

In contrast in the support groups she found

> When I hear these other women talking I think to myself - I'm not alone. I think to myself: You are not crazy. It is like me talking. The stories I'm hearing. It's like this lady is where I was 10 years ago. This lady is where I was 5 years ago. This lady is where I am today. This other one is where I might be in a couple of years. We were all helping each other and pulling each other through things.

In the open support groups June experienced caring, warmth, and connection with others. She was entering the stage of getting ready. Once readiness is established a motivating event may occur, resulting in survivors dealing with stuff.

Motivating event

Motivating events are internal. They result from a woman's understanding that many difficulties in her life are related to unresolved issues stemming from the sexual assault(s). Survivors reported that they were tired of experiencing difficulties in relationships, of feeling fear and anger, and were concerned that old issues were adversely affecting their parenting. Pearl, a survivor of childhood assaults, reported that she decided to join the more intense closed group because "I was real, real tired of carrying that fear and that anger around." Rosemary was motivated to begin the difficult work of dealing with stuff after she began what she hoped would be a permanent relationship with a caring partner. At the same time her eight year old son was experiencing difficulties making friends. When she realized that her depression and difficulty trusting limited her ability to parent effectively and to establish an intimate relationship she began attending support groups for survivors of sexual assaults.

Dealing with stuff

Dealing with stuff has as its goal a desire for more than a rudimentary sense of stability, safety, and trust. Bea had a stable job and stable friendships. She noted "I did rather well not dealing with it." Her desire to be more than an adequate mother to her daughter and her own ongoing struggle with depression "triggered me to start dealing with my shit."

Dealing with stuff may be overwhelming if the survivor does not have adequate preparation and support. Bea said of dealing with stuff, "Walk through fear and pain. I think that is what it is. Like I relive it, the pain, humiliation, shame." Rosemary reported,

> A lot of times the pain feels bad and I'm like, I'd rather be numb again. But it is important to do this. I also know that as horrible as it is there is something I can learn from this and it can make me a stronger and better person - have to wait.

Part of dealing with stuff may include having to face ones own actions. Jennifer said, "I had to face the way I turned around and victimized others." Many of the participants in this study emphasized the importance of the support of their peers in the closed groups as they confronted their most gut wrenching experiences. In these groups the other survivors "already get it - such a freedom." Group members provide support and help to each other. When dealing with stuff is successful, emotional healing takes place.

Healing

Survivors who are healing feel trust in themselves and others as well as hope for the future. They stop victimizing themselves and others and are better able to make choices. They stop blaming themselves for what happened while still acknowledging the importance of the experience in their lives, and they accept that the assault(s) will always be a part of their life. Some may have found that the process of dealing with the issues has changed and benefited them. In the words of one experienced volunteer "from a tragedy can come so many positive things in your life." They have realized their strength. Even

their reactions to brief, nonsexual exchanges with men may change. Pearl experienced these changes following participation in the closed group.

> All my life I was afraid of men. It has taken individual and group therapy, realizing not every man rapes and molests. Not every man is violent and abusive. Now I can walk into my bosses' office without being so afraid. Before, I had to do all these mental assurances. You know. Calm down. You are going to be OK. Now I don't have to do that as much.... I have times when I really feel happy.

While going through the process of arriving at readiness, Pearl supported and raised a child who is now a successful adult. Her life was productive and positive, but she lived with depression and few experiences of happiness. Dealing in a concerted, in-depth manner with the "stuff" that resulted from her experiences of sexual assault led her to experience happiness. Her already meaningful life is now much richer, filled with new opportunities.

Credibility and Generalizability

In addition to using the constant comparative method to evaluate for truth error, the findings were evaluated by the rape crisis program staff. In addition to brief informal discussions, the researcher met twice with staff members to review the emerging and complete findings. In both meetings, the credibility of the findings was confirmed. The experts gave examples from their experiences of working with survivors that supported the findings. A nurse psychodramatist who worked with survivors in inpatient and

outpatient settings reviewed the final findings of the study. In addition to helping refine the model she confirmed the generalizability of the findings to other settings, describing the findings as "true" based on her experiences.

Although the sample was reflective of the population at the Women's Center it may not reflect other populations of women who were sexually assaulted or who received care in other settings. The sample was a specific group of women who did seek help. The findings may not reflect the behavior of women who were not able to get help dealing with sexual assault.

Summary

The process model Arriving at Readiness was discovered using grounded theory methods. The constant comparative method was used to analyze data obtained by semistructured interviews. Informants were experts because they had personal experiences recovering from sexual assault. Rape Crisis program staff reviewed the findings and found them accurate, supporting the credibility of the findings. A nurse clinician who was expert in emotional recovery from sexual assault determined that the findings fit her experiences working with WSSA, supporting the generalizability of the findings. The study findings add to the knowledge of the behaviors and processes that lead WSSA to seek help with emotional recovery.

The process of arriving at readiness is not linear. Survivors use the behavioral strategies associated with different aspects of the model at different times and for differing

reasons. Generally, survivors do not progress from protecting behaviors unless there is some triggering event. Survivors may test the waters in an attempt to determine if it is safe to change strategies. A triggering event or an indication that it is safe to change strategies may lead to survivors changing strategies and telling others about their experiences. The responses that survivors receive from testing the waters and/or telling may reinforce the wisdom of protecting strategies. Then survivors may use crying silently for help strategies, which may be destructive to the survivor and perhaps, to others. Helping responses lead to the stability associated with getting ready. At this stage survivors have relatively stable and productive lives. A motivating event may lead survivors to begin the often painful and intense work of dealing with stuff. Several respondents were expecting, and some had discovered, that this work would lead to a satisfaction with their lives that they had not experienced before.

CHAPTER 5

SUMMARY OF THE STUDY

This study was designed to discover the behaviors and processes that lead women survivors of sexual assault (WSSA) to seek help with emotional recovery. WSSA have an increased risk of emotional difficulties. Help to alleviate the suffering help is available from a variety of sources but few WSSA receive help. A greater understanding of what leads WSSA to seek help will enable nurses to develop protocols to support WSSA to seek help, thus ameliorating some of the severe problems survivors may experience.

Summary

Data collected during semistructured interviews with 11 WSSA and three other informants who were expert in recovery from sexual assault were evaluated using the methods of grounded theory. This evaluation led to development of the process model Arriving at Readiness. Selective sampling based on ongoing analysis guided subsequent data collection. Expert witnesses, including Women's Center staff and an experienced nurse psychodramatist, determined that the findings were credible (not showing signs of truth error) and generalizable to other settings.

The model reflects survivors' experiences and behavior strategies as they respond to the sexual assault event(s) and the consequences of the event(s). Survivors may experience stable periods, cycles of limiting or destructive events and behaviors, and

progression to healing.

Discussion of Findings

This study revealed that many of the behavioral strategies used by WSSA, such as keeping silent, had as their goal avoiding further harm. Although these strategies protected survivors from harming reactions they also prevented survivors from getting help. Survivors did not tell unless they experienced triggering events.

Psychological consequences

As a group, the survivors who participated in this study suffered many of the severe short and long term consequences of sexual assault reported in previous studies (Burgess & Holmstrom, 1974; Zeitlin, McNally, & Cassiday, 1993). Informants described serious psychological problems that were consistent with the literature, including poor self-esteem, depression, suicidal impulses, substance abuse, and parenting problems. Other consequences of sexual assault reported in the literature, and described by participants in the present study, include an inability to develop stable, satisfying relationships with partners, distrust of men, withdrawal from friends and acquaintances, and symptoms that resulted in psychiatric hospital admissions.

Getting help makes a difference

Participants in this study emphasized the importance of groups, whether therapy groups or support groups, in decreasing their sense of isolation by giving them a sense of connection with other survivors and by providing role models for survivors preparing to

deal with their experiences. Researchers, comparing outcomes of treatment in various group therapy modalities, found that survivors participating in any of them experienced symptom improvement (Foa, Rothbaum, Riggs, & Murdock, 1991; Frank et al., 1988; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988; Resick & Schnicke, 1992). Perhaps the various group therapies evaluated were beneficial because the survivors were able to experience a feeling of connection with other survivors rather than because of specific therapy techniques.

Never telling

The first task that confronted survivors of sexual assault was to protect themselves from further harm. WSSA were aware that telling might be harmful. Survivors were silent, unless they experienced a triggering event. Walker, Torkelson, Katon, and Koss (1993) found that 41 (62%) of 64 women who survived childhood sexual abuse and 26 (64%) of 47 women who survived sexual assault as adults had never told anyone. Gallop and her collaborators (1995) found that 42 nurse survivors of childhood sexual abuse had been abused by a total of 67 abusers. The survivors had only told a parent about 17 (27%) of the abusers. It is possible that WSSA in Walker and Gallop's studies did not experience triggering events or experienced harming responses following their attempts to tell.

Nursing responses

Survivors experienced being left alone in an emergency room following a sexual assault as a harming response. Helpful responses included being encouraged to attend support groups. These findings support recommendations for nursing care found in clinical literature. Nursing authors recommend that nurses facilitate continual support for survivors during their emergency room stay and provide referrals for ongoing help (Andrews, 1992; Ledray, 1990 & 1992; Ledray & Arndt, 1994; Minden, 1989; Raiha, 1983).

Unsupportive responses and poorer adjustment

WSSA who experienced helping responses were in the getting ready stage, leading relatively stable lives despite ongoing emotional problems (for example, depression and difficulty establishing stable, satisfying relationships) related to their assault experiences. WSSA who experienced harming responses engaged in the often destructive behaviors of silently crying for help. These findings support Popiel and Susskind (1985) and Davis, Brickman, and Baker's (1991) counterintuitive results. They found that unsupportive responses were associated with poorer adjustment, following sexual assault, while supportive responses were not associated with adjustment. Supportive responses prevent further harm to survivors and facilitate survivors' progress to the getting ready stage. Supportive responses are necessary but not sufficient for healing to take place.

Waiting to participate in groups?

The few WSSA who attended open groups before the assault was many weeks in the past found the groups very helpful. However, these few attended groups only after some individual counseling (less than 6 sessions). Herman (1992, p. 218) recommended that survivors of an acute trauma participate in individual or family therapy for weeks, or even a year, following the trauma before joining a group. Findings from the current study do not support waiting so long to participate in groups.

Conclusions and Implications

Survivors need help for a variety of reasons (triggering events): to stop ongoing assaults, to better meet role expectations including parenting and partnering, to understand what happened to them, and to aid them in managing emotional problems such as depression and substance abuse. Survivors are often unable to determine whether telling will be met by helpful or harming responses. Nurses should therefore include information about resources available to WSSA (for example, rape crisis programs) in routine preventive teaching and in recommendations for ongoing help after an assault has occurred.

Survivors of childhood assault whose mothers knew they were being molested engaged in crying silently for help behaviors. They hoped other adults in schools and churches would understand what these behaviors meant because they were unable to tell what was happening to them. They had learned from experience that telling could make

them feel worse. They were vulnerable to ongoing assaults. School nurses, pediatric nurses, and others working with children should be vigilant for behaviors that reflect protecting, testing the waters, or crying silently for help. These behaviors may indicate sexual assault or some other problem. Children showing these behaviors should be carefully assessed and protected from further harm. All children need to be taught which people, outside the family, are safe to tell.

Survivors of childhood assaults whose mothers had acted effectively to protect them (helping response) described their emotional problems as less severe than those whose mothers had made ineffective, or no, attempts to protect them (harming response). Survivors in the latter group described major emotional problems including suicide attempts and substance abuse. Respondents whose mothers took definitive action to protect them also had other helpful adult family members. Although informants did not discuss the reasons why mothers remained in, or returned to, situations in which their daughters were being abused, contributing factors may include the lack of a support system and fear of extreme poverty. Nurses should educate mothers about sources of financial and emotional support so that mothers will be able to protect their children. In a time when social supports such as food stamps and welfare are becoming increasingly limited, nurses should be involved in developing and implementing public policy about support for families and children.

Survivors whose therapists urged them to focus on sexual assault events, rather than on establishing a sense of stability, safety, and trust, remained angry about this harming

response years later. Clinical nurse specialists in mental health should support clients to gain the stability necessary to meet developmental tasks and roles. The intense work of dealing with stuff should be delayed until their clients are at the stage of readiness and feel a need (motivating events) to engage in this work.

WSSA who were encouraged not to report the assault(s) to the police (harming response) regretted that action was not taken against the assailant. Survivors who were encouraged to report the crime (helping response) found knowing that the perpetrator had a complaint noted on a police record or was tried and convicted for their crime helpful. Unless the nurse is legally obliged to report the assault, nurses should provide the survivor and/or family with support and information as they make a decision to report or not report the crime.

Recommendations for Further Study

The process model Arriving at Readiness was developed from interviews with women survivors of sexual assault participating in support groups at a rape crisis center. The applicability of the model to survivors who have not sought help, who have sought different types of help, or who sought help in other rape crisis centers needs to be investigated.

Nurses should develop and test protocols that support WSSA through the process of arriving at readiness. The protocols should be designed to ensure (1) that survivors, their families and friends, and those responsible for caring for children have information about

behaviors that may indicate sexual assault; about sources of help such as rape crisis programs; and about sources of financial and emotional help for mothers; (2) that survivors who seek care in emergency rooms have ongoing support during their stay; (3) that survivors have the information and support they need to make decisions about whether or not to report the assault to the authorities; (4) that clinical nurse specialists in mental health facilitate their clients to develop a sense of stability.

Further research needs to be done to explore and confirm these suggestions. For example, does the presence of a counselor at the time the survivor is in the emergency room or clinic for a sexual assault exam increase the likelihood that the survivor will seek help, or that family and friends will participate in support groups available to them? What impact does reporting or not reporting the assault to legal authorities have on survivors' long term well-being?

Many of the informants in this study were assaulted as children. Will educating nurses, teachers, and others about the behaviors of protecting, testing the waters, and crying silently for help lead to an increase in the early identification and protection of children suffering similar experiences? Research that includes child and adolescent participants is indicated because data were obtained from survivors' recollections of childhood experiences rather than their current experiences. Research is also needed to explore events and behaviors that influence mothers who ignore, attempt to protect, or successfully protect their children from further assaults once they are aware of the assaults.

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APPENDIX A

Human Subjects Review Committee Approval

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

HUMAN SUBJECTS REVIEW COMMITTEE - HOUSTON CENTER

HSRC APPROVAL FORM

Name of Investigator(s): Lene Symes

Social Security Number(s): 390-82-5001

Name of Research Advisor(s): Diane Ragsdale, Ed.D.

Address: 7807 Chinon Circle, Houston TX 77071

Dear: Lene Symes

Your study entitled: Women's Perception of Events Following Sexual Assault

(The applicant must complete the top portion of this form)

has been reviewed by the Human Subjects Review Committee - Houston Center and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health and Human Services regulations typically require that signatures indicating informed consent be obtained from all human subjects in your study. These are to be filed with the Human Subjects Review Committee Chairman. Any exception to this requirement is noted below. Furthermore, according to HHS regulations, **another review by the HSRC is required if your project changes or if it extends beyond one year from this date of approval.**

Any special provisions pertaining to your study are noted below:

_____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

_____ Other: see attached sheet.

__X__ No special provisions apply.

Sincerely,

Doris E. Wright, Ph.D.
Chairperson, HSRC - Houston Center

Aug 2, 1995
Date

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

HUMAN SUBJECTS REVIEW COMMITTEE - HOUSTON CENTER

HSRC APPROVAL FORM

Name of Investigator(s): Lene Symes

Social Security Number(s): 390-82-5001

Name of Research Advisor(s): Diane Ragsdale, Ed.D.

Address: 7807 Chinon Circle, Houston TX 77071

Dear: Lene Symes

Your study entitled: Women's Perception of Events Following Sexual Assault

(The applicant must complete the top portion of this form)

has been reviewed by the Human Subjects Review Committee - Houston Center and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health and Human Services regulations typically require that signatures indicating informed consent be obtained from all human subjects in your study. These are to be filed with the Human Subjects Review Committee Chairman. Any exception to this requirement is noted below. Furthermore, according to HHS regulations, **another review by the HSRC is required if your project changes or if it extends beyond one year from this date of approval.**

Any special provisions pertaining to your study are noted below:

_____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

_____ Other: see attached sheet.

__X__ No special provisions apply.

Sincerely,

Doris E. Wright

Doris E. Wright, Ph.D.
Chairperson, HSRC - Houston Center

Aug 2, 1995
Date

Extension request approved July 25, 1996

HSRC 1994-95

APPENDIX B

Agency Approval

MEMORIAL HOSPITAL SOUTHWEST
An Affiliate of the Memorial Healthcare System

October 1, 1995

Lene Symes
7807 Chinon Circle
Houston, Texas

MEMORIAL
Not-for-Profit Health Care System

Dear Ms. Symes,

I am writing to inform you that your research proposal entitled, "Women's Perceptions of Events Following Sexual Assault", has been approved by the Houston Area Women's Center Research Committee.

Thank you for your interest in conducting research at the Houston Area Women's Center. Best wishes and great success in your research endeavors.

Sincerely,

Vicki A. Lucas, Ph.D.
Chairman
Houston Area Women's Center Research Committee

cc: Mitzi Vorachek

VAL\pg

7600 Beechnut, Houston, Texas 77074

APPENDIX C

Written Consent to Participate

8/4/96

TEXAS WOMAN'S UNIVERSITY

DENTON / DALLAS / HOUSTON

COLLEGE OF NURSING
Houston Center
1130 M.D. Anderson Blvd.
Houston, TX 77030-2897
Phone: 713/794-2100

Women's Perceptions of Events Following Sexual Assault. Consent Form

I agree to take part in a study conducted by Lene Symes R.N., M.S.N., who is a doctoral student at Texas Woman's University. This study is designed to find out how people recover from sexual assault. I was told that the researcher will ask me some questions and my answers to these questions will be audio taped. It is my understanding that the interview will last about one hour and take place where there is privacy.

I understand that a possible risk to me is that my name might become known or my voice might be identified by others. To avoid this my name will only be on the consent forms and not on the audio tapes. The audio tapes will be kept locked up or in the researcher's possession. No one but the investigator will have access to or be able to listen to the tapes. Only a number will be placed on my data forms and audio tapes. I know this is necessary to keep my data separate. All data will be reported in group format only. No one will be able to identify me anywhere in the report. I understand that all audio tapes will be destroyed at the end of the study.

I understand that another possible risk to me to me is that I may experience some anxiety during the interview. I know that if I experience some anxiety or have questions during the interview enough time will be allowed for me to ask these questions or to discuss any concerns. I am free to interrupt the interview at any time, either to rest or to stop the interview. I understand that the interviewer will remain in the room after the interview is completed to answer any questions or to discuss any other concerns. Additionally, if I have any questions or concerns, I may call the Office of Research and Grants Administration at 817-898-3375 and /or Lene Symes at 713-721-6860, during business hours.

I understand there are no direct benefits to me from participating in this study. I understand that I am free to participate or not participate. The choice is mine. If I choose to join the study, I may withdraw from the study at any time without penalty.

In the unlikely event of injury, I was told that Texas Woman's University is not able to offer money nor to pay the costs of medical treatment arising from participating in this study.

I was given a chance to ask any questions I had about the study. I understand that I may stop my participation in the study at any time without penalty.

_____ _____

Subject's signature Date

_____ _____

Witness Date

APPENDIX D

Consent to be Audiotaped

TEXAS WOMAN'S
UNIVERSITY
DENTON / DALLAS / HOUSTON

COLLEGE OF NURSING
Houston Center
1130 M.D. Anderson Blvd.
Houston, TX 77030-2897
Phone: 713/794-2100

Women's Perceptions of Events Following Sexual Assault

Consent to Record

I consent to the recording of my voice by Lene Symes RN, MSN acting under the authority of Texas Woman's University, for the purposes of the research project entitled "Women's Perceptions of Events Following Sexual Assault." I understand that the material recorded for this research will only be used by the researcher for the purposes of this project. I hereby consent to such use.

_____ _____

Participant Date

The above form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge and understanding of its contents.

_____ _____

Authorized Representative
of the Texas Woman's University Date

APPENDIX E

Interview Guide

Interview Guide

A. Semi-structured Questions

The interview will begin with the following:

1. What happened after you were sexually assaulted?
   *first person you told? *report to police?
   *sexual assault exam at emergency room or clinic?

2. How did others respond to you?

3. How did that response make you feel?

4. What do you think about the response?

5. Would a different response have made a difference to how you have coped with having been sexual assault?

6. From your experience, what can nurses and other helpers (friends, family, police, counselors, and doctors) do to help women who have been sexually assaulted recover?

B. Demographic Data

1. Age _____

2. Ethnic identity _____

3. Length of time since the assault _____

4. Years of education _____

5. Length of time attending Women's Center _____

*=probes