Article

TRAUMA, VIOLENCE, & ABUSE
1-15

DOI: 10.1177/1524838016659484
tva.sagepub.com
SAGE

Responding to Delayed Disclosure of Sexual Assault in Health Settings: A Systematic Review

Stephanie Lanthier[1,2], Janice Du Mont[1,2], and Robin Mason[1,2]

Abstract

Few adolescent and adult women seek out formal support services in the acute period (7 days or less) following a sexual assault. Instead, many women choose to disclose weeks, months, or even years later. This delayed disclosure may be challenging to support workers, including those in health-care settings, who lack the knowledge and skills to respond effectively. We conducted a systematic literature review of health-care providers' responses to delayed disclosure by adolescent and adult female sexual assault survivors. Our primary objective was to determine how health-care providers can respond appropriately when presented with a delayed sexual assault disclosure in their practice. Arising out of this analysis, a secondary objective was to document recommendations from the articles for health-care providers on how to create an environment conducive to disclosing and support disclosure in their practice. These recommendations for providing an appropriate response and supporting disclosure are summarized.

Keywords

sexual assault, adolescent victims, adult victims, reporting/disclosure, support seeking

Sexual assault in adolescence and adulthood is a pervasive, violent crime that results in a significant trauma to victims, with negative health impacts that can persist for appreciable amounts of time (Cahill, 2009). Although research has shown that men and transgendered persons experience sexual assault (Du Mont, Macdonald, White, & Turner, 2013; Mcdonald & Tijerino, 2013), it is women who continue to be disproportionately impacted (World Health Organization, 2013).

Women who have been sexually assaulted report poorer health and use medical services more frequently than those who have not been sexually assaulted (Du Mont & White, 2007; Resnick et al., 2000). Negative health outcomes include immediate physical injuries, pregnancy, gynecological complications (e.g., vaginal bleeding, infection, pain during intercourse, chronic pelvic pain) and mental health consequences including depression, anxiety, and posttraumatic stress disorder (PTSD; Wathen, 2012). More severe sexual assaults have been associated with worse health outcomes than less severe assaults (Ullman & Brecklin, 2003; Ullman & Siegel, 1995).

Despite its significant health impacts, sexual assault remains underreported (Du Mont & White, 2007). Although more than one third (39%) of Canadian women report having experienced a sexual assault (Statistics Canada, 1994), less than 10% of these assaults are reported to law enforcement (Statistics Canada, 1994). Underreporting of sexual assault is also a problem in the United States where it has been found that only an estimated 28% of sexual assaults were reported to law enforcement in 2012 (Truman, Langton, & Planty, 2013).

However, research shows that the majority of survivors do eventually disclose to someone (Ahrens, Stansell, & Jennings, 2010; Golding, Siegel, Sorenson, Burnam, & Stein, 1989; Neville & Pugh, 1997). Disclosure most often occurs weeks, months, or years after the assault (Dunleavy & Slowik, 2012; Esposito, 2006; Filipas & Ullman, 2001; Lessing, 2005; Monroe et al., 2005; Plumbo, 1995; Ullman, 1996a) with fewer survivors disclosing in the acute period (7 days or less) when specialized sexual assault services (e.g., Sexual Assault Nurse Examiner programs) may be available in some jurisdictions (Du Mont & White, 2007; Resnick et al., 2000; Zinzow, Resnick, Barr, Danielson, & Kilpatrick, 2012).

Survivors most often choose to disclose to informal support providers such as friends, family, or an intimate partner, with

[1] Women's College Research Institute, Women's College Hospital, Toronto, Ontario, Canada
[2] Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada

Corresponding Author:
Stephanie Lanthier, Women's College Research Institute, Women's College Hospital, 76 Grenville Street, Floor 6, Rm. 6443, Toronto, Ontario, Canada M5S 1B2.
Email: stephanie.lanthier@mail.utoronto.ca

substantially fewer disclosing to formal support providers including police, health-care providers, mental health professionals, and rape crisis workers (Baker, Campbell, & Straatman, 2012). Although informal support providers are often a good source of social and emotional support for survivors, it is formal support providers who are well positioned to assist women in their recovery through the provision of services that address the physical and mental health consequences of sexual assault (World Health Organization, 2013). Health-care providers in particular have the potential to play a central role in assisting women in their recovery. In addition to providing health care in the aftermath of sexual assault, they are uniquely positioned to act as a gateway, providing referrals to counseling, social, and legal services (World Health Organization, 2013).

Women who have experienced violence often seek out health care though they may not disclose sexual assault to their health-care providers (World Health Organization, 2013). Those who do disclose to health-care providers suggest that too often they receive inappropriate responses to their disclosure (Baker et al., 2012; Borja, Callahan, & Long, 2006). Negative responses from support providers, including health-care providers, have been associated with greater PTSD symptom severity, depression, and physical health symptoms, as well as predictive of maladaptive coping by survivors (Baker et al., 2012; Borja et al., 2006; World Health Organization, 2013). Evaluations of acute sexual assault services are clear that survivors positively rate providers trained to deliver an appropriate response to sexual assault disclosure, one that sensitively addresses both their medical and social/emotional needs (e.g., Du Mont et al., 2014). Therefore, health-care providers who come into contact with sexual assault survivors who delay disclosure also should know how to respond appropriately (World Health Organization, 2013).

The purpose of this study was to examine health-care providers' responses when presented with a delayed sexual assault disclosure by adult and adolescent female survivors in their practice. Our primary objective was to determine how health-care providers can respond appropriately to delayed disclosure in health-care settings. Arising out of this analysis, a secondary objective was to document authors' recommendations for health-care providers on how to create an environment conducive to disclosing and support disclosure in their practice. To answer these questions, we conducted a systematic review of the literature centered on health-care providers' responses to the delayed disclosure of sexual assault. To our knowledge, no best-evidence synthesis has been conducted in this area to date.

Method

Literature Search

In consultation with a medical librarian, we conducted a search of OVID Medline, EMBASE, PsycInfo, and PubMed using combinations of the following terms: "truth disclosure," "disclosure," "self-disclosure," "self-reporting," "rape," "sexual assault," "sexual violence," "sexual trauma," "post-assault," "post-rape," "sex," "sexual," "post-traumatic," "PTSD," "psycho-trauma," "social support," "social perception," "social adjustment," "patient acceptance of health care," "health services accessibility," "communication barriers," "health personnel," "health care facilities, manpower, services," "primary health care," "general practice," "patient care," "support," "reaction," "barrier," "examiner," "clinician," "doctor," "provider," "nurse," "formal," "informal," and "long term."

The search was limited to English language records published between 1985 and 2013. In addition, we hand-searched the reference lists of relevant articles. In total, we identified 1,166 records. After removing duplicates, the total remaining was 779 (see Figure 1).

Selection of Included Articles

In the first stage of the review, all three authors screened the titles of the 779 records. Articles were set aside for further review if their titles contained the terms "rape," "sexual assault," "sexual trauma," "sexual violence," or "unwanted sexual attention." Titles that contained the word "sexual abuse" were included if it was clear that the term referred to the sexual abuse of adults or adolescents, or where it was unclear whether the term referred to adults or adolescents. Any title that clearly referred to child sexual assault or abuse or sexual assault of adult males was excluded. Additionally, we excluded titles where it was apparent that the focus was solely on acute sexual assault, as well as titles that focused on sexual offenders. Finally, we excluded identifiable dissertations, chapters, book reviews, books, editorials, commentaries, conference proceedings, and any remaining non-English language articles.

The title screen yielded a total of 178 records. The abstracts for each of these records were subsequently screened for further review by two authors. Articles were set aside for further review if abstracts referred to responses to disclosure from formal sources of support (physicians, therapists, police, etc.), formal and informal (friends or family) sources of support, and in instances where it was unclear whether disclosure was to formal or informal support persons. Abstracts that referred solely to disclosure to informal support sources were excluded, as were those which focused on acute sexual assault, child sexual assault or abuse, or routine screening for violence (although articles referring to "assessment" were included). Also excluded were abstracts where disclosure was made within the mental health-care system, as these professionals are assumed to have received specialized training. Dissertations, chapters, book reviews, books, editorials, commentaries, fact sheets, and conference proceedings were also excluded.

The abstract screen yielded 49 articles for which a full review was conducted by two authors. Articles were included in the final sample only if they included responses to disclosure of sexual assault to a health-care provider. If the only health-care provider included was a mental health professional, the

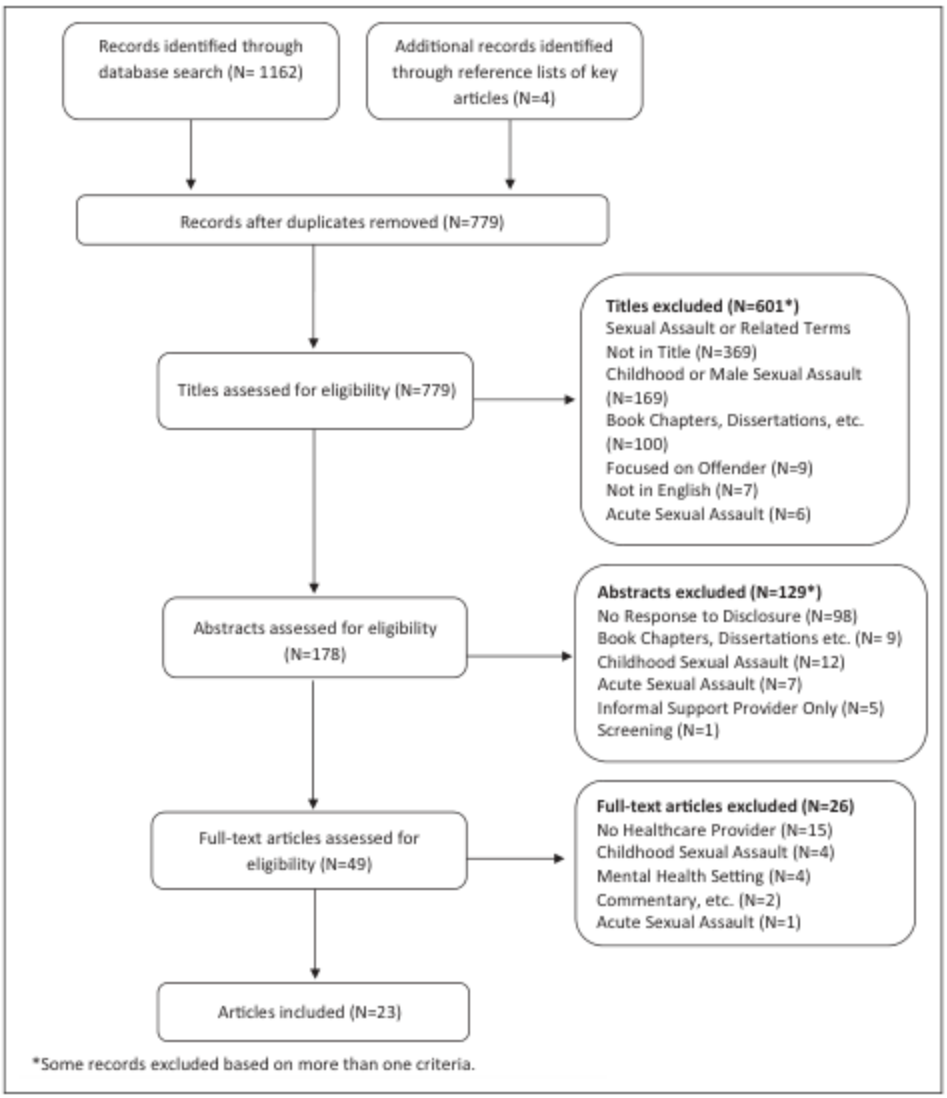

Figure 1. Flowchart of search results.

article was excluded as were any remaining articles focused on child sexual assault or abuse.

Data Abstraction

The final sample included 23 articles. From the articles, we extracted country, participants, disclosure recipients, methods, key findings, including helpful and unhelpful responses to sexual assault, and specific recommendations from the articles for health-care providers to create a suitable environment for and improve their response to delayed disclosures of sexual assault and organized the information in table format (see Table 1). Helpful and unhelpful responses, and recommendations to improve health-care provider responses, were organized into themes, the most common of which are reported in the text.

Results

Characteristics of Included Articles

The articles included in the review examined women's experiences of delayed disclosure to a range of health-care providers. Health-care providers included physicians (Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007; Diaz et al., 2004; Filipas & Ullman, 2001; Golding et al., 1989; Mazza, Dennerstein, & Ryan, 1996; Popiel & Susskind, 1985; Starzynski, Ullman, Filipas, & Townsend, 2005; Sturza & Campbell, 2005; Ullman,

Table 1. Description of Included Articles.

Authors, Year, Country	Participants and Disclosure Recipients	Type/ Method	Key Findings		
			Helpful responses	Unhelpful responses	Recommendations
Ahrens et al. (2009) United States	$N = 103$ women. Generic medical providers	Mixed methods	Providing emotional support including supportive listening, expressions of care and concern, and assurances that the survivor is not to blame Providing tangible aid Blaming and/or doubting reactions from medical personnel only when survivors interpreted this response as trying to protect them from future harm Attempting to control the survivor's decisions if the survivor believes the support provider is reacting out of concern Having an egocentric reaction	Blaming or doubting the survivor Treating the survivor differently after disclosure Distracting the survivor Controlling the survivor Doing nothing to help the survivor after disclosure	
Ahrens et al. (2007) United States	$N = 102$ women. Physicians	Mixed methods	Providing emotional support including listening to the survivor, telling them it was not their fault, providing reassurance Providing tangible aid	Blaming the survivor Doubting the survivor Doing nothing to help the survivor after disclosure Maintaining a cold/detached demeanor Doing "their job" but failing to communicate any sympathy or concern for the survivor's well-being Having no reaction at all	Train medical personnel on how to support survivors Consider incorporating sexual assault screening questions into medical intake procedures
Ahrens et al. (2010) United States	$N = 103$ women. Generic medical providers	Mixed methods		Blaming the survivor Taking control Treating the survivor differently after disclosure Distracting the survivor	Train formal support providers including health-care providers about how to respond in a positive manner and avoid responding in a negative manner
Diaz et al. (2004) United States	$N = 146$ women. Physicians	Quantitative	Providing emotional support and responding in a professional yet compassionate manner Ensuring survivor seeks the appropriate follow-up Clarifying misconceptions about sexual assault (e.g., victim is to blame) Informing survivors of services available to assist them with recovery Providing referrals		Inquire directly about sexual assault victimization as part of routine assessment Use a series of concrete questions to elicit disclosure of a past sexual assault Take time to build trust and help the survivor feel comfortable to disclose

(continued)

Table 1. (continued)

Authors, Year, Country	Participants and Disclosure Recipients	Type/ Method	Key Findings		
			Helpful responses	Unhelpful responses	Recommendations
Dunleavy and Slowik (2012) United States	$N = 1$ woman. Physical therapists	Qualitative	Validating the disclosure and providing emotional support using the simple statement: "I am so sorry that this has happened to you" Referring survivor to psychotherapy and community resources, providing support without attempting to serve as a counselor or psychotherapist		Use a patient-centered approach to help establish trust and a feeling of safety that encourages disclosure and continuity of care Provide a confidential environment and do not "rush" the survivor Have a heightened awareness of nonverbal stress responses during examinations Consider regular screening in health-care settings where many individuals are likely to have experienced sexual violence (e.g., veterans)
Esposito (2006) United States	$N = 43$ women. Nurses	Qualitative	Providing compassionate and emotionally supportive care Acknowledging the disclosure through statements and questions such as "I'm so sorry that happened to you. When did it happen?" "Have you ever spoken to anyone about it? Was that helpful?" and "You are very brave to share that information" Making referrals if needed	Criticizing the survivor Treating the survivor with contempt Asking the survivor what they were doing "in that area" or telling the survivor "they deserved it" or "asked for it" Accusing the survivor of lying Avoiding eye contact with the survivor or changing the subject quickly	Do not push the survivor to disclose Find another nurse to speak with the survivor, if unable to respond appropriately Use a nonjudgmental and culturally competent approach Discuss the sexual assault in a private, one-on-one setting Have brochures or other materials about sexual assault available in patient rooms Ask the survivor how she can be most comfortable during examination and explain the procedure Be sensitive to the survivor's behaviors during examination and allow the survivor to stop the examination if she wishes Assess for sexual assault using the approach recommended for intimate partner violence
Filipas and Ullman (2001) United States	$N = 323$ women. Physicians	Quantitative	Providing emotional support Not blaming the survivor Providing tangible aid Providing informational support Validating or believing the disclosure Not distracting the survivor Sharing their own experience with the survivor Not treating survivor differently	Treating the survivor differently (e.g., stigma) Promoting rape myths Blaming the survivor Distracting the survivor Having an indirect negative reaction (e.g., comments about sexual assault in general that survivors find hurtful) Violating trust	Educate formal support providers including health-care providers about sexual assault and the negative impacts of "rape myths"
Golding et al. (1989) United States	$N = 447$ women and men. Physicians	Quantitative			Design interventions to change physicians' negative attitudes Train physicians on behaviors used by those with direct experience working with sexual assault survivors such as rape crisis workers

(continued)

Table 1. (continued)

Authors, Year, Country	Participants and Disclosure Recipients	Type/ Method	Key Findings		
			Helpful responses	Unhelpful responses	Recommendations
Lessing (2005) United States	N/A Nurses	Literature review	Providing emotional support, nurturance, a feeling of safety Establishing safety, both physically and emotionally Providing appropriate referrals Recounting the events surrounding the sexual assault until it is clear that the survivor knows that the assailant is to be blamed for the assault Document sexual assault in the survivors' own words		Create an environment that is conducive to disclosure Do not assume that the survivor will automatically disclose sexual assault Conduct sexual violence screening as part of routine assessment Use an "icebreaker" to allow patients more comfort in disclosing information by letting them know that others have experienced similar events Be alert to signs and symptoms of sexual assault (e.g., sleep disturbance, decreases in appetite, self-blame, decreases in self-esteem, relationship difficulties, phobias, motor behavior difficulties, suicidal and homicidal ideation, somatic reactions) Provide ongoing education for primary care providers to keep current on treating sexual assault
Littleton (2010) United States	$N = 262$ women. Generic medical providers	Quantitative		Blaming or stigmatizing the survivor Treating the survivor differently Distracting the survivor Taking control	Assess strength of survivor's social support networks Inquire about survivor's past disclosure experiences Assist survivors with understanding and coping with negative disclosure reactions Proceed with caution when encouraging survivors to disclose
Long, Ullman, Long, Mason, and Starzynski (2007) United States	$N = 1,022$ women. Generic medical providers	Quantitative			Be sensitive to issues of sexual orientation when providing care to survivors Check that the survivor perceives your actions as supportive
Mazza et al. (1996) Australia	$N = 2,181$ women. Physicians	Quantitative			Assess for signs and symptoms of sexual assault Develop the skills to diagnose sexual assault Have knowledge of local social services and legal options in order to make appropriate referrals
Muganyizi et al. (2009) Tanzania	$N = 50$ women, $N = 44$ Nurses, $N = 1,505$ Community members Nurses	Mixed methods	Providing emotional support and coping information Advising survivor to seek legal or medical assistance Providing information on how to avoid sexual assaults in the future Distracting the survivor	Blaming the survivor Using statements meant to degrade or shame the survivor Avoiding or segregating the survivor Distracting the survivor	Educate formal support providers including health-care providers on responding to sexual assault

(continued)

Table 1. (continued)

Authors, Year, Country	Participants and Disclosure Recipients	Type/ Method	Key Findings		
			Helpful responses	Unhelpful responses	Recommendations
Muganyizi Nystrom, Axemo, and Emmelin (2011) Tanzania	$N = 10$ women, $N = 20$ Social supports Generic medical providers	Qualitative		Acting in an unprofessional manner	Train health-care providers to improve caring and communication skills Provide more sensitive care Understand how survivors cope with sexual assault
Plumbo (1995) United States	N/A. Nurse-midwives	Clinical practice	Providing support and encouraging healing Acknowledging the sexual assault Reassuring the survivor that the decision to disclose was appropriate Using simple statements such as "I'm so sorry this has happened to you" and "I'm glad you told me about this" after disclosure Verifying that the survivor is not isolated Listening to and supporting the survivor Assisting the survivor to understand that she is in charge of her recovery and that there are support systems available to her Providing referrals to survivors who have a history of abuse, ongoing difficulties with adult relationships, substance use problems, suicidal ideation, and/or who express maladaptive sentiments Identifying and acknowledging survivor's strengths and coping skills (e.g., "It took a great deal of strength to deal with this event in your life. I'm glad you decided to share this with me today") Emphasizing that the survivor's reactions are normal Reinforcing that the survivor was a victim of a crime and not responsible for the sexual assault	Dismissing the survivor Not providing a referral when appropriate	Be empathic and open to encourage disclosure Assess the degree of support and counseling required Differentiate survivors who need referral from those who do not Be sensitive to survivor's verbal and nonverbal behaviors Assess survivor's safety Educate the survivor about the physical and emotional symptoms of sexual assault Provide advice that is brief, focused, and practical Ask the survivor to remember other difficult episodes in which she may have coped well Ask the survivor about her support network
Popiel and Susskind (1985) United States	$N = 25$ women. Physicians	Quantitative	Reassuring the survivor Taking time to talk with the survivor Trying to understand what the survivor is going through Providing information and discussing options Encouraging the survivor to seek further assistance	Feeling sorry for the survivor Making decisions for the survivor Talking about the sexual assault	Provide training to the medical community to enhance communication skills
Starzynski et al. (2005) United States	$N = 1,084$ women. Physicians	Quantitative			Be aware of and reject "rape myths" Provide more positive and less negative reactions to disclosure

(continued)

Table 1. (continued)

Authors, Year, Country	Participants and Disclosure Recipients	Type/ Method	Key Findings		
			Helpful responses	Unhelpful responses	Recommendations
Sturza and Campbell (2005) United States	$N = 44$ women. Physicians	Mixed methods		Giving the survivor a prescription without acknowledging the sexual assault or asking further questions Dismissing or ignoring the survivor's disclosure Being cold or silent upon disclosure Appearing uncomfortable after the disclosure Not providing other options for dealing with the sexual assault other than medication Looking away from the survivor (not maintaining eye contact)	Ensure physicians' offices are safe places for women to disclose Train physicians and nurses on how to respond appropriately to disclosure Provide more responsive care with information about multiple treatment options Refer survivors where appropriate to mental health and social services
Ullman (1996a) United States	$N = 155$ women. Physicians	Quantitative			Provide more positive and less negative reactions to disclosure Provide education to improve medical personnel reactions to survivors
Ullman (1996b) United States	$N = 155$ women. Physicians	Quantitative	Providing tangible aid/information support Providing emotional support Providing validation Listening to the survivor Not blaming the survivor	Blaming the survivor Being treated differently Distracting/discouraging the survivor from talking Taking control	
Ullman and Filipas (2001) United States	$N = 323$ women. Physicians	Quantitative			Train medical professionals about sexual assault and common negative reactions to survivors Train formal support providers including health-care providers on the realities of sexual assault to help them to be more empathic and reduce their blaming responses
Ullman and Najdowski (2009) United States	$N = 969$ women. Generic medical providers	Quantitative	Providing tangible aid/informational support		
Ullman and Siegel (1995) United States	$N = 155$ women. Physicians	Quantitative	Providing emotional support Validating the disclosure Believing the survivor Listening to the survivor	Blaming the survivor Treating the survivor differently Distracting the survivor or discouraging them from talking about the sexual assault Providing tangible aid	Provide interventions for formal support providers including health-care providers on how to support survivors in a helpful and effective way

Note. N/A = not applicable.

1996a, 1996b; Ullman & Filipas, 2001; Ullman & Siegel, 1995), nurses (Esposito, 2006; Lessing, 2005; Muganyizi et al., 2009), nurse-midwives (Plumbo, 1995), and physical therapists (Dunleavy & Slowik, 2012). In six articles, the generic terms "medical personnel," "medical staff," or "health-care system" were used by the authors without specifying the type of provider (Ahrens, Cabral, & Abeling, 2009; Ahrens et al., 2010; Littleton, 2010; Long, Ullman, Long, Mason, & Starzynski, 2007; Muganyizi, Nystrom, Axemo, & Emmelin, 2011; Ullman & Najdowski, 2009).

The articles varied widely in terms of their approach. Of the 23 articles, there were 21 empirical studies, 1 literature review, and 1 clinical practice. The empirical studies included quantitative methodologies (Diaz et al., 2004; Filipas & Ullman, 2001; Golding et al., 1989; Littleton, 2010; Long et al., 2007; Mazza et al., 1996; Popiel & Susskind, 1985; Starzynski et al., 2005; Ullman, 1996a, 1996b; Ullman & Filipas, 2001; Ullman & Nadjowski, 2009; Ullman & Siegel, 1995), qualitative methodologies (Dunleavy & Slowik, 2012; Esposito, 2006; Muganyizi et al., 2011), and mixed methods designs (Ahrens et al., 2009; Ahrens et al., 2007; Ahrens et al., 2010; Muganyizi et al., 2009; Sturza & Campbell, 2005). In all, 19 articles were U.S.-based, 2 were from Tanzania, and 1 from Australia.

The number of participants in the empirical studies ranged from 1 to 43 in the qualitative studies and up to 2,181 in the quantitative studies. In all, 13 studies utilized the Social Reactions Questionnaire, a self-report instrument developed by Ullman (1996c, 2000) from earlier research on social support and social reactions received by sexual assault survivors upon disclosure (Ullman, 2000). The instrument consists of 48 items that are characterized as either positive reactions or negative reactions to disclosure. Positive reactions fall into 2 categories including "emotional support/belief" and "tangible aid/information support," whereas negative reactions fall into five categories including "victim blame," "treat differently," "distraction," "take control," and "egocentric."

Disclosure to Health-Care Providers

Eight empirical studies specified the precise proportion of survivors in their sample who disclosed to a health-care provider. Disclosure rates among sexual assault survivors to health-care providers in these studies were 6% (Golding et al., 1989), 9% (Mazza et al., 1996), 10% (Ahrens et al., 2009), 11% (Littleton, 2010), 17% (Starzynski et al., 2005), 19% (Ullman & Siegel, 1995), and 27% (Filipas & Ullman, 2001). One study, Ahrens, Campbell, Ternier-Thames, Wasco, and Sefl (2007), found that only 5% of women chose their doctor as the first person to whom to disclose.

Two empirical studies provided reasons why survivors chose to disclose to a health-care provider. In Ahrens et al. (2007), some survivors indicated that they disclosed for medical reassurance. As one woman who disclosed to her physician stated, "I wanted information, to know that I was physically and emotionally all right" (Ahrens et al., 2007, p. 41). In Sturza and Campbell (2005), women also disclosed to their physician to access medication to deal with the sexual assault.

Three empirical studies indicated reasons why women chose not to disclose having been sexually assaulted to a physician. Mazza, Dennerstein, and Ryan (1996) found that 53% of the women in their study had not disclosed to their physician because they did not think it relevant to their consultation. Additional reasons for not disclosing sexual assault included that their physician did not ask (27%), embarrassment (10%), and lack of trust in their physician (1%; Mazza et al., 1996). Ullman (1996b), as well as Sturza and Campbell (2005), further suggested that survivors' fear of their physicians' response to the disclosure was an important factor in influencing their decision to not disclose.

Golding, Siegel, Sorenson, Burnam, and Stein (1989) found that 26% of survivors who experienced a stranger sexual assault told their physician, as opposed to only 5% of those who experienced an acquaintance sexual assault. Survivors were more likely to tell their physician if the sexual assault involved penetration, physical or psychological threats, or if they identified having experienced emotional consequences (Golding et al., 1989).

Helpful Responses to Disclosure

The most common helpful responses from formal support providers including health-care providers among the 13 articles that provided data were validating the disclosure and providing emotional support, and providing tangible aid.

Validating the disclosure and providing emotional support. Five articles indicated that having the provider acknowledge or validate the disclosure was a positive response from formal support providers generally (Ullman, 1996b) and health-care providers specifically (Dunleavy & Slowik, 2012; Esposito, 2006; Plumbo, 1995; Ullman & Siegel, 1995). Acknowledging or validating the disclosure was described as including simple statements such as "I'm so sorry that this has happened to you" and "I'm glad you told me about this" (Dunleavy & Slowik, 2012, p. 346; Esposito, 2006, p. 76; Plumbo, 1995, p. 425).

Twelve articles indicated that receiving emotional support from formal support providers including health-care providers was a positive response to disclosure (Ahrens et al., 2009; Ahrens et al., 2007; Diaz et al., 2004; Dunleavy & Slowik, 2012; Esposito, 2006; Filipas & Ullman, 2001; Lessing, 2005; Muganyizi et al., 2009; Plumbo, 1995; Popiel & Susskind, 1985; Ullman, 1996b; Ullman & Siegel, 1995). Ahrens, Cabral, and Abeling (2009) found that "emotional support from medical staff was almost always considered healing" for survivors (p. 87).

Emotional support included the health-care provider showing compassion for the survivor or providing nurturance (Esposito, 2006; Lessing, 2005), being empathic (Ahrens et al., 2007; Plumbo, 1995; Popiel & Susskind, 1985), listening in an active and supportive manner (Ahrens et al., 2009; Plumbo, 1995; Ullman, 1996b; Ullman & Siegel, 1995), and acknowledging

the survivor's skills in dealing with the sexual assault (Plumbo, 1995). Telling survivors that they were not to blame for the sexual assault also was considered a key component of emotional support (Ahrens et al., 2009; Ahrens et al., 2007; Diaz et al., 2004; Filipas & Ullman, 2001; Lessing, 2005; Plumbo, 1995; Ullman, 1996b). In a study conducted by Ullman (1996b), 10% of women cited not being blamed as the most helpful response they received from a formal support provider, including health-care providers.

Providing tangible aid. Twelve articles indicated that "tangible aid" was a helpful response to disclosure from formal sources of support, including health-care providers (Ahrens et al., 2009; Ahrens et al., 2007; Diaz et al., 2004; Dunleavy & Slowik, 2012, Esposito, 2006; Filipas & Ullman, 2001; Lessing, 2005; Muganyizi et al., 2009; Plumbo, 1995; Popiel & Susskind, 1985; Ullman, 1996b; Ullman & Najdowski, 2009). Tangible aid is described by Ullman (2000) not only as assisting the survivor to access medical care, providing them with resources, particularly those that focus on coping with the aftermath of sexual assault, and encouraging them to see a counselor or other mental health professional, but also encompassed clarifying misconceptions about sexual assault and assessing safety (e.g., Diaz et al., 2004).

Although across the articles, tangible aid was typically described as helpful and in some cases "healing" (Ahrens et al., 2009), Ahrens, Cabral, and Abeling (2009) found that survivors could interpret tangible aid from formal support providers (in this case legal workers) negatively if the tangible aid was not accompanied by validation or support. In another study, receiving tangible aid from formal support providers was associated with poorer health outcomes for survivors who had experienced a severe sexual assault (Ullman & Siegel, 1995). Ullman and Siegel (1995) suggested that this may have been because survivors who have experienced severe sexual assaults are more likely to seek tangible aid from formal support providers such as physicians or the police, who have been shown to react more negatively than other support providers.

Unhelpful Responses to Disclosure

The most common unhelpful responses from formal support providers including health-care providers among the 13 articles that provided data were blaming the survivor; minimizing, dismissing, and/or distracting responses; treating the survivor differently after disclosure; displaying a cold and/or detached demeanor; and doubting the survivor.

Blaming survivor for sexual assault. Identified in 10 articles, being blamed for the sexual assault was the most commonly cited unhelpful response from formal support providers, including health-care providers (Ahrens et al., 2009; Ahrens et al., 2007; Ahrens et al., 2010; Esposito, 2006; Filipas & Ullman, 2001; Lessing, 2005; Littleton, 2010; Muganyizi et al., 2009; Ullman, 1996b; Ullman & Siegel, 1995).

Although blaming responses were generally experienced negatively, two empirical studies found that such reactions from medical staff and other support providers' could be interpreted positively if the survivor felt that the intention was to help them prevent another sexual assault from occurring (Ahrens et al., 2009; Muganyizi et al., 2009). For example, Ahrens et al. (2009) reported that while blaming responses were often considered hurtful by survivors when coming from informal support providers, they were often considered healing when coming from medical personnel if they believed that the provider was trying to help them avoid an assault in the future.

Minimizing, dismissing, and/or distracting responses. In nine articles that indicated negative responses to disclosure, minimizing and/or dismissing the sexual assault was cited as unhelpful (Ahrens et al., 2009; Ahrens et al., 2010; Filipas & Ullman, 2001; Littleton, 2010; Muganyizi et al., 2009; Plumbo, 1995; Sturza & Campbell, 2005; Ullman, 1996b; Ullman & Siegel, 1995). Minimizing and dismissive responses included statements or attempts to make the sexual assault seem less troubling than how the survivor perceived it, or suggesting to her that it was "not a big deal" or that she "stay silent." Ahrens et al. (2009) found that such statements were taken by survivors to mean that the support provider did not care about them or about what had happened to them.

Three articles also noted that attempts by support providers, including health-care providers, to distract the survivor were considered unhelpful even when they were meant to be of assistance (Ahrens et al., 2007; Filipas & Ullman, 2001; Ullman, 1996b). In one study, the results were mixed; Muganyizi et al. (2009) reported that half their sample of sexual assault survivors found distraction attempts to be helpful, whereas the other half described them as unhelpful. Distracting responses from support providers, including health-care providers, encompassed telling the survivor to stop talking or thinking about the sexual assault or attempting to discourage them from further speaking about the sexual assault (Ullman, 1996b).

Treating survivor differently after disclosure. Eight articles indicated that being treated differently by the support provider after the disclosure is unhelpful to survivors (Ahrens et al., 2009; Ahrens et al., 2010; Esposito, 2006; Filipas & Ullman, 2001; Muganyizi et al., 2009; Popiel & Susskind, 1985; Ullman, 1996b; Ullman & Siegel, 1995). In fact, Ahrens et al. (2009) found that every survivor in their sample who had disclosed having been sexually assaulted described being treated differently post-disclosure and that this was hurtful. Being treated differently after the disclosure included treating the survivor with contempt (Esposito, 2006; Muganyizi et al., 2009), feeling sorry for the survivor (Popiel & Susskind, 1985), and avoiding or segregating the survivor (Muganyizi et al., 2009). Ullman (1996b) found that physicians or police were more likely to treat a survivor differently after disclosure than either an informal support provider or a mental health professional.

Displaying a cold and/or detached demeanor. Five articles suggested that it was unhelpful to survivors when formal support providers, including health-care providers, displayed a cold and/or detached demeanor (Ahrens et al., 2009; Ahrens et al., 2007; Esposito, 2006; Plumbo, 1995; Sturza & Campbell, 2005), even when they "did their job" by providing the necessary information and/or aid (Ahrens et al., 2007). A cold and detached demeanor included such reactions as not making eye contact with the survivor or asking another question unrelated to the sexual assault in an effort to change the subject (Esposito, 2006; Sturza & Campbell, 2005), ignoring the survivor (Sturza & Campbell, 2005), not providing any emotional assistance upon hearing the disclosure (Ahrens et al., 2009; Plumbo, 1995), and having no reaction at all (Ahrens et al., 2009; Ahrens et al., 2007). For example, in the Ahrens et al. (2007) study, a survivor relayed that when she told her physician that she was sexually assaulted by her husband, "he didn't seem surprised ... he didn't really seem to give any reaction at all" (p. 43).

An article by Sturza and Campbell (2005) reported that many women described their physicians as "cold" or "silent" upon disclosure and felt silenced when these physicians "got out their pad" to write a prescription as the sole response to the disclosure (Sturza & Campbell, 2005, p. 361). Half the women in their sample using medications acquired them with a prescription given as a means of dealing with the sexual assault.

Doubting the survivor. Three articles demonstrated that doubting the survivor's account of the sexual assault (Ahrens et al., 2009; Ahrens et al., 2007), or accusing the survivor of not telling the truth (Esposito, 2006), constituted unhelpful responses. In particular, Ahrens et al. (2007) described support providers including health-care providers, who questioned the accuracy of the survivors' account of the sexual assault or suggested that the sexual assault did not qualify as a "real" rape.

Recommendations for Health-Care Providers

The most common recommendations extracted from the articles focused on improving formal support providers' including health-care providers' responses to sexual assault disclosure were prompt for disclosure, recognize indicators, create an environment supportive of disclosure, use a patient-centered and culturally competent approach, and enhance training.

Prompt for disclosure. Four articles recommended direct inquiry of all women for sexual assault as part of routine assessment (Ahrens et al., 2007; Diaz et al., 2004; Esposito, 2006; Lessing, 2005), with an additional study advocating for screening in settings with large numbers of potential victims of physical and psychological trauma (Dunleavy & Slowik, 2012). Esposito (2006) suggested that when taking a sexual assault history as part of a routine assessment it is best to start the discussion by asking: "Has anyone ever touched you, or forced you to do something sexual that you did not want to do?" (p. 73). When treating adolescents, specifically, Diaz et al. (2004) recommended that the health-care provider use a series of questions, rather than just one. Lessing (2005) cautioned that the health-care provider should not assume that the survivor will automatically disclose information about the sexual assault, whereas Esposito (2006) suggested "it would be inappropriate or even harmful to push someone to disclose" (p. 71).

Recognize indicators. Five articles suggested that it was important for health-care providers to be aware of the signs and symptoms of sexual assault (Dunleavy & Slowik, 2012; Esposito, 2006; Lessing, 2005; Mazza et al., 1996; Plumbo, 1995). Two articles indicated that the health-care provider should be alert to signs and symptoms of distress or anxiety during routine examinations, particularly those that can be considered invasive such as a Pap test (Dunleavy & Slowik, 2012; Esposito, 2006). Esposito (2006) further suggested that during routine examinations, the health-care provider should explain the procedure to the woman, be sensitive to any behaviors that indicate that she is feeling distress, and allow her to stop the examination if she appears to require a rest.

Create an environment to support disclosure. The importance of being able to speak with the survivor in a private, safe, and supportive environment and "not rushing" them was indicated by the authors of five articles as particularly important in assisting survivors to disclose (Diaz et al., 2004; Dunleavy & Slowik, 2012; Esposito, 2006; Lessing, 2005; Sturza & Campbell, 2005). Diaz et al. (2004) suggested that having the time to help the survivor feel comfortable and build trust with the provider may also encourage disclosure. In addition, Esposito (2006) recommended having brochures or other media in examination rooms outlining information about sexual assault and the local services available to survivors.

Use a patient-centered and culturally competent approach. Three articles recommended the use of a patient-centered and/or culturally competent approach when responding to delayed disclosure of sexual assault in health-care settings (Dunleavy & Slowik, 2012; Esposito, 2006; Long et al., 2007). Dunleavy and Slowik (2012) understood a patient-centered approach to include viewing the patient as an active participant in their own care with the health-care provider listening and learning from the patient about how their needs can best be met. Esposito (2006) further recommended that the health-care provider use a "culturally competent" approach when supporting a survivor after disclosure. Though not defined by Esposito, a culturally competent approach is described elsewhere as taking into account individual differences such as age, race, gender, socioeconomic status, and sexual orientation when discussing a traumatic event with a survivor (Roberts, Watlington, Nett, & Batten, 2010). A culturally competent health-care provider is sensitive to potential power differences between themselves and the survivor and shows a general level of sensitivity to diverse communities (Long et al., 2007; Roberts et al., 2010).

Enhance training. The authors of 11 articles suggested that formal support providers including health-care providers require (further) training on how to sensitively respond to disclosures of past sexual assault (Ahrens et al., 2007; Ahrens et al, 2010; Filipas & Ullman, 2001; Golding et al., 1989; Muganyizi et al., 2009; Muganyizi et al., 2011; Popiel & Susskind, 1985; Sturza & Campbell, 2005; Ullman, 1996a; Ullman & Filipas, 2001; Ullman & Siegel, 1995).

Ahrens, Stansell, and Jennings (2010) suggested that formal support providers including health-care providers require training focused on minimizing negative and increasing positive social reactions. Starzynski, Ullman, Filipas, and Townsend (2005) recommended that becoming aware of rape myths will help formal support providers including health-care providers move beyond the notion that the only "real" sexual assaults are those committed by strangers (Baker et al., 2012). Learning about the realities of sexual assault was also emphasized by Ullman and Filipas (2001) who suggested this may assist in reducing blaming responses. Finally, Golding et al. (1989) put forward that it may be useful for health-care providers to learn helping behaviors used by those with direct experience working with sexual assault survivors such as rape crisis workers.

Discussion

Although the research focused on delayed disclosure in health-care settings is sparse, the evidence thus far suggests that health-care providers respond both appropriately and inappropriately to survivors' disclosures of past sexual assault. There appears to be a general consensus about what constitutes an appropriate response to the delayed disclosure of sexual assault. Twelve of the 13 articles that included an examination of appropriate responses to delayed disclosure found the provision of emotional support to be helpful. The evidence for the provision of tangible aid/informational support (e.g., referrals) was slightly more nuanced, with one study indicating that tangible aid was not helpful in the absence of emotional support. Unhelpful responses were most commonly associated with health-care provider "unprofessionalism" (Muganyizi et al., 2011), with blaming the survivor most frequently cited.

Few articles examined delayed disclosure in health-care settings as their primary objective. Only 6 of the 23 articles focused exclusively on health-care settings (Diaz et al., 2004; Dunleavy & Slowik, 2012; Esposito, 2006; Lessing, 2005; Mazza et al., 1996; Plumbo, 1995) and named the practicing health-care provider (i.e., nurse, nurse-midwife, physician, physical therapist). Of these six articles, one was a literature review, one was a clinical practice, and two of the remaining four articles were studies with relatively small sample sizes. In the 17 articles that did not focus exclusively on health-care settings, 11 identified the health-care provider, whereas the remaining 6 employed general terms such as "medical personnel" and "medical staff" (Ahrens et al., 2009; Ahrens, et al., 2010; Littleton, 2010; Long, et al., 2007; Muganyizi et al., 2011; Ullman & Najdowski, 2009). Further, some studies collapsed health-care providers with other formal support providers, making it unclear if the results would have differed had these support providers been analyzed separately. For example, in one study that reported the proportion of survivors who disclosed to physicians, the remainder of the analyses considered physicians along with a number of other formal support providers as "other."

Future research in the area should include specific and detailed information about the recipients of a disclosure, including profession (e.g., family physicians) as it is possible that some health professions provide more helpful responses than others. It is also possible that certain responses may be considered helpful from one type of health-care provider, but not another. There is some basis for this, with Ahrens et al. (2009) finding that the same reaction may be viewed differently depending on who the support provider is (e.g., informal vs. formal, legal vs. medical). Additionally, little is known about the specific characteristics of survivors who have disclosed past sexual assault (e.g., race, sexual orientation, socioeconomic status, immigration status, lifestyle) and how these characteristics may impact the health-care providers' response.

The recommendation in four articles to inquire about sexual assault with every adolescent and adult woman as part of routine practice (Ahrens et al., 2007; Esposito, 2006; Diaz et al., 2004; Lessing, 2005) has also been made by Probst, Turchik, Zimak, and Huckins (2011). Although not much is known about the impact of routine screening for sexual assault, within the context of intimate partner violence, some research has shown there to be challenges and questionable benefit (Klevens et al., 2012; MacMillan et al., 2009; Wathen & MacMillan, 2012). This had led to some experts advising "a case-finding approach to partner violence identification" (Wathen & MacMillan, 2012, p. 712). Research focused on routine screening for sexual assault is required. Until we have such evidence, a similar case finding approach which prompts for disclosure in the presence of signs and symptoms of sexual assault, may be appropriate.

There are limitations that temper the strength of these findings. Of the 23 articles, the findings of 4 empirical studies appear to be based on data drawn from the same sample population (Ahrens et al., 2009, Ahrens et al., 2007, Ahrens et al., 2010; Sturza & Campbell, 2005). Similarly, three other studies appear to draw on the same data set (Ullman, 1996a, 1996b; Ullman & Siegel, 1995). This effectively limited the number of distinct women's perspectives included in this systematic review. To draw stronger conclusions about helpful and unhelpful responses to disclosure, research with more (and more diverse) groups of women is required. Finally, six studies that met inclusion criteria focused primarily on outcomes that were not associated with positive or negative responses from health-care providers (Golding et al., 1989; Long et al., 2007; Mazza et al., 1996; Starzynski et al., 2005; Ullman, 1996a; Ullman & Filipas, 2001).

The review itself may be limited by the search terms we used as well as the way in which the search terms were combined. In addition, we restricted our search to four databases,

which raises the possibility that articles not included in the chosen databases could have been missed. However, to assist with minimizing this risk, we searched the reference lists of key articles. We also included only scholarly articles published after 1985 and only those articles which were written in the English language. Finally, we included some studies that did not differentiate between those who disclosed sexual assault immediately and those who delayed disclosure.

Conclusion

Health-care providers are uniquely positioned to assist adolescent and adult women survivors of past sexual assault by providing relevant health care and acting as an important gateway to other support services. As inappropriate or negative responses such as blaming can lead to secondary victimization, it is important that health-care providers are able to respond to survivors appropriately by validating the disclosure and providing emotional support and tangible aid. There is strong agreement that to improve practice in this area, health-care providers need enhanced training on how to create an environment that supports disclosure, including use of a patient-centered and culturally competent approach and, further, recognition of indicators of sexual assault when disclosure is not forthcoming.

Implications for Practice, Policy, and Research

Practice

- Enhance training for health-care providers on (a) creating an environment that supports disclosure; (b) using a patient centered and culturally competent approach; and (c) recognizing indicators of past sexual assault.
- Respond to disclosures of past sexual assault with validation, emotional support, medical care, information, and referral.

Policy

- Include the care of sexual assault survivors in health-care professional practice guidelines.
- Develop policies to ensure that health-care settings are conducive to disclosure of sexual assault.

Research

- Examine how characteristics such as gender, race, sexual orientation, socioeconomic status, immigration status, lifestyle, and assault characteristics impact the responses the survivor receives upon disclosure to a health-care provider.
- Research routine screening for sexual assault to determine its impact on diverse survivors.

Acknowledgment

The authors gratefully acknowledge the support of medical librarian Mona Frantzke, BSc, MLSc, from the Health Sciences Library at Women's College Hospital.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Dr. Du Mont is supported in part by the Atkinson Foundation.

References

Ahrens, C. E., Cabral, G., & Abeling, S. (2009). Healing or hurtful: Sexual assault survivors' interpretations of social reactions from support providers. *Psychology of Women Quarterly*, *33*, 81–94.

Ahrens, C. E., Campbell, R., Ternier-Thames, N. K., Wasco, S., & Sefl, T. (2007). Deciding whom to tell: Expectations and outcomes of rape survivors' first disclosures. *Psychology of Women Quarterly*, *31*, 38–49.

Ahrens, C. E., Stansell, J., & Jennings, A. (2010). To tell or not to tell: The impact of disclosure on sexual assault survivors' recovery. *Violence and Victims*, *25*, 631–648.

Baker, L. L., Campbell, M., & Straatman, A. L. (2012). *Overcoming barriers and enhancing supportive responses: The research on sexual violence against women*. Centre for Research & Education on Violence Against Women and Children, Western University. Retrieved from http://www.vawlearningnetwork.ca/sites/learningtoendabuse.ca.vawlearningnetwork/files/LN_Overcoming_Barriers_FINAL.pdf

Borja, S. E., Callahan, J. L., & Long, P. J. (2006). Positive and negative adjustment and social support of sexual assault survivors. *Journal of Traumatic Stress*, *19*, 905–914.

Cahill, A. (2009). Sexual violence and objectification. In R. J. Herbele & V. Grace (Eds.), *Theorizing sexual violence* (pp. 14–30). New York, NY: Routledge.

Diaz, A., Edwards, S., Neal, W. P., Ludmer, P., Sondike, S. B., Kessler, C., . . . Nucci, A. T. (2004). Obtaining a history of sexual victimization from adolescent females seeking routine health care. *The Mount Sinai Journal of Medicine*, *71*, 170–173.

Du Mont, J., Macdonald, S., White, M., & Turner, L. (2013). Male victims of adult sexual assault: A descriptive study of survivors' use of sexual assault treatment services. *Journal of Interpersonal Violence*, *28*, 2676–2694.

Du Mont, J., Macdonald, S., White, M., Turner, L., White, D., Kaplan, S., & Smith, T. (2014). Client satisfaction with nursing-led sexual assault and domestic violence services in Ontario. *Journal of Forensic Nursing*, *10*, 122–124.

Du Mont, J., & White, D. (2007). *The uses and impacts of medico-legal evidence in sexual assault cases: A global review*. Geneva, Switzerland: World Health Organization. Retrieved from: http://www.svri.org/medico.pdf

Dunleavy, K., & Slowik, A. K. (2012). Emergence of delayed post-traumatic stress disorder symptoms related to sexual trauma:

Patient-centered and trauma-cognizant management by physical therapists. *Physical Therapy Journal*, *92*, 339–351.

Esposito, N. (2006). Women with a history of sexual assault: Health care visits can be reminders of a sexual assault. *American Journal of Nursing*, *106*, 69–73.

Filipas, H. H., & Ullman, S. E. (2001). Social reactions to sexual assault victims from various support sources. *Violence and Victims*, *16*, 673–692.

Golding, J. M., Siegel, J. M., Sorenson, S. B., Burnam, M. A., & Stein, J. A. (1989). Social support sources following sexual assault. *Journal of Community Psychology*, *17*, 92–107.

Klevens, J., Kee, R., Trick, W., Garcia, D., Angulo, F. R., Jones, R., & Sadowski, L. S. (2012). Effect of screening for partner violence on women's quality of life: A randomized controlled trial. *The Journal of the American Medical Association*, *308*, 681–689.

Lessing, J. E. (2005). Primary care provider interventions for the delayed disclosure of adolescent sexual assault. *Journal of Pediatric Health Care*, *19*, 17–24.

Littleton, H. L. (2010). The impact of social support and negative disclosure reactions on sexual assault victims: A cross-sectional and longitudinal investigation. *Journal of Trauma & Disassociation*, *11*, 210–227.

Long, S. M., Ullman, S. E., Long, L. M., Mason, G. E., & Starzynski, L. L. (2007). Women's experiences of male-perpetrated sexual assault by sexual orientation. *Violence and Victims*, *22*, 684–701.

MacMillan, H. L., Wathen, C. N., Jamieson, E., Boyle, M. H., Shannon, H. S., Ford-Gilboe, M. F., ... McNutt, L. A. (2009). Screening for intimate partner violence in health care settings: A randomized trial. *The Journal of the American Medical Association*, *302*, 493–501.

Mazza, D., Dennerstein, L., & Ryan, V. (1996). Physical, sexual and emotional violence against women: A general practice-based prevalence study. *The Medical Journal of Australia*, *164*, 14–17.

McDonald, S., & Tijerino, A. (2013). *Male survivors of sexual abuse and assault: Their experiences*. Research and Statistics Division, Department of Justice Canada. Retrieved from http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rr13_8/rr13_8.pdf

Monroe, L. M., Kinney, L. M., Weist, M. D., Dafeamekpor, D. S., Dantzler, J., & Reynolds, M. W. (2005). The experience of sexual assault: Findings from a statewide victim needs assessment. *Journal of Interpersonal Violence*, *20*, 767–776.

Muganyizi, P. S., Hogan, N., Emmelin, M., Lindmark, G., Massawe, S., Nystrom, L., & Axemo, P. (2009). Social reactions to rape: Experiences and perceptions of women rape survivors and their potential support providers in Dar es Salaam, Tanzania. *Violence and Victims*, *24*, 607–626.

Muganyizi, P. S., Nystrom, L., Axemo, P., & Emmelin, M. (2011). Managing in the contemporary world: Rape victims and supporters experiences of barriers within the police and the health care system in Tanzania. *Journal of Interpersonal Violence*, *26*, 3187–3209.

Neville, H. A., & Pugh, A. O. (1997). General and culture specific factors influencing African American women's reporting patterns and perceived social support following sexual assault: An exploratory investigation. *Violence Against Women*, *3*, 361–381.

Plumbo, M. A. (1995). Delayed reporting of sexual assault: Implications for counseling. *Journal of Nurse-Midwifery*, *40*, 424–427.

Popiel, D. A., & Susskind, E. C. (1985). The impact of rape: Social support as a moderator of stress. *American Journal of Community Psychology*, *13*, 645–676.

Probst, D. R., Turchik, J. A., Zimak, E. H., & Huckins, J. L. (2011). Assessment of sexual assault in clinical practice: Available screening tools for use with different adult populations. *Journal of Aggression, Maltreatment & Trauma*, *20*, 199–226.

Resnick, H. S., Holmes, M. M., Kilpatrick, D. G., Clum, G., Acierno, R., Best, C. L., & Saunders, B. E. (2000). Predictors of post-rape medical care in a national sample of women. *American Journal of Preventive Medicine*, *19*, 214–219.

Roberts, S. T., Watlington, C. G., Nett, S. D., & Batten, S. V. (2010). Sexual trauma disclosure in clinical settings: Addressing diversity. *Journal of Trauma & Disassociation*, *11*, 244–259.

Starzynski, L. L., Ullman, S. E., Filipas, H. H., & Townsend, S. M. (2005). Correlates of women's sexual assault disclosure to informal and formal support sources. *Violence and Victims*, *20*, 417–432.

Statistics Canada. (1994). *Violence against women survey, 1993* [public use microdata file]. Ottawa, Ontario: Statistics Canada.

Sturza, M. L., & Campbell, R. (2005). An exploratory study of rape survivors' prescription drug use as a means of coping with sexual assault. *Psychology of Women Quarterly*, *29*, 353–363.

Truman, J., Langton, L., & Planty, M. (2013). *Criminal victimization, 2012*. U.S. Department of Justice. Retrieved from http://www.bjs.gov/content/pub/pdf/cv12.pdf

Ullman, S. E. (1996a). Correlates and consequences of adult sexual assault disclosure. *Journal of Interpersonal Violence*, *11*, 554–571.

Ullman, S. E. (1996b). Do social reactions to sexual assault victims vary by support provider? *Violence and Victims*, *11*, 143–157.

Ullman, S. E. (1996c). Social reactions, coping strategies and self-blame attributions in adjustment to sexual assault. *Psychology of Women Quarterly*, *20*, 505–526.

Ullman, S. E. (2000). Psychometric characteristics of the social reactions questionnaire: A measure of reaction to sexual assault victims. *Psychology of Women Quarterly*, *24*, 257–271.

Ullman, S. E., & Brecklin, L. R. (2003). Sexual assault history and health-related outcomes in a national sample of women. *Psychology of Women Quarterly*, *27*, 46–57.

Ullman, S. E., & Filipas, H. H. (2001). Correlates of formal and informal support seeking in sexual assault victims. *Journal of Interpersonal Violence*, *16*, 1028–1047.

Ullman, S. E., & Najdowski, C. J. (2009). Correlates of serious suicidal ideation and attempts in female adult sexual assault survivors. *Suicide and Life-Threatening Behavior*, *39*, 47–57.

Ullman, S. E., & Siegel, J. M. (1995). Sexual assault, social reactions and physical health. *Women's Health: Research on Gender, Behavior, and Policy*, *1*, 289–308.

Wathen, C. N., & MacMillan, H. L. (2012). Health care's response to women exposed to partner violence: Moving beyond universal screening. *The Journal of the American Medical Association*, *308*, 712–713.

Wathen, N. (2012). *Health impacts of violent victimization on women and their children*. Department of Justice Canada. Retrieved from http://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/rr12_12/rr12_12.pdf

World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Retrieved from http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf?ua=1

Zinzow, H., Resnick, H., Barr, S., Danielson, C., & Kilpatrick, D. (2012). Receipt of post-rape medical care in a national sample of female victims. *American Journal of Preventive Medicine*, *43*, 183–187.

Author Biographies

Stephanie Lanthier is a PhD candidate in Social/Behavioral Health Sciences at the Dalla Lana School of Public Health, University of Toronto and a trainee in the Violence and Health Research Program at Women's College Research Institute.

Janice Du Mont is an applied psychologist and a scientist in the Violence and Health Research Program at Women's College Research Institute. She is also an associate professor at the Dalla Lana School of Public Health at the University of Toronto. She examines the impact of gender-based violence on women's health, with a particular focus on the medical and legal responses to sexual assault.

Robin Mason is a scientist in the Violence and Health Research Program at Women's College Research Institute and an assistant professor in the Dalla Lana School of Public Health and the Department of Psychiatry at the University of Toronto. In addition, she is the scientific lead of Women's Xchange, a women's health knowledge translation and exchange center at Women's College Hospital designed to promote the development of women's health research across the province.